THERAPIES FOR LOW SELF-ESTEEM REVIEW: CLINICAL PROFILE AND ACTION MECHANISMS

REVISIÓN DE TERAPIAS PARA LA BAJA AUTOESTIMA: PERFIL CLÍNICO Y MECANISMOS DE ACCIÓN

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Abstract

Six different therapies that have been used to treat low self-esteem are reviewed. Although their clinical approaches are very diverse, all of them, nevertheless, end up improving the patient's self-esteem. To try to answer this question, we approach this review in two successive phases. First, the clinical profile of each therapy will be extracted and analyzed – e.g., its etiology, assumptions, therapeutic objectives or treatment techniques; and, secondly, its specific mechanisms of action (AM) –its therapeutic nucleus– will be compared with respect to the achievement of the patient's personal objectives - positioning those on a system of components of personal competence and efficacy. It is concluded that all the therapies would be effective because, although each one of them acts only on one or two components, its effect would then radiate through the system from there to self-esteem.

Keywords: *self-esteem, low self-esteem, therapy, review, action mechanisms.*

Resumen

Se revisan seis terapias diferentes que se vienen utilizando para tratar la baja autoestima. Aunque sus enfoques clínicos son muy diversos, todas ellas, sin embargo, acaban por mejorar la autoestima del paciente. Para intentar responder a esta cuestión, abordamos esta revisión en dos fases sucesivas. Primero, se extraerá y analizará el perfil clínico de cada terapia –e.g., su etiología, supuestos, objetivos terapéuticos o técnicas de tratamiento; y, en segundo lugar, se compararán sus específicos mecanismos de acción (MA) –su núcleo terapéutico– respecto del logro de objetivos personales del paciente -posicionando aquellos sobre un sistema componentes de competencia y eficacia personales. Se concluye que todas las terapias resultarían eficaces porque, aunque cada una de ellas actúe únicamente sobre uno o dos componentes, su efecto se irradiaría luego por el sistema desde ahí hasta la autoestima.

Palabras clave: *autoestima, baja autoestima, terapia, revisión, mecanismos de acción.*

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Low self-esteem is detrimental to individual's mental health, and is present in all ages of the population (Steiger et al., 2015; Taylor & Montgomery, 2007; Wanders et al, 2008). Hence, extensive research has been carried out in this study field -in the PsycINFO database there are more than three hundred and fifty references whose title includes the terms "low + self-esteem"-and more than one hundred and fifty for "self-esteem + therapy". This review is motivated by the fact that all therapies to treat low self-esteem achieve an improvement in the patients' self-esteem, even deriving from very different clinical approaches, which constitutes an unknown -now ruling out the placebo effect. The initial question would be, then, how does such improvement occur? Furthermore, bearing in mind that the achievement of personal goals constitutes a key aspect of self-esteem (Lindsay & Scott., 2005), even determining the state of the personal self-regulation system (Wells, 2000), we would come to a second question, how to compare the therapeutic effect of the treatments regarding said achievement? We will try to answer both questions by first reviewing each therapy to extract their principles and clinical peculiarities, and then analyzing and comparing their mechanisms of action (AM) with respect to the aforementioned achievement of goals.

For reasons of space, this review will not be exhaustive and will only be representative of the therapies that are routinely applied to combat low self-esteem. For this purpose, we have chosen three classical therapies and three others of more recent implementation, whose set, we believe, sufficiently covers our field of application.

Although the objective of this work is not to present a self-esteem theory, in order to facilitate the understanding of our analysis, we consider it appropriate to specify first of all what are our starting assumptions regarding the concept and model of self-esteem. Specifically, the following is assumed: (a) although self-esteem is not reduced to the achievement of personal goals, it does reflect the degree to which they have been met (Lindsay & Scott, 2005) -irrespective of whether the individual is or not aware of it; (b) personal goals emerge and are always oriented towards those domains valued by the individual (Hayes-Skelton & Roemer, 2013) -for example, personal appearance or social acceptance; and (c) the achievement of personal goals is highly dependent on the individual`s competence and performance (Soral & Kofta, 2020).

It is worth noting that the orientation towards goals is something constitutive of the behavior of all living beings (Locke, 1969), being linked to the satisfaction of basic motivations (Maslow, 1954), and depends on those all values that inform the action (Morales et al., 2019) In the treatment of some mental disorders, the patient's personal values and goals are already being considered -e.g., in therapy for generalized anxiety in adults (Hayes-Skelton & Roemer, 2013) or for anxiety and depression in adolescents (Kumara & Kumar, 2016).

We will carry out this study in two phases. We will first analyze the different therapies in order to extract their essential therapeutic aspects -e.g., what etiology of the disorder they defend (Bouton et al., 2001; Ioannidis, 2015) or what are their

respective AMs (Bergmann, 2010; Desrosiers et al., 2013). However, the analysis of those other more protocolary aspects of their treatments -number of sessions, periodicity ...- as well as the empirical results that support them will be omitted. Secondly, we will proceed to compare the respective AM of each therapy. We will make use the AMs because they constitute the therapeutic core of each clinical approach since: (a) they act on those aspects that each approach considers key in psychopathogenesis, (b) they are consistent with their respective definitions of self-esteem, and (c) they also determine their own therapeutic objectives and the techniques to use. That is, the AMs are the backbone of all therapy.

