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Low Self-Esteem of Psychotherapy Patients: A Qualitative Inquiry

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In this article the story of 11 male psychotherapeutic patients with low self-esteem is told within the context of the research process. The literature suggests that the concept of "self-esteem" has a significant influence on the way an individual experiences his/her world. Therefore, the meaning that the psychotherapeutic patients associated with negative and positive labels, as it relates to self-esteem, was examined using grounded theory. The main storyline is conceptualized as follows; negative suggestion from the patient's past leads to low self-esteem which is, within his emotional problematics and by means of a negative thinking scheme, unhealthily handled. Therapy from a medical hypno-analytical perspective is used to replace negative labels by facilitating the attachment of positive meaning to his self-esteem. Key Words: Grounded Theory, Holism, Hypnotherapy, Labeling Theory, Meaning, Medical Hypno-Analytical Approach, Negative Labels, Positive Labels, Psychotherapy Patients, Qualitative Research, Self-Esteem, Self-Esteem Induction, Understanding

Introduction

Self-esteem, which is the evaluative aspect of the self-concept, and therefore the evaluation of a person's own competence, is related to accepting and approving of one's own characteristics (Berk, 2003; Plug, Louw, Gouws, & Meyer, 1997), and greatly impacts individuals' attitudes, emotional experiences, future behavior, and long-term psychological adjustment (Berk; Branden, 1969; Judge, Erez, & Bono, 1998; Rugel, 1995; Williams, 2001). It actually influences the way in which each person experiences his/her world as well as his/her aspirations and decisions to be made during important life moments such as the choice of occupation and life partner and his/her functioning in the workplace as well as decisions to take certain risks to protect himself/herself against unnecessary threats.

This study supports the view of Rugel (1995) that low self-esteem, and that which can be deduced from it, often cause**s** the basic problems leading to psychopathology. A low or negative self-esteem and related conditions in the patient form part of the root problems, which should be addressed by the psychotherapist. Rugel indicates that this view is not new and that it is also supported by the theories of Adler, Rogers, Sullivan, Ellis, and Kohut (as cited in Rugel). It can be stated that almost all persons suffering from psychological disturbances also suffer from low self-esteem.

In psychotherapy, a patient's self-esteem is not treated in isolation, the "whole self," including self-esteem, is treated. Related concepts such as "self-image," "self-concept," "self-understanding," the "ideal self," "body image," "self-presentation," and "self-actualization" (Plug et al., 1997) are involved in the process within the context of a particular patient's emotional problems, his/her expectations of therapy, and his/her clinical history.

A review of studies done in the field of self-esteem in South Africa indicate that room exists for a qualitative study in which the meaning patients associate with negative and positive labels, as it relates to self-esteem, could be examined. The review of literature showed studies in which self-esteem, as a concept in relation to other phenomena, had been studied in various scientific disciplines such as psychology, social work, occupational therapy, sociology, and nursing. All the studies mentioned here used quantitative research as a method, highlighting the need for qualitative inquiry on meanings of labels associated with self-esteem.

Recent quantitative studies on self-esteem, in the discipline of psychology, with regards to psychotherapeutic issues include those of Blumberg (2000) on the relationship between locus of control and the impact of traumatic events; Hattingh (1999) on the arts as a therapeutic medium; Riekert (1999) on cognitive behavioural therapy for adults who were molested; and Smith (1991) on the stigmatic effects of rape. Studies done on aspects related to group psychotherapy include those by Chapman (1997) and Malan (1991) on human modelling; Morgan (1995) on child sexual abuse, using two different modalities of group psychotherapy treatment; Runciman (1994) on a cognitive-behavioural approach; and Tinsley (1996) on the development of self-empowerment for juvenile delinquents.

Studies in the field of nursing, medical psychology, and medical social work in connection with self-esteem include those by Fourie (1992) with respect to the diagnosis of breast cancer; Marais (1993) on those with spinal cord injuries; McGill (1998) on paraplegics; McKay (1993) on reducing the risk of AIDS; Van Wyk (1991) on the HIV carrier; Modisane (1998) on the psychological impact of lupus for patients and their families; and Jacobson (1992), Modise (2000), and Tibbs (1996) on eating disorders.

A number of studies placed emphasis on social issues in society related to self-esteem, such as those by Mako (1992) on street children in Bophuthatswana; Meintjies (1997) on race and social stratification in children; and Moolman (1998) on unemployment. Only one quantitative examination focusing on hypnotherapy and self-esteem was found, namely that of Fredericks (1999) who did a study on hypnotherapy in which he examined a technique in building positive self-esteem.

No research concerning itself with the qualitative meaning attached by patients to labels (negative or positive), as it relates to self-esteem, could be found. Through my therapeutic work with patients, I became aware that in order to facilitate change in self-esteem it is important to understand the meaning of labels that patients attach to themselves. The concept "labels" in this article relates to the so-called labeling theory that refers to positive and negative labels originating from the individual's self-evaluation as well as evaluation by other people, who make determinations of how a person feels about himself/herself. Labeling can be defined as the over-simplified categorizing of an individual or group by way of a single word, for instance "stupid" (Plug et al., 1997). The work of Heckert and Best (1997) and Fife and Wright (2000) show that labeling leads to stigmatizing, which in turn leads to low self-esteem. It seems that labels regarded as negative unfortunately have a more powerful impact than the input of positive labels on the subconscious mind of individuals.

Practicing psychologists strive to address the problem of low self-esteem: It has already been established that improvement of self-esteem and self-efficacy can be a powerful tool of intervention in the therapeutic process (Hammond, 1990). Self-esteem interventions enable the psychotherapist to address a wide variety of problems relating to low self-esteem (for example**,** depression), low self-image, extreme emotionality, substance abuse, post-traumatic stress disorder, victimization, developmental or eating disorders, anxiety and phobias, grieving reactions, and adjustment to chronic illnesses. These problems can be found in a wide variety of patients such as athletes, business people, professionals, government officials, and tradesmen all who can be in different stages of life, from children

to adolescents or adults (Barber, 1984; Barnett, 1981; Gibbons, 1979; Gindhart, 1981; Gorman, 1974; Hadley & Staudacher, 1996; Hammond; Hartland, 1971; Myss, 1997; Pelletier, 1979; Stein, 1963). When applying self-esteem interventions much attention is generally given to the negative and positive labels assigned by patients to self-esteem. The research for this article endeavors to contribute to psychological theory by embarking on a qualitative inquiry of these labels. In this study, in order to elicit and explore the negative and the positive meanings that each research participant associated with his self esteem, I worked with a self-esteem induction technique in hypnosis with the respective research participants.

