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Cognitive-Behavior Therapy for Low Self-Esteem: A Case Example

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Low self-esteem is a common, disabling, and distressing problem that has been shown to be involved in the etiology and maintenance of a range of Axis I disorders. Hence, it is a priority to develop effective treatments for low self-esteem. A cognitive-behavioral conceptualization of low self-esteem has been proposed and a cognitive-behavioral treatment (CBT) program described (Fennell, 1997, 1999). As yet there has been no systematic evaluation of this treatment with routine clinical populations. The current case report describes the assessment, formulation, and treatment of a patient with low self-esteem, depression, and anxiety symptoms. At the end of treatment (12 sessions over 6 months), and at 1-year follow-up, the treatment showed large effect sizes on measures of depression, anxiety, and self-esteem. The patient no longer met diagnostic criteria for any psychiatric disorder, and showed reliable and clinically significant change on all measures. As far as we are aware, there are no other published case studies of CBT for low self-esteem that report pre- and posttreatment evaluations, or follow-up data. Hence, this case provides an initial contribution to the evidence base for the efficacy of CBT for low self-esteem. However, further research is needed to confirm the efficacy of CBT for low self-esteem and to compare its efficacy and effectiveness to alternative treatments, including diagnosis-specific CBT protocols.

Low self-esteem has been associated with and cited as an etiological factor in a number of different psychiatric diagnoses (Silverstone, 1991), including depression (Brown, Bifulco, & Andrews, 1990), obsessive-compulsive disorder (Ehntholt, Salkovskis, & Rimes, 1999), eating disorders (Gual, Perez-Gaspar, Martinez-Gonzallaz, Lahortiga, Irala-Estevez, & Cervera-Enguix, 2002), substance abuse (Akerlind, Hornquist, & Bjurulf, 1988), chronic pain (Soares & Grossi, 2000), and psychosis (Freeman et al., 1998). Silverstone and Salsali (2003) report lower self-esteem in all psychiatric diagnoses than in a comparison group, and that the effects of psychiatric diagnoses on self-esteem may be additive in that those patients with more than one diagnosis had the lowest self-esteem, particularly when one of the diagnoses was major depression. Low self-esteem has also been associated with self-harm and suicidal behavior (Hawton, Rodham, Evans, & Weatherall, 2002; Overholser, James, Adams, Lehnert, & Brinkman, 1995). Furthermore, low self-esteem has been shown to be a poor prognostic indicator in the treatment of depression (Brown, Andrews, Harris, Alder, & Bridge, 1986; Sherrington, Hawton, Fagg, Andrew, & Smith, 2001), eating disorders (Button & Warren, 2002; Fairburn, Peveler, Jones, Hope, & Doll, 1993; Van der Ham, Strein, & Egneland, 1998), and substance abuse (Kerlind, Hernquist, & Bjurulf, 1988), and to predict relapse following treatment (Brown et al., 1990; Fairburn et al.).

While low self-esteem has been associated with many psychiatric conditions, the nature of this relationship is unclear: Some studies show that having a psychiatric illness lowers self-esteem (Ingham, Kreitman, Miller, Sashidharan, & Surtees, 1987) and other studies show that low self-esteem predisposes one to a range of psychiatric illnesses (Brown, Andrews, Harris, Alder, & Bridge, 1986; Miller, Kreitman, Ingham, & Sashidharan, 1989). There is evidence that changes in either depression or self-esteem can affect the other (e.g., Hamilton & Abramson, 1983; Wilson & Krane, 1980). Despite the uncertainty about the direction of causality in the relationship between self-esteem and psychiatric illness, it is clear that the impact of low self-esteem is far reaching; it is associated with teenage pregnancy (Plotnick, 1992), dropping out of school (Guillon, Crocq, & Bailey, 2003), mental illness (e.g., Brown et al., 1990), and self-harm and suicidal behavior (Hawton et al., 2002; Kjelsberg, Neegaard, & Dahl, 1994; Overholser et al., 1995). It also has a negative impact on economic outcomes, such as greater unemployment and lower earnings (Feinstein, 2000). In summary, low self-esteem is common, distressing, and disabling in its own right; it also appears to be involved in the etiology and persistence of different disorders, and attending to these processes may improve treatment

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outcome. Hence, it is a priority to develop effective treatments for low self-esteem that can be applied across the range of diagnoses associated with low self-esteem.