Our comparison objective responds to the following approach: given that self-esteem depends on the achievement of goals, let us then investigate its conditioning factors -consequently, this matter will become the primary object of the second phase of our review. To this end, and in order to offer here at least a hypothetical explanation to the second question posed, we propose and will use a set of components of individual's effectiveness and competence. Such components are related to the achievement of personal goals, they are organized systematically, and their final term is just such goal achievement. With this set, it will be possible to first frame, and then compare each other, the therapeutic effect of each AM in relation to the achievement of goals (see figure 1).

The proposed system of components, it should be noted, is not presented as a theoretical model to explain self-esteem, but only as a mere instrument, of practical value, that allows us to position the different MAs, and then compare them with each other to answer the second question raised above. Its detail and preliminary justification will be explained below in the corresponding section. From a methodological perspective, it is a pre-theoretical concept system, but perfectly compatible with scientific research tools (Bunge, 2000). Its internal structure presents unity of discourse around the achievement of personal goals; divides its components into two well differentiated classes -components of efficacy and competence of the individual-, orders them linearly into two vectors of effects -vectors of efficacy and competence-, and represents objective -that is, non-arbitrary- connections between them (op.cit., pp. 67-68).

Clinical Approaches

We will perform an orderly exposition of several current approaches to treat low self-esteem, grouped into two categories: classical therapies and latest-generation therapies. Within the first category, we will review trait and construct, cognitive-behavioral and behavioral-rational-emotional therapies; and within the second, the mindfulness approach, the EMDR technique and metacognitive therapy. Unlike classical therapies, new-style therapies do not initially focus on *content*, be it content of traits, content of constructs, or content of mental representations, but on cognitive *processes* such as refocusing attention or consolidating memories in memory. In general, these last therapies seek to implant in the patient a new pers-

pective about what is occurring in his mind. Such a dichotomy supposes actually a simplification, but we resort to it with didactic intentions. Indeed, content and processes are involved in all therapy, be it to one degree or another.

On the other hand, the succession in time of various therapeutic approaches to cure or alleviate an identical disorder does not occur by chance. It is paced according to the revolutions produced in psychology, which, in turn, follow from the general revolutions that would have previously taken place in science (Leahey, 1992). Specifically, the changes that have been producing in psychotherapy are explained by the theory of dynamic systems (Hayes & Strauss, 1998).

Classical Therapies

Trait and Construct Therapies

Within this class of therapies, we will jointly examine those of Hall and Terrier (2003) and the fixed-role therapy, magnificently exposed by Pervin (1975), based on the constructs of Kelly (1955/1991). We include these therapies in the same group because in both cases the treatment revolves around the therapeutic objective that the patient identifies himself with a series or structure of personal attributes. In fact, in fixed-role therapy, a personality model is outlined and given to the patient, a role to which he has to conform.

It should be noted that, although the first two authors present their treatment as cognitive-behavioral therapy, in reality the essence of it is concentrated around personal traits, as we will see later. Conversely, fixed-role therapy is not reduced to the content of the constructs, but from them an atmosphere of experimentation is generated that obviously implies the processing of new information.

For these therapies, the etiology of low self-esteem lies in the fact that the patient does not know or does not behave according to certain personal traits or constructs that he values positively -be it explicitly or implicitly. The underlying therapeutic assumption is that self-esteem occurs when the individual is -and so he recognizes himself- in a particular way. Therefore, their therapeutic objective is to help the patient to be just that way -identifying and behaving according to his profile of desired traits. Hall and Terrier (2003) postulate that, if the patient were already in possession of such traits, then their application and staging would be facilitated. On the other hand, in fixed-role therapy, the best option is to reveal to the patient his own implicit personal constructs, which he has already used to value others and value himself although without being fully aware of it, and a personality model (construct structure) is offered to him as a role to become that person. Indeed, the patient is urged to think, feel, and act according to the role (Pervin, 1975).

The *technique* applied to fix the "model" traits will be to list a set of positive qualities that the patient admits that he already possesses (Hall & Terrier, 2003) or to make his personal constructs clear from a list of significant social roles in his life (Kelly, 1955/1991), having to abandon certain constructs and admit others (Pervin,

1975). The selected traits are then first practiced in therapy and then applied to real situations. Thus, the bulk of the therapeutic task falls on shaping and modeling certain specific behaviors derived from those traits or constructs. Their AMs work when the patient sees himself and behaves according to that profile. Despite their importance, the patient's personal goals are not explicitly addressed in this therapy.

Cognitive-Behavioral Therapies

As is clear from its name, theses therapies work at the same time on the patient's cognitions -contrasting them- and his behaviors -training new skills. Both therapeutic moments are integrated in order to improve the patient´s interaction with his environment. In this category, we are going to review the therapies applied by Whelan et al. (2007), McManus et al. (2009), Jacob et al. (2010), Waite et al. (2012), Parker et al. (2013), and Pack and Condren (2014) -almost all of them given in groups. As we will see, even if these authors share the same therapeutic approach, they later differ in the details.

They consider as a cause of low self-esteem, as its etiology, the acceptance by the patient of irrational beliefs about himself, which bring him an outcrop of symptoms and lead him to behavioral inhibition and, even, to the performance of counterproductive compensation behaviors. According to McManus et al. (2009), these compensation behaviors are governed by certain "rules of life" that the patient has established to behave. The therapeutic assumption is that self-esteem will ensue once the patient holds rational self-beliefs about himself, opening himself up to new experiences as a result. Their AMs work by consolidating these last self-beliefs and fostering new adaptive behaviors -which will reinforce the change (McManus et al., 2009). It is understood that valid self-knowledge will tend to clarify the patient's personal goals, while the practice of new skills will instill him self-confidence -thus dynamizing the patient's interaction with his environment.

