Recent decades have witnessed an unprecedented increase in the popularity of the self-esteem construct. Public health professionals and sexuality educators have touted children and adolescents’ positive self-esteem as a vital protective factor for various risk behaviors. Despite such widespread recognition, evidence in support of self-esteem as a protective factor is inconclusive, and within academic circles considerable debate and lack of consensus envelop the construct. Questions linger regarding dimensions of self-esteem, the trait’s stability, its operationalization, measurement and its applicability in health promotion. The rationale for conducting this review, therefore, stems from the contrast between self-esteem’s extreme popularity within mainstream American culture and prevalent academic debates coupled with ambiguous research findings supporting its role in adolescents’ sexual health.

This review systematically examines the relationship between self-esteem and a variety of adolescents’ sexual be-
behaviors, attitudes, and intentions, as empirically investigated and reported by researchers in various fields. The review specifically answers the following questions: within the research literature of the past two decades, (a) is self-esteem associated with adolescents’ sexual behaviors, attitudes, and intentions? (b) if related, what is the nature of the association (i.e., is self-esteem a protective or a risk factor)? (c) what are the methodological characteristics of this literature? and (d) do studies’ methodological characteristics moderate findings?

Self-Esteem’s Popularity

Because the notion that positive self-esteem might be health-promoting is intuitively appealing, and research evidence is available supporting associations between self-esteem and various outcomes, some scholars have claimed that “...self-esteem has been related to almost everything at one time or another” [1] (p. 22). For instance, researchers have demonstrated the impact of self-esteem on human cognition, emotion, motivation [2], competition, conformity, attraction, causal attribution, achievement, helping and coping behaviors [2], personal satisfaction, effective functioning [3], social relationships, academic achievement, alcohol and drug abuse, juvenile delinquency, suicide, loneliness, depression, social anxiety, alienation [4,5], and a host of sexuality-related factors such as early sexual initiation, risky sexual behavior, unplanned pregnancies and sexually transmitted infections [6–10].

Albeit the nature of self-esteem’s impact on these outcomes is largely unclear [1], enhancing adolescents’ self-esteem as a means of fostering academic success, moral behavior and healthy decision-making has been a trend consistently supported by state legislators, school administrators, health promotion curricula publishers, and deliverers of social, educational and health programs in America. The trend is evident, for instance, in publications such as the state-commissioned California Task Force to Promote Self-Esteem and Personal and Social Responsibility [11]; in the guide for parents, schools, and communities published by the American Association of School Administrators to help “...create a climate in which students can learn to like themselves, and to succeed” [12] (p. 2), and within propositions of the Character Education movement in U.S. public schools, claiming self-esteem is a precondition for moral action and moral behavior contributes to positive self-esteem [13,14].

Likewise, health education tools and interventions have intensively focused on self-esteem as a pivotal factor, affecting individuals’ risk-avoiding and preventive behaviors, particularly those of children and adolescents [10,15,16]. Sexuality education efforts, especially, have placed concerted emphasis on improving youth’s self-esteem as a means of promoting healthy decision-making and avoiding negative consequences of sexual behavior [17,18]. Comprehensive and abstinence-only approaches to sexuality education (antagonistic philosophical frameworks regarding school-based sexuality education [19]) have equally stressed the value of high (or positive) self-esteem in developing sexually healthy adolescents. A former president of the Sexuality Information and Education Council of the United States affirmed that, among the four primary goals of comprehensive sex education programs, is “to give [young people] an opportunity to develop their values and increase self-esteem” [20] (p. 9). An evaluation of 16 abstinence-only-until-marriage programs funded by Title V monies in Texas revealed that 93% alluded to self-esteem as the most important intra-personal “target” of their programmatic activities [21].

Sexuality education materials also reflect the trend of valuing self-esteem. An assessment of school-based comprehensive sexuality education curricula diagnosed that 12 of the 23 curricula reviewed (52.2%) included components aimed at increasing self-awareness or building self-esteem [22]. Similarly, a review of 21 school-based curricula for abstinence-only-until-marriage programs identified 13 curricula (62%) that covered self-esteem extensively [23].