A cognitive conceptualization of low self-esteem has been proposed (see Figure 1) and a cognitive-behavioral treatment (CBT) program described (Fennell, 1997, 1999, 2004). Despite self-evaluative beliefs commonly being a target for intervention in CBT (e.g., Padesky, 1991, 1994), the effectiveness of CBT for low self-esteem has yet to be systematically evaluated. To date, the evidence base consists only of single-case examples with little or no empirical evaluation (Fennell, 1997, 2006) and two evaluations of adapted versions of CBT for low self-esteem applied to specific populations in group settings (Hall & Tarrier, 2003; Rigby & Waite, 2007). Although results are encouraging, data are needed on the efficacy of CBT for low self-esteem for individual outpatients presenting at psychotherapy services.

Fennell's (1997) cognitive-behavioral model of low self-esteem incorporates both longitudinal elements (early experience, "bottom line," "rules for living") as well as current maintenance cycles for the anxiety and depressive symptoms that result from low self-esteem. This model suggests that, on the basis of life experiences, which will typically but not always occur early in life, the person forms a fundamental "bottom line" about themselves. When this self-appraisal is excessively negative (e.g., "I'm worthless" or "I'm not good enough"), the consequence is low self-esteem. In response to a negative bottom line, people develop strategies to negotiate their way through life in spite of their perceived inadequacies. Fennell terms such strategies "rules for living," and they map onto what Beck (1976) in his original cognitive model of emotional disorders termed "dysfunctional conditional assumptions." The purpose of these "rules for living" is to allow the person to feel better about themselves in spite of their negative bottom line—that is, while the conditions of the rule are met, the person escapes awareness of their negative bottom line. For example, in response to a negative bottom line, "I'm unlikable," a patient may develop a rule to live by, such as "I must not let people see the real me." As long as the conditions of the rule are met, then they can avoid awareness of the bottom line and thus moderate their low self-esteem. Rules for living generally relate to the domains of acceptance, control, and achievement—what the person believes they must do in order to be liked/loved/accepted, to be sufficiently in control, or to be successful, and ultimately, to be happy. However, the rules for living that develop in response to a very negative bottom line tend to be excessive either in their content or their application. Of course, it is nice to be liked, but if you feel that you must always give being liked priority over everything else, then common sense tells us psychological distress may result. The effort of behaving in accordance with such rigid and extreme rules for living is considerable, and there is a strong likelihood that at some point in the person's life their terms will not be met. Needing to be liked by everyone, to be the best at everything, or to be completely in control all the time, are likely to be unachievable in the longer term. When these rules are (or might be) broken, the bottom line is triggered. When there is a threat that the rules might be broken (e.g., "I *might* not succeed"), anxiety results; once the individual perceives that the rule has been broken (e.g., "I *have* failed"), the response shifts towards depression.

Once the bottom line is triggered, the anxiety and depressive symptoms are maintained by a range of maladaptive behaviors such as avoidance, safety seeking, and interpreting positive events negatively (e.g., Alden, Taylor, Mellings, & Laposa, 2008). Thus, the system more or less guarantees that, whatever happens, the bottom line will seem to have been confirmed (Fennell, 2004). For example, there is evidence from experimental studies showing that believing that you are not liked is a self-fulfilling prophecy in that it leads you to change your behavior, which in turns makes you less easily liked (Alden & Bieling, 1998). This confirmation of the bottom line leads to further depressive thinking. Hence, this model explains the co-occurrence of both depression and anxiety disorders in low self-esteem and accounts for the oscillation of patients with low self-esteem between anxious and depressed maintenance processes. The model helps us to understand how anxiety and depression can interact, and to find a possible common root in low self-esteem (Fennell, 2004).

The aim of this case report is to describe the assessment, treatment, and outcome of a patient treated with CBT for low self-esteem based on Fennell's (1997, 1999) model. The effectiveness of the treatment is evaluated on measures of self-esteem, depression, anxiety, and general functioning.

Case Study

Presenting Problems and Diagnosis

Jane[1] was referred for CBT for depression and anxiety. She sought help for depression and anxiety after experiencing increasingly low mood, struggling to cope with panic attacks, and spending increasing amounts of time checking and cleaning. The treating clinican (FM) used the Structured Clinical Interview for DSM-IV-TR (SCID; First, Spitzer, Gibbon, & Williams, 2002) to establish diagnosis. Jane met criteria for the diagnosis of major depressive disorder: She experienced persistently

[1] Names and identifying details have been changed to preserve anonymity.

