Clinical Case Report

Trans-Cultural Application of Cognitive Behavioural Therapy for Depression and Low Self-Esteem

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Article history: Received 20 August 2012, Received in revised form 31 August 2012, Accepted 1 September 2012, Published 20 September 2012.

Abstract: This paper outlines the case of ‘Jane’ - a client who presented to a primary care mental health service with depression and low self-esteem. She was offered and engaged in a course of Cognitive Behavioural Therapy. Longitudinal formulations were developed for presenting difficulties and resilience factors which guided the cognitive-behavioural intervention. Evaluation via psychometric measures suggested positive psychological change, including improved mood and self-esteem, which was supported by self-reported change. Treatment implications and recommendations to other clinicians are considered. Consent to produce this report was obtained from the client and identifiable information has been removed with some details altered to maintain anonymity.

Keywords: Depression, Culture, Low Self-Esteem, Cognitive-Behavioural Therapy, Adult Mental Health

1. Theoretical and research basis for treatment

Depression is estimated to affect approximately 6% of the general population (Roth & Fonagy, 1996) and has been identified as a public health concern (Kessing, 2007) with a well-documented link between depression and poorer overall physical health (Cassano & Fava, 2002). The National Collaborating Centre for Mental Health ([NCCMH], 2010) identifies depression as the most common mental health disorder and...
describes the symptoms as a collection of cognitive, emotional, physical and behavioural difficulties. The DSM-IV-TR (American Psychiatric Association, 2000) provides guidelines for diagnosing depression and the key features of this presentation include: low mood; loss of interest; changes in appetite and weight; sleep problems; fatigue; feelings of worthlessness and/or guilt; poor concentration; and suicidal ideation.

Depression is a ‘common experience’ (Nairne & Smith, 1984: 5) of which low self-esteem is often a consequence (NCCMH, 2010). Moore and Garland (2004) identify low self-esteem as a central component of persistent depression alongside helplessness and hopelessness, and individuals often feel worthless and like a failure (Stoudemire, 1998). Successful treatment of depression also alleviates self-esteem concerns in the overwhelming majority of cases where both of these diagnoses are present (Fennell, 2009).

There are a number of theories as to why depression develops and is maintained, including biological and psychosocial theories (Fava & Kendler, 2000), though the focus of key literature for depression centres on behavioural (Lewinsohn, 1974) and cognitive theories (Beck, 1967). Behavioural theories propose that a lack of positive reinforcement and rewards in the environment lead people to withdraw from, or avoid, situations which leads to the development of depression. Continued avoidance maintains the depression and can lead the individual to feel worthless, hopeless and helpless, often impacting negatively upon their self-esteem. Cognitive theories suggest that a negative thinking style leads to depressive thoughts which are maintained by thinking errors and negative biases. These two approaches were combined into a Cognitive Behavioural model.

The Cognitive Behavioural model works on the assumption that unhelpful thoughts, feelings and behaviours can create a vicious cycle causing distress, and an individual’s negative views of the self, the world and the future can lead to depression (Beck, 1976). In particular, negative beliefs about the self can have a damaging effect on the individual’s self-esteem. Core beliefs are developed during childhood, upon which underlying assumptions are based. If these are unhelpful, then difficulties are likely to be encountered in later life, such as depression. Therapy within the Cognitive Behavioural model seeks to address these maladaptive core beliefs and underlying assumptions, giving rise to more adaptive beliefs and behaviours. Treatment of depression using CBT has been found effective by a wealth of research (Roth & Fonagy, 1996).

It was important that the treatment choice was evidence based and therefore likely to improve Jane’s depression and low self-esteem (Roth & Pilling, 2007). Guidelines produced by the National Institute for Clinical Excellence ([NICE], 2009) suggest that a range of therapies should be considered for the treatment of depression, though treatment also needed to reflect: what the client wanted; what the service could feasibly provide; and was within the therapist’s competence and could be supervised appropriately. After discussion with both client and supervisor, it was agreed that Cognitive Behavioural Therapy would be the most appropriate course of treatment.
2. Case introduction

Jane had been referred from her GP to Primary Care Mental Health Services because she had been affected by depression and low self-esteem for approximately four years. She was a student studying part-time and working part-time as a waitress. Jane had lived in Spain all her life until she had moved to Liverpool three years ago. Jane did not want to be prescribed psychotropic medication and instead opted for Psychological Therapy.

