The Self and Mental Health: Self-Salience and the Emergence of Internalizing and Externalizing Problems*

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How do schemas about self-salience—the importance of the self versus the collective in social relations—affect mental health? We propose that self-salience shapes the likelihood of experiencing internalizing or externalizing problems. Schemas that privilege others over the self increase the risk of internalizing symptoms, including depressive symptoms and anxiety, whereas those that privilege the self over others predispose individuals to externalizing behaviors of antisocial behavior and substance abuse. Furthermore, we propose that these schemas contribute to the gender differences that exist in these problems. We test these predictions with data from adolescents, the stage at which these problems and the gender differences in them arise. Results show that self-salience underlies both internalizing and externalizing problems. In addition, schemas about self-salience help explain the gender differences found in mental health problems.

Several lines of research link dimensions of the self to mental health problems. One connects self-evaluations such as low self-esteem to internalizing problems of depression and anxiety (Pearlin et al. 1981; Rosenberg 1989; Mirowsky and Ross 1996). Others tie low self-esteem to some externalizing problems, including substance abuse and antisocial behavior (Kaplan 1980; Kaplan, Martin, and Johnson 1986). A separate line of work links aspects of boundaries such as interpersonal dependency to internalizing problems (Turner and Turner 1999). Other researchers connect perceptions of low power or inequity in relationships to internalizing symptoms (Mirowsky 1985; Lennon and Rosenfield 1995).

We extend prior research by examining an unexplored aspect of the self that encompasses these dimensions and underlies both internalizing and externalizing problems. Each dimension of selfhood above bears on the relative primacy of the self in general or in relationships. Our research explores this aspect of the self directly. We term this concept self-salience to refer to the relative importance of the self versus the collective in social relations. Self-salience is a set of relational schemas ranging from high levels that privilege the self over others to low levels that privilege others above the self. Components incorporate and expand on the dimensions in previous research, including the worth of the self generally and relative to others, the

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boundaries between the self and others, and the ranking of the self versus others. These schemas are social in origin, shaped by messages from others.

We argue that self-salience at its extremes shapes individuals’ tendencies toward internalizing or externalizing problems. Schemas that elevate others at the expense of the self raise the risk of internalizing symptoms. Those that promote the self at the expense of others predispose individuals to externalizing problems.

To the extent that they promote high or low self-salience, social distinctions generate these problems. We illustrate this with gender. Consistent gender differences exist in mental health problems: females predominate in internalizing symptoms, males in externalizing behavior. Dominant conceptions of femininity privilege the needs of others above the self, while conceptions of masculinity privilege the self more strongly. Thus, our dominant gender system produces an excess of internalizing and externalizing problems in part by pushing males and females to opposite extremes of self-salience.

In sum, we propose that self-salience contributes to internalizing and externalizing problems in general and to the differences by gender. These problems and gender differences first arise in adolescence (Avison and McAlpine 1992; Kessler et al. 1994; Turner and Lloyd 1995). Self-salience schemas reach their full development at the same time. Thus, we test our perspective using a sample of adolescents.

Researchers have recently called for integrating cognitive aspects of the self more firmly into sociological analyses of mental illness (Thoits 1999). We argue that relational schemas about self-salience add a crucial element. It seems clear that individuals’ locations in social hierarchies would shape their internal hierarchies of the self and others and thus their mental health.

**SE SELF-SALIENCE AND MENTAL HEALTH**

How do people form their self-conceptions? Symbolic interactionism suggests that the ability to take ourselves as an object is a fundamental social process by which we develop our ideas about the self (Mead 1934). Individuals incorporate the outlooks of others as part of the self by taking the role of the other and identifying with their positions (Cooley 1902; Mead 1934). Some of these messages are assessments of the self as good or worthy in general and relative to others (Thoits and Virshup 1993).

We propose that such messages are internalized as part of individuals’ schemas about self-salience, that is, the importance of the self versus the collective in social relations (Rosenfield 1999a, 1999b). Schemas are basic assumptions that organize information and guide the interpretation of experience in a seemingly automatic way (Markus 1977). Self-salience is one type of schema, which involves individuals’ internal models of relationships and their place in those relationships.

One component of self-salience is individuals’ evaluations of their worth in general and relative to others. These schemas include self-evaluations such as self-esteem and competence, which refer to the degree to which individuals see themselves as having value and abilities, respectively (Pearlin et al. 1981; Rosenberg 1989). Such self-evaluations are implicitly relational insofar as they are based on social comparisons (Rosenberg 1989; Harter 1999). Schemas about relative worth directly compare individuals’ assessments of the self to their evaluations of others. People can assess others as higher, lower, or similar to themselves in esteem or competence.

Another component of self-salience involves the boundaries between the self and others in relationships. Boundaries range from high degrees of autonomy to high degrees of connectedness in relations with others. Individuals vary in the extent to which they see themselves as independent in relation to others versus the extent to which they see the self as inseparable from others.

Self-salience also involves individuals’ ranking of their own needs, interests, and desires relative to those of others. Ranking schemas range from putting one’s own needs and interests first to giving the desires of others higher priority. Individuals can privilege the self and devalue others, put others first to the exclusion of the self, or regard self-interests and the interests of others as equally important.