Hence, it is understandable that their primary therapeutic objective is precisely the change of core beliefs that maintain low self-esteem, followed in second place by skills training. To achieve this, they resort to a wide repertoire of cognitive and behavioral techniques – e.g., self-recording and contrasting of automatic thoughts, conducting behavioral experiments. In particular, Whelan et al. (2007) try to get the patient to first invalidate his bottom-line belief -this expression refers to the belief that the patient has about himself made up of negative global self-evaluations and an insufficient evaluation of his value as a person, generated in the wake of negative experiences usually at a young age, making him aware of the qualities he possesses afterwards. McManus et al. (2009) claim that he develops adaptive life rules, guided by a rational theory about himself; Jacob et al. (2010) focus on strengthening his self-confidence, self-acceptance and self-care; and Waite et al. (2012) seeks to implement beliefs, rules of conduct and skills that favor his adaptation and future planning. Finally, Pack and Condren (2014) lead the patient to challenge both his beliefs of low self-esteem and their associated behaviors, and to practice new skills.

The task of therapy is focused on helping the patient to invalidate his biased beliefs, replacing them with rational ones, refocusing the attention on his positive aspects, and promoting the learning and implementation of new skills. A decisive role in these therapies is played by psychoeducation: Whelan et al. (2007) explain to the patient how his bottom-line emerges as a result of negative experiences; McManus et al. (2009), and Pack and Condren (2014) show him the origin and maintenance of low self-esteem; while Parker et al. (2013), on the other hand, include aspects concerning depression and anxiety and a healthy lifestyle in patient education. Nor does this clinical approach address personal traits, focusing its work, as we have been commenting, on dismantling biased cognitions of the patient about himself -due to cognitive errors (Beck et al., 1979). Regarding the latter, it is worth noting that each author uses their own terminology to effectively refer to the same concept of irrational belief: McMannus et al. (2009) speak of "dysfunctional assumptions", Jacob et al. (2010) of "dysfunctional basic assumptions", Waite et al. (2012) of "self-critical beliefs", and Pack and Condren (2014) of "negative core beliefs".

As we anticipated before, all these therapies include, as their essential component, the development and learning by the patient of new behaviors and skills. Whelan et al. (2007) lead him to behave in such a way as to obtain positive social responses that reinforce his self-esteem, and they also train him in assertive skills. McManus et al. (2009) teach him cognitive skills to reevaluate his thoughts and beliefs and to change his rules of life. Jacob et al. (2010) facilitate both that he identifies his basic dysfunctional assumptions and exposes them in the therapy group, as well as that he carries out behavioral experiments in order to invalidate such assumptions, also promoting that he develops a kind treatment with himself. Waite et al. (2012) also uses behavioral experiments in order to establish functional behavior rules. Parker et al. (2013), meanwhile, instruct him in behavioral activation tasks, relaxation techniques and stress management; while Pack and Condren (2014) teach him new rules of life and how to establish a self-management plan.

It should be noted that these therapies act on the patient's goals only tangentially. Whelan et al. (2007) limit themselves to suggesting that he meets his own needs; Jacob et al. (2010) that he recognizes the importance of his needs; while Waite et al. (2012) does not go beyond helping him plan his future.

Behavioral-Rational-Emotive Therapy

Even if, actually, it is one more element of the set of cognitive therapies, we analyze it separately in attention to its peculiarities. We will review in this place the therapy applied by Roghanchi et al. (2013) to improve low self-esteem -that they combined with art therapy in order to also increase resilience.

For the present approach, the *etiology* of low self-esteem consists in that the patient elevates himself -and the world in general -a set of irrational demands that are completely unattainable. See some instances of these: "I have to do things well and that the people I care about approve what I do or, if not, it will mean that I am

not good enough", "The situations that surround me must be such so that they provide me with what I want, when I want it, and they should never provide me with anything that I don't want"(Ellis, 1996). Therefore, the therapeutic assumption is that if the patient held more reasonable expectations about himself and the world, then he would feel self-esteem. Its AM works by exchanging the patient's irrational "shoulds" for an unconditional acceptance of how things really are and how he is himself along with them. This would reduce his frustration and concomitant discomfort even when impossible expectations had not been met.

The therapeutic objective to be achieved is none other than the patient being aware of such self-demands -and demands in general-, lower their level of demand, and carry out adequate and satisfactory behaviors. With regard to the technical apparatus, these authors use, as in all cognitive-behavioral therapy, different cognitive and behavioral techniques -e.g., cognitive dispute, contextualization of events, cost-benefit analysis, self-dialogue, role playing. Within the tasks of therapy, the counterargument with the patient in order to modify his thoughts, and the negative feelings that they drag with them, and psychoeducation stand out. They teach the patient both the classic A-B-C-D-E model -where A = activating events, B = behavior, C = consequences; D = debate and E = new effects-, as well as the most salient irrational beliefs as compiled by Ellis (1996). It does not expressly work on the patient's goals, although, nevertheless, it does offer him a design for the change of his future life -albeit of a very generic nature.

Latest-Generation Therapies

Mindfulness Approach

We will examine in this section the therapy of Fennell (2004) -a leading author in the field of self-esteem, although this work of his also applies to depression.

