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Cognitive behaviour therapy for low self-esteem: A preliminary randomized controlled trial in a primary care setting

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ABSTRACT

Background and Objectives: Low self-esteem (LSE) is associated with psychiatric disorder, and is distressing and debilitating in its own right. Hence, it is frequent target for treatment in cognitive behavioural interventions, yet it has rarely been the primary focus for intervention. This paper reports on a preliminary randomized controlled trial of cognitive behaviour therapy (CBT) for LSE using Fennell's (1997) cognitive conceptualisation and transdiagnostic treatment approach (1997, 1999).
Methods: Twenty-two participants were randomly allocated to either immediate treatment (IT) ($n = 11$) or to a waitlist condition (WL) ($n = 11$). Treatment consisted of 10 sessions of individual CBT accompanied by workbooks. Participants allocated to the WL condition received the CBT intervention once the waitlist period was completed and all participants were followed up 11 weeks after completing CBT.
Results: The IT group showed significantly better functioning than the WL group on measures of LSE, overall functioning and depression and had fewer psychiatric diagnoses at the end of treatment. The WL group showed the same pattern of response to CBT as the group who had received CBT immediately. All treatment gains were maintained at follow-up assessment.
Limitations: The sample size is small and consists mainly of women with a high level of educational attainment and the follow-up period was relatively short.
Conclusions: These preliminary findings suggest that a focused, brief CBT intervention can be effective in treating LSE and associated symptoms and diagnoses in a clinically representative group of individuals with a range of different and co-morbid disorders.

1. Introduction

Self-esteem has been defined as the "conviction that one is competent to live and worthy of living" (Branden, 1969; p.110) and is a term used to reflect a person's overall evaluation or appraisal of his or her own worth. It can be seen as a schema, in that it is a broad, pervasive theme or pattern, comprised of memories, emotions, cognitions and bodily sensations regarding oneself and one's relationships with others, developed during childhood or adolescence and is elaborated throughout one's lifetime (Young, Klosko, & Weishaar, 2003). Evidence suggests that the majority of people with mental health problems suffer from low self-esteem (LSE) (Silverstone & Salsali, 2003), in that they evaluate their competence and worthiness negatively. However, due to difficulties operationalizing and evaluating the concept of self-esteem (Mruk, 1999), it has been inadequately studied.

Although LSE is not a psychiatric diagnosis, it has been shown to have far-reaching consequences. It is associated with dropping out of school (Guillon, Crocq, & Bailey, 2003), self-harm and suicidal behaviour (Kjelsberg, Neegaard, & Dahl, 1994) and teenage pregnancy (Plotnick, 1992). It also has a negative impact on economic outcomes, such that those with LSE experience greater unemployment and lower earnings (Feinstein, 2000).

LSE has been associated with and cited as an etiological factor in a number of different psychiatric diagnoses including depression (Brown, Bifulco, & Andrews, 1990), psychosis (Hall & Tarrier, 2003), eating disorders (Gual, Perez-Gaspar, Martinez-Gonzallaz, Lahortiga, & Cervera-Enguix, 2002), obsessive compulsive disorder (Ehntholt, Salkovskis, & Rimes, 1999), substance abuse (Akerlind, Hornquist, & Bjurulf, 1988; Brown, Andrews, Harris, Adler, & Bridge, 1986; Button, Sonuga-Barke, Davies, & Thompson, 1996) and chronic pain (Soares & Grossi, 2000).

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Silverstone and Salsali (2003) report 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. Furthermore, LSE has been shown to predict poorer outcome in psychological treatments (Button & Warren, 2002) and to predict relapse following treatment (Brown et al., 1990; Fairburn, Peveler, Jones, Hope, & Doll, 1993). It may also affect the natural course of disorders, making recovery more difficult (Fairburn et al., 1993; van der Ham, Strein, & Egneland, 1998).

While LSE has been associated with many psychiatric conditions, the nature of this relationship remains unclear with some studies showing that having a psychiatric disorder lowers self-esteem (Ingham, Kreitman, Miller, Sashidharan, & Surtees, 1987) and others showing lowered self-esteem to pre-dispose one towards a range of psychiatric illnesses (Brown et al., 1986; Miller et al., 1989). There is also evidence that changes in either depression or self-esteem can affect the other (Hamilton & Abramson, 1983; Wilson & Krane, 1980), suggesting that the relationship between LSE and psychiatric illness may be circular.

In summary, LSE is common, distressing and disabling in its own right; it also appears to be involved in the aetiology and persistence of disorders across the range of diagnoses. Thus attending to LSE has the potential to improve treatment outcome and is in accord with recent calls to develop transdiagnostic approaches to treating common mental health problems, particularly those with high rates of co-morbidity (Harvey, Watkins, Mansell, & Shafran, 2004; McManus, Shafran, & Cooper, 2010; Mansell, Harvey, Watkins, & Shafran, 2009; Norton & Philipp, 2008). Hence, it is a priority to develop effective treatments for LSE that can be applied across the range of diagnoses associated with LSE.