The Academic Debates Regarding Self-Esteem

Spanning more than a century of social-psychological studies, various theoretical perspectives—psychoanalytical theory, existentialism, symbolic interactionism, self-consistency theory, self-identity theory, and self-esteem theories—have described self-esteem’s origins and development [5,24]. Stemming from studies of the “self,” and fitting within the general framework of attitude research [3], definitions of self-esteem vary but are anchored in the notion that self-esteem is a central dimension of self-concept [2]. Broadly defined, self-concept is “the totality of an individual’s thoughts and feelings having reference to himself [sic] as an object” [1] (p. 3). Specifically, self-esteem refers to

...the evaluation which the individual makes and customarily maintains with regard to himself [sic]: it expresses an attitude of approval or disapproval, and indicates the extent to which the individual believes himself to be capable, significant, successful, and worthy [3] (pp. 4–5).

Because self-esteem constitutes a central dimension of self-concept, both constructs are often used interchangeably and receive a variety of labels: self-evaluation, self-respect, self-confidence, self-attitude, self-image, self-view, self-schema, self-worth, self-approval, and self-satisfaction, among a few [1–4,25,26].

Considerable variability exists, also, in characterizing self-esteem as comprising a single, dual, or triple dimension structure. For some, self-esteem is formed exclusively by the dimension of feelings or emotions associated with an individual’s evaluations of him/herself [2]. Other scholars propose—similar to the dual structure of attitudes—that
self-esteem consists of both cognitive and emotional dimensions [3,25] and yet others propose a triadic structure for the construct: beliefs about the self as they relate to competence and ability, valence associated with these beliefs, and attributions of value or worthiness according to some pre-established social standard [10].

Even though researchers do not agree on the number of dimensions self-esteem may, theoretically, exhibit, most concur it possesses an uncontestable social aspect. But the role of this social element in forming and developing the concept is intensely disputed. Essentialist viewpoints of the self and self-esteem (found within psychology and clinical studies) postulate that self-esteem is undoubtedly a product of social interactions, as it is shaped and influenced by the constant assessments an individual makes of him/herself against a set of (usually socially established) standards. Conversely, post-modernist perspectives (found within sociology and anthropology) emphasize self-esteem as fundamentally determined by relations of power within societal groups, with very little individual choice or agency over such determination [1,24,27].

Compounding discussions regarding self-esteem’s dimensions and degree of social determination is the debate surrounding self-esteem’s object. Another characteristic it shares with attitudes is that self-esteem can be directed toward an object as a whole (attitude toward the self as a whole is termed global or general self-esteem) and toward specific “facets” or dimensions of that object (attitude toward one aspect or “piece” of the self is termed facet-specific, or specific, self-esteem) [25]. Whereas global self-esteem relates to issues of general self-worth (e.g., “On the whole, I’m satisfied with myself” [26], specific self-esteem relates to individual behaviors (e.g., academic self-esteem, which assesses a students’ views of him/herself regarding academic performance) [25]. Most reviews of research on self-esteem have indicated that global self-esteem is the most prevalent form of self-esteem studied [25].

Although the assumption underlying most interventions designed to improve self-esteem is that the construct is changeable, this issue, too, is under dispute [1,10,28]. Most concur that self-esteem shows more significant “disturbances” or changes in adolescence, while becoming more stable later in life [1]. However, there is debate whether self-esteem should be regarded (and measured) as a stable trait or variable state [29], whether facet-specific self-esteem might be more malleable than global self-esteem, whether extremely low levels of self-esteem are at all changeable through interventions, and whether there are specific risks associated with “boosting” already high levels of self-esteem [2,5,30,31].

Although fascinating from a theoretical perspective, the controversies briefly outlined above have grave implications for research. Variability regarding definitions, dimensions, object and stability translates into numerous available measures for self-esteem and into data not easily comparable.

Publications from the early 1980s acknowledge the use of 200 instruments for measuring self-esteem [27]. Although only a few of these instruments have dominated the field [3,26] it is important to note that most of these assess global self-esteem and are self-reported measures. These limitations, coupled with a consistent lack of testing newly collected data for its validity and reliability [32], and the common absence of effect-size data (allowing for meta-analyses across research findings) [33], paint a “fuzzy” picture regarding the “cumulative and valid knowledge in this area” [1] (p. 26). The systematic review presented here, therefore, contributes toward clarifying this picture, as it presents both the cumulative findings and the quality of research regarding the relationship between self-esteem and adolescent sexual behaviors, attitudes, and intentions documented in the social-scientific literature within the past two decades.