In sum, we propose that self-salience involves the primacy of the self relative to others in worth, boundaries, and ranking. Their evaluative character infuses these schemas with a strong emotional valence (Cooley 1902; Harter 1999). Thus, self-salience combines cognitive, emotional, and moral components.

In this article, we focus on overall self-salience, which we conceptualize as part of indi-
individuals’ global self-conceptions—“a certain average tone of self-feeling,” in James’s terms (James [1890] 1950:306; see also Cooley 1902). Schemas such as these are typically forged early in life from significant others and repeated messages, which give them considerable weight and stability (Rosenberg 1989; Dodge 1993; Hoyle et al. 1999). These schemas become most fully developed in adolescence, when individuals acquire increasing capacities for abstraction, self-reflection, and social comparison, which underlie the looking-glass self (Rosenberg 1989; Harter 1999). Thus, self-salience schemas become strongest at the time that internalizing and externalizing problems first arise.

Self-salience schemas that privilege the collective but demote the self will, at the extreme, facilitate internalizing problems. For example, negative self-assessments are more detrimental when individuals think there is something uniquely wrong with them but that others are undamaged. In this situation, people feel bad about the self in general and because they are worse off than others, which adds an extra measure of distress. Moreover, strong connections to others imply a reliance on other people and a sense of responsibility for their welfare, leading to self-blame for others’ difficulties. In addition, to the extent that others’ interests come first, individuals deny the desires of the self. Note that schemas that facilitate internalizing problems also diminish the possibility of externalizing behavior. Doubts about one’s impact on the world mitigate against taking risky, antisocial actions. Empathy with others’ feelings makes it harder to act in direct opposition to their interests.

It follows that schemas privileging the self and demoting others will, at the extreme, facilitate externalizing reactions. The belief that one is not only a person of great worth but also better than others grants rights to the self that can easily be denied to others. In this sense, individuals are relatively free to act against others’ interests. Other people are viewed as a hindrance to getting what one wants. In addition, if the self is valued more highly than others, one is less likely to look inward to affix blame for things gone wrong and more likely to see others as the source of difficulties. On the other hand, assumptions that increase the likelihood of externalizing behaviors also decrease the chances of internalizing problems. Extreme assumptions of entitlement make it unimaginable to hurt oneself.

This perspective is consistent with several lines of theorizing about the self and mental health. For example, theories of the stress process and of self-concept posit that self-evaluations such as self-esteem are fundamental aspects of the self, critical for mental health (Pearlin et al. 1981; Pearlin 1989, 1999; Rosenberg 1989; Brown et al. 1990; Mirowsky and Ross 1996). Circumstances undermine well-being to the extent that they threaten these self-perceptions. These perceptions also affect mental health by guiding interpretations and responses to stressors, or by allowing individuals to avoid stressors in the first place (Pearlin et al. 1981; Pearl 1989; Thoits 1999).

Our approach also fits with certain cognitive theories of psychopathology, which emphasize the importance of schemas for mental health problems (Beck 1967; Seligman 1975; Dodge 1993; Harter 1999; Hoyle et al. 1999). Schemas shape the information people selectively attend to, the attributions they make, and their mental representations of current situations—all of which affect mental health (Dodge 1993; Menaghan 1999).

Our perspective is consistent with certain psychodynamic approaches that stress the importance of early experiences and nonconscious processes for mental health. In particular, object relations and interpersonal theories focus on the consequences for mental health of internalized representations of relationships with significant others (Fairbairn 1952; Sullivan 1953; Winnicott 1965; Chodorow 1978).

Finally, our approach fits into a general debate about boundaries. One side holds that autonomy is positive for mental health, while another claims that connections promote well-being (Kohlberg 1983; Miller 1976; Gilligan 1993). A third position posits that the balance of separateness and communion rather than extreme alone benefits mental health (Bakan 1966; Helgeson 1994; Rosenfield, Vertefuille, and McAlpine 2000).

Research in these and other areas provides evidence for different aspects of our approach. As noted, ample research demonstrates that low self-evaluations increase depressive symptoms and anxiety (Rosenberg 1989; Pearlin 1999; Turner and Lloyd 1995, 1999; Mirowsky and Ross 1996). Some work also links overly high self-evaluations to externalizing problems, particularly when these evaluations are challenged (Baumeister, Smart, and Boden 1999; Beck 1999). Research on boundaries finds that extreme connectedness such as emotional
reliance raises internalizing symptoms, and extreme individuation such as low empathy increases externalizing problems (Hagan, Gillis, and Simpson 1985; Ohbuchi, Ohno, and Mukai 1992; Guisinger and Blatt 1994; Turner and Turner 1999). Other work demonstrates that both autonomy and connection are problematic if unbalanced by the other (Helgeson 1994; Rosenfield et al. 2000).