3. Presenting complaints

These difficulties had a large impact on Jane’s life. She found that the autonomic effects of depression affected her ability to study successfully. Although she maintained her employment, she often felt lethargic and found it a great effort to attend. Interpersonal difficulties also seemed dominant in Jane’s presentation, as she acted aggressively and avoided spending time with friends. Jane felt unable to understand her emotions or control her mood which had led to relationship difficulties and a sense that she was misunderstood.

4. History

Jane was born in Spain and lived with her mother, father and older brother until she was 18. During her first eight years, the family moved house many times before her parents separated and Jane, her mother and brother went to live with her grandparents. After three years, her parents reconciled and the family moved into a flat together. Jane reports that her parents’ relationship was volatile, with frequent arguments and threats of separation. Jane reported that her mother was critical of her and would frequently compare Jane unfavourably to her brother and other children. Her father was often absent, but when he was there he was either dismissive and distant or angry and would argue with family members. Jane described her brother as being deliberately nasty towards her when they were growing up, and from their teenage years he would either be withdrawn and quiet or speaking incessantly. Jane disclosed that she did not enjoy school and moved several times. She stated that she was made to feel stupid on numerous occasions and other children were ‘rejecting’ of her.

After moving away from home for university, Jane commenced a relationship which lasted ten years. She stated that she had not loved her ex-boyfriend but was under pressure from her friends and family to stay with him because he had been viewed as the ‘perfect boyfriend’. She ‘escaped’ this
relationship by moving to England and Jane reported that she still felt distressed about this whole situation because she was “too weak to leave”.

Since moving to England, Jane studied part time and had undertaken various waitressing jobs. Jane had been in her new relationship for approximately two years and lived with her boyfriend.

5. Assessment

Psychometric Assessment

Jane completed the Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM) to indicate areas of strength and difficulty. The CORE-OM is widely utilised to measure the outcomes of Psychological Therapies (CORE Partnership, 2007) and measures four areas to determine whether the presentation suggests a clinical case. Table 1 illustrates the CORE-OM scores demonstrating that Jane’s scores constitute a clinical case.

<table>
<thead>
<tr>
<th>Raw Score</th>
<th>Wellbeing</th>
<th>Problems</th>
<th>Functioning</th>
<th>Risk</th>
<th>Total</th>
<th>Total - Risk</th>
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<tr>
<td>11</td>
<td>29</td>
<td>29</td>
<td>6</td>
<td>75</td>
<td>69</td>
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</table>

<table>
<thead>
<tr>
<th>Mean Score</th>
<th>Wellbeing</th>
<th>Problems</th>
<th>Functioning</th>
<th>Risk</th>
<th>Total</th>
<th>Total - Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.75</td>
<td>2.42</td>
<td>2.41</td>
<td>1</td>
<td>2.21</td>
<td>2.46</td>
<td></td>
</tr>
</tbody>
</table>

(Interpretations from Barkham et al., 2001)

Low self-esteem was measured using The Rosenberg Self-Esteem Scale (SES). The SES is one of the most widely used self-esteem measures worldwide (Rusticus, Hubley & Zumbo, 2004) and has been utilised to across nationalities and cultures (e.g. Feather, 1998) so it seemed particularly suitable for Jane where her cultural background might influence the way in which low self-esteem could present. The SES is marked out of a total of 30, with higher scores indicating higher self-esteem. Jane scored 16 on this scale.

Before intervention commenced, the Patient Health Questionnaire-9 (PHQ-9) was administered in order to assess effectiveness. The PHQ-9 was developed by Kroenke and Spitzer (2002) and is routinely used in Primary Care to assess the severity of depression (Rost & Smith, 2001). Jane scored 9 on this measure, which indicated mild depression.

