# Differentiating Ego and Self-Esteem

# John F. Elliott, MA, MFT

**(Originally published in: CLINICAL SOCIAL WORK ASSOCIATION – THE NATIONAL VOICE OF CLINICAL SOCIAL WORK Access Fall 2015**

**S T R E N G T H I N G I D E N T I T Y | P R E S E R V I N G I N T E G R I T Y | A D V O C A T I N G P A R I T Y**

“The ego is not master in its own house”. ~ Sigmund Freud

“Every autobiography is concerned with two characters, a Don Quixote, the Ego, and a Sancho Panza, the Self”. ~ W. H. Auden

“As a musician and a songwriter, it is an act of the ego to believe that other people might be interested in your point of view. But it is usually an empathetic nature that gets you going in the first place. Music keeps the heart porous in many ways”. ~ Bono

“To me the ego is the habitual and compulsive thought processes that go through everybody's mind continuously. External things like possessions or memories or failures or successes or achievements. Your personal history”. ~ Eckhart Tolle

“Ego is to the true self what a flashlight is to a spotlight”. John Bradshaw

“His ego was so big it had its own climate”. Unknown

Think of “balance” and what it means to you. For most of us it implies stability. Yet balance is a dynamic process. It also implies movement and flux. It isn’t so much as standing on your own two feet and not falling; it’s more like standing on a board that lays on top of a small barrel. Shifting left to right and…not falling off. Most of us confuse balance with stasis. Stasis implies a stopping, a frozen quality, a fixed and unchanging structure/process. Its antithesis, chaos, implies a random state of disorder. Balance may be the interface between the two.

In past psychoanalytic theory, the “Ego” was seen as an integration of two other psychic “entities” (for lack of a better term), -the Id and the Superego. Think of these as two circles overlapping, and the ego as the area they intersect and coalesce.

In simple terms, the Id is our instinctual self, the urges we have to satiate our needs, our hungers, our aggression, our sexuality, our fears, our primeval needs. Our Id is the selfish aspect of our being, (with the exception perhaps of the instinctual need to protect our children. Perhaps this aspect of ourselves is selfishly selfless…). The Id wants immediate gratification. Generally, we need it, want it, got to have it, --and act to get it.

So, the Id tends to act out with impulsivity, projection, etc.

The Superego is that set of internalized behaviors gained in our experiences growing up in our families and culture. It’s what we learn to avoid punishments, to get rewards and to gain and maintain a sense of belonging. These include our values, mores and ethics we maintain to facilitate our belonging and security with others. The Superego correlates with our conscience and the “ideal self” we envision for ourselves. It is based on delayed gratification. The Superego tends to act in suppressing and repressing.

Ego is the synthesis of these aspects and usually mediates between these two states of being and provides us with a “balance”. We can then sustain our social belonging while also fulfilling our innate needs. In a sense, we are integrating security and belonging.

The ego employs defense mechanisms that can both obscure our awareness of base impulses and justify why we act on them. In this sense, we can also act out in righteous anger to punish those who fail to follow the values of family and society.

Self-esteem is a constellation of feelings, ideas, beliefs and attitudes directed towards the worth of oneself. It is a valuation, negative or positive, of one’s own importance. It can be specific, about a talent or ability, or a general estimation of one’s worth. According to Nathaniel Brandon, it is the sum of our self-confidence and self-respect and right to achieve happiness. Loving and affectionate parents, peer acceptance, and achievement in academics, sports or creative/artistic ventures are all causally related to healthy self-esteem. And as Maslow pointed out, basic needs must be met for this to occur as well. For researchers Erol and Orth (2011, p. 613), “a high sense of mastery, low risk taking and better overall health predicted higher self- esteem in participants at each age level.” They also indicated that “emotionally stable, extroverted and conscientious participants” experienced higher self-esteem as well. It seems logical that esteem originates from the ego through our interactions with the world around us, (much as a pearl manifests within an oyster). So, before we go on knocking or devaluing ego, let’s remember that esteem can’t develop without it. There is the diamond in the rough and there is the diamond that has been shaped to be a jewel. We need positive validation and success to achieve esteem, but to maintain it, we need to be more involved in our own process than our concerns with outcome.