Review of the Literature

Contributing Factors to and Consequences of Low Self-Esteem

From the literature, it seems that factors contributing to the development of low self-esteem tend to form the essence of the negative labels that patients associate with their low self-esteem later in their lives. The contributing factors include family background, specifically negative parental behavior (Berk, 2003; Hadley & Staudacher, 1996; Modlin, 1999), a bad or negative relationship with the mother or father respectively (Gunnar & Stroufe as cited in Pollack, 1999) as well as traumatic incidents such as molestation (Hunter, 1991, Jehu, 1992; Morrow, 1991; Romans, Martin, & Mullen, 1997). In contrast with positive parental behaviour, which leads to a healthy self-esteem, negative parental behaviour will influence the child's self-esteem in a negative way. Some negative parental behaviour, for instance periodic judgment, according to Hadley and Staudacher is quite common among most parents, and apparently it does not have a huge negative impact on the psychological development of the child. If constant parental judgment is involved in the upbringing of the child however, it will lead to problems within the child's self-esteem. The parent who often makes a categorical negative classification (labeling) makes himself or herself guilty of negative judgment (for example, the parent who decides that the child is only good or bad, right or wrong, an achiever or loser). This parent tends to make a one-dimensional evaluation in the process of parenthood and child education, and becomes a global **"**labeller**"** in the attribution of mostly negative labels, which are imprinted in the child's subconscious mind. For the sake of protecting his or her ego, the child suppresses the most painful labels in the subconscious mind, which contribute to the way the child perceives himself or herself and influences his or her self-esteem. On a subconscious level the child "inherits" the parent's judgmental way, developing a critical inner voice, or dialogue that causes internal fear. When the child is not under pressure he or she manages to suppress these negative labels or contents that he or she has internalized. Under severe pressure though, these negative labels or contents come to the surface and the child becomes aware of it in the form of fear of failure, loss of emotional stamina, poor self-confidence, and low self-esteem (Hadley & Staudacher; Hammond, 1990; Modlin).

Others factors that can also influence self-esteem, and that are reflected in the content of labels which patients associate with their self-esteem, include being called "stupid," "brainless," "lazy," or "good for nothing," which leads to feelings of inadequacy, especially in the workplace (Tang & Sarsfield-Baldwin, 1991; Valas, 1999; Williams, 2001); being labeled as "bully," "rejected," or "dependent on your mommy," leads to feelings of being socially unacceptable (Fife & Wright, 2000; Heckert & Best, 1997; Pollack, 1999); and perceptions about one's own physical appearance reflected in labels like "fatty," "beast," "ugly," and "hunchback" (Jacobson, 1992; Modise, 2000; Tibbs, 1996).

Low self-esteem can additionally affect the ways in which an individual processes information and the way an individual protects or strengthens his or her low self-esteem as

well as interpersonal relationships. With regards to information processing, the following was found in patients with low self-esteem; personalizing of negative events (Hillman, 1997; Rogers, Kuiper, & Kirker, 1977; Taylor, 1989), the use of negative schemes (Markus, 1977; Rugel, 1995; Williams, Watts, MacLeod, & Matthews, 1988), rejection of positive information about the self (Rugel; Traverse & Dryden, 1995), and the inability to see the perspective of another person (Berk, 2003; Selman, 1980). The way patients process information shows that they tend to focus and dwell more on the negative labels than the positive labels that they associate with their self-esteem. With regards to protecting or strengthening his/her low self-esteem, the following phenomena have been found in literature; the "benefectance" phenomenon, as described by Greenwald (1980), which combines the concepts "beneficience" and "effectiveness" as the individual displays "beneficience" towards himself/herself, by attributing success only to the self; the process of downward comparison, which harms significant others (Burish & Houston, 1979; Wills, 1981); misleading the self as part of the denial process (Sackheim, 1983); and overcompensation through relationship dependency and achievements (Gilligen, as cited in Rugel). With regards to interpersonal factors, the literature mentioned a lack of self-assertiveness, including a misconception of inferiority towards others (Rakos, 1991; Rugel); socializing aspects including isolation; withdrawal from interpersonal relationships and social reservation (Jack & Dill, 1992; Rakos); and fear of disapproval or anger (Baumeister, 1993) as well as dysfunctional marital and family systems in persons with low self-esteem (Rugel; Symington, 1996).

Approaches in the Psychological Treatment of Patients with Low Self-Esteem

The review of literature by Hammond (1990) also showed that the interventions for improving self-esteem are relatively limited, even though the presence of a low or unhealthy self-esteem is a general phenomenon among patients requesting psychological treatment. Low self-esteem often sustains the psychopathology, at the same time preventing a favorable prognosis due to the lack of inner strength or ego strength. Furthermore, low self-esteem prevents the patient from optimal interpersonal functioning and impacts negatively on functioning in the work place. A psychologist can provide positive feedback and compliments, but very often these positive comments are not regarded highly in the patient's conscious thoughts. It has therefore, become necessary for the helping professions to give attention to more formal interventions for the improvement of self-esteem and self-efficacy. Currently, relatively few interventions are available to therapists working towards this goal (Hammond).

I used the hypnotherapeutic approach, particularly the medical hypnotherapeutic approach, to record the clinical history of the participants, and to explore and treat through the self-esteem induction designed by Hadley and Staudacher (1996). The hypnotherapeutic approach allows creative intervention with techniques such as this specific self-esteem induction through which I could explore the negative and positive labels that the patients associated with their self-esteem. The nature of self-esteem is so complex that I also had to involve the theoretical perspectives and insights of other therapeutic approaches eclectically in order to treat the problem as effectively as possible. The perspective that any psychological approach can be applied within the hypnotherapeutic approach (Matez, 1992; Scott, 1996) supports the inclusion of other approaches in this particular research. Other approaches I used in addition to hypnotherapy, and that were in accordance to Rugel's (1995) self-esteem perspective as well as my own perspective, were rational-emotive, behavioral therapeutic, and psychodynamic approaches, which are subsequently briefly discussed.

Cognitive therapists holding different perspectives presented practicing psychologists with methods to help patients examine, analyze, control, and replace the preconceptions and irrational thought patterns undermining their self-esteem (Beck & Weishaar, 1989). Ellis's rational-emotive behavioral therapy, for example, aims to empower patients with self-esteem problems and to identify and change irrational beliefs about themselves in order to think more positively about themselves, other people, and their environment (Ellis 1989; Traverse & Dryden, 1995).

Behavioral therapists like Pavlov, Skinner, Bandura, and Wolpe (as cited in Wilson, 1989) emphasize that improvement in self-efficacy follows when patients experience success. Behavioral therapists also increasingly stress role-play and drama techniques (drama therapy) as methods to improve self-efficacy and the ability to adjust, which in turn improves self-esteem (Marlatt, 1985).

In the psychodynamic approach it is important to offer a corrective experience to the patient with low self-esteem (Alexander & French as cited in Rugel, 1995). Traditional psychodynamic insight approaches, for example that of Adler (Mosak, 1989), examine the historical origin of an individual's self-esteem in order to assist him/her in acquiring an experience of power to combat feelings of inferiority.

From the review of literature we know that self-esteem, as the evaluative aspect of self-concept, forms an integral part of the psychological dynamics as well as the emotional problems a patient can experience. As shown, there is a wealth of research on the contributing factors to, and consequences of, low self-esteem as well as on certain approaches in the treatment of this phenomenon. The review of literature that I did for this study pointed out that there were no studies or research done qualitatively or exploring the meaning patients attach to their self-esteem, especially with regards to the labels they associate with it. In this inquiry, I attempt to fill the void, both in terms of content and method, by qualitatively examining the meanings of the negative as well as positive labels that 11 male patients associated with their self-esteem in order to form a new understanding and psychological theory on self-esteem and what mental health entails.

Research Purpose and Question

The purpose of this research is to qualitatively examine the meanings of the negative as well as positive labels that psychotherapy patients associate with their self-esteem in order to get a better understanding *(verstehen)* of what these patients' views of low and high self-esteem entail.

With the aforementioned in mind, it is now possible to ask the following question, "What is the meaning of the negative as well as positive labels that psychotherapeutic patients associate with their self-esteem?"