Other studies bear on the impact of ranking on mental health. Perceptions of low power in relationships raise the risk of internalizing symptoms in particular (Mirowsky 1985; Lennon and Rosenfield 1995). For instance, individuals who perceive they have few alternatives to a relationship endure greater levels of depressive symptoms than those who perceive more alternatives (Lennon and Rosenfield 1995).

Our perspective differs from other approaches by focusing on the balance of self-regard and regard for others. Also, we envision internalizing and externalizing problems as opposite extremes with common roots rather than as independent problems (Aneshensel, Rutter, and Lachenbruch 1991). In addition, our nonlinear approach differs from the linear relationships and the focus on one extreme more often proposed in previous work. Furthermore, our concept of self-salience fills a gap in theorizing about the self and mental health. As internal representations of social hierarchies, self-salience is a particularly sociological dimension of selfhood missing from prior research. Self-salience, in turn, forms a pathway by which social inequalities such as gender shape mental health.

We argue that American society’s dominant practices and conceptions of gender—middle class and white in origin—vary in the degree to which individuals privilege the self versus the collective (Connell 1995). Dominant images and practices of femininity associate females with the private sphere of domesticity, caretaking, and emotion work, and with personal characteristics of nurturing, sensitivity, and emotional expressiveness—all of which privilege others over the self. In contrast, dominant practices and ideals of masculinity associate males with the public sphere of the market and the consonant characteristics of assertiveness, competitiveness, and independence—all of which privilege the self more highly (Bordo 1993; Valian 1999).

Gender socialization transmits these messages, giving rise to the opposing self-salience schemas in males and females. This process begins in childhood but intensifies in adolescence, as parents and others hold adolescents to more stereotyped ideas of womanhood and manhood (Chodorow 1978; Nolen-Hoeksema 1990). Thus, gender socialization and the resulting self-salience schemas achieve their full force in adolescence, coinciding with the divergence in mental health problems.

We propose that these disparities in schemas about self-salience help produce the observed gender differences in internalizing and externalizing problems. The higher levels of self-salience contribute to males’ tendencies toward behaviors that turn against others. Lower self-salience facilitates females’ tendencies toward symptoms that disadvantage the self.


Summarizing our predictions, we hypothesize that messages from the social environment affect the degree to which individuals put the self or others first in schemas about self-salience. We expect that these schemas shape individuals’ proclivities to problems that are more harmful to the self or others. We also predict that females experience more internalizing problems and that males experience more externalizing problems in part because dominant gender conceptions and practices push them to opposite extremes of self-salience.

METHODS

Sample

Our data are part of the Rutgers Health and Human Development Project, a prospective study that examines adolescent development (Pandina, Labouvie, and White 1984). The initial sample comes from a statewide survey of New Jersey, contacted through random telephone calls. Eighty-three percent of the eligible ado-
The total sample for the present analysis consists of 1,380 New Jersey adolescents in three age groups. Respondents were tested initially between 1979 and 1981 (time 1) at the ages of 12, 15, and 18, and retested three years later between 1982 and 1984 (time 2) using the same battery of instruments. Sample characteristics are generally comparable to the entire state at that time. The sample is 89 percent white with a median income between $20,000 and $29,000. Half the respondents are Catholic, 30 percent are Protestant, 9 percent are Jewish, and 11 percent report another or no religion.

A comparison of variables at time 1 between those subjects who were retested and those who dropped out indicates high comparability in demographic characteristics and selected behaviors sampled during the original telephone survey (Pandina et al. 1984). This comparison did not include self-salience. However, given the similarities in the distributions of self-salience and mental health problems at times 1 and 2, there appears to be no serious attrition bias in the sample. Also, analyses of age and gender differences replicate the literature on personality traits and mental health related outcomes. In addition, our main purpose is to examine the relationship between self-salience and mental health problems. There is sufficient variation in self-salience to test for such relationships.

### Measures

**Socialization messages.** Our data include information on messages from the social environment, listed in the Appendix. Respondents were asked how adults expect a girl/boy of their age to be or behave in a range of areas. Responses range from “not at all” to “very much” expected to be or behave in each way, on a five-point scale. The questions are adapted from the Personal Attributes Questionnaire (PAQ; Spence and Helmreich 1978). They represent the kinds of attitudes individuals acquire in the process of taking the role of the other. The attitudes of significant others toward the self are averaged to form an indicator of the generalized other (Harter 1999). Since the messages are from respondents’ perceptions, they reflect the processes by which individuals interpret and internalize the attitudes of others. As symbolic interactionism asserts, people internalize what they perceive to be others’ perceptions of them (Cooley 1902; Mead 1934).

Several PAQ questions bear on messages about self-salience. For example, adolescents were asked how much self-confidence adults expect from a boy/girl of their own age. We use this item as a measure of messages about self-worth.

We use questions on perceptions of adult expectations about competition, independence, empathy, and helpfulness as indicators of messages about boundaries in relationships. We average expectations promoting competition and independence to construct an indicator of messages about autonomy. We average expectations encouraging empathy and helpfulness as an indicator of messages about connectedness.