**Methods**

Following the procedures outlined in the Matrix Method for conducting systematic literature reviews [34], we searched five electronic databases (ERIC, MEDLINE, PsycINFO, Sociological Abstracts, Academic Search Premier) using variations and Boolean connections of the key terms self-esteem, sexual behavior, attitudes, beliefs, and adolescents. We also searched reference lists of reviewed studies for additional publications. For inclusion in the review, studies had to: (a) be published in a peer-reviewed, English language journal; (b) empirically examine the relationship between self-esteem and adolescents’ sexual behaviors, attitudes, or intentions; (c) be published between January 1980 and December 2004; and (d) focus on primary and secondary school-aged adolescents (youth between 11 and 18 years of age). Studies were excluded if they examined self-esteem but did not explore the association among self-esteem and adolescents’ sexual behaviors/attitudes/intentions (e.g., if program evaluations conducted pre- and post-intervention tests to assess changes in self-esteem). Also excluded were empirical studies involving college students, and theoretical or commentary pieces. Thirty-eight (n = 38) publications met these criteria and comprised the final sample [35–72].

Using an abstraction form, we systematically recorded several of the reports’ conceptual and methodological characteristics. Assessment of methodological characteristics led reviewers to assign an overall methodological quality score (MQS) to each study [73]. The highest possible MQS was 20. Table 1 presents the criteria used to judge each study’s methodological quality, alongside the range of possible scores. Data from each study were abstracted twice and inter-rater reliability scores were calculated for each pair of abstractions. The average inter-rater reliability across all studies was 0.84 (Cohen’s kappa; range: 0.43 to 1.00 with 89% of scores ranging from 0.71 to 1.0).

Each study’s test of the relationship between self-esteem
and a behavior/attitude/intention variable was examined and counted, in this review, as a separate finding. Similar to meta-analytical procedures, this review defined a finding as a “statistical representation of one empirical relationship involving the variable(s) of interest . . . measured on a single . . . sample” [33] (p. 35). A single reviewed study could, thus, contribute multiple findings to the review. Furthermore, when unadjusted and controlled analyses were reported in the same study, only findings from the controlled analyses were counted (based on the assumption that these yield better estimates of population parameters).

We classified and coded each finding according to: (a) which category it related to (behavioral, intention, or attitudinal) and (b) the nature of the relationship between self-esteem and the category/variable being tested. Findings were classified as exhibiting an inverse linear relationship, no statistically significant relationship, or a positive relationship. A positive relationship meant that high self-esteem was a protective factor. Only for contraception/condom use and for intention to use contraception did an inverse relationship signify a risk factor (i.e., increased self-esteem associated with nonuse of contraceptive methods).

### Results

#### Studies’ characteristics

Of the 38 reviewed studies, twice as many were published in the last decade (n = 26) than between 1983 and 1993 (n = 12). Twenty-nine journals, representing assorted disciplinary fields, published studies on self-esteem and adolescent sexuality. Nearly half the studies (n = 16) were found in health promotion, medical or nursing research journals. Ten reports were published in adolescent-specific journals (such as Adolescence and Journal of Adolescent Health). Five were published in psychology journals, and two were identified in sexuality journals.
Three studies [41,51,52] examined self-esteem as a peripheral (or control) variable. In the other 35 studies, self-esteem was the primary variable of interest. Despite the centrality of the construct, however, only 12 articles presented a conceptual definition of self-esteem [35,44,55,57–59,62,63,65,66,68,69] and fewer than half (47%) reported use of a theoretical framework to guide the inquiry. When the research was theory based, the most commonly employed perspective was Problem Behavior Theory [38,39–42,47,48,51,52,64,71,74]. Other theories cited in more than one study were Social Cognitive Theory [40,42,48,75] and Theory of Planned Behavior [40,42,48,75].