Risk

Jane had no history of self-harm and had never experienced intent to take her own life. She occasionally experienced fleeting suicidal thoughts but was confident that she
would never act upon them. These were monitored on a weekly basis, discussed in supervision and were not deemed a risk issue.

At the start of therapy, Jane’s CORE-OM results indicated that there was no significant risk of harm to herself or others. One item of initial concern was later revealed to be a language issue: Jane marked ‘I have threatened or intimidated another person’ as happening often (Jane clarified that she had verbally threatened to end the relationship with her boyfriend). On the PHQ-9, no risk of harm was detected.

### Expectations of Therapy

Jane was keen to engage in therapy and appeared motivated to change. She stated that she could commit to a 16 session course of Cognitive Behavioural Therapy including the homework that would be involved. Jane was hopeful for the future and personal goals were easily elicited:

- Think more positively
- To be less critical of myself
- Know what I can do to improve my mood
- Understand why I am feeling this way
- To share my opinion without fear of looking stupid or being attacked
- To be able to express my emotions, without being aggressive

#### Goal Setting

6. Case Conceptualisation

Clinical case formulation constitutes an essential stage in therapy and enabled Jane and the practitioner to develop a thorough understanding of the areas of difficulties (Greenberger & Padesky, 1995). Formulation from a CBT perspective covers: predisposing factors; precipitating factors; presenting problems; perpetuating factors; and protective factors (Wells, 2004; 2008) and these were addressed through the use of longitudinal formulations adapted from Kuyken, Padesky and Dudley (2006). Jane identified what she wanted to be included and we reviewed and adapted the formulations together. Therefore, Jane had a sense of ownership and fully understood her formulations.

Jane expressed the struggle she found in producing the area of difficulties formulation and became distressed in the sessions on a number of occasions. As Jane had not communicated these areas of her life to anybody prior to therapy, sensitive and collaborative development of this formulation was required. Despite this, Jane stated that she valued this stage as it enabled her to understand what might have contributed to her difficulties and what maintained them. This guided the intervention, enabling a number of key underlying assumptions to be tested out and dysfunctional core beliefs to be modified (as suggested by Moore & Garland, 2004). Constructing the strengths formulation alleviated Jane’s distress as she explored more positive areas of her life, and completing the healthy maintenance cycle enabled Jane to identify her helpful patterns of thoughts, feelings and behaviours and ways of breaking out of the vicious cycle (as documented by Hawton, Salkovskis, Kirk & Clark, 1989). Thus, completing the formulation stage acted as an intervention in itself (supported by Tarrier, 2009) and assisted Jane to progress
towards her goal of ‘understand why I am feeling this way’.

Two formulations were constructed with Jane in a collaborative way within the sessions: one encompassing her presenting difficulties (see Figure 1) and the other incorporating her strengths and resilience factors (see Figure 2).

**Figure 1:** Longitudinal Formulation for Jane’s Presenting Difficulties (adapted from Kuyken, Padesky & Dudley, 2006)

**Developmental Experiences**
- Mother critical and compared me to others. I was affected by depression.
- Father was absent or ‘freaking out’.
- Instability in home life and parents’ relationship.
- Brother tried to upset me – was deliberately nasty and his behaviour was inconsistent.
- I was rejected at school by other girls, felt different and made to feel stupid.

**Core Beliefs**
- I am not good enough.
- I am not loveable.
- I am misunderstood.
- Others are absent.
- Others are changeable and insecure.
- The world is an uncertain place.

**Underlying Assumptions**
- If I confront others, they will freak out.
- If I express my needs then others might attack me.
- If I don’t have an identity, I am weak.
- If I am different, it will cause conflict.
- If I share my opinion, I will look stupid.