Research Paradigm

The study was done within a qualitative paradigm (Babbie & Mouton, 2002). The participants' responses were so rich and descriptive (Denzin, 1978; Denzin & Lincoln, 1994) that I felt obliged to analyze them and to tell their stories. This study therefore, focuses on the understanding *(verstehen)* of the meanings attached to self-esteem rather than the explanation (*erklärung*) thereof, relating to the hermeneutic tradition. The hermeneutic tradition (forming part of the qualitative paradigm) was developed by the Germans, Wilhelm Dilthey and Max Weber (Dilthey, 1911/1997). They put the emphasis on the subjective understanding of interpretation (*verstehen*, a research concept developed by phenomenologist Alfred Schutz) in contrast with explanation (*erklarung*, a concept developed in the period before Kant, for practices of explanation). Within this tradition they

differentiate clearly between the natural sciences and the human sciences, especially with regards to the methods used. According to Dilthey, the purpose of natural sciences is to explain the external relationship between natural phenomena, in terms of their universal liability and causal laws, while the purpose of human sciences is to understand the internal relations between behaviour by setting it in relation to the ideas, values, and purpose to which it leads. He is of the opinion that the purpose of human sciences (and the qualitative researcher) entails rather the understanding, and not the explanation, of human behaviour and social phenomena; naturalistic observation rather than controlled measurement; and the subjective exploration of reality from the perspective of the insider rather than the outsider perspective that you find in quantitative research. Therefore, the emphasis in this tradition is on the understanding of individuals in terms of what their own interpretation of reality entails as well as on the understanding of society in terms of the meaning that people attach to social practices in their society.

Researcher Context

As a clinical psychologist in private practice for 10 years, I have a special interest in individual psychotherapy for adults and hypnotherapy, especially medical hypno-analysis. This approach enables me to help the patients in a short-term, dynamic, and creative way with many options from which to choose. I chose this holistic perspective by exploring and treating the origin of the *dis-ease* in the patient's subconscious mind in order to reach specific outcomes and facilitate health in his or her body, mind, and soul. Based on my practice background, I thought I could make a contribution in the area of self-esteem and hypnotherapy, in the discipline of psychology. Doing research in this area also gave me the opportunity to integrate different thoughts, knowledge, insights, and perspectives I gained over a period of approximately 10 years of working with psychotherapeutic patients with self-esteem issues. The research I did enabled me to obtain my doctorate in psychology in the process.

In this research project, I (as a therapist as well as a researcher) had a close therapeutic and professional relationship with the 11 research participants. Therefore, I could not be totally free of values or distant and be objective in my attitude towards them. This also applies to the nature of the qualitative research I did in this research project. Both my supervisors and I were deeply touched by the intensity and meaningfulness of the data we analyzed qualitatively, in accordance with the principles of the grounded theory.

Method

Sampling and Data Collection

Qualitative research calls for the collected data to be rich in describing people and places (Patton, 1990). From the typology of qualitative sampling that was developed by Patton, the extreme or deviating case method was used for this study. The extreme or deviating case method of sampling allows for selecting participants who will probably supply very rich informative data. This method directs the researcher to be consciously aware of data that can support or challenge his/her understanding of the phenomenon.

From all the files (approximately 120 files) of patients I had available, in which I applied medical hypno-analysis, including the self-esteem induction technique of Hadley and Staudacher (1996), I selected the files of only 11 patients to serve as research participants for this particular study on psychotherapeutic patients and self-esteem. For all of these particular patients I used the same first clinical interview from a medical hypno-analytical approach as well as the same self-esteem induction technique, developed by

Hadley and Staudacher, in order to treat the self-esteem issues they reported as part of their psychological problems. Furthermore, the research participants were selected on the basis of homogenous demographic characteristics, namely white, Afrikaans-speaking men from an average socio-economic sphere. Nine men were in their 20s and 30s, while two were in their 40s. Three were unmarried, four in their first marriage, two in their second marriage, and two were in the process of divorce. The participants held a wide variety of occupations and all of them were my patients.

All of the patients who consulted me as a registered clinical psychologist in my private practice signed a contract before they commenced with psychotherapeutic sessions. By signing the contract each patient agreed to and gave consent to participate anonymously in any research that can possibly stem/originate from the clinical information they shared with me, to make a contribution in the field of psychology. As a doctorate student of the University of South Africa, I was requested to conduct my research according to the *Ethical Code of Professional Conduct* as stipulated by the Professional Board for Psychology (2004) of the Health Professions Council of South Africa. This means inter alia (apart from the basic principles of respecting the dignity and rights of every participant) that the participants' informed consent, to participate in the research project, was obtained after being informed of what the project would entail. This consent included giving permission to me to elicit the information from their confidential files for my research, and understanding that their anonymity would be protected.

The 11 male patients that I used as research participants in this study were recruited after they had been working with me in a therapeutic process. The reason why I only selected men was to make the profile of the research participants more homogenous. Also, I (as a male psychologist and researcher) thought I could hold a stronger insider perspective with regards to the stance I would take in analyzing their data. I attempted to understand the meaning they gave to their self-esteem and world in which they lived.

According to Berg (as cited in Schurink, 2000), more than one method of data collection should be used in qualitative research because different methods offer different facets of the same symbolic reality, leading to more valid results. The data collection techniques used in this study presented the researcher with rich descriptive information. These data collection techniques included individual interviews (Babbie & Mouton, 2002; Denzin, 1978; Denzin & Lincoln, 1994; Frey & Fontana, 1993; Kvale, 1996); the self-esteem induction, through which the negative and positive labels that participants attach to the self-esteem were acquired (Hadley & Staudacher; 1996); and lastly, observation (Babbie & Mouton).

Procedure

The process started with interviews I had with each of the 11 research participants, during which the participants were requested to answer open questions. This formed the wider context and background generating rich descriptive data in which the meaning the participants attached to their self-esteem was studied and analyzed with grounded theory. The following nine areas were explored in the first interview: the current illness or problem, the history of the problem, family history, sexual history, psychological history, habits, social history, religious background, and marital history. Examples of open questions asked in the first interview from a medical hypno-analytic perspective follow in Table 1.

Table 1

Examples of Open Questions

Category	**Example of question**
1. The current illness or problem	"*What makes your problem worse?*"
	"*What makes your problem better?*"
2. The history of the problem	*Inquiry through open questions were made on the patient's history with regards to allergies, serious illness or accidents, childhood diseases, surgery and or hospitalisations, near death experiences and mental status examination*
3. Family history	"*What was unhappy about your childhood?*"
	"*What was happy about your childhood?*"
	"*What sort of person is your father?*"
	"*What would you like to change about your father if you could?*"
4. Sexual history	"*Tell me about any early sexual incidents you can recall.*"
	"*Tell me about the first sexual incident you had with another person.*"
	"*Is there any other sexual or other incident you have not told me that you think I really should know?*"
5. Psychological history	"*Any traumatic incidents from the past like accidents, deaths, illnesses, high fevers, operations, embarrassing moments, emotional incidents, dating experiences …*?"
6. Habits	*Inquiry with regards to the patient's use of alcohol, coffee and other beverages, drugs, tobacco, meals, sleep pattern, exercise, any abnormalities and nervous habits*
7. Social history	"*What do you think people say behind your back that you don't like?*"
	"*If you could change one thing about yourself, what would that be?*"
8. Religion	"*What is God like?*"
	"*What is your image of God?*"
9. Marital history	"*Why did you marry this specific person?*"
	"*For what reason did you get married?*"
	"*What would you like to change in your marriage?*"

The interviews were structured interviews adapted from Scott (1996), with open questions which served as first interviews in the process of medical hypno-analytical therapy. The interviews were conducted in person and recorded in handwriting by myself myself, in my private practice, in a warm and therapeutic atmosphere. For the purpose of this research, I also recorded the written notes I made on audiocassettes. The multiple interviews usually lasted about 3 to 4 hours, within the time span of two to three sessions. Some sessions were 1-hour sessions, while others were 2-hour sessions. The data I gained

from these first interviews formed the context in which I attempted to explore the meaning of the negative as well as positive labels that the psychotherapeutic patients associated with their self-esteem, according to the self-esteem induction which I planned to do with each patient later in the process. In analyzing the data, I did not only analyze the various negative and positive labels, but also the data I gained from the first interviews.