Studies’ methodological quality

We assigned each study a methodological quality score (MQS), representing a composite of individual elements for rating each study’s quality (Table 1). Values for the MQS ranged from 5 to 15 points (maximum possible = 20). The mean, median and mode values for the distribution of MQSs were nearly identical (mean = 11.71, SD = 1.60, median = 11.0 and mode = 11.0).

Table 1 presents frequency distributions for each element of the MQS. Although none of the reviewed studies employed a qualitative research paradigm, one used a mixed-methods approach (quantitative and qualitative) [63]. All others followed a quantitative paradigm with cross-sectional designs featured most frequently. Eight studies employed a longitudinal design [38,39,41,44,55,58,67,69].

Most inquiries (76%) used large samples (>300 respondents), but the majority of these (66%) were convenience/nonprobability samples. Five studies had samples that were both randomly selected and nationally representative [40,47,51,53,69]. Samples from 16 studies (42%) consisted mostly of Anglo/white respondents (>60% of each sample). Seven studies (18%) focused on international samples (Australia, New Zealand, Europe and Africa) [36,41,44,47,57,68,70]. Four reports employed predominantly African-American samples (>80% of samples) [58,61,63,64] and two studies had mainly Hispanic participants (>90% of samples) [45,50]. Six studies used female-only samples [46,52,57,58,61,63].

The preferred method for data collection was self-administered surveys (given in groups or classrooms in 28 studies). Six inquiries utilized interviewing [47,51–53,61,64] whereas the remainder employed either computer/telephone-assisted interviews [40,41] or self-administered (in classrooms) and mailed surveys combined [37].

Operationally, the majority of studies utilized global measures of self-esteem (66%); one-third (34%) employed facet-specific measures. Facet-specific measures included home, school, and peer self-esteem [35,62,70,72], academic self-esteem [44,65], physical and emotional self-esteem [47], self-mastery, power and trust-worthiness [48,67], popular, conventional and deviant schemas [55], self-identity and ethnic identity [57,63], self-concept (in four dimensions: behavioral, intellectual/school status, happiness/satisfaction, and popularity) [63,64], self-esteem regarding relationships with same-sex and opposite-sex peers [68], and peer, school, family, sports and body image self-esteem [70]. Nearly half of the reports (n = 18) utilized Rosenberg’s 10-item scale measuring global self-esteem [26]. Other measures used by more than one study included Hare’s Self-Esteem Scale [77,78], Piers-Harris Self-Concept Scale [79] (each reported in 3 studies, respectively), and the Coopersmith Inventory (reported in two studies) [3].

Testing of individual studies’ data for validity and reliability was infrequently reported. Regarding the self-esteem variable, 18% of studies reported tests of validity and 40% reported reliability testing of their own data. Similarly, 21% of studies reported validity or reliability testing of data for the behavior/attitude/intention variables. The most common practice was to cite published validation studies of the measures.

Most researchers utilized multiple or logistic regression techniques to analyze their data (76%). Nearly one-fifth (18%) of the studies utilized bivariate methods (correlations or analysis of variance) and two studies reported use of multivariate analytical techniques (structural equation modeling and event history analysis) [47,51].

A final criterion this review employed to ascertain studies’ methodological quality was author’s inappropriate inference of causality. Given many of the studies’ sample and design limitations, reviewers were interested in capturing researchers’ care in admitting limitations and their study’s inability to establish cause-effect relationships. Among the reviewed studies, 79% accurately reported limitations of their findings, whereas 21% inappropriately implied that self-esteem caused selected outcomes.

Studies’ findings

The 38 reviewed studies contained a total of 189 findings (average = 4.97/study, range 1–28). The majority (86%) reflected tests of self-esteem as an independent or predictor variable; 14% tested self-esteem as a dependent variable (most commonly in ANOVA-type analyses).

Most findings (n = 138, 73%) consisted of tests of self-esteem and sexual behaviors (Table 2). The most frequently examined behavior was “ever had sex” (tested in 52 findings), followed by “sexual activity” (n = 17) and “risky sexual behavior” (n = 17) (the category ‘sexual activity’ applied to studies using a composite measure of sexual behavior, usually an index of various activities such as sexual debut, birth control use and history of STIs). The variables “number of sexual partners” and “frequency of sexual intercourse” were classified as behaviors because their small numbers did not warrant the creation of a separate category). Additional behaviors are listed in Table 2. Twenty-one percent (n = 39) of findings comprised tests of
association between self-esteem and sexual attitudes. Two categories of attitudes were tested: attitudes toward sex (29 findings) and attitudes accepting of premarital sex (10 findings). Only 12 findings (6%) related to intentions. Most intentions were timing variations of ‘intention to have sex’, and the most commonly examined time-frame was intention to have sex before marriage (four findings) (Table 2).