Other questions focus on messages about ranking. Adolescents were asked how much adults expect them to be superior to others. They also were asked how much adults expect devotion to others. We use these questions to indicate high ranking of the self and of others, respectively. We caution that devotedness is an imperfect measure, since it does not explicitly target the ascendance of others’ interests above one’s own.

Using these measures, we develop indicators of the components of self-salience. We subtract messages favoring connectedness from those promoting autonomy to measure the boundary component. We subtract messages encouraging devotion from those encouraging superiority to measure the ranking component. Each of these measures ranges from a high of +4 to a low of −4. Unfortunately, these data do not have information on esteem for others for constructing a measure of relative worth. We are thus limited to the measure of self-worth described above, which represents an aspect of the worth component but does not provide a full test.
We combine these measures to construct a general indicator of self-salience messages. We first average together messages that encourage high self-salience, including expectations about self-worth, autonomy, and superiority. Similarly, we average messages that promote low self-salience, including expectations for devotedness and connectedness to others. We then subtract the composite measure of low self-salience from the composite measure of high self-salience for an overall indicator of the salience of the self. We use difference scores in constructing this measure of messages, as well as the measure for schemas, because they represent the most direct operationalization of our definition of self-salience, that is, the balance of self-regard and regard for others. This measure ranges from -4, which represents low self-salience, to +4, representing high self-salience.

**Self-salience schemas.** Adolescents were also asked to describe themselves. These measures of schemas appear in the Appendix. For example, as part of the PAQ, respondents were questioned about their level of self-confidence. We use this item as an indicator of schemas about self-worth. Responses range from not at all to very confident on a 5-point scale.

We use a number of scales in the Personality Research Form (PRF) to measure other components of self-salience (Jackson 1974). Respondents answered true or false to questions. Scores range from a low of 0 (all false) to a high of +12 (all true). These scales have high levels of reliability (Stricker 1974).

We use scales of autonomy and nurturance as indicators of boundaries. For example, the autonomy scale includes items about whether respondents like feeling unattached and whether they are unaffected by the opinions of others. Examples of the nurturance scale, which measures the connectivity dimension of boundaries, are whether it is very important to respondents that they demonstrate interest in others’ problems and whether they feel most worthwhile when helping someone else.

Scales of dominance and abasement indicate schemas about ranking. The dominance scale includes questions on whether respondents desire positions of power over others and whether they try to control others rather than permitting others’ control over them. The scale of abasement includes items asking whether respondents are uncomfortable when others try to make them feel important and whether they try to be a good sport when they think people are taking advantage of them.

Using these indicators, we construct measures of the components of self-salience schemas. We subtract scores on nurturance from scores on autonomy for an indicator of self-salience in boundaries. We subtract scores on abasement from scores on dominance for a measure of self-salience in ranking. We are limited to the score on self-confidence as a measure of worth.

We also combine these measures for a general indicator of self-salience schemas. We average together scores on self-worth, autonomy, and dominance to indicate high self-salience. We convert response categories for self-confidence (ranging from 1 to 5) to the same metric as the PRF scales (ranging from 0 to 12) by recoding self-confidence as follows: 1 = 0, 2 = 3, 3 = 6, 4 = 9, 5 = 12. We average scores on nurturance and abasement to measure low self-salience. We subtract the second score from the first for an indicator of general self-salience. This measure ranges from a low of -12 to a high of +12.

Correlations and factor analyses for both messages and schemas support the theorized structure of components that constitute self-salience. Correlations indicate that the components of self-salience are significantly associated but are independent variables (the strongest are around .30). Factor analyses yield three factors, one of which correlates most highly with boundaries, a second that correlates most strongly with worth, and a third that correlates most with ranking.

**Internalizing and externalizing problems.** We use the Symptom Checklist (SCL-90R) as a measure of internalizing problems. This scale, which has been shown to be a reliable indicator of psychological symptoms, is comprised of several subscales (Derogatis and Cleary 1977). We use the subscales of depressive symptoms, general anxiety, and phobic anxiety as indicators of internalizing problems. The depression scale includes symptoms such as feeling lonely, blue, or worthless; feeling hopeless about the future; and having thoughts of suicide. The general anxiety scale includes symptoms of nervousness or shakiness inside, feeling fearful, having spells of terror or panic, and having thoughts and images of a frightening nature. Symptoms of phobic anxiety include feeling afraid in open spaces, in the streets, in crowds, in the house alone, when traveling on buses, subways, or trains, and having to avoid certain things because they are frightening. Responses
are averaged for each scale and range from 0 to 4, which correspond to experiencing symptoms “very little” to “very much.” Alpha coefficients are .80 or above for each of these scales at both test occasions.

We use scales of delinquency, aggression, and alcohol problems as measures of externalizing problems. Questions on delinquency ask how often respondents have (1) avoided paying for such things as movies, bus or subway rides, and food; (2) broken into a building to look for something to steal or to steal something; (3) stolen (or tried to steal) a motor vehicle; (4) stolen things worth less than $50; and (5) stolen things worth more than $50. Questions on aggression ask respondents how often they (1) have used a weapon such as a club, knife, or gun in a fight; (2) hit or struck one of their parents; (3) hurt someone badly enough that the person needed bandages or a doctor; (4) used a knife or gun or some other thing (such as a club) to get something from a person (i.e., robbed someone); and (5) damaged property on purpose (such as slashing tires, breaking windows, setting fire to someone else’s property). For these questions, respondents indicated whether, over the last three years, they have engaged in this behavior at all, 1–2 times, 3–5 times, 6–10 times, or more than 10 times. Possible scores range from 5 to 25. Because these scales are composed of behaviors that would not necessarily be expected to occur together, we did not compute a reliability coefficient.