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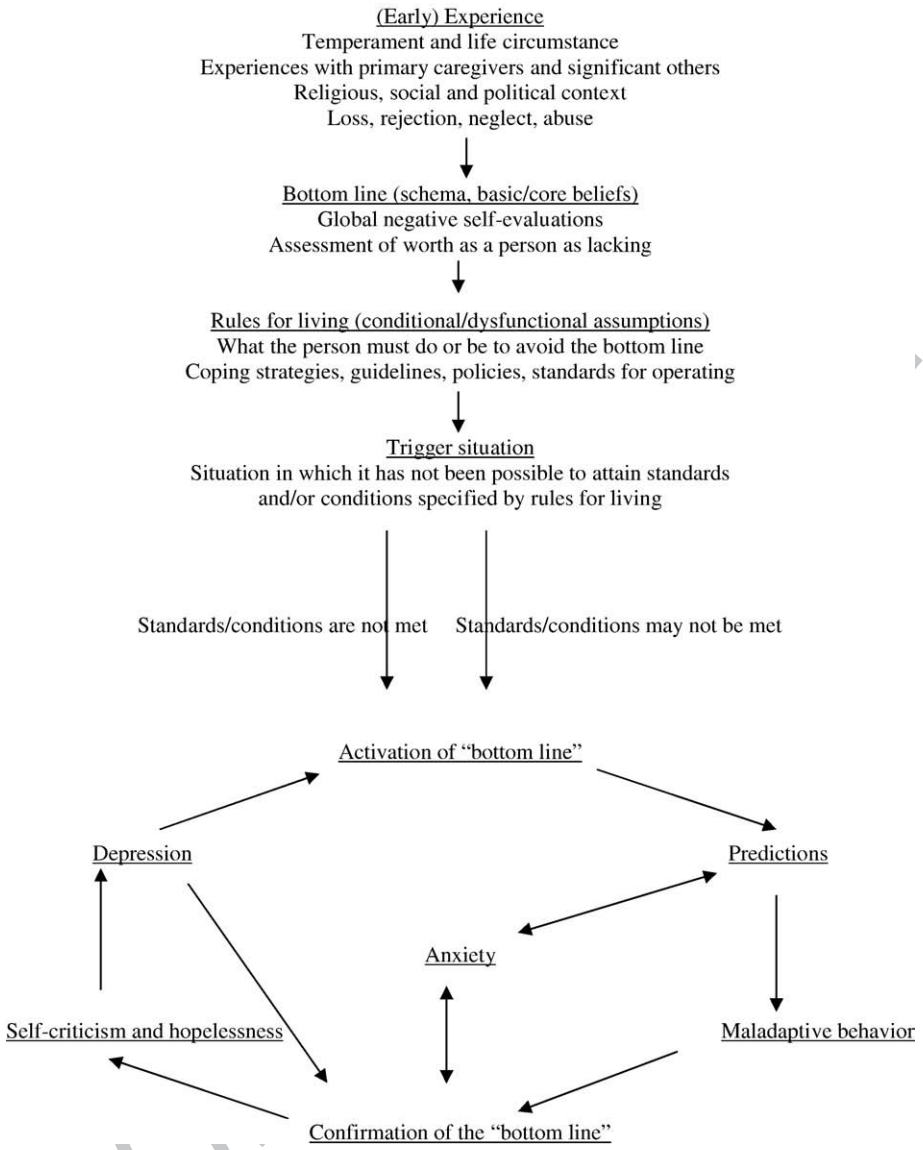

Figure 1. Cognitive Model of Low Self-Esteem.

low mood, loss of interest and pleasure in activities that she normally enjoyed (e.g., socializing), weight loss, sleep disturbance, fatigue, feelings of worthlessness and guilt, poor concentration, and suicidal thoughts (but no plan or current intent to act on the suicidal thoughts).

Jane also met criteria for obsessive-compulsive disorder in that she experienced recurrent intrusive thoughts that caused marked anxiety about being responsible for harm (e.g., her home catching fire), and she responded to these intrusive thoughts by attempting to suppress the thoughts and by engaging in cleaning and checking rituals. Her rituals were excessive and caused marked interference and distress (e.g., being late for work as she spent several hours checking everything in the house was switched off, unplugged, and/or locked). She spent several hours a day cleaning or checking, and at the time of assessment was unable to leave the house unaccompanied. Jane was also subthreshold for the diagnosis of a number of other disorders. She experienced occasional out-of-the-blue panic attacks in relation to times of stress (e.g., having to leave the house without somebody else to check for her), but she did not show persistent avoidance in relation to these attacks. Jane was excessively concerned about how she appeared to others and was avoidant of social situations. However, this appeared to be more of a result of her depression and low self-esteem (not wanting others to ask about her [lack of] career and discover what a worthless person/failure she was) than a true fear of embarrassment or humiliation as in social phobia. Related to this overconcern about how