Regarding the nature of the relationship between self-esteem and the various behavior/attitude/intention variables, 60% of the findings yielded no statistically significant association, 26% indicated an inverse relationship, and 14% rendered a positive association (Tables 2 and 3). When examining the nature of these relationships by specific categories, a similar pattern emerged: 62% of behavior findings and 72% of the attitudinal findings exhibited no statistically significant association. All of the intention-related findings exhibited some type of relationship (either positive or inverse) (Table 2).

Among the 32 studies investigating mixed-gender samples (six had female-only samples), 19 contained no gender-specific empirical tests. Among the 13 studies that did analyze gender differences, a larger number of empirical tests for females exhibited inverse or protective findings (27.3%) when compared with number of protective findings encountered for males (6.9% of findings). This difference, however, was not statistically significant (Pearson chi-squared = 7.325, df = 4, p = .120).

Studies’ methodological quality scores (MQSs) correlated significantly with the nature of findings (Cramer’s V = .329, p = .001). Higher quality studies were associated with findings of no relationship and with findings of positive relationships. Findings exhibiting an inverse association between self-esteem and sexual behaviors/attitudes/intentions originated from studies with average MQSs of 11.27 (SD 1.35; 95% CI 10.88–11.65). Findings of no statistically significant relationship came from studies with an average MQS of 11.71 (SD 1.60; 95% CI 11.48–11.94).

Table 2
Percentage distribution of reviewed studies’ findings—related to the association between self-esteem and adolescents’ sexual behaviors, attitudes and intentions—according to the nature of the finding

<table>
<thead>
<tr>
<th>Finding: relationship between self-esteem and</th>
<th>Nature of finding/relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>...</td>
<td>Positive n (%)</td>
</tr>
<tr>
<td>Sexual behaviors</td>
<td>19 (14%)</td>
</tr>
<tr>
<td>Ever had sex</td>
<td>7</td>
</tr>
<tr>
<td>Sexual activity (index)</td>
<td>4</td>
</tr>
<tr>
<td>Risky sexual behavior</td>
<td>3</td>
</tr>
<tr>
<td>Contraception/condom use</td>
<td>3</td>
</tr>
<tr>
<td>Had sex in previous month/year</td>
<td>1</td>
</tr>
<tr>
<td>Early sexual debut</td>
<td>1</td>
</tr>
<tr>
<td>Becoming pregnant</td>
<td>0</td>
</tr>
<tr>
<td>Fathering a child</td>
<td>0</td>
</tr>
<tr>
<td>Contracting an STI</td>
<td>0</td>
</tr>
<tr>
<td>Number of sexual partners</td>
<td>0</td>
</tr>
<tr>
<td>Frequency of sexual intercourse</td>
<td>0</td>
</tr>
<tr>
<td>Non-compliance with oral contraceptive use</td>
<td>0</td>
</tr>
<tr>
<td>Sexual attitudes</td>
<td>3 (8%)</td>
</tr>
<tr>
<td>Attitudes toward sex</td>
<td>3</td>
</tr>
<tr>
<td>Attitudes accepting of premarital sex</td>
<td>0</td>
</tr>
<tr>
<td>Sexual intentions</td>
<td>5 (42%)</td>
</tr>
<tr>
<td>Intention to have sex before marriage</td>
<td>2</td>
</tr>
<tr>
<td>Intention to have sex in the next year</td>
<td>1</td>
</tr>
<tr>
<td>Intention to have sex before graduation</td>
<td>1</td>
</tr>
<tr>
<td>Intention to use contraception</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>27 (14%)</td>
</tr>
</tbody>
</table>

Table 3
One-way ANOVA of reviewed studies’ mean methodological quality scores by nature of relationship between self-esteem and adolescents’ sexual behavior, attitudes and intentions