As a clinician it’s important for me to differentiate what I’m supporting and empowering in my client. It’s equally important to know where I’m coming from: my ego or my esteem. Trying to prove yourself “right”, the smartest and most capable, attempting to impress others with our prowess is purely ego-based. A more esteem-based approach would be to know that you will do the best you can and acknowledge both your limitations and capabilities. Rather than getting others to admire and respect you, esteem involves acting in a way so that you respect and admire yourself.

When you begin to accept your own arrogance and work to become the most humble person in the room, you’ve missed the point entirely. Pride in achievement is a prerequisite for humility yet humility it is a ballad that requires a refinement in volume and tone.

In some ways, I would contend that all self-esteem is an aspect of ego that has evolved and formed through positive feedback from our environment and experiences of being able to cope with loss and adversity. Being able to be rewarded and respected by rational authority for our growth and achievements is one aspect of this. Being able to tolerate frustration and rejection is yet another. In most ways, ego is still based on an external locus of control, while esteem is more founded on an internal locus of control. There are elements of aggression that still drive ego forward, especially to compete. The desire to win and dominate others and to succeed may be necessary in certain social contexts. Yet, it may also be necessary to let go of this aspect of self in other situations. As we perceive the world through the lenses of our ideas and beliefs, it’s easy to see our clients as “victims” so our egos can play “hero”. Then of course we have to look for (or sometimes make up) the “villain” to solidify our roles. In this sense we can overlook the strengths and capabilities of our clients, vilify some significant other and become validated for our own competency, at everyone else’s expense. Or we covertly blame the “victim” for their behavior that “attracted” the tragedy, or caused it, or failed to prevent it. Although many of our clients have been “victimized”, labeling them as victims is a disservice. They are survivors. We need to provide empathy for their losses, pain and anger; much as a cast and crutches provide temporary support for healing to occur. We also need to provide interventions and experiences that help to strengthen those aspects of self that were injured. These may be painful, frustrating and challenging. In some cases we even need to nurture the aspects of self that never really manifested in the first place. This does not mean that we initially reject the client’s definition of self if they do indeed see themselves as a victim. We need to empathize for now, as well as bring up new possibilities for later. The process of maintaining esteem becomes more like a friendly competition against our own former performance. Being effective trumps being right. In this sense we achieve a certain kind of role flexibility with others. We may relate being an authority, or a subordinate or a peer. We may lead on a certain path, follow on another, or walk side by side.

CLINICAL SOCIAL WORK ASSOCIATION – THE NATIONAL VOICE OF CLINICAL SOCIAL WORK access Fall 2015

S T R E N G T H I N G I D E N T I T Y | P R E S E R V I N G I N T E G R I T Y | A D V O C A T I N G P A R I T Y 24

The following chart makes some distinctions between ego and self-esteem that I believe are useful:

## EGO SELF-ESTEEM

Selfish/Selfless Self/Other Caring

Compulsive Intentional-Planned

Impulsive Intentional-Spontaneous

Obligation Choice

Reflexive/Reactive Responsive

Arrogant Confident

Mistakes are Failures Mistakes are Opportunities

Dependent Variable Independent Variable

**HAVING: BEING:**

Having to BE Right Being Effective, Happy Having to Win How Well You Play

Having to Prove Yourself Being Good Enough

“Better Than” Others “Different” from Others

### Having the RIGHT”: Being A “Good Enough”

Job, Car, Spouse Employee, Driver, Partner

House, Money etc. Owner, Budgeter, etc

Attachment to Outcomes Attachment to Process Detachment from Process Detachment from Outcome

(The End Justifies the Means) (The Means MAY Justify…)

Making the “Right” Decision Making Decisions Right

**VALUE SET VALUE SET**

Right/Wrong Right/Left

Good/ Bad Same/Different

Healthy/Sick Capable/Incapable

Winners/Losers Players

Conventional (Kohlberg) Post Conventional (Kohlberg)

We all need to develop our own values, style and ways of conducting therapy.

A few that have helped maintain my own self-esteem over the years can be applied regardless of your theoretical orientation.