**Strategies**
- Avoid conflict.
- Leave difficult situations.
- Withhold feelings.
- Withhold opinions.

**Triggers**
- Perceived criticism.
- Potential conflict.
- Not being listened to.

**Thoughts**
- I look stupid.
- I am not good enough.
- I am misunderstood.
- They will leave me.

**Behaviours**
- Leave or avoid situation.
- Withhold feelings / ‘freak out’.

**Feelings**
- Angry
- Frustrated
- Upset
- Hurt

**Figure 2:** Longitudinal Formulation for Jane’s Strengths and Resilience Factors (adapted from Kuyken, Padesky & Dudley, 2006)

**Developmental Experiences**
- When I was growing up, I had good holidays as a family which I enjoyed.
- I was able to establish and maintain good friendships during my childhood years.
- I achieved good grades when I was in school.
- I valued education and always tried hard so I could attend university.

**Core Beliefs**
- Family is important.
- Education is important.
- I am capable.
- I am independent.
- I am likable.
- I am supportive of others.
- Others motivate me.

**Underlying Assumptions**
- If I try hard, I can achieve what I want.
- If I am a good friend to others, we have good relationships.
- If I persevere, I can overcome any difficulties.
- If friends or family need me, I am supportive.
- If I am independent, I am strong.

**Strategies**
- Able to establish and maintain good relationships.
- Strive to achieve.
- Have firm goals for the future.
- Be independent.
- Be consistent of other people.
- Work hard to overcome difficulties.
- Attend therapy and be in charge of my own recovery.
- Attend university and strive to achieve.

**Triggers**
- Perceived criticism.
- Potential conflict.
- Not being listened to.

**Thoughts**
- I can do this.
- I can overcome this.
- I am a good person.
- I have good friends.

**Behaviours**
- Maintain relationships.
- Talk about my feelings.
- Ask for help if needed.
- Stay in difficult situations.
- Set realistic goals.
- Attend university.

**Feelings**
- Motivated.
- Happy.
- Content.
- Proud.

### 7. Course of treatment and assessment of progress

Intervention was guided by the client’s formulations, based upon the CBT evidence base for depression and low self-esteem and reflected upon / adapted through the use of weekly supervision with a Registered Clinical Psychologist.

**Early Sessions (1-4)**

Preliminary sessions involved establishing a good therapeutic alliance and socialising Jane to the CBT model. Proficient listening skills, appropriate questioning style and a collaborative approach were utilised in attempt to build the rapport with Jane (as
suggested by Larner, 2004) and warmth and empathy were displayed in order to aid the use of CBT (Beck, Rush, Shaw & Emery, 1979). Normalisation of depression and low self-esteem appeared to give Jane motivation and hope for improvement, whilst basic psycho-education gave Jane insight into her symptoms of depression that she believed to be unrelated (e.g. poor sleep and appetite). This helped Jane to progress towards the goal of ‘understand why I am feeling this way’.

Contracting therapy assisted socialisation to the model and agendas were implemented within sessions enabling the therapy to be structured and collaborative. Jane agreed to complete weekly homework tasks and apply CBT techniques outside of sessions. During the assessment and formulation sessions, cognitive, emotional, behavioural and physical elements were elicited and preliminary maintenance cycles were constructed to assist socialisation.

**Mid Sessions (5-8)**

Evidence suggests that a critical internal voice is linked to both depression and low self-esteem, and cognitive restructuring can achieve a more balanced and compassionate way of relating to the self (Gilbert & Irons, 2004). Two main techniques were utilised with Jane to promote cognitive restructuring; an example of each will be presented.

Jane recalled a recent situation when she was critical of herself, following which a maintenance cycle was drawn. Questioning around thoughts revealed the ‘bottom line’ of ‘I am not good enough’ which is one of Jane’s unhelpful core beliefs, and this was rated for strength, and ensuing feelings rated for intensity (see Figure 3). Evidence before and against this thought were elicited from Jane using a worksheet of which Jane was provided copies.