We measure alcohol problems with questions about the frequency of experiencing negative consequences as a result of or while drinking (White and Labouvie 1989). Scores are derived by summing the frequency of each of 42 potential problems that might follow alcohol use. Examples of these problems include getting into fights, wanting to stop drinking but being unable to, losing a job, blacking out, being told by a physician to cut down, being in trouble with the police, and having a drink before or instead of breakfast. Respondents were asked how often they experienced these negative consequences because of drinking or while drinking during the last three years. Response choices range from never to more than 10 times on a five-point scale. Possible scores range from 0 to 168. We also have not computed reliability coefficients for this scale because experiencing one consequence does not necessarily mean that someone experiences a second. However, the odd-even split-half reliability is greater than .90 at both test occasions.

Background characteristics. These data include information on age, race/ethnicity, gender, and socioeconomic status (SES). Age at baseline is categorized into three groups: 12, 15, and 18. We create dummy variables for race/ethnicity: African Americans and “other” race/ethnicities, using whites as the omitted reference group. In the first variable, African American is coded as 1 and whites as 0. In the second variable, “other” race/ethnicity is coded as 1 and whites as 0. Gender is coded 0 for males and 1 for females. SES is measured by the highest educational level attained by either parent.

RESULTS

We predicted that socialization messages influence adolescents’ schemas about self-salience. These schemas, in turn, shape their tendencies to internalizing or externalizing problems. We also expect that self-salience helps explain the gender differences in these mental health problems.

Messages and Schemas of Self-Salience

Using regression analysis, we examine the relationship between messages and schemas about self-salience and present the results in Table 1. Model 1 shows the association of gender, other background characteristics, and schemas at time 1 to schemas at time 2. Model 2 reports the impact of messages at time 1 on changes in schemas from time 1 to time 2. Model 3 presents the relationships of changes in messages from time 1 to time 2 to changes in schemas over the same time period.

Table 1 indicates that adolescents internalize messages from the adult world in forming their schemas about self-salience. On the one hand, the more these messages privilege the self over the collective, the more adolescents put the self first. Thus, when adults expect more confidence, independence, and dominance but less connectedness and accommodation in relationships, adolescents come to think of themselves as more important than others. On the other hand, the more these messages privilege the collective, the more adolescents place others above the self. That is, when adults encourage strong ties and subordination to others’ interests
but discourage self-assurance, autonomy, and influence, adolescents increasingly assume that others are more important than themselves. Since messages of greater self-salience at time 1 increase the level of self-salience schemas from time 1 to time 2, these results are consistent with a causal direction from messages to schemas.

Analyses of demographic characteristics show, first, that self-salience schemas vary by race/ethnicity and SES. Self-salience increases more over time among African Americans than whites. Adolescents from higher SES groups also rise more in self-salience than those from lower socioeconomic backgrounds.

In addition, schemas vary significantly by gender. Over time, adolescent boys tend to privilege the self over others, while girls more strongly favor others above the self. More specifically, boys increasingly see themselves as of higher worth, as more independent, and as more dominant in relationships. Girls progressively view themselves as lower in worth, more connected to others, and more subordinate in relationships over time.

**Self-Salience Schemas and Mental Health Problems**

Tables 2 and 3 show the relationships of self-salience schemas to internalizing and externalizing problems, respectively. In these regression analyses, model 1 presents the associations of gender, other background characteristics, and mental health problems at time 1 to changes in these problems from time 1 to time 2. Model 2 reports the impact of time 1 self-salience schemas on changes in mental health problems from time 1 to time 2. Model 3 shows the relationship of changes in schemas to changes in problems from time 1 to time 2.

**Internalizing problems.** Results in Table 2 show that low self-salience is related to high levels of internalizing problems. The more that adolescents privilege others over the self, the more likely they are to suffer from symptoms of depression, general anxiety, and phobias. Those who see themselves as highly connected and adaptive to others but as low in self-esteem, autonomy, and ranking are prone to live with greater fear and sense of despair. In contrast, the more that adolescents privilege the self over others, the less likely they are to suffer from such symptoms. Thus, those with high self-esteem, autonomy, and ranking coupled with low connectedness and accommodation experience less anxiety and feelings of loss, sadness, and helplessness. Schemas at time 2 are related to mental health symptoms, which indicates that changes in self-salience are
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<th>TABLE 2. Regression on Internalizing Problems of Self Salience Schemas</th>
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* p < .05; ** p < .01; *** p < .001

a Girls = 1; boys = 0.
b African Americans = 1; others = 0
associated with changes in internalizing problems. Table 2 also reports significant differences between demographic groups in internalizing problems. For example, some symptoms vary by age and race/ethnicity. Older adolescents suffer from fewer phobias. African Americans have lower levels of general anxiety than whites, a finding consistent with previous research on these differences (Williams and Harris-Reid 1999). This difference declines to nonsignificant after controlling for self-salience.