This was followed by teaching self-hypnosis (Alman & Lambrou, 2002; Modlin, Nel, & Hartman, 1997) to each participant and in some cases also by a word association test and dream analysis (Scott, 1996).The self-esteem induction, within the medical hypno-analytical process (Hadley & Staudacher, 1996), was applied to each participant to identify the negative as well as positive labels which they associated with self-esteem In the self-esteem induction technique two suggestions were made to the research participants. On the one hand, the participants were told to visualize a blackboard with the uncomfortable labels (in a colour he does not like) that he has been given in the past, the labels that slowed him down and failed to reflect the strong and good qualities that he has: On the other hand, the suggestion was made to the research participant to visualize himself writing anything on the blackboard he wants to write (in a colour he likes) representing the positive and good qualities he would like to use to describe himself. Further information about the patients was obtained by clinical observation that was recorded by me, during each session; in the clinical notes I made according to the following observable data (Kelleher as cited in Babbie & Mouton, 2002).

- External physical signs, for example, clothing, personal hygiene, neatness, and the general impression the patient made.
- Expressive movements, for example, eye movements, eye contact, body language, and posture.
- Physical localization, for example, the place in which the researcher observes as well as personal space.
- Language behaviour, for example, stuttering, the use of strange words at times, and “Freudian slips” during verbal exploration.
- Duration, for example, how long the patient took to answer and the pauses between certain words.
- Emotional expressions, for example, signs of depression, anxiety, or tension.

I therefore used the data I gathered from the first interviews with each of the 11 research participants and the negative and positive labels I gathered from doing the self-esteem induction with each of them as well as the data I gathered from the clinical observations I made of each patient.

Analysis of Qualitative Data

The data obtained from the above mentioned interviews, self-esteem induction, and clinical observations were analyzed qualitatively as textual data, transcribed from audiocassettes (and vice versa) with the help of the *ATLAS.ti 4.1*-computer program (Muhr, 1997), according to the open, axial, and selective coding principles of grounded theory (Strauss & Corbin, 1990).

Glaser and Strauss’s (1967) original conception of grounded theory methodology was framed in terms of a series of iterations that the authors referred to as a process of “constant comparison,” in which the researcher moved back and forth among the data and gradually advanced from coding to conceptual categories to theory development. Strauss and Corbin (1998), in a development of this approach, referred to the first step in the

process as "open coding" through which the researcher names events and actions in the data and constantly compares them with one another to decide which belong together. In Glaser and Strauss's language, the "basic defining rule for the constant comparative method" is that while coding an incident, the researcher should compare it with all previous incidents so coded, a process that "soon starts to generate theoretical properties of the category" (p. 106). A total of 3600 quotes were analyzed with open coding, generating about 518 codes. For example, in this study, the following quote of one of the research participants were analyzed with open coding, "I feel very depressed. I hide away. I withdraw from society. My self-image is a big problem. It is low. I feel very inferior." Using open coding in analyzing these quotes generated the following codes, depression, isolation, withdraw, self-image, low self-esteem, and inferiority.

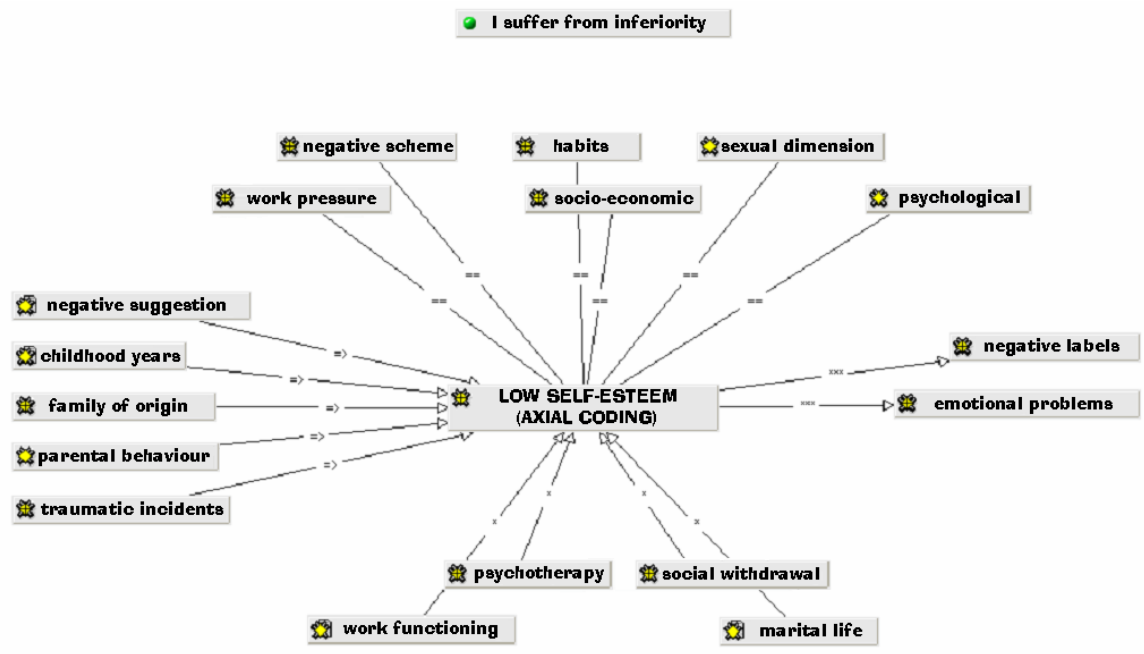
The next step in grounded theory is to group the discrete codes according to conceptual categories that reflect commonalities among codes. Strauss and Corbin (1990, 1998) refer to this as "axial coding," reflecting the idea of clustering the open codes around specific "axes" or points of intersection. It is important to note that, when engaging in categorizing/axial coding, these properties are being identified through the interpretive lens of the researcher who is already beginning to abstract from the data. These above mentioned 518 codes were grouped into 23 categories. Literally hundreds of conceptual labels can emerge in the process of research. These concepts must be grouped according to the specific phenomenon that is being studied in order to reduce the number of conceptual units the researcher has with which to work. This grouping of concepts that refers to the same phenomenon is called categorizing. The phenomenon represented by a category gets named or labeled with a conceptual name that is more abstract than the names that are given to all the different concepts, forming part of it. The researcher usually names the category because it must relate to the data in the most logical way. Categories must be named so that they can be analytically developed. Categories do have conceptual power because they can unite other concepts or subcategories (smaller units of data, sub-headings, or concepts forming the category) contained within. The process of forming categories can take place in different ways. For each concept of the phenomenon under discussion, the following question can be asked, "To which class of phenomenon does this apply to, and is it the same or different from the previous or future ones?" (Strauss & Corbin, 1990). Each category was further described by sub-categories also formed according to criteria like frequency, duration, location, and time. For example, depression in one of the research participants was experienced chronically with acute episodes, especially when he found himself in the company of his family, and/or in the home where he grew up, and when he was reminded by the death of somebody. The 23 categories formed in terms of low self-esteem, the most important phenomenon of the study, are as follows (in alphabetical order): childhood years, cognitive functioning, emotional problems, expectations, family of origin, functioning in the workplace, health, habits, interpersonal relationships, low self-esteem, marital life, molestation, negative labels, negative scheme, negative suggestion, positive labels, psychotherapy (psychological help), religion, sexual problems, social, socio-economic, substance abuse, and traumatic incidents.