**Figure 3: Maintenance Cycle of a Recent Event**

The belief ‘I am not good enough’ was re-rated by Jane at 20%, and a new cycle was drawn out based upon this change in cognition (see Figure 4). Jane was able to identify how the maintenance cycle would have been broken if she had only believed this thought 20%. This appeared to be a powerful exercise to complete with Jane, as she found it easy to
generate evidence against this unhelpful thought, and afterwards she laughed at herself for believing it so intensely. Therefore, this technique was repeated numerous times, as Craske (2010) states that this will alter maladaptive cognitions, beliefs and self-statements.

**Figure 4: Adapted Cycle Following Thought Challenging Activity**

![Diagram of the cycle following thought challenging activity]

Generating alternatives to an unhelpful thought was also introduced whereby Jane was asked to think of other ways of viewing a situation. This was conducted with Jane in the session about a recent incident where Jane did not think a friend wanted to spend time with her and thought ‘she’s not listening to me and is more interested in the catalogue’. Jane was able to alter the strength of this belief from 55% to 15% by looking at the evidence and providing a more objective appraisal of the situation. Jane continued finding alternatives to address her negative bias in interpreting situations (as suggested by Beck et al., 1979).

Whilst Jane found these techniques useful for helping to produce a more balanced thinking style to achieve goals 1 and 2 (think more positively; and to be less critical of myself) Jane also expressed her desire for a more balanced way of relating to others – neither passive nor aggressive. Williams (2009) states that assertiveness often a key deficit in individuals presenting with depression and low self-esteem. As such, we began intervention to address goals 5 and 6: to share my opinion without fear of looking stupid or being attacked; and to be able to express my emotions, without being aggressive.

It seemed appropriate to refer to the ‘seesaw’ metaphor here (as suggested by Stott, Mansell, Salkovskis, Lavender & Cartwright-Hatton, 2010) as Jane was being passive, then having bursts of aggression when her needs were not met. We constructed a scale where Jane operationalised passive, assertive and aggressive, so she could identify these positions and work towards the goal of being assertive. Jane was also signposted to online assertiveness materials and psycho-educational handouts were provided. This helped to give Jane and the therapist clear goals to work towards, and formed the basis for further behavioural techniques.
Later Sessions (9-11)

Behavioural experiments are utilised to test out maladaptive underlying assumptions (Bennett-Levy, Butler, Fennell, Hackmann, Mueller, Westbrook, & Rouf, 2004), which can then be disconfirmed and adapted into factual based assumptions (Moore & Garland, 2004). Jane’s assumption of ‘if I am different, it will cause conflict’ was tested out through a jointly devised behavioural experiment.

Craske (2010) suggests that role plays provide behavioural rehearsal for areas of deficit in social skills. Two role plays were undertaken, one with Jane giving an opinion and the therapist disagreeing, the second with Jane disagreeing with the therapist’s opinion. Jane found this exercise “odd” and “difficult”, but said that it had been useful for preparing her to carry out the behavioural experiment. After the first role play, we reflected on the process and Jane identified that there had been no conflict as predicted, thus providing evidence against Jane’s underlying assumption. Following the second role play, Jane stated that she recognised that it is “ok to have a different opinion”.

Jane rated the way she expressed herself on a scale where 1 was completely unhappy and 10 was completely happy before and after the behavioural experiment; her scores were 4 and 9 respectively. Jane also rated the strength in her belief ‘if I am different, it will cause conflict’ as 60% before, which dropped to 10% after. She reported that none of her feared outcomes had materialised and generated a new adaptive belief ‘if I express my opinions in the right way, people will respect me’ which she believed 95%. Jane spoke about the activity positively, stating that she avoided the passive and aggressive positions on her assertiveness scale. We explored ways in which these techniques could be extended and applied to novel situations. In summary, it seemed that the behavioural experiment and role plays assisted Jane with her difficulty in relating to others.

As therapy progressed towards the final session, the ending was acknowledged and discussed. Beck et al. (1979) advocate relapse prevention work, and as part of this Jane was asked to complete a Maintaining Progress worksheet prior to the final session which we then reviewed together. This helped Jane to think about what she had learned so far and how she could continue to apply this outside of therapy. It also enabled her to speculate about what sort of challenges she might encounter, and how she could implement her newly-learned skills to cope with these.