A cognitive conceptualisation of LSE has been proposed and a cognitive behavioural treatment (CBT) program described (Fennell, 1997, 1999). As shown in Fig. 1, Fennell's (1997) conceptualization of LSE is an elaboration of the cognitive model of emotional disorder (Beck, 1976) and accounts for the presence of anxiety as well as depressive symptoms. It suggests that people form global negative judgements about themselves ('the bottom line') as a result of experiences, typically early on in their lives (Fennell, 1997, 2006). The development of dysfunctional assumptions ('rules for living') enables them to function and cope with or compensate for their negative beliefs as long as the 'rules for living' are adhered to. However, when situations are encountered where the 'rules for living' may be or have been transgressed, the 'bottom line' belief is activated and triggers vicious cycles of thoughts, feelings and behaviour that maintain and exacerbate the bottom line belief. In particular, anxiety is triggered when it is perceived that the rules *may be* transgressed, and depression is triggered when it is perceived that the rules *have been* transgressed.

Fennell' treatment approach (1997, 1999) is consistent with other transdiagnostic approaches that emphasize common pathways across diagnostic categories (Barlow, Allen, & Choate, 2004; Fairburn et al., 2009; McManus, Clark, Muse, & Shafran, submitted for publication). The treatment protocol arises from a transdiagnosic formulation of LSE which provides a framework for making sense of both anxiety and depressive symptoms and this forms the basis of a coherent treatment approach (Butler, Fennell, & Hackmann, 2008). The focus is on understanding how the person's difficulties interrelate rather than treating them separately and all interventions are carried out in the context of the enduring negative beliefs about the self (the 'bottom line'). Specific interventions are derived from established evidence-based protocols for specific emotional disorders and from cognitive approaches to working with enduring negative beliefs about the self (Beck & Freeman, 1990; Young, Klosko, & Weishaar, 2003).

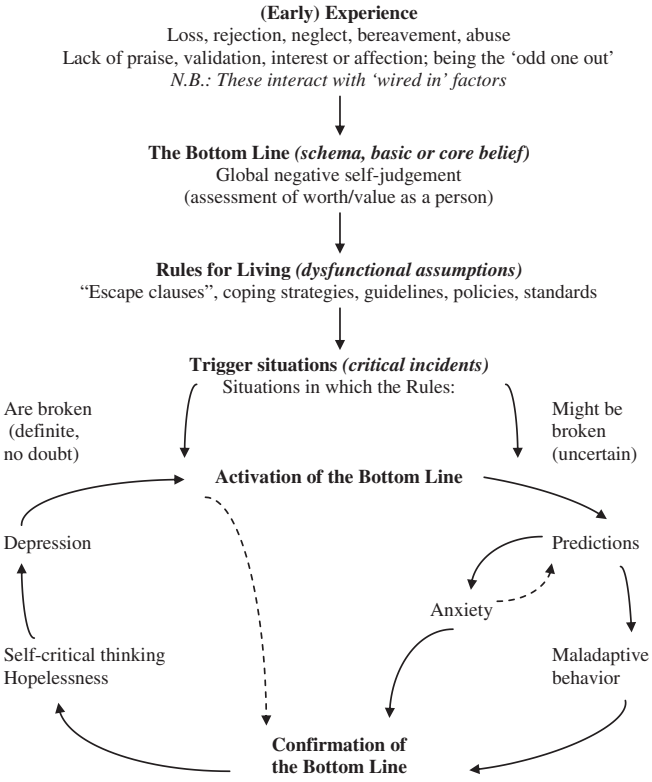

Fig. 1. Fennell's (1997) cognitive model of low self-esteem.

The CBT for LSE protocol incorporates techniques from standard CBT (e.g., Beck, Rush, Shaw, & Emery, 1979) and also schema approaches (Young, Klosko, & Weishaar, 2003), but specifies how they can best be applied to LSE, and in particular to changing pervasive negative self-evaluative beliefs and related behaviour patterns. Depending on the nature of the individual's difficulties, early sessions may include elements from other well-established cognitive therapy approaches for specific disorders. For example, a patient with social anxiety may carry out behavioural experiments to manipulate safety behaviours and shift to external attention (Clark & Wells, 1995; McManus, et al., 2009). As well as techniques designed to attenuate negative beliefs and behaviours, Fennell's treatment also incorporates strategies to enhance self-esteem and promote positive self-evaluative beliefs, such as identifying, recording and reviewing positive qualities in order to correct the perceptual bias of noticing and placing greater weight on perceived failings or flaws and screening out information that is inconsistent with this.

As with Young et al.'s (2003) schema therapy, dysfunctional assumptions and core beliefs are addressed, and there is consideration of the childhood origins of such beliefs. However, unlike schema therapy, CBT for LSE begins by utilising standard CBT techniques to address the current maintenance cycles of depression and anxiety, and does not apply Young's category system to identify problematic schemas. Instead, the focus is limited to negative self-evaluative beliefs. Techniques such as continuum work, the use of the Prejudice model (Padesky, 1993), reviewing and reinterpreting evidence consistent with the old belief and a search for new evidence through a positive data log are used to consider the evidence for core beliefs and to modify the degree to which beliefs are held. In order to then establish and strengthen a new and more positive perspective, the evidence collected from therapy is used to generate alternative beliefs and rules for living and these are