According to this approach, the etiology of low self-esteem -and also depression- consists in the patient falling and indulging himself in excessive processes of self-devaluation, exaggerating his failures and defects, and minimizing his successes and qualities. In short: repeated processes of exacerbated self-criticism and self-blame underlie low self-esteem. His therapeutic *assumption* is that if someone managed to see himself as completely normal, even when thoughts of being inadequate came over him, then he would perceive self-esteem. As can be seen in this assumption, the approach that concerns us seeks to mark distances between the individual and his own cognitions, something that is not strange at all given its metacognitive foundation.

Its AM exercises its function by de-centering the patient from his self-critical thoughts. By distancing him from long-standing mental schemata -keep in mind that low self-esteem usually originates from difficult early experiences- their emotional, motivational, physical, and behavioral consequences are attenuated or neutralized. The work of Desrosiers et al. (2013) shows how mindfulness works

together through common and different mechanisms depending on the particular clinical context -specifically, the associations between mindfulness and anxiety are mediated by rumination and worry, while the associations between mindfulness and depression are mediated by rumination and assessment of negative experience.

The therapeutic objective is that the patient goes from seeing his thoughts about himself as a faithful reflection of objective reality to conceptualizing them as mere transitive mental events –that they are solely and exclusively ideas or opinions learned in previous experiences that occur now in consciousness. The content of the cognitions is not contrasted or adjusted in any way, but rather an attempt is made to change the relationship that the patient maintains with them, seeking a change in attitude about his internal experiences -by distancing thought and reality, hypotheses and facts. This general objective is then specified in particular objectives such as making interpretations more flexible -anything, including oneself, can be viewed from different angles; realizing that the habitual negative view is just another possibility and not necessarily the truest; or develop a conscious thought about oneself instead of being carried away by one thought of an automatic nature.

As its idiosyncratic technique, its uses insight meditation –non-critical self-awareness-, which is accompanied by other external techniques, such as verbal discussion and behavioral experiments. The therapy work focuses precisely on breaking the negative connection between the individual and his self-critical thoughts -which end up leading him to discouragement and depression.

The mindfulness core is not concerned with traits, cognitive contents, or new overt behaviors. In any case, the mental strategy instilled in the patient could be categorized as new covert behavior so that he no longer struggles or tries to get rid of his cognitions, but instead of doing that, he simply gets used to staying in them, exploring them, moving away from such internal processes of his instead of identifying with its contents. Nor does mindfulness expressly connect with the patient's goals, although it does encourage him to build a new vision of himself, acting with himself from now on from a friendly and self-accepting perspective -which in the end could result in a modification, adequate or rethinking of such goals.

EMDR technique

In this section we will review Wanders et al. (2008) therapy -although they compare cognitive-behavioral therapy with the EMDR technique, we will limit ourselves here solely and exclusively to the latter. They use the general procedure of the EMDR technique -acronym for "Eye Movement Desensitization and Reprocessing"- although applied to traumatic situations that caused the patient his perennial dismissal.

They estimate the etiology of the low self-esteem that the patient suffers in those traumatic events that he would have experienced, mostly, but not exclusively, at an early age; and whose memories and deep personal impact have not yet fully consolidated in memory, which is why they continue to easily surface in his

consciousness along with the negative emotions that they carry. The latent therapeutic assumption is that, if the trauma was definitively stored in memory, then self-esteem would ensue.

Its AM works in two consecutive phases. First, interconnecting the "floating" memories about the trauma that anguish the patient with various other memories, indistinctly positive or negative, already consolidated previously in his memory -in its desensitization phase. And then assigning a more rational and benign personal meaning to the response that the patient gave to the trauma -in its reprocessing phase. Both processes together will mitigate or eliminate the frequent re-experience of the traumatic situation and the concomitant hyperarousal. Regarding the specific performance of this technique, Pagani and Carletto (2017) favor the hypothesis called SWS for "Slow Wave Sleep" to explain the reorganization of distant functional networks as well as the reconsolidation of the new associated information. For their part, Maxfield (2008), and Bergmann (2010) offer us detailed information on this mechanism and even its historical review.

Therefore, its therapeutic objectives are none other than desensitizing traumatic memories to release the negative emotional charge that they carry and install a satisfactory self-assessment of the patient about himself in the triggering situation. For this, they exclusively use the EMDR *technique*, in the company of some auxiliary strategy -for instance, the processing of a safe place. The task of the therapist is limited first to collecting and graduating the aversity of the memories about the trauma as the patient values them, and later to redirecting the entire EMDR process, as the desensitization and reprocessing turn out. During the sessions, the patient intervenes only passively, reducing his role to transmitting to the therapist what is emerging in his consciousness and to reevaluate, when the latter asks him to do so, how the aversive charge of each one of them is evolving at the present moment. the memories that are being treated -during desensitization-; and to evaluate the confidence that is acquired in the new self-belief -during reprocessing.

In this technique, the contrast of beliefs that the patient had about himself as a result of the trauma experienced is not contemplated, but rather they are directly replaced by others in memory – e.g., replacing the previous belief "I am worth nothing" by the new belief "I am worth enough, but that situation overwhelmed me …". Neither are the purpose of this therapy nor the personality traits, nor the learning of new behaviors, nor, of course, the goals of the patient.

Metacognitive Therapy

We will examine the work of Kolubinsky et al. (2016, 2018 and 2019). In their article of the year 2018, they review the cognitive-behavioral interventions based on the Fennell model mentioned above.