This analysis also shows significant gender differences in internalizing problems. Adolescent girls are significantly higher than boys in depressive symptoms and phobias. Girls also exceed boys in general anxiety, although the difference falls short of statistical significance.

Self-salience helps explain the disparities by gender. Differences in depressive symptoms, general anxiety, and phobic anxiety decline dramatically, by over 70 percent, when self-salience at time 2 is controlled. In this sense, self-salience helps to account for females’ predominance in internalizing problems.

Externalizing problems. Results in Table 3 reveal that high self-salience is related to greater externalizing problems of delinquent behavior and alcohol problems. The relationship between self-salience and aggression is marginally significant, but the trend is in the same direction. Adolescents who define themselves as higher in worth, autonomy, and power than they are in attachment and adjustment to others’ interests commit more aggressive and other antisocial acts and have more drinking problems than those with lower self-salience. Conversely, adolescents whose sense of self emphasizes connection and submissiveness more than self-worth, autonomy, and dominance less often act out against others or drink heavily enough to impair functioning. High self-salience at time 1 raises the risk of delinquency and alcohol problems over time, indicating a possible causal direction from schemas to problems. Changes in self-salience between times 1 and 2 are also associated with changes in delinquent and aggressive behavior.1

Externalizing problems differ by demographic characteristics, particularly race/ethnicity and SES, consistently with previous research. For example, African Americans have fewer alcohol problems than whites (Williams and Harris-Reid 1999). Adolescents with lower SES exhibit more aggressive behavior and more alcohol problems than those with higher SES (Eaton and Muntaner 1999). The class differences in alcohol problems reduce to nonsignificant controlling for self-salience schemas.

Table 3 also shows significant gender differences in externalizing problems. Boys predominate in delinquency, aggression, and drinking problems. Self-salience contributes to these differences to varying degrees. The gender coefficient for aggression reduces by only 13 percent when self-salience is controlled. However, gender differences in alcohol problems decline approximately 20 percent after adjusting for initial levels of self-salience. Moreover, disparities in delinquency diminish by nearly half when self-salience is held constant.

DISCUSSION

We proposed that certain versions of the self give rise to major types of mental health problems that first appear in adolescence. Relational schemas overprivileging the collective or the self generate problems that are self-destructive or destructive to others. Schemas about self-salience are differentially distributed by gender and contribute to the greater internalizing problems in females and externalizing problems in males. Self-salience is social in origin, shaped by socialization messages about one’s relative worth, boundaries, and ranking in relationships.

The research generally supports this perspective. Adolescents who receive messages to put the self first develop schemas privileging the self over others. Those who are expected to give others higher priority construct schemas privileging the collective. The amount of self-salience in messages shapes the development of self-salience schemas, which is consonant with a causal relationship between messages and schemas.

Self-salience schemas, in turn, shape mental health. Those who underprivilege the self in general and relative to others become more vulnerable to problems that damage the self. Those who overprivilege the self are predisposed to acts that damage others. Changes in self-salience from any level contribute to both internalizing and externalizing problems. The absolute amount of self-salience also affects subsequent externalizing problems.

Gender shapes these messages and schemas. As part of gender socialization, adolescent boys
# TABLE 3. Regression on Externalizing Problems of Self-Salience Schemas

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### Footnotes
- † p = .10; * p < .05; ** p < .01; *** p < .001
- a Girls = 1; boys = 0.
- b African Americans = 1; others = 0.

### Table Notes
- R² values are presented for each model, indicating the proportion of variance explained by the predictors.
more often receive messages and construct schemas that elevate the self over others. Girls more often receive messages and develop schemas that put others first. These schemas help explain gender differences in mental health problems. Males and females differ in internalizing and externalizing problems in part because they tend toward opposite ends of self-salience. By pushing males to value the self over others and females to value others above the self, our dominant gender system generates an excess of internalizing and externalizing problems patterned by gender.

A remaining issue is whether certain components of self-salience most strongly predict these outcomes. This issue is important given that certain components, such as self-esteem, have a long history of research with established relationships to psychiatric problems and may account for the impact of overall self-salience. We analyzed the components to test which aspects of self-salience contribute most highly to these mental health problems (not shown). We found that schemas about ranking and worth have the strongest relationships with each of the internalizing problems. Schemas about ranking are also most highly related to antisocial behaviors, including delinquency and aggression. Furthermore, schemas about boundaries predict problems with alcohol as well as delinquency. Finally, schemas about worth are related to alcohol problems. Thus, each component of self-salience is involved in some types of internalizing or externalizing symptoms.

Furthermore, schemas about ranking most strongly differentiate internalizing and externalizing problems. Ranking schemas figure prominently in both types of problems, in opposite directions. Subordinate positions in relationships predispose individuals to internalizing symptoms. With the exception of problems with alcohol, dominance in relationships facilitates externalizing symptoms.