1) The first set involves relating with and to my clients from a variety of dimensions: a) Empathically, I accept what they are experiencing without judging them as good or bad, sick or healthy. They are who they are. More important to me is who do they wish to become? For me, this is manifested in what they want to change about themselves and their relationships.

b) Relationally, I assume the position of either/and –expert, peer and employee (yes,-I remember I work for my clients as well as myself) depending on what they most prefer and what appears to be effective. These positions may be consistent or fluid throughout the time of treatment, again, depending on the client.

c) I solicit and use the client’s definitions of the problem, solution and means to resolve difficulties and conflicts, provided this is not harmful to self or others. I am aware that any problem may also be a solution, and that these initial definitions may also transform. In this sense, I continually focus on intent, both theirs and mine. What do they wish to change about their lives? Do they have the capacity to change this? What are their resources, strengths and skills in some area that could translate to help them in another? What tools or experiences can help develop these skill sets if they are unavailable? Do I have the ability to facilitate this? If not me, who or what?

d) I look for, listen for, and feel for our similarities of experience, preferences and values, bringing them to the dialogue when appropriate. I also do the same for our differences and where I can help with a balance. What are my own strengths and potential vulnerabilities that can assist/hinder this client?

e) I solicit feedback on an ongoing basis on my process, their progress and the outcome of our sessions together.

f) I realize that as a psychotherapist I am always operating from a restricted perspective, based on my training. I need to consider other possibilities of problem/solution definitions including biological, psychodynamic, existential and systemic paradigms.

2. The second set involves paying attention to my attention internally:

a) I monitor my affect and thinking and imagery when I am with my client to differentiate what is my stuff, and what is my client’s.

b) If the client reminds me of someone from my past or present, I need to determine if I have any unfinished business in order to protect the client from my own countertransference.

c) If there are intense emotions brought up for me I also need be aware of the possibility of the client’s projections. I need to be able to tolerate and accept these experiences without blaming the client and process them as best I can as I explore the relationship of these feelings to the client. Once I have a strong alliance I can begin to gently explore these as parts of the client’s own process.

d) If images come up that seem to relate to the process at hand, I explore them; first with myself and if an alliance is solid, with the client as well.

e) If thoughts relative to a “diagnosis” or “pathology” emerge for me, and the client is not requesting this, I again explore my needs to define and control relative to that client. I remember that my own way of perceiving is first and foremost a definition of myself, which may or may not have anything to do with the person in front of me.

f) Affectively, I continually explore and accept my aggression and authority, my passivity, my fear, anxiety and pain, my vulnerabilities, my love, my compassion, my sexuality without having to act this out with the client. When am I bored, excited? When do I feel empathic, when do I feel disdain?

g) What is my body doing throughout the session, my posture, my voice tone, my contact (or lack thereof), my breathing all give me cues…when do I drift, or get more focused?

h) Cognitively, I maintain awareness of how is everything I perceive may be the same as, the opposite from and completely different from my and the client’s initial formulations of the problem/solution.

References

Erol,R.Y. & Orth, U. Self (2011). Esteem From Age 14 to 30 Years, A Longitudinal Study. Journal of Personality and Social Psychology, Vol 101, No 3, 607-619

John F. Elliott, MA, MFT founded the first crisis intervention center at Penn State University in 1972. He went on to establish numerous residential and outpatient treatment centers in Los Angeles and has been licensed as a MFT in private practice since 1981.

John is the author of Directions In Life for the Occasionally Confused, a CEU provider for the California Board of Behavioral Sciences and a member of the International Center for Clinical Excellence.

John F. Elliot may be reached at: 13440 Ventura Blvd, Suite 109, Sherman Oaks CA 91423 818-509-0600, jfelliott@aol.com

POSSIBLE ATTITUDES AND MIND-SETS THAT HELP MAINTAIN A CLINICIAN’S SELF-ESTEEM

 Compassion without pity.  Pride without arrogance.  Humility for its own sake.  Adaptation without placation.  Honesty without righteousness.  Humor without depreciation.  Knowledge without idealization of said knowledge.  The ability to follow, to lead and to wait.  A healthy disrespect for unnecessary pain, martyrdom and tyranny.  A healthy respect for the intent behind behavior.  A genuine liking and respect for human beings.  A genuine liking and respect for one's self.  The ability to hold a position that maintains integrity.  The choice to be effective as opposed to merely being right.  A capability to accept and admit to confusion and limitations.  An equal capability to embrace certainty and strength.  Openness, receptivity, and natural warmth.  The ability to hold the client accountable for their choices and behavior.  The ability to readily admit to one's mistakes, errors and to actively repair the alliance.