From this approach, the etiology of low self-esteem resides both in: (a) a bottom-line belief of the patient -low self-esteem scheme- caused both by previous situations of disaffection, neglect or rejection to which he has been subjected and

in (b) rules of life that he has developed for himself since then and that he has been using to compensate for the unfavorable consequences of that scheme. Such rules end up failing when faced with certain present situations, thus reactivating low self-esteem along with negative emotions and counterproductive behaviors. Low self-esteem is maintained by a set of metacognitive beliefs and control strategies activated when self-esteem needs are not covered. The most pronounced manifestation of low self-esteem and its best predictor is found in self-critical rumination, the recurrence of which is based on positive metacognitions about its value or usefulness – e.g., "getting involved in rumination helps me to be more realistic and logical "; and negative metacognitions about its harmful effects – e.g., "getting hooked on rumination makes me feel very tired and without any motivation or appetite to do something else" and about its uncontrollability — e.g., "I will constantly think about it (mistakes)". In sum, for this therapy, chronic self-critical rumination is just the process that perpetuates low self-esteem.

The therapeutic assumption that can be ascribed to this approach is that if the patient were able to eliminate self-critical rumination along with the processes of avoidance and control that it brings with it, then he would experience self-esteem; and its AM works by eliminating such self-punishments from the patient after having made a mistake, having a personal failure or receiving a social rejection -by questioning the underlying meta-beliefs. The therapeutic objective is to reduce the symptoms by eliminating CAS -acronym for "Cognitive Attentional Syndrome" -a persistent and toxic way of thinking with rumination, worry, persistent threat monitoring, and control strategies such as thought suppression or distraction.

These authors work with a rich range of techniques. To collect information about the case, they use a structured interview on antecedents, positive and negative metacognitive beliefs self-critical rumination, objectives of this last process and its stop signal, and on the patient´s distancing from invasive self-critical thoughts. To combat metacognitive beliefs, they resort to Socratic reattribution and questioning. Instead, to interrupt self-critical rumination, gain flexibility in the face of invasive thoughts and learn new responses to them, disengaging from them, they use attention management and training techniques -ATT, "Attention Training Technique", and DM, "Detached Mindfulness". The *task of the therapist* is solved by following the thought patterns carried out by the patient and the application, where appropriate, of the suitable corrective measures.

In this therapy, the cognitions that are contrasted are those metacognitions that maintain self-critical rumination in force. Regarding new behaviors, they train the patient in the two aforementioned cognitive strategies, ATT and DM, leading him to reflect at the same time on his past mistakes to learn from them and solve problems. Neither personal traits nor overt behaviors are the object of this therapy; nor are the patient's goals, although in this regard they do try to install a kind of unconditional acceptance of himself (Ellis & Bernard, 1985), regardless of his true personal ability or the external approval received.

Action Mechanisms

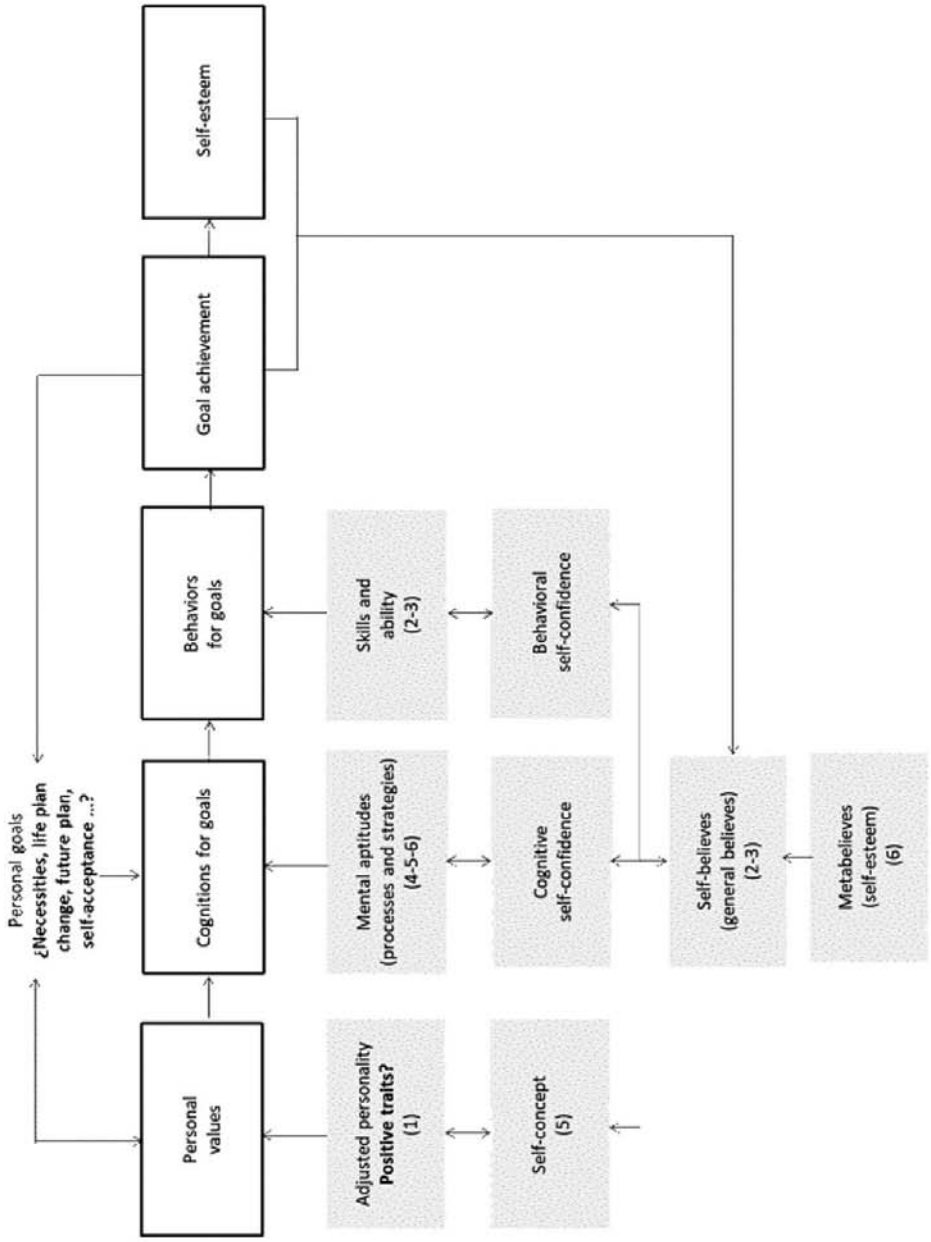
As we anticipated in the Introduction, we will now compare AMs using a system of components, all of them relevant to the achievement of personal goals (see Figure 1).