Alcohol problems form a somewhat separate category. High levels of some components of self-salience and low levels of others predict these problems. Specifically, individuals who are high in boundaries but low in self-worth are more prone to drinking problems. The latter finding is consistent with prior research that traces substance abuse to low self-esteem (e.g., Kaplan 1980; Kaplan, Martin, and Johnson 1986).

These findings bear on a general debate about the social roots of mental health problems. One side holds that distinct types of mental health problems result from different underlying experiences. Our perspective illustrates this view inasmuch as we predict that internalizing and externalizing problems arise from different schemas about self-salience. The other side of the debate claims that internalizing and externalizing problems are functional equivalents. That is, different norms for expressing emotion, not different underlying experiences, determine whether an individual will exhibit internalizing or externalizing problems.

Our analysis suggests that both sides of this debate are correct, depending on the particular problem. The schemas that underlie delinquent and aggressive behavior are polar opposite to those that underlie anxiety and depressive symptoms. For example, the former rank the self over others, while the latter rank others over the self. In contrast, some of the schemas that underlie alcohol problems also predict internalizing symptoms. Schemas of low self-worth characterize the roots of both. In this sense, alcohol problems more closely resemble a functional alternative to internalizing problems than delinquency or aggression.

These results also address why self-salience explains more of the gender differences in internalizing than externalizing problems (Rosenfield et al. 2000). While self-salience schemas explain nearly half the differences in delinquency, these schemas account for much less of the disparity in alcohol problems. One reason is that our theory pertains more to antisocial problems than to alcohol problems. We hold that, while low self-salience produces self-destructive mental health problems, high self-salience facilitates problems destructive to others. Antisocial behavior more clearly indicates destructiveness to others compared to substance abuse, which includes self-destructive elements. That different components underlie alcohol problems and antisocial behaviors supports this distinction. Thus, antisocial behavior more closely represents the opposing side of internalizing problems specified in the theory, which may account for the greater explanatory power of self-salience.

However, self-salience also explains little of the gender difference in aggression, which is clearly destructive to others. These results may be partly due to the low frequency of aggressive conduct, especially among females, only 13 percent of whom report any aggressive act. This low rate may result from the extreme behaviors,
such as using a weapon, that are included in the aggression scale. We need research with larger samples and broader measures of aggression, incorporating less extreme acts such as slapping, shoving, or hitting another person, to fully test the relationship between gender and aggression.

Another issue concerns the relationship between self-salience and mental health in cultures with differing dominant orientations. For example, Asian cultures and subcultures hold more collectivist orientations compared to Western cultures’ greater emphasis on individualism (Shweder 1991). This difference is reflected in greater interdependent self-construals or self-conceptions among Asians, as opposed to the more independent self-construals in Western cultures (Markus and Kitayama 1991). Because of the consistency with dominant orientations, low self-salience may produce fewer internalizing problems in Asian compared to Western cultures. This argument fails to hold in research, however. Numerous studies find that Asians and Asian Americans exceed white Americans in depression and anxiety (Greenberger and Chen 1996; Okazaki 1997; Zheng et al. 1997; Norasakkunkit and Kalick 2002; Rosenfield, Phillips, and White 2004). Asians’ greater interdependent self-construals help account for the higher levels of these problems (Okazaki 1997). Thus, low self-salience engenders greater internalizing problems regardless of the dominant cultural values.

Our analyses are limited in several ways. Information on messages from adults is restricted to self-reports and would benefit from independent data from significant others. Further research should also include multi-item measures of messages, as well as aspects of self-salience that are missing from this data set, such as relative worth. Information on different life stages is necessary to understand what factors underlie the origins versus the maintenance or alteration of self-salience over time, and how self-salience interacts with adult social locations and roles to shape mental health. Furthermore, research should investigate comorbidity of internalizing and externalizing problems. We suggest that a mixture of high and low self-salience in different components or at different points in time may produce co-occurring problems. Finally, future work should examine interactions between gender and other identities, particularly race/ethnicity, given the substantial variations in conceptions of gender across racial/ethnic groups.

CONCLUSION

Our research has implications for interventions, specifically those that equalize self-regard and regard for others. Lower risks of both internalizing and externalizing problems should result from conceptions of the self as neither better nor worse than other people, neither overly connected nor detached, and neither dominant nor submissive in relationships. Well-being should be enhanced by balanced self-salience, that is, a sense of self that is equally worthy, equally tied, and equally influential in relation to others.

Although dimensions of the self are only one source of mental health problems, they are particularly promising for sociological investigations of mental health. The internal workings of the self are easily misconstrued as unique characteristics of the individual, relatively unaffected by social processes. However, research demonstrates that dimensions of the self have strong social roots. This internal colonization may thus be the most insidious form of social influence, obscuring the role of the social by making it appear purely personal (Foucault 1980). By establishing the consequences of such dimensions of the self for mental health problems, we underscore that danger.