Part of axial coding also involves finding connections between categories and sub-categories. Axial coding was done in this study by using different elements in relation to the central phenomenon (namely low self-esteem in the case of this study), within the grounded theory paradigm, namely (a) causal conditions, (b) central phenomenon, (c) context, (d) intervening conditions, (e) action or interactional strategies, and (f) consequences of the central phenomenon (Strauss & Corbin, 1990).

The networking function of the program, *ATLAS.ti*, using the different elements of the above mentioned grounded theory paradigm, was used for the axial coding of the 23 categories generated from the codes in open coding. The product of the network function is

a visual display of different categories in relation to one another. In the caution of Harry, Sturges, and Klinger (2005) I want to note that although such a model is helpful to the researcher themselves, and instructive to those desirous of learning the method, any visual representation of a complicated cognitive process is a vast simplification of the way that researchers actually arrive at interpretations. I acknowledge that no model can represent the intuitive leaps that are an essential part of any analysis. For example, Figure 1 presented below (only one of the 23 figures I, Jacob van Zyl generated with *ATLAS.ti* in this study) represents the axial coding of the core category and central phenomenon of the study, low self-esteem. The central phenomenon (element b of axial coding in grounded theory as mentioned above), namely low self-esteem, was placed in the center of the visual display. Causal conditions (element a, contributing factors in this study), namely negative suggestion, childhood years, family of origin, parental behaviour, and traumatic incidents appear to its left. Intervening conditions (element d), namely negative scheme, habits, sexual dimension, work pressure, socio-economic, and psychological are placed at the top. Action or interactional strategies (element e), namely psychotherapy, social withdrawal, work functioning, and marital life appear at the bottom. Consequences (element f) of the central phenomenon, namely negative labels and emotional problems appear to the right.

Figure 1. Representation of axial coding: Low self-esteem.



All these factors are in accordance with those currently in the literature (see discussion). However, this axial coding organizational scheme as laid out here reveal a uniqueness in the sense of combining different elements generated from the data, putting them in relation to one another from a grounded theoretical perspective, laying the path for a new theory regarding self-esteem.

Strauss and Corbin (1998) refer to the third analytic level as "selective coding," meaning that at this point the researcher treats the various code clusters in a selective fashion, deciding how they relate to each other and what stories they tell. Thus the analyst "constructs … a set of relational statements that can be used to explain, in a general sense, what is going on" (p. 145). I find it more explanatory to call the third analytical level in grounded theory the "thematic" level, referring to the underlying message or stories of these categories as "themes." It is in seeking the interrelationships between these themes that the

researcher begins to build a theory. In selective coding the central phenomenon and a conceptualized story line were identified in this study. The conceptualized story line in this particular study, constructed with the help of the elements elicited in axial coding as explained above, follows in Table 2.

Table 2

Conceptualized Story Line

(A) Negative suggestion from the patient's past leads to

(B) low self-esteem

(C) which is within his emotional problematics,

(D) by means of a negative thinking scheme,

(E) handled unhealthily for which therapy from

a medical hypno-analytical perspective is used to replace

(F) negative labels by facilitating the attachment of

positive meaning to his self-esteem.

Rigor and Trustworthiness

For this study, the researcher involved an independent clinical psychologist experienced in research to conduct an audit trail, one of the procedures to improve internal reliability by means of triangulation (Denzin, 1978; Denzin & Lincoln, 1994). This psychologist analyzed the transcribed data using open coding. Ninety percent of the codes in the open coding performed by the psychologist using audit trail correlated with the coding of the researcher. The other ten percent were audit trailed again by my two supervisors. We decided to accept it as part of the data-analysis.

The Story of the Patients with Low Self-Esteem

The story of the psychotherapy patients with low self-esteem now follows, told in the voices of the participants themselves. While reading this story, the reader could try to imagine the lives of the participants as they continually crystallize the "insider's perspective," endeavoring to see the world through the eyes of the research participants (Babbie & Mouton, 2002).

The story is told within the constructed grounded theory which connected the elements (a) causal conditions (in this study, contributing factors to low self-esteem), (b) the central phenomenon, (c) the context, (d) intervening conditions, (e) action or interactional strategies, and (f) the consequences of the phenomenon.

Factors Contributing to Low Self-Esteem: Negative Suggestion from the Patient's Past Leads to ….

The contributing factors to low self-esteem co-constructed in this study and which, according to Strauss and Corbin (1990), can be seen as possible causal conditions for low self-esteem also show strong similarities with existing research. The data collected for this study indicates negative suggestion as a contributing factor to low self-esteem. The process of negative suggestion includes negative suggestion during the childhood years, by significant others in the family of origin as well as traumatic incidents such as molestation. The negative suggestion that occurred in the lives of the research participants is illustrated by the following quotes.

> *I am very afraid of my brother, he is seven years older [than me]. He took over from my dad when he died. I always had to listen to my brother. He broke me down. He broke down my self-esteem. I am also afraid of water. I did not learn to swim. As we were a family of six brothers and two sisters, we were eight children, there was a need for authority. Yes, that was the reason why my brother took over the authority ... After that I accepted a package and became a hawker with my older brother, but that didn't work out … Eventually I had to flee from [my brother], because of the amount of conflict we had. He used to call me a "maid" and "spineless" …*

> *I realize that I have no self-image inside of me. My self-esteem is low. I have a poor self-image. I feel inferior. I can think back very far, as far as my own birth … or when I was still in a pram. My mother had the pram out on the fields where she worked on the farm … She would cook our food on a fire out in the field. It was my mother's second marriage. My fathers' dad was very hard on him … My father did not show any love towards me. My father often asked me, "What will become of you, bloke?" or "Are you worth nothing then …?" … and that had an impact on my faith in myself. I don't believe in myself. Other children also mocked me and I believed what they told me. What they said I made my own and that had a snowball effect on my identity. I am not acceptable to myself. In my deepest core I feel inferior.*

In connection with the above, the data of this study (in which the research participants' voices can be heard firsthand) linked meaningfully with Rugel's (1995) self-esteem model, with the basic assumption that patients' experiences during childhood and adolescence have a lasting effect on their self-esteem. The data of this study are also supported by the viewpoint of Hadley and Staudacher (1996), stating from a hypnotherapeutic perspective, that the main cause of low self-esteem is seated in the negative programming from the past, which is a product of condemning parents.

Negative parental behavior

The data of this study clearly emphasized the important role of negative parental behavior in the forming of low self-esteem. This is reflected in the words of research participants who struggled with self-esteem issues, handling it in an unhealthy way by misusing alcohol themselves.