System of Components

It is made up of two component vectors: a personal efficacy vector whose effects go towards the achievement of goals, and another personal competence vector whose effects go just towards the previous vector. The overall final effect would be received by the patient's self-esteem. Apart from this, the system includes personal goals and two feedback processes, since the achievement of goals is subject to self-regulation (Webb & Sheeran, 2005). In order to achieve a conceptually adequate combination among the various components of personal competence and effectiveness, both types of components are articulated with each other according to their meaning and function. Thus, the skills and abilities component are linked to the behaviors for goals component, while the mental aptitudes (processes and strategies) component is linked to the cognitions for goals component. As it is verified, the systems of components provides us with an ideal conceptual "frame" to carry out the subsequent comparison of the AMs (see Figure 1).

Figure 1

System of Components of Personal Competence and Efficacy for Individual's Personal Goal Achievement and Self-esteem



Note: Personal efficacy vector (boxed blocks and white background). Personal competence vector: first row: objective components; second row and the two lower blocks: subjective components (blocks without a box and with a gray background). The numbers within the blocks indicate the component where the therapeutic effect of the mechanism of action of each of the six reviewed therapies directly affects: 1. Trait and construct, 2. Cognitive-behavioral, 3. Rational-emotional, 4. Mindfulness; 5. EMDR; and 6. Metacognitive.

The development of the personal efficacy vector has been based on the theory of action cited by Frese and Zapf (1984) -see also (Hacker, 1985: Morales et al., 2019). Its sequence of components -personal values, cognitions for goals, behaviors for goals and goal achievement- takes as given that from the reciprocal action between personal goals and personal values, cognitions and behaviors oriented to the achievement of such goals will be followed by the individual. The final result will affect the patient's self-esteem. This structure of components is equally consistent with theories on: reasoned action (Fishbein & Ajzen, 1975), planned behavior (Ajzen, 1991), the achievement of personal goals (Weeb & Sheeran, 2005), action-activation of decision making (Walczyk et al, 2014) and intentional action (Plaks & Robinson, 2017). The inclusion of this vector in the system of components is motivated because the result of any individual action does not fall exclusively on personal skills. There are also factors of person-environment interaction that always decide on the ability to achieve the desired effect. In fact, recently Bardach et al. (2020) have corroborated how such achievement depends closely on contextual factors.

For its part, the personal competence vector, compatible in turn with Bandura's theory of self-efficacy (1986), includes two types of components: (a) objective components: adjusted personality, mental aptitudes (processes and strategies), and skills and ability, which in the system are located in direct connection with the personal efficacy vector since, we estimate, the internal adjustment and competence of the individual play a determining role in the achievement of personal goals; and (b) subjective components: these components are arranged in three levels. The first includes the components of self-concept, cognitive self-confidence, and behavioral self-confidence. They collect the self-awareness of the individual on various aspects of himself. These subjective components would have an effect on the objective components of competence, enhancing or weakening them. Their position in the system, just below the objective components, is motivated because there are internal barriers to the achievement of goals (Hayes-Skelton & Roemer, 2013), and also because different subjective features and variables come to moderate academic performance (Poropat, 2009). The second and third levels, already deeper in the mind, respectively house the self-beliefs (general beliefs) and metabeliefs (self-esteem) components.

In general terms, this system is consistent with the metacognitive approach in clinical psychology, where metabeliefs influence beliefs, and these, in turn, influence behavior (Wells, 2000). The end result of the behavior would be obviously conditioned by personal effectiveness and competence. From the foregoing it follows that beliefs could act on pre-existing competencies in the individual, but not generate them -a matter of learning.

In accordance with the ordering and logic underlying the system of components, it follows that an AM that works on personal traits or constructs will be located at a greater (conceptual) "distance" from the achievement of personal goals than another AM that directly trains instrumental behaviors for just this purpose. In

addition, it is assumed that the greater "proximity" of the therapeutic effect of AM with respect to the aforementioned achievement of personal goals will improve the patient's goal-oriented behavior, what will benefit his self-esteem. Finally, note that the transfer of effects between two successive or contiguous components of the system -within each vector individually or even between both vectors -always necessarily involves certain actions on the part of the individual. That is, the transfer of effects requires the individual to make certain logical inferences and/or to select and implement certain behaviors. Such actions are essential for the achievement of goals because, if they were not correct, they would compromise patient's final effectiveness. This would be the case, for example, of someone who had a good plan (cognitive aspect) to achieve his goals, but whose performance (behavioral aspect) was not adequate in the end due to lack of skills or ability. Thus, and according to our argument, the efficacy of those AMs that act on more distant components in the system with respect to the goal achievement component would be more at risk precisely because their therapeutic effect would have to be transmitted through a greater number of components.