NOTES

1. Although social comparison theory suggests that self-evaluations are implicitly comparative, we need direct measures of relative worth for a more complete test of this component, since people can regard others as higher, similar, or lower in worth regardless of their assessments of the self (Rosenberg 1989).

2. We also examined self-salience as a ratio, dividing the indicators of the salience of the self by indicators of the salience of others. Furthermore, we controlled for component indicators, for example, examining the difference between autonomy and nurturance controlling for the absolute level of autonomy. We also examined the average of the components of self-salience, as well as interactions between the components. Results
using each of these measures were similar to those reported.

3. Although we are primarily interested in the effects of self-salience on mental health problems, this relationship may be reciprocal. We explore this possibility using two-stage least squares regression. We examine the relationship between self-salience and each mental health problem at time 2, using time 1 self-salience and mental health problems as instrumental variables. We find that, controlling for the reciprocal relationships, the hypothesized relationships remain, with self-salience significantly predicting mental health problems.

APPENDIX

Measures of Self-Salience Messages and Schemas

1. SELF-SALIENCE MESSAGES (adapted Spence and Helmreich Personal Attributes Questionnaire)

   We would like to know how you think adults expect young men (women) your age to be and to behave. Each item is made up of a pair of characteristics with the letters A through E between. The letters form a scale between two opposites (from not at all to very much). You are to choose a letter that describes where you think adults expect young men (women) your age to fall on each scale.

   **Worth**
   - Not at all self-confident: A
   - B
   - C
   - D
   - E Very self-confident

   **Boundaries**
   - Not at all independent: A
   - B
   - C
   - D
   - E Very independent
   - Not at all competitive: A
   - B
   - C
   - D
   - E Very competitive
   - Not at all aware of the feelings of others: A
   - B
   - C
   - D
   - E Very aware of the feelings of others
   - Not at all helpful to others: A
   - B
   - C
   - D
   - E Very helpful to others

   **Ranking**
   - Feels very inferior: A
   - B
   - C
   - D
   - E Feels very superior
   - Not at all able: A
   - B
   - C
   - D
   - E Able to devote yourself completely to others

2. SELF-SALIENCE SCHEMAS

   **Worth** (Spence and Helmreich Personal Attributes Questionnaire)

   We would like to know how you describe yourself. The letters form a scale between two opposites (from not at all to very much). You are to choose a letter that describes you.

   - Not at all self-confident: A
   - B
   - C
   - D
   - E Very self-confident

   **Boundaries**

   Please answer true or false to the following statements.

   Autonomy (Personality Research Form Autonomy Scale)
   1. I find that I can think better when I have the advice of others.
   2. I delight in feeling unattached.
   3. Family obligations make me feel important.
   4. I would feel lost and lonely roaming about the world alone.
   5. I could live alone and enjoy it.
   6. I would not mind living in a very lonely place.
   7. I would like to be alone and be my own boss.
   8. I like to do whatever is proper.
   9. I would like to have a job in which I didn’t have to answer to anyone.
   10. I usually try to share my problems with someone who can help me.
   11. I am quite independent of the opinions of others.
   12. I don’t want to be away from my family too much.
Connection (Personality Research Form Nurturance Scale)
1. I feel no great concern for the troubles of other people.
2. I would rather have a job serving people than a job making something.
3. It doesn’t affect me one way or another to see a child being spanked.
4. I have never done volunteer work for charity.
5. If someone is in trouble, I try not to become involved.
6. People like to tell me their troubles because they know I will help them.
7. If I could, I would hire a nurse to care for a sick child rather than do it myself.
8. It is very important to me to show people I am interested in their troubles.
9. Seeing an old or helpless person makes me feel that I would like to take care of them.
10. I am not always willing to help someone when I have other things to do.
11. I feel most worthwhile when I am helping someone who is disabled.
12. Sometimes when a friend is in trouble, I cannot sleep because I want so much to help them.

Ranking
Dominance (Personality Research Form Dominance Scale)
1. I would like to be a judge.
2. I avoid positions of power over other people.
3. I try to control others rather than permit them to control me.
4. I don’t like to have the responsibility for directing the work of others.
5. I would like to play a part in making laws.
6. I have little interest in leading others.
7. In an argument, I can usually win others over to my side.
8. I feel uneasy when I have to tell people what to do.
9. The ability to be a leader is very important to me.
10. Most community leaders do a better job than I could possibly do.
11. I would like to be an executive with power over others.
12. I would not want to have a job enforcing the law.

Subordination (Personality Research Form Abasement Scale)
1. I like to be the first to apologize after an argument.
2. I would never call attention to any of my weaknesses.
3. I don’t like running errands for others, even my friends.
4. I have often let others take credit for something I have done rather than be impolite about it.
5. Several people have taken advantage of me, but I always take it like a good sport.
6. I resent being punished.
7. If someone accidentally burned me with his cigarette I would certainly mention it to him.
8. When someone bumps into me in a crowd, I usually say I am sorry.
9. When people try to make me feel important, I feel uncomfortable.
10. I do not particularly enjoy being the object of someone’s jokes.
11. I remember my failures more easily than my successes.
12. When standing in line, I don’t let other people get ahead of me.

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