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she came across to others, Jane met some criteria for the diagnosis of anorexia nervosa—she had a Body Mass Index of 18 and restricted both the quantity and range of foods eaten for fear of gaining weight. She had a distorted impression of her body size and perceived herself to be "disgustingly fat" and "a fat pig." However, she did not meet *DSM-IV-TR* (American Psychiatric Association, 2000) criteria for the diagnosis of anorexia nervosa because her BMI was not sufficiently low, and because she had not experienced persistent amenorrhea. In addition, as with the social anxiety, Jane felt that her need to be "thin" had to do with wanting to make herself acceptable to others and to compensate for her "unacceptability" by being thin/pretty/funny/successful—she reported that in the past when she had felt better about herself as a person she had been comfortable with a body weight in the normal range. Finally, Jane was also subthreshold for the diagnosis of posttraumatic stress disorder (PTSD). She had been the victim of an acquaintance rape approximately 7 years previously. For a period of time after the rape, Jane had met full criteria for PTSD, but since leaving the situation in which the rape occurred, she no longer experienced frequent enough intrusive symptoms to meet criteria for the diagnosis of PTSD. However, she still engaged in significant avoidance behaviors (avoidance of sex, particular sexual acts and positions, and extreme caution regarding safety).

Psychometric Measures

Jane completed the Beck Anxiety Inventory (BAI; Beck & Steer, 1993), Beck Depression Inventory (BDI; Beck, Steer, & Brown, 1996), and Robson Self-Concept Questionnaire (RSCQ; Robson, 1989). The BAI and BDI are widely used 21-item measures of anxiety and depression (respectively) that have been shown to have acceptable or high internal consistency, validity, and reliability (e.g., Beck, Steer, & Garbin, 1988). Total scores range from 0 to 63, with higher scores indicating more severe anxiety or depression. At assessment, Jane scored in the severe range on both the BAI and BDI.

The RSCQ (Robson, 1989) is a 30-item self-report scale measuring self-esteem. Statements are rated on an 8-point scale from "strongly disagree" (0) to "strongly agree" (7). Scores range from 0 to 180 *with higher scores indicating greater (more positive) self-esteem.* Robson reported a Cronbach alpha coefficient of 0.89 and test-retest correlations of 0.87. At assessment Jane scored 94 on the RSCQ, which is below the mean for psychiatric outpatients and more than 2 standard deviations below the mean for nonclinical groups.

Prior and Current Treatment

Jane had had several courses of counseling/psychotherapy and medication in the past and although she felt that these interventions had helped her during that particular crisis, she recognised that her low self-esteem remained unchanged and felt that this left her vulnerable to experiencing further episodes of anxiety and depression in response to life events. At the time of assessment Jane was taking 20 mg/day of fluoxetine and she was advised to keep this does stable.

Relevant Personal History

Jane reported a happy childhood. Having grown up in a high-achieving family, she was an academic high achiever herself and attended a prestigious university. It was while at university that Jane first experienced significant symptoms of anxiety and depression. Previously she had always managed to excel academically but this became more onerous as she progressed through the academic system and she found that she had to work extremely long hours, and even that didn't guarantee her position at the top of the class. She also found it difficult to be successful socially, as well as academically, and felt that she no longer knew "how to get it right for people." During her time as an undergraduate Jane was raped by an acquaintance. Following the rape, Jane engaged in risky sexual behaviors, which she later regretted. In response to these perceived failures she became depressed and began a broad range of checking behaviors (e.g., that she had not forgotten something, that she had not offended someone, as well as checking electrical appliances, water sources, and locks). These symptoms persisted, at a higher or lower level in response to life stress, for the next 5 years. During the 5 years since graduation, Jane had failed to establish herself in a career, and at the age of 27 she was referred for CBT for depression and anxiety.

Treatment

Jane attended 12 sessions of individual CBT spread over a 6-month period, with 3 follow-up appointments in the following year. Sessions were scheduled at the convenience of the patient and therapist's work schedules and were generally weekly for the first 6 weeks, with longer gaps between sessions as treatment progressed. Treatment was carried out by a clinical psychologist (FM) who is accredited by the British Association of Behavioral and Cognitive Psychotherapists as a CBT therapist, supervisor, and trainer, and who has experience providing CBT for low self-esteem. Treatment was based on Fennell's (1997, 1999, 2004, 2006) CBT for overcoming low self-esteem. The four phases of treatment were:

1. Goal-setting, individualized formulation, and psychoeducation (Sessions 1–2).

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2. Breaking into maintenance cycles: learning to reevaluate thoughts/beliefs through cognitive techniques and behavioral experiments (Sessions 3–6).
3. Reevaluating "rules for living": developing alternative, more adaptive rules (Sessions 5–9).
4. Reevaluating the "bottom line": formulating an alternative, more helpful "bottom line"; combating self-criticism and enhancing self-acceptance; and planning for the future (Sessions 7–12).