<table>
<thead>
<tr>
<th>Nature of statistical relationship</th>
<th>N (% of total)</th>
<th>Mean (SD)</th>
<th>95% CI</th>
<th>F</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inverse relationship</td>
<td>49 (26%)</td>
<td>11.27 (1.35)*</td>
<td>10.88–11.65</td>
<td>4.647</td>
<td>.011</td>
</tr>
<tr>
<td>No relationship</td>
<td>113 (60%)</td>
<td>11.73 (1.71)</td>
<td>11.42–12.05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive relationship</td>
<td>27 (14%)</td>
<td>12.41 (1.27)*</td>
<td>11.90–12.91</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>189 (100%)</td>
<td>11.71 (1.60)</td>
<td>11.48–11.94</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Indicates the groups that differed significantly in post hoc analyses (Tukey’s HSD).
MQS of 11.73 (SD 1.71, 95% CI 11.42–12.05) and findings of positive relationships, from studies with the highest average MQS (12.41, SD = 1.27, 95% CI = 11.90–12.91) (Table 3).

When specific components of the total MQS were examined individually, we found statistically significant associations between the nature of findings and both use of a theoretical framework (Cramer’s V = .211, p = .015), and statistical technique employed Cramer’s V = .215, p = .002). The relationships were positive, indicating that the use of a theoretical framework and more complex analytical techniques correlated with absence of, or with positive (risk-factor) relationships between self-esteem and dependent variables. There was no association between use of a global or facet-specific measure of self-esteem and type of finding (Cramer’s V = .134, p = .182). The distribution of findings indicates, nonetheless, that a higher number of nonsignificant findings (65.1%) were obtained with global measures of self-esteem than with facet-specific measures (55.7%).

**Discussion**

This review contributes to the adolescent health literature in two ways. First, despite the usefulness of systematic reviews and the availability of several publications reviewing the impact of self-esteem on various outcomes (including sexual behavior), to date none have focused on adolescent sexuality nor have any reviewed this body of literature systematically. Second, our review critically assesses this literature’s overall methodological quality and, in evaluating the relationship between quality and findings, offers an analytical dimension absent from nonsystematic reviews. This dimension allows a more legitimate critique of the research’s internal validity and implications for practice.

The review suffers, nonetheless, from particular limitations. The search strategies employed, for instance, may have led us to miss specific reports, especially those neither indexed in the databases nor cited in reviewed articles. Moreover, the instrument used to rate each study’s methodological quality was not tested for validity, though the data it generated were assessed for inter-rater reliability and found adequate. As the MQS favors longitudinal and mixed-method designs, large probability samples, and validity and reliability reporting, these criteria may have been inappropriately stringent for the type of research considered feasible with school-aged populations. The MQS’ bias toward rigor, therefore, may have tainted our findings and conclusions in a more conservative direction.

Despite limitations, however, our main finding—that 60% of empirical tests of the relationship between self-esteem and adolescents’ sexual behavior/attitudes/intentions show no statistically significant associations—echoes those from other reviews. In 2003, a synthesis of literature focusing on self-esteem and numerous outcomes (health, sexual behavior, financial status, grades, intelligence, job performance, job satisfaction, and interpersonal relations) concluded that self-esteem does not have the protective effect touted by health promotion professionals. Instead, high self-esteem may promote experimentation in the case of sexual activity or drinking, while its general protective effects are “negligible” [80] (p. 01). A similar review examined whether low self-esteem led to various types of violence and aggression, and found no evidence supporting a causal relationship. In contrast, researchers concluded that violence may, in fact, result from threatened egotism, or “highly favorable views of the self that are disputed by some person or circumstance” [81] (p. 26).

This review also concurs with the literature regarding the quality of published research in general, and the absence of statistically significant findings in better quality studies, in particular. Many reviewers consistently affirm that studies of the impact of self-esteem suffer from uneven methodological quality and lack of conceptual or measurement specificity [29,80]. The average MQS for our reviewed studies supports this assertion: the mean 11.71 was slightly above the MQS scale’s mid-point of 10, suggesting that, on average, studies of the relationship between self-esteem and adolescent sexual behaviors/attitudes/intentions have substantial room for improvement. Additionally, we found better-quality studies tended to yield either positive (self-esteem as a risk-factor), or no associations between self-esteem and the outcomes reviewed, further supporting the hypothesis of absence of relationships among better quality studies [27].