Position and Effects

Summarizing the prior review, trait and construct therapies would act primarily on the personality; the two modalities of cognitive-behavioral therapies would do it on beliefs and abilities; mindfulness and EMDR on mental strategies and EMDR also on self-concept; and, instead, metacognitive therapy would work on metacognitions and cognitive strategies. The core AM of each approach would have a direct impact on certain components of personal competence -one or more. Then, from there, their therapeutic effect would spread in a cascade, first on the immediate components in the system, which would be their close therapeutic collateral effects, and then on the subsequent and remaining components, which would already be their remote therapeutic collateral effects. All these effects would converge first on the goal achievement component and then, from here, on self-esteem. Finally, effects would be fed back from the achievement of goals and self-esteem to the personal goals and self-beliefs of the individual -the systemic collateral effects.

Trait and Construct Therapies

Although their AMs act on a deep substrate of the patient, which is his personality, the *Adjusted personality* component is located at a considerable distance from self-esteem -as shown in Figure 1. Their effect on personal efficacy vector would be received by the of *Personal values* component, and from there it would be transmitted throughout this vector to the *Goal achievement* component. But since this issue is not expressly addressed in these therapies, the aforementioned transmission of the therapeutic effect through the efficacy vector seems somewhat difficult besides hazardous. Therefore, the therapeutic efficacy of their AMs will ultimately depend on how all those behaviors previously rehearsed in therapy, and

derived from certain traits or constructs, affect the achievement of goals. On the other hand, it is plausible that the identification and performance of the patient according to certain appreciated traits (fixed-role therapy) or constructs would improve his self-concept, later radiating different therapeutic effects from here to other components of the system.

In our opinion, both therapeutic approaches would have to solve two important questions: (a) how some positive traits or constructs would become by themselves, just like that, in an adjusted personality capable of clarifying personal goals, proposing them and achieving them -hence in Figure 1 the "positive traits" in the adjusted personality component are placed between question marks; and (b) how exactly those traits or constructs would be connected with those personal values that start all goal-oriented behavior -personal efficacy vector. In this regard, consider the interrelation between traits and goal achievement, as revealed by the trait-action motivation theory (Bernard, 2016).

Examining it rigorously, a juxtaposition of positive features or constructs, without any structure, could suffer from the lack of consistency necessary for the patient to achieve the goals that have been proposed. Based on this small digression, it could be suggested that a consistent personal structure, that is, what we call an adjusted personality, should encompass both instrumental traits to ensure success in goals and palliative or buffer traits to minimize failures that may be experienced. For instance, among the 16PF personality factors of Cattell et al. (1980), Factors B for intelligence and N for astuteness could count as instrumental traits, while Factor C for emotional stability would be a buffer trait. Indeed, it has recently been proven that emotional stability is significant for innovative execution and job performance (Lado & Alonso, 2017; Rodrigues & Rebelo, 2018).

Cognitive-Behavioral Therapies

Their AMs operate jointly on different levels of the personal competence vector: (a) on the *Self-beliefs* component, at a deeper level of the mind, and (b) on the *Skills and ability* component, at a more superficial level (see Figure 1). On the other hand, since also in these therapies the patient is urged to satisfy his needs and plan his future, a combined therapeutic action is then originated, as in clamp. from his self-beliefs and from his own personal goals, which would reinforce their final therapeutic effect. However, satisfying needs is a kind of somewhat imprecise version of meeting personal goals, which is why in the aforementioned Figure 1 "needs" are between question marks. Nevertheless, it could be conceded that this approach, being closer to personal goals achieving, would have some therapeutic advantage in treating low self-esteem.

Likewise, it is assumed that the new self-beliefs would also have a therapeutic effect on the self-concept, cognitive self-confidence and behavioral self-confidence components. These components in turn would enhance the three objective components of competence on which each of them acts. In addition, training in new skills

would by itself enrich the *Skills and ability* component, and would also improve the behavioral self-confidence component. On the other hand, those behavioral experiments successfully solved by the patient would raise his self-esteem, thus stimulating a beneficial feedback that would reinforce the recently acquired beliefs about themselves.

Without questioning their undoubted virtues, this therapy group avoids two difficulties worth taking into account: (a) a valid self-belief does not in itself guarantee the achievement of goals; and (b) neither does a generic skills training -the patient could find himself lacking just those particular skills that he needs to resolve each occasion of self-esteem. We call "occasion of self-esteem" to any situation that, depending on whether it is resolved by the patient, with success or failure, will thus affect his self-esteem. Even so, we understand that as the clinical approach in question suffers from a lack of direct connection between efficacy and competence, this would somehow diminish their therapeutic effects. In reality, it could be that the patient was not clear about what to do to achieve his personal goals and thus maintain a high self-esteem on a day-to-day basis.