Sessions 1–2

Goals, formulation, and psychoeducation. In terms of her goals for therapy, Jane wanted to be able to value herself more, to reduce the time she spent checking and cleaning, to be less rigid about diet and exercise, to be able to be more open and honest with people close to her, and to be less upset by perceived failure or rejection. An initial formulation was drawn out collaboratively with Jane in the second session. Further detail was added across the course of therapy, and this is included in the version shown in Figure 2.

Jane felt that her self-worth had always been dependent on achieving externally validated high standards (e.g., reaching the top of the class, receiving a first-class degree from a top university, having lots of friends, having a good job, praise from important others, being thinner than her peers, having male admirers, being witty and fun). Most of her life she had been able to regularly achieve these standards. However, in her early twenties the costs of achieving these standards (i.e., having to work all the time) became too high and she began to feel that she was failing and was not good enough as a person. The symptoms of depression and anxiety that she developed in response to these feelings of failure further prevented her from meeting the high standards she aspired to and confirmed her feeling that she was somehow not good enough. For example, the fact that her excessive checking caused her to be late for work confirmed her "bottom line" that she wasn't good enough. Her difficulties were further exacerbated when she was raped by an acquaintance. She blamed herself for not preventing the rape and for being unable to "just put it out of my mind and move on" and was critical of herself for her sexual behavior following the rape. Dealing with the rape and its aftermath made it even more difficult for Jane to meet her high standards for achievement and, consequently, she felt even more of a failure and not worthwhile as a person.

Jane felt that the formulation as shown in Figure 2 was a good account of her current difficulties and she was able to identify situations in which her interpretation of the event had exacerbated her distress. For example, one day at work, she felt upset over not being offered cake, which she interpreted as meaning that her colleagues didn't like her/want to include her; yet, on another day, Jane felt upset upon being *offered* cake, because she believed it meant that her colleagues thought she was a fat, greedy pig. Jane was able to see that no matter what the situation, she tended to interpret it to mean that she was in some way not good enough. The formulation was used as a basis for psychoeducation and normalization. It was suggested that treatment would involve gathering and reviewing evidence for the validity of the following two theories:

> ***Theory A:*** Jane was an inadequate person who needed to compensate for her worthlessness by achieving especially highly and being especially nice to others, in order to ensure that she was acceptable as a person.
>
> ***Theory B:*** Jane was as worthwhile as any other human being but her low self-esteem/believing that she was not good enough caused her to get stuck in vicious circles of maladaptive thought and behavior that led to her experiencing symptoms or depression and anxiety.

For example, not trusting her own judgment/memory led to her spending a lot of time checking, and thus not having enough time to complete the work she wanted to complete. This inability to get as much as she wanted done further confirmed her low self-esteem.

Sessions 3–6

Learning skills to reevaluate thoughts/beliefs through cognitive techniques and behavioral experiments. Jane was able to complete daily thought records (Greenberger & Padesky, 1995) in order to challenge her negative thinking on a day-to-day basis. For example, Jane reevaluated such thoughts as, "I'm a bad friend," "I look ugly in photos, I don't know how to dress properly," and "They think I'm a failure because I haven't got a successful career, and won't want to know me." Behavioral experiments (Bennett-Levy et al., 2004) were collaboratively devised to enable Jane to test out her negative predictions (e.g., answering her phone when she wasn't feeling very entertaining or disclosing her perceived failings to others). She also used behavioral experiments to test out the consequences of reducing her cleaning and checking (e.g., leaving her mobile phone charger plugged in to see if it did catch fire). She was also able to survey the opinions of others to find out their standards for safety and cleanliness, and to find out what they thought of other people who had different standards from themselves. This work was continually linked back to the formulation and used to reevaluate her bottom line that she wasn't good enough.

Sessions 5–9

Reevaluating rules for living: Developing more adaptive rules. The formulation in Figure 2 identifies several rules