> *I had a negative role model and lack of love … He was an alcoholic. Our family did not know love. Where there is alcohol, there is no love … He was very strict …I had to do gardenwork over weekends … I built a wall and pushed cement in a wheelbarrow … then my father hit me so many times with a gardenhose that blood started to flow … When he got angry he stayed angry for three or four days. He did not talk to anybody. That was not nice ... and I do the same thing with my present wife. I would have liked it if my father did not have the alcohol problem and if he could have shown more care in the way he behaved. The fact that he was so domineering was not pleasant at all ... In our home children were seen and not heard …*

> *He [my father] worked on the railways as a clerk. My father sometimes tied me by my neck to a kerosene tin on the farm. In Grade 7 he shot me through my leg in an attempt to kill me. My father always predicted that I would become a "washout." He took me to the police station twice to be given a hiding … each time six strokes. When I was a child he used to send me to the liquor-store to buy him some alcohol. He cut my fingers …*

The data therefore correlate with the research of Berk (2003), Coopersmith (1967), Hales (1979), Hammond (1990), Modlin (1999), and Pollack (1999) highlighting the importance of positive parental behavior in establishing a healthy self-esteem as opposed to negative parental behavior establishing a low self-esteem in the child.

The mother's personality and the relationship with the mother

Some participants described their mothers' personalities and their relationships with their mothers mainly positively, while others gave a negative description, like the following patient who acknowledged that he projected all of his problems on his mother.

> *Most of the time I feel that other people take advantage of me. I can not assert myself. After my father's death I was in a dream world. I am still searching for my father. I keep on looking for him. I did not want to hear that he was dead. My father sometimes appears in a dream. I feel I want to break free. As a child I never played. I also want to be a young boy. Why do girls see more in other guys than in me? I experiment with different stuff to have the life of a boy again. I try hard … I take lots of vitamins, use marijuana, thins, alcohol. It is an emotional thing. I sometimes drink too much ... I have always accused my mother for things that went wrong in my life. Things that I am guilty of myself. I feel guilty.*

Another participant did not have a good relationship with his mother due to her drinking problem.

> *My mother died of cancer about 7 years ago. Two years after my father's death she had a serious drinking problem which made her very aggressive, but before that I remember her as a fantastic person. They were good parents She had a lot of love to give … but I also remember how my eldest brother would boss her around after my father passed away … I experienced a lot of difficulty in accepting her death.*

These data correspond with the literature emphasizing the importance of the safe relationship with the mother in preventing pathology, improving academic performance, and establishing high self-esteem (Gunnar and Stroufe as cited in Pollack, 1999; Rugel, 1995).

The father's personality and the relationship with the father

In this study, within some of the categories themes of absent fathers, lack of a positive role model, alcoholism or serious alcohol misuse, short temper, strictness, and distance in the relationship between father and son abound in the negative ways that men with low self-esteem consistently described their fathers and their relationships with them.

> *My father was a labourer who always worked outside. He was not available. He always withdrew from conflict. My father was very absent. I feared him. I loved him very much. He was a good man … and I see much of myself in him but he was very absent. He did not come to terms with my mother's death. He always had to punish me. He became very cross … I think he felt powerless and helpless and he was totally smothered by my stepmother. Yes, my father married my stepmother only one year after my mother's death.*

> *My father – I have no respect for my father. It has only been for the last 2 ½ years that I have built a relationship with him. My father was hit severely by his father. He was abused and I think that is why he verbally abused me …*

For three of the participants the death of their fathers had a huge impact. Two of them lost their fathers at a very young age. It is my viewpoint that this was the core of their problems. One patient was 10 years old when his father died and he particularly missed his father's guidance.

> *After my father's death, I was in a dream world. I am still searching for my father. I keep on looking for him. I did not want to hear that he was dead. My father sometimes appears in a dream.*

These themes, which occurred in the data, are also reflected in the literature, notably that of Pollack (1999) where it would seem that the effect of the father-child relationship on self-esteem mostly corresponds with the availability of the father and the amount of time he spends with his children.

Molestation

Molestation as a theme appears strongly amongst most of the participants, and the majority (5) who experienced it described it as traumatic. Seven of the participants were molested as children by one or more men. Two examples are the following:

> *When I was a child of 12 years old … on a farm … my sister's friend and I shared a bed. I woke up while I was being hurt. He kept on. He kept on trying between my legs and also anally. He reached an orgasm. I was hurting badly. Sometimes I have feelings of guilt. Maybe it's my fault that it happened.*

> *It was the two brothers of my father who molested me in [grade six]. They were disgusting, filthy people. "Jesus will punish you!" I said to them and my mother knew about it, but was under the pressure and power of her in-laws.*

Three of the research participants were themselves guilty of molestation. One of them molested many children in the childrens' home. He said,

> *I experience aggression in a sexual manner, as sexual aggression; especially towards children I became very impatient. I was a house parent in the children's home and I must confess that I got sexual with some of the children. There were phases during which I repressed it, but then it popped out in other ways … It happened again with other children and I'm scared that it will happen again.*

This caused the interviewee/participant to think very negatively about himself, as is clear from the negative labels he associated with his self-esteem.

The research findings of this study correlated with research relating to self-esteem and molestation in the literature, indicating molestation (being molested or as molester) as a possible cause or contributing factor to self-esteem problems (Hunter, 1991; Jehu, 1992; Morrow, 1991; Romans et al., 1997).

Central Phenomenon: Low Self-Esteem

Self-esteem, a vitally important concept in psychology (Berk, 2003; Branden, 1969; Judge et al., 1998; Rugel, 1995; Williams, 2001), crystallized as the central phenomenon of this study. The research participants used a wide variety of terms to verbalize negative evaluating of the self (low self-esteem) like "low self-image" or sometimes "no self-image," "inferiority," "a feeling that I'm silly," "low self-esteem," "loss of respect for self," "being unacceptable for myself," and disparaging self-esteem. The following quotes abound with such terms. "I realize that I have no self-image inside of me. My self-esteem is low. I feel inferior." "My problem is my aggression and my sexual problems. My unpredictable state of mind, I believe is linked to my rejection as a child and my feelings of inferiority."

All of these references to the participants' self-esteem agree with definitions of self-esteem found in the literature, namely that it is the evaluative aspect of the self-concept (Berk, 2003; Branden, 1969; Coopersmith, 1967; Plug et al., 1997).

Context: Within His Emotional Problematics

The central phenomenon, low self-esteem, was placed within the context of the emotional problematics experienced by the participants in this study. The data showed that the participants with self-esteem problems experienced a wide variety of emotions, which were mostly pathological or problematic. The following sub-categories regarding their emotions were co-constructed: feelings related to depression; anxiety; interpersonal aspects; worthlessness; spiritual aspects; and aggression, especially where depression and anxiety were experienced as is illustrated by the following quotes.

> *I feel very depressed … On a scale of 1 to 10 I will generally evaluate myself between five and six. But I go down to minus ten when I feel very depressed. Then I feel like a prisoner.*

> *I am relatively well, but I experience fear. I struggle to go to sleep. I do not really experience problems but I fear death. When I was a little boy of 7 years old my father died because of his heart. If that did not happen I would not have this fear … My father died at a young age. He was only 46. I fear that it will happen to me too. My mother also died 7 years ago. Two weeks ago I had such a constriction in my throat because of tension and fear … or maybe it was because of the spray painting I did in my job. Two years ago I had an anxiety attack. My heart beat fast … What makes it worse for me is when I go to bed and get palpitations … like my father did … then it creates fear.*

The spectrum of the emotional problematics in patients with self-esteem problems observed in this study seemed to be more extensive than those reported in the literature. The literature mostly refers to feelings of depression in individuals suffering from low self-esteem (Pollack, 1999; Webster, 1990; Winick, 1995). In this study the data showed that about half of the participants experienced lack of happiness and self-actualization, which was connected to a feeling of incompetence in their respective occupations, and which contributed to low self-esteem.