Behavioral-Rational-Emotive Therapy

Comments about the immediately preceding therapy applies perfectly to this other therapy, with one caveat. Here, instead of adjusting self-beliefs, it is intended to attenuate some of the patient's self-demands, and also demands in general, of an irrational nature, what in some way could have a favorable effect on his achievement of personal goals, admitting that here it could be equated "self-demands" with "goals to be met". Putting a stop to unreasonable demands, in our opinion, would lower the patient's standards for evaluating his own achievement in personal goals and would consequently facilitate his self-esteem. In addition to this, the change of life expressly designed and promoted by this therapy, something similar to new personal goals, would also contribute to its final therapeutic efficacy.

Mindfulness Approach

In this case, its AM is actually the implementation of a new mental strategy. It operates directly on the *Mental aptitudes* (*processes and strategies*) component, optimizing the use of cognitive resources by making a more flexible refocusing of attention, and cultivating a distancing from the patient's assessment and self-assessment processes. This would produce a diffusion of the therapeutic effect to the *Cognitive self-confidence* component, and also another, more distant effects, to the *Self-beliefs* component. The effect of this AM on the personal efficacy vector would logically have the *Cognitions for goals* component as its natural destination. However, this approach does not explicitly consider personal goals. Hence, the transmission of therapeutic effects from the personal competence vector to the personal efficacy vector is here practically hampered with the consequent loss of therapeutic capacity. However, it could well be that a perspective of broad self-

acceptance instilled in the patient would end up acting favorably on his personal goals, then radiating therapeutic effects from here to other components of the system.

EMDR Technique

In this case, its MA is actually a truly novel approach, undoubtedly a new paradigm, works in two successive phases. Its first phase of desensitization acts and also has effects on the same components of competence seen in the previous approach. However, its particular dynamics differ: here, as traumatic memories are already consolidated in the MLP, reducing the re-experience of the trauma by the patient, cognitive resources are freed up to be used for any other purpose. By thus improving the functioning of the mental aptitudes (processes and strategies) component, it is expected that the cognitive self-confidence component will also improve. In addition, its reprocessing phase acts on the *Self-concept* component by providing the patient during therapy with a more benign interpretation of his reaction to and during the trauma that triggered his low self-esteem. Even so, this AM has no connection whatsoever with the achievement of personal goals; this technique being perhaps, in our opinion, the furthest from it of all the clinical approaches reviewed here.

Metacognitive Therapy

The AM of this therapy acts on two different levels of competence. On the one hand, on the inner core of the functional architecture of the patient's mind, just on the component of metabeliefs (self-esteem). It is also supposed to spread therapeutic effects to the self-beliefs and cognitive self-confidence components, and also, although with a more diffuse character, to the self-concept confidence and behavioral self-confidence components. On the other hand, this AM also works directly on the mental aptitudes (processes and strategies) component by training attention, and the management of negative thoughts. These latter therapeutic effects would spread to the cognitions for goals component, already belonging to the personal efficacy vector. The connection of this AM with the personal efficacy vector's components is weak. Despite this, by leading the patient towards unconditional self-acceptance, it could well indirectly contribute to a restructuring of his own personal goals, thus spreading positive effects to other components of the system.

Conclusions

In accordance with the preceding review, and in response to the question raised in the Introduction, it can be concluded that each of the clinical approaches examined has a therapeutic effect. This is hypothetically due to the fact that, although each AM works in a direct and restrictive way on one or more components of personal competence, its therapeutic effect would subsequently spread, to a greater or lesser degree, to the remaining components of competence. All of this would then affect the personal efficacy components that make it possible to achieve goals, what would

ultimately affect the patients' self-esteem. In addition, a feedback from the very achievement of goals and self-esteem would progressively adjust over time both personal goals and the maintenance of self-esteem. Ultimately, all therapies would alleviate low self-esteem because, underlyingly, their AMs would have affected, more or less deliberately, on various key aspects of the patients' competence with subsequent diffusion of effects. This would enhance their effectiveness in achieving personal goals, thereby favoring their self-esteem.

In general, the curative value of these clinical approaches would be that all of them, through the transmission of therapeutic effects, originate a general activation of the system of components of personal competence and efficacy for the achievement of goals with effects on self-esteem. Its drawback, in our opinion, would be a loose and perhaps somewhat fortuitous connection between the personal competence that they promote and that necessary efficiency for the fulfillment of the patients' goals. Such disconnection would diminish their therapeutic potential, since in order for self-esteem to remain high, the individual must fulfill his personal goals on a day-to-day basis. In fact, the very conception of self-esteem has evolved in this study field just from the individual having *to be* a certain way, through having *to believe* or *do something*, to having to *achieve goals*.

Among the limitations of the present study is mainly its partiality, only a selection of therapies has been reviewed. The various sources of information involved in the validation of the pursued personal change have not been examined -while behavioral experiments are open to an objective feedback of results from the environment, the covert nature of metacognitions does not transcend the patients' mind; nor has it been studied which source would prevail in the event of a discrepancy. For the rest, the AMs have been examined here too synthetically. Finally, the system of components at present is nothing but a systematic classification of concepts.

In future research, such limitations should be overcome. For example, a more analytical study of AM should be carried out. Furthermore, it would be timely to address two issues. In the first place, it should be studied the possibility of starting any therapy for low self-esteem from the patients' own goals and then progressively adjusting from there all the appropriate components of personal competence to enhance the individuals' personal efficacy in achievement their particular personal goals. Perhaps for this purpose, it could be adapted applications of problem-solving therapy or even some stress inoculation techniques could be used in the event of failure. Second, the proposed system of components should be developed towards a more theoretical phase through the organization and formalization of its relationships into a model as well as execute its subsequent measurement (Bunge, 2000, p. 74).

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