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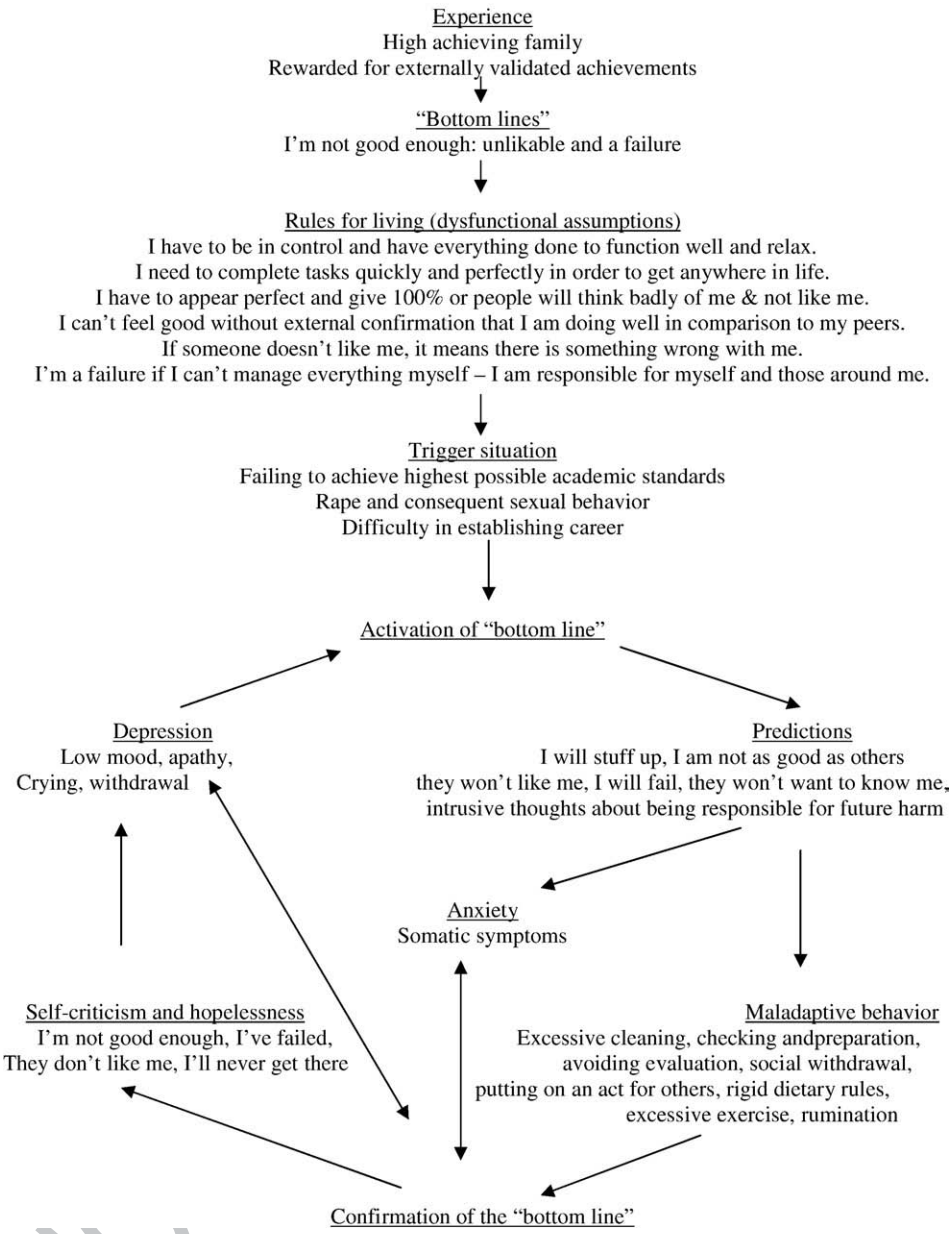

Figure 2. Formulation of Jane's Current Difficulties According to Fennell's (1997) Cognitive Model of Low Self-Esteem.

for living (dysfunctional assumptions) that Jane agreed were unrealistic and left her vulnerable to experiencing low self-esteem, anxiety, and depression. She used the "flashcard technique" (Fennell, 1999) to reevaluate her dysfunctional assumptions. This involved the following stages: specifying the old rule; considering the origins of the rule and looking at the impact it has had on her life; specifying in what ways the rule is helpful and in what ways it is unhelpful; considering how the rule is unreasonable/doesn't reflect the way that the world is; specifying a new rule that has most of the advantages of the old rule but fewer of the disadvantages; and specifying what needs to be done in order to work towards living according to the new rule. For example, Jane used this technique to reevaluate the rule, "I need to complete tasks quickly and perfectly in order to get anywhere in life." She reflected that this rule was unrealistic in that nobody completed everything quickly and perfectly yet most people got somewhere in life, and it was unhelpful in that it caused her to feel pressured and to spend more time on tasks than she wanted or needed to. She decided that a more helpful alternative would be, "While there is satisfaction in carrying out tasks well, you can't do everything well so it is necessary to prioritize what you will invest time in doing well and which tasks you will do to a lower standard." Her plan for living according to the new rule involved

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choosing some tasks to do to a lower standard (e.g., cleaning, menial tasks at work, buying presents for people she wasn't especially close to) and testing out the consequences of doing these to a lower standard, whether or not it does in fact stop her from getting anywhere in life. What she found was that it helped her to go where she wanted as it freed up her time for the things that were important to her. Jane used the same technique to reevaluate the other dysfunctional assumptions in the formulation shown in Figure 2.