> *In my current job I lack motivation … I work under a tremendous amount of pressure. I do the work six people had previously done. There are a lot of politics involved. In my current job I lack motivation … It is as if I am in the wrong place at the wrong time … I do not want to die in this job.*

> *My work is at the core of my problem … I experience intense depression. Alcohol and smoking marijuana played a big role in my life for a very long time, but I got better again. The sudden change in my job makes it very difficult for me because I am a perfectionist – everything must be done correctly and I put my job first. I used to like my job but gradually I lost self-motivation and my love for my job diminished. Therefore I do not find my present job satisfactory. Presently I do not have a good view of the future.*

In the data, there were also clear signs of fear, feelings of isolation and rejection, and the tendency to withdraw socially. The patient, who described himself as feeling like a prisoner when he feels very depressed, described his defense mechanism, namely isolation and withdrawal as follows. "I feel very depressed. I hide away. I withdraw from society. My self-image is a big problem. It is low. I feel very inferior."

The literature emphasizes feelings of social acceptability for a healthy self-esteem as opposed to fear of social disapproval, which contributes to low self-esteem (Barnett & Nietzel, 1979; Baumeister, 1993; Pollack, 1999; Short et al. as cited in Rugel, 1995).

Intervening Conditions: By Means of a Negative Thinking Scheme

This study showed clearly that a negative scheme in the thoughts of the participants (by which they process information negatively) constantly appeared as an intervening condition, affecting their low self-esteem. One research participant said the following about his girlfriend with regards to their problematic relationship.

> *My Christian faith is creating a problem for me in my current relationship. I am a guy that did not sleep around with others but she had sexual relationships in the past and I have a big problem with that. She dated a guy*

> *for 4 years and in that relationship she told me she got date raped, and that it happened more than once … in this relationship she was also emotionally abused. So for me to proceed with this relationship I first need to talk about it. I want to give the relationship a chance but I experience mistrust. She hates the sexual aspect of a relationship after what had happened to her, and I feel very uncomfortable in church when she looks at this guy who is in the same church … I am afraid that she will be mad at me after her previous boyfriend, just like my mother was mad at my father after her first husband.*
>
> *Traumatic incidents in my life were the way I grew up and all the negative things I started believing about myself…Every time I get promoted, I feel insecure, because my whole life I had to come in through the back door. I was used to coming from behind. I perform well under immense pressure, but I realize that as a manager I am unsure and scared.*

This corresponds with the literature, emphasizing negative ways of information processing in individuals with low self-esteem: Such individuals selectively pay much more attention to negative information, which corresponds with their negative self-concepts (Rugel, 1995). Personalizing of negative events (Hillman, 1997; Rogers et al., 1977; Taylor, 1989); application of negative schemes (Berk, 2003; Kuiper, MacDonald, & Derry, 1983; Markus, 1977; Rugel; Williams, Watts, MacLeod, & Matthews, 1988); and rejection of positive information about the self and others (Rugel; Traverse & Dryden, 1995) are themes reported in literature that also appeared in the data of this study. The inability to accept the perspective of another person, as described in Selman's (1980) model, forms part of the negative scheme that also clearly appeared in the data of this study.

Action or Interactional Strategies: Unhealthily Handled for which Therapy from a Medical Hypno-analytical Perspective is Used to Replace …

Unhealthy or bad handling of emotional problems (including low self-esteem and emotions like depression and anxiety) and searching for psychological help for the problem were the two actions or interactional strategies, which clearly surfaced amongst the research participants of this study.

Unhealthy or bad handling

Substance abuse, whether currently or in the past, by the participant or his parents formed a central part of the responses obtained during the clinical interviews, as seen from the following. "I drink until I'm drunk … I take lots of vitamins, weed, thins, alcohol. It's an emotional thing. Sometimes I drink too much. Then I feel excited. It makes me feel free."

> *I become very cross … then it feels as if I want to do something to the girl [his stepdaughter whom he had molested] and myself. My life is not much worth at the moment. I struggle with self-confidence. Other people's trust in me has been shocked and my trust in other people has been disappointed. I cannot find a way of releasing my anger in a meaningful way. I sometimes share it with my friends. I used marijuana for the past 12 years. I do not get any kick from it anymore. I cough regularly. I drank alcohol regularly with my wife for approximately 8 to 10 years … I have been feeling so bad for the past 12 years … Contributing to my problems is the criticism of my partner, especially when I am drunk. She will make comments about our sex life, the*

> *size of my penis and accuse me of relationships. Every time she did this I would lose my self-respect and my respect for others.*

The researcher formed the impression that the participants tried to escape from their problems (including low self-esteem) by the abuse of substances. Therefore, in this research the problematic behaviour, namely the abuse of substances/substance abuse, is seen as an action or interactional strategy, regarding the handling of their low self-esteem. Literature supports this tendency of bad handling of emotional problems, which includes substance abuse in patients with low self-esteem (Rugel, 1995; Rakos, 1991; Sackheim, 1983). The participants' bad handling could also be related to learned negative behavioral patterns fixed in the unconscious (Matez, 1992). It is activated by some form of stress in the individual's life. It often surfaces as a pathological symptom to help the person handle the stress because the information (the learned negative behavioral pattern in the unconscious) is negative and intensely emotionally loaded.

Psychotherapy

The research participants who experienced self-esteem problems sought help in the form of psychotherapy. In this study, viewed from a grounded theory perspective, it is seen as an action or interactional strategy used to prevent or handle their self-esteem problematics. As mentioned earlier, the improvement of self-esteem and self-efficacy can be a powerful tool of intervention in psychotherapy for a wide variety of patients, and this can be facilitated by different psychological approaches.

Other action or interactional strategies

Another action or interactional strategy employed by participants, as indicated in the research data, is functioning in the workplace. The participants tried to overcompensate, losing balance in the process and adding to work stress and pressure.

> *What makes my problems worse is when I have a fight with my wife or when my karate-students do not do well, or when I have tension at work. The colour of my skin also counts against me. There are a lot of politics involved. I do not want to die in this job. I would rather do Korean karate fulltime … and also combine it with other activities for children like parachuting and target-shooting …*

This tendency correlates with Rugel's (1995) findings that overcompensation is often an action that manifests itself in individuals with low self-esteem.

Other actions or interactional strategies used by participants to handle their self-esteem were, on the one hand, involvement in social life or with friends, usually coupled with substance abuse, and on the other hand, social withdrawal, isolation, or social reservation. The literature underlines (Rakos, 1991; Rugel, 1995) the fact that individuals with low self-esteem cannot maintain interpersonal relationships. They can be overly careful, shy, and anxious within relationships and even withdraw socially. They show a lack of self-assertiveness to avoid disapproval or anger and to protect their self-esteem. They can also be aggressive and attacking in an effort to ward off perceived threats to their self-esteem. From the data of this study, the latter is especially true for participants abusing substances.

Consequences of Low Self-Esteem: To Replace Negative Labels by Facilitating the Attachment of Positive Meaning to His Self-Esteem

Negative labels

With the help of selective coding, it was determined that the consequence of low self-esteem is negative labeling of the cognitive, physical, emotional, functional, habitual, interpersonal, sexual, and spiritual nature according to which the male patients think, feel, and act. Examples of such negative labels acquired with self-esteem induction in hypnosis are the following, "brainless;" "stupid;" "hunchback;" "bad self-image;" "washout;" "backward;" "inferior to many people;" "immature;" "passive;" "uncertain;" "I'm worthless;" "good for nothing;" "rapist;" "weakling;" "bully."