Given the room for improvement in this body of research, one development deserving consideration is operationalization and measurement of the self-esteem construct. Most of the reviewed studies employed global measures of self-esteem to assess its relationship with sexual behaviors, even though facet-specific measures are better predictors of behaviors than global ones [25]. Could this measurement-related incongruence account for the large number of nonassociations detected in this review? Additional studies using facet-specific measures of self-esteem as they relate to adolescent sexual behaviors are needed to compensate for such weakness in the research literature and to test this hypothesis [29,82].

Another area for improvement in this literature regards directionality of hypothesized relationships. The majority of reviewed studies focused on self-esteem as a determinant or causal factor; rarely was self-esteem examined as an outcome. If stronger statistical associations are often observed when self-esteem is tested as the outcome variable—as seems to be the case within the academic performance literature [25,80]—further inquiry should examine whether “a person’s level of self-esteem may be the result rather than the cause of sexual activity” [80] (p. 32), [83].

Research on self-esteem and adolescent sexuality might benefit, furthermore, from questioning (and testing) the lin-
earity assumption relating self-esteem to specific outcomes. Many scholars suggest that outside the limits of a certain range of self-esteem scores, self-esteem becomes a risk factor [30]. This suggestion points to a strong possibility that the relationship between self-esteem and certain outcomes may, in fact, be nonlinear. Albeit the studies in our review employed, in large numbers, robust statistical analyses, none employed quadratic regression models or other types of nonlinear assessments. Future tests of nonlinearity may help clarify the true nature of the relationship between self-esteem and specific outcomes.

Finally, this review raises the question of why—given such lack of supporting evidence—do health promotion and educational programs continue to target self-esteem enhancement as a means to promote healthy decision-making and behavior. Given the absence of empirical data on this issue, perhaps a more fruitful and pressing matter is, instead, whether practitioners’ emphasis on self-esteem could be dismissed as innocuous. In other words, is there a problem with health promotion and educational practice continuing to emphasize the improvement of self-esteem?

Although many researchers and practitioners think Americans suffer from an epidemic of low self-esteem, it appears that self-esteem improvement and maintenance may be costly for both individuals and society. Crocker’s research suggests, for instance, that people engaged in pursuing self-esteem assume a psychologically defensive posture, and avoid or dismiss information about their weaknesses, shortcomings, and failures. This dismissal of information, in turn, deprives them of valuable opportunities for learning and personal growth. Moreover, “the degree of self-focus required by the pursuit of self-esteem is incompatible with awareness and responsiveness to others’ needs,” and often is achieved at the expense of other people’s own self-worth (as when needing to feel “smart,” one also needs to feel “smarter than” others) [84] (p. 599). Other researchers have documented that narcissistic entitlement (i.e., a grandiose and inflated sense of self) is a significant predictor of unforgiveness [85]. Arguing that the ability to forgive is a key element for restoring and repairing damages caused by inter-personal conflict, Exline and colleagues convincingly claim that the ability to forgive is vital for the promotion of individuals’ physical and mental health, as well as for the preservation of social harmony [85]. Ironically, programs that emphasize enhancing children and adolescents’ self-esteem may be reinforcing individualistic and egotistical normative patterns of behavior that contribute to the weakening of inter-personal connectedness and, thus, generate outcomes that are, mainly, unhealthy and potentially unethical [86].

In conclusion, overemphasis on self-esteem improvement should be discouraged because programs focusing on factors that have a demonstrated absence of effect waste valuable resources and opportunities to target effective variables (such as self-efficacy, self-control, youth development) [87–90]. In this sense, the No Child Left Behind Act of 2001 and the Education Sciences Reform Act of 2002 provide important reminders that education should be an evidence-based field, thus posing interesting challenges to the overemphasis on self-esteem [91]. Whether health promotion and sexuality education practitioners will heed the available research is uncertain, but to ignore the evidence may, in the long run, prove costly, unhealthy and unwise.

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