Sessions 7–12

Combating self-criticism and enhancing self-acceptance. Jane was able to reflect on her self-criticism and recognize that it was not helpful in that it more often undermined her motivation than enhanced it, and it certainly undermined her enjoyment of life. She was very aware that she would not judge another person so harshly or think that it would be helpful to them to be treated in such a way. She was able to record her self-critical thoughts and link these to self-defeating behaviors. She used a list of key questions (e.g., How would you view someone else in this situation?) to try to challenge her self-critical thinking. Despite this insight, she found it very difficult to remain unaffected by self-critical thoughts. Jane decided that she would aim to work towards the basic philosophy that the point of life is not to get top marks as often as possible, but to enjoy the ride as much as possible. With this aim in mind she was able to overcome her high standards and self-criticism in order to be able to work on enhancing self-acceptance. This work included making a list of her positive qualities and tracking them on a daily basis (e.g., instances where she was friendly or helpful to others, or completed a task to a satisfactory standard) and using an activity schedule to increase the range and frequency of activities that she engaged in that gave her a sense of pleasure and/or satisfaction (e.g., walking to work instead of getting the bus, visiting an art gallery, spending time with friends whose company she genuinely enjoyed). Over time, Jane reported that these methods were effective in undermining her negative bottom line and strengthening the alternative ("I am a person of equal worth to others and, thus, deserve to have a balanced life with some achievement of what is important to me and some enjoyment").

Ending treatment. Jane constructed a relapse management plan by summarizing what she had learned from therapy and reviewing what she had found most helpful in bringing about change. Possible risk factors for relapse were identified as stress at work, comparing herself unfavorably to her peers, interpersonal rejection, and any perceived failure. Jane reported that the techniques that she had found particularly helpful were: thought records for dealing with specific situations; the flashcard technique for reviewing her rules for living and coming up with a general strategy; activity scheduling for managing her mood; and behavioral experiments for testing anxious predictions. She particularly thought that she needed to continue to review the progress she was making towards living according to her new rules on a weekly basis. Jane also mentioned that she had stopped taking her antidepressant medication some weeks previously. She explained that once she began to feel better she had so frequently forgotten to take her medication that it didn't seem worth it when she did remember.

Results

The questionnaire scores shown in Figure 3 reveal that Jane's progress in treatment fluctuated in response to life events and stressors. The events that prompted increases in anxiety and depressive symptoms (e.g., the death of her aunt and guilt at not attending the funeral, ending her relationship with her boyfriend) were utilized in therapy not only to practice Jane's CBT skills (e.g., challenging the guilt about not attending her aunt's funeral, checking out anxious predictions about not being able to manage without her boyfriend), but also for developing the formulation (i.e., about Jane's "bottom line" and "rules for living," and also about her typical responses to stressful life circumstances). By the end of treatment Jane felt that she had made significant progress towards her goals. More specifically, she had stopped excessive cleaning and checking and was able to eat and exercise as she wanted. She felt that she was less affected by perceived failures or rejection and was better able to value herself, even in the absence of objective measures of success. She also felt that she had made progress in being more open and honest with those around her—for example, she now answered her phone rather than vetting calls until she could "put on a good show."

Figure 3 shows Jane's response to treatment on the BAI and BDI during the course of her treatment and at 1-year follow up. Effect sizes (Cohen's *d*) at the end of treatment were 1.70 on the BAI and 3.61 on the BDI. At 1-year follow-up, effect sizes (Cohen's *d*) were 2.64 on the BAI and 3.92 on the BDI.

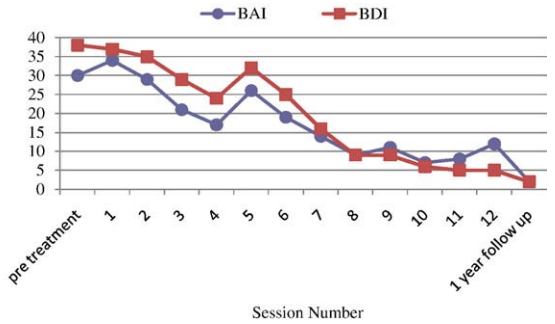

Figure 3. Jane's scores on the Beck Anxiety Inventory (BAI) and the Beck Depression Inventory (BDI).

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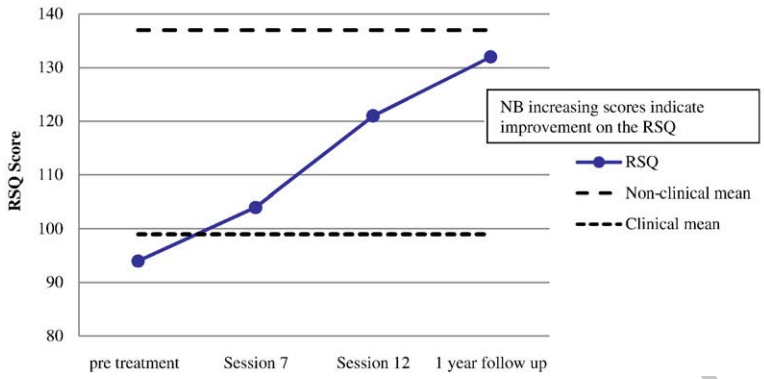

Figure 4. Jane's scores on the Robson Self-concept Questionnaire (RSQ).