The nature of these labels corresponds with Branden's (1969) understanding of mental illness, namely the continuous weakening of the capacity to maintain and carry out reality bound cognitive functioning. The medical hypno-analytical model of Matez (1992) sheds further light on the dynamics related to negative labels. Since the unconscious mind is unable to think, reason, and understand it can only receive information and react to whether the information is right or wrong, good or bad, negative or positive. The unconscious also cannot delete thought, and that is why individuals experience problems with regards to their self-esteem.

Positive labels

Examining the positive labels of the participants is also helpful in understanding how the participants view themselves. Positive labels, like negative labels can be divided into different dimensions, namely cognitive, physical, emotional, work functioning, habits/lifestyle, sexual, and spiritual. The awareness of these positive labels was increased in the participants through psychotherapy. The following are examples of such positive labels, which were found by means of self-esteem induction in hypnosis, "intelligent;" "clever;" "wise;" "attractive;" "good self-esteem;" "good self-image;" "joy;" "loving;" "well balanced;" "potential;" "friend;" "good husband;" "good father;" "dignified;" "masculine;" "God loves [me] very much;" "peace".

The nature of these positive labels correspond with the definition in Plug et al. (1997) of mental health, "a condition of being relatively well adjusted coupled with a feeling of contentment, zest for life and actualizing of potential and abilities, as well as the absence of psychopathological conditions" (p. 117). The positive labels therefore, not only shed light on the participants' positive association with self-esteem, but also on their perspective of what mental health entails for them.

Discussion

Since the qualitative research paradigm was used, it led to intense moments during the collection and analyzing of the data, where I felt as if I was standing in the shoes of the respective participants. I could greatly empathize with them because of the increased understanding facilitated by the study regarding psychotherapy patients. This reflects on some of the functions (e.g., acceptance, empathy) a psychologist has to perform when treating patients with low self-esteem (Egan, 1994; Rogers, 1951; Rugel, 1995). Since I (both as psychologist and researcher in this study) formed close relationships with the participants in this study, it undoubtedly follows that qualitative research cannot be without any values: The researcher is subjectively involved with the participants and cannot assume a totally objective uninvolved position. This study offers *a* perspective on the self-esteem of

psychotherapeutic patients. It does not claim to be the only way of understanding (*verstehen*) the participants' self-esteem.

Although my supervisors and I were satisfied with the general theoretical conclusions of the study, there are several limitations that we must live with, and from which we have learned lessons that will influence possible future research. The limitations of this study can mainly be found in the selection of the research participants. I selected only 11 men (and not women) as research participants. They were Afrikaans speaking and the original research was done in Afrikaans, therefore I had to translate their words into English for the purpose of publication. This has the potential to take away or influence some of the original meanings that the patients attached to certain phenomena.

The fact that only 11 men were selected for this research creates the opportunity for future research in which the self-esteem of more/other groups can be studied (e.g., women, retired or old aged people, teenagers, children, and members of other ethnic and or culture groups). Qualitative research with regards to self-esteem issues must be done, in which more research participants can be selected in order to construct more theories from the data. Qualitative research with regards to the self-esteem of psychotherapy patients, in which only one of the 23 categories co-constructed in this study (e.g., childhood years, family of origin, interpersonal relationships, marital life or sexual problems), can be focused on in the future. Studies relating to what the impact of the negative and positive labels that psychotherapy patients attach to their self-esteem, based on role players' (in the social science) definition of what psychopathology and mental health is, can be conducted. Research that can attempt to answer the following question should be done, "In what way can the meaning that patients attach to their self-esteem be elicited in order to enhance the quality of psychotherapy from a medical hypno-analytical approach with patients who suffer from low self-esteem?" Studies relating to the impact of negative suggestion on the psychological problems of psychotherapeutic patients versus the impact of positive suggestion on the prevention of psychological problems and enhancement of mental health can also be conducted. I would encourage therapists using hypnotherapy as their main therapeutic approach to do more qualitative research in order to make a contribution to psychology from the rich data their patients give to them.

Conclusions

The main storyline was conceptualized as follows:

> Negative suggestion from the patient's past leads to low self-esteem, which is within his emotional problematics, and by means of a negative thinking scheme, unhealthily handled for which therapy from a medical hypno-analytical perspective is used to replace negative labels by facilitating the attachment of positive meaning to his self-esteem.

The analyzed and interpreted data indicated the significant influence of low self-esteem, which crystallized as the core category and central phenomenon of the study in almost all areas of the psychotherapeutic patient's life, including cognitive, physical, emotional problems, experience of the family of origin during the childhood years, sexuality, habits, social or interpersonal relationships, religion, and marital life. This finding closely relates to the literature described above.

In this study it was found that the meanings of both negative and positive labels could be placed on a holistic level (e.g., the cognitive, physical, emotional, interpersonal, work functioning, habits/lifestyle, sexual, and spiritual). Holism is defined by Plug et al. (1997) as "the perspective that a living being is a whole and should be studied as such since

the whole exhibits characteristics which cannot be discovered in a study of its separate parts" (p. 147). This study therefore studied the respective participants as a whole in terms of their experience of their self-esteem. The different dimensions of self-esteem reflected by negative and positive labels (e.g., the cognitive, physical, emotional, interpersonal, work functioning, habits/lifestyle, sexual and spiritual) were seen as composite elements of self-esteem and were therefore not examined separately. This corresponds with Du Toit (2000) who is of the opinion that a holistic approach to man as a unity of mind and body supposes spirituality, which is universally true of the human nature.

I found it significant that the negative labels were mostly related to labels that can be categorized under emotional problematics. The physical and sexual dimension, however, did not carry much weight with regards to positive labels of the male psychotherapy patients, but the spiritual dimension featured strongly. This finding differs from that of Rugel (1995) who found a much stronger link between physical appearance and low self-esteem, although it must be mentioned that he used male and female research participants. The strong featuring of the spiritual dimension corresponds with the revaluation of the post-modern man as a spiritual being as reflected in recent cultural scientific literature (De Villiers, 1997, 1999; Du Toit, 2000). The negative labels of the participants, especially those linked to cognitive functioning, relate with what is understood as mental illness, namely the continuous decrease in capacity for reality bound cognitive functioning (Branden, 1969) as opposed to the positive labels which relate to what is understood as mental health, namely "a condition of being relatively well adjusted coupled with a feeling of contentment, zest for life and actualizing of potential and abilities, as well as the absence of psychopathological conditions" (Plug et al., 1997, p. 117).

This study endeavored to tell the stories of a group of male psychotherapeutic patients with low self-esteem within the context of the research process. The voices of the participants in this study are those of people finding themselves in a post-modern spirit of the time. This study supports Du Toit's (2000) viewpoint that a revaluation of man as a spiritual being is surfacing as a significant gain within the postmodernism, where human behavior is not only determined by reason and logic. The participants' voices not only verbalized the content of their conscious thoughts, but also the strong emotional content of their unconscious thoughts. This account of the study is concluded with the voice of a participant who expressed his expectations with regards to an improved self-esteem.

> *I would like to become a better person. I want to make a success. I do not want to commit suicide. I would like to experience happiness, love, respect, self-esteem, self-respect and self-confidence. I want to change. I am going to change. I am making a promise to myself. I do not want to be the person I was. I want to feel that I am becoming a better person. My expectation is to become a better person …*

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