Figure 4 shows Jane's response to treatment on the RSQ over treatment and at 1-year follow-up. Effect size (Cohen's *d*) on the RSQ at posttreatment was 1.22 and was 1.68 at 1-year follow-up. By the end of treatment and at 1-year follow-up Jane was scoring in the nonclinical range on all measures. There are three methods for calculating clinically significant change (Jacobson, Follette, & Revenstorf, 1984; Jacobson & Truax, 1991). Using a clinical mean of 99.8 (*SD*=24) and a nonclinical mean of 137 (*SD*=20) (Robson, 1989), Jane's change on the RSQ from 94 at pretreatment to 121 at posttreatment meets the criterion for clinically significant change by methods B (being within 2 *SD* of the nonclinical mean at the end of treatment) and C (being on the "normal side" of the halfway point between the clinical and nonclinical means, but not by method A (being more than 2 *SD* from the clinical mean). This change on the RSQ also meets Jacobson, Follette, and Revenstorf's (1984) criteria for reliable change (RSC alpha=.83). Similarly, her changes on the BDI and BAI also met criteria for reliable change and for clinically significant change (by methods A, B and C). At the end of treatment and at 1-year follow-up, Jane no longer met diagnostic criteria for any psychiatric disorder, as assessed by the SCID.

Conclusions

CBT for low self-esteem was effective in helping Jane to meet her therapy goals and in reducing her symptoms of depression and anxiety. At the end of treatment, and at 1-year follow-up, she no longer met diagnostic criteria for any psychiatric disorder and scored in the nonclinical range on measures of anxiety, depression, and self-esteem. As far as we are aware, there are no other published case studies of CBT for low self-esteem that report pre- and posttreatment evaluations or follow-up data. Hence, this case provides an initial contribution to the evidence base for the efficacy of CBT for low self-esteem.

In many ways the treatment described in the current case report could be considered to be "standard CBT"—it is comprised of standard CBT techniques, and is formulation driven. Also, it may be typical of the kinds of CBT that are carried out in routine clinical practice where patients often show high levels of comorbidity and where there is little or no evidence base to guide clinicians in choosing how to structure, sequence, or combine interventions for patients who meet criteria for more than one disorder (Harvey, Watkins, Mansell, & Shafran, 2004). However, what is unusual is that the treatment is driven by a formulation of the patient's low self-esteem, rather than of her diagnosis/diagnoses. Fennell's (1997, 1999, 2006) cognitive approach to low self-esteem may offer the clinician a way of conceptualizing and treating patients with low self-esteem that incorporates elements of both symptom-focused CBT and schema-focused CBT, and can be applied to patients whose problems fall into or between several diagnostic categories. The key element of this approach is combining standard CBT interventions to break maintenance cycles with more core-belief focused work to change basic beliefs about the self and the dysfunctional ways in which the person interacts with the world. Standard CBT techniques are used not only to break the maintenance cycles of anxiety and depression, but also to look at changing the rules and strategies that leave the person vulnerable to responding to life stress with similar symptoms in the future. In the later stages of treatment the clinician may also utilize more schema-focused techniques in order to combat the "bottom line."

How this approach compares to diagnosis-led interventions is yet to be established. The approach yielded large effect sizes that were maintained at 1-year follow-up. However, it is hard to draw any firm conclusions on the basis of one case. One obvious advantage of this approach is that it would have taken longer than 12 sessions to carry out CBT protocols for both depression and OCD, and these would not have addressed her other problems directly (subthreshold panic disorders, social phobia, PTSD, and eating disorder), so it may be that intervening directly on self-esteem is a more efficient route. However,

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more research is needed to determine whether intervening directly on self-esteem is more (or less) effective than using diagnosis-led formulations, either in sequence or in combination, to guide CBT.

A limitation of the current study is that the assessment relied heavily on patient self-report. Such self-report questionnaires are usually fairly transparent and thus could be susceptible to being biased by the patient's desire to please the therapist by appearing to improve. Future studies may wish to consider including observational data from video or audio transcripts of sessions. For example, a relevant index of improvement for the current patient could have been the frequency of self-critical statements made during the therapy sessions. Such observational data may give a broader repertoire of assessment and help to identify whether any changes made in therapy are having an impact on the patient's behavior both within and outside of the sessions.

Uncited Reference

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