As suggested by Wells (2008), a summary of the therapy was produced and given to Jane to provide a succinct overview of what we had learnt in therapy together. This included Jane’s formulations and gave suggestions on how she could continue the journey on her own to be in charge of her own recovery. A copy of Williams (2009) Planning for the Future workbook was also given to Jane, to build resilience and prevent relapse which Roth and Fonagy (1996) state is an important area to address when completing therapy.

Self-Reported Change

As suggested by NCCMH (2010), the therapist ensured that the client was involved in evaluating the efficacy of the therapy. Goals were rated at the start and end of therapy on a scale from 1 to 10, where 1 was ‘not at all
achieved’ and 10 was ‘completely achieved’; these are displayed in Table 2.

Table 2: Self-Reported Achievement of Goals

<table>
<thead>
<tr>
<th>Goal</th>
<th>Rating at Start of Therapy</th>
<th>Rating at End of Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Think more positively</td>
<td>4</td>
<td>6.5</td>
</tr>
<tr>
<td>2. To be less critical of myself</td>
<td>2.5</td>
<td>6</td>
</tr>
<tr>
<td>3. Know what I can do to improve my mood</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>4. Understand why I am feeling this way</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>5. To share my opinion without fear of looking stupid or being attacked</td>
<td>2</td>
<td>6.5</td>
</tr>
<tr>
<td>6. To be able to express my emotions, without being aggressive</td>
<td>2</td>
<td>9</td>
</tr>
</tbody>
</table>

Jane reported that she was closer to completely achieving all her goals and expressed confidence in being able to continue this progression after therapy. The biggest progress made was seen in relation to goal 6, and this could be due to the focussed intervention involving the behavioural experiment particularly devised to test out the underlying assumption relating to this goal. Generating clear goals and rating them at both points in therapy facilitated: understanding of what the client wanted from therapy; choice of appropriate intervention and its efficacy; monitoring of client progress; and collaborative working between therapist and client, which appeared to enhance therapeutic alliance, improve motivation and impact positively upon outcomes.

Jane clearly articulated the changes she perceived. Whilst she had always tried to please others and withhold her feelings, Jane reported that she had become more open and honest with her boyfriend. She acknowledged that she was staying in the unhappy relationship to please him and avoid conflict, and she “found her identity” by leaving him prior to the final therapy session. This represented Jane finding her voice and expressing her own needs, and she reported feeling “strong” and was “no longer fearful of the future”. Jane was able to discuss what she had learnt from therapy and how making changes such as addressing avoidance had improved her depression and low self-esteem. Jane stated: “I feel like I am finally living properly”.

Clinician Reported Change

Initially, Jane was observed to be down, distressed and hopeless, which is common for individuals presenting with this presentation (Fennell, 2009). Throughout therapy, Jane’s mood improved and she became more animated in sessions. Jane discussed the Cognitive Behavioural Model and techniques accurately and it was clear that she was applying these successfully outside of therapy. She gained a better understanding of her difficulties and could discuss her formulations in a meaningful way, helping her to identify helpful and unhelpful patterns. From the therapist’s perspective, it appeared that Jane
had made progress, including improved mood, confidence and patterns of relating to others.

**Psychometric Re-assessment**

Psychometrics were re-administered; they were beneficial to both client and clinician as they assessed the presenting difficulties, informed intervention and documented change in the client’s presentation (as suggested by Marks, 1986; and Mundt, Marks, Shear & Greist, 2002). Table 3 displays the psychometric scores acquired at both times of administration.

<table>
<thead>
<tr>
<th>Measure</th>
<th>First Administration</th>
<th>End of Therapy</th>
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<tbody>
<tr>
<td>CORE-OM (Mean scores)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wellbeing</td>
<td>2.75 (clinical case)</td>
<td>Wellbeing</td>
</tr>
<tr>
<td>Problems</td>
<td>2.42 (clinical case)</td>
<td>Problems</td>
</tr>
<tr>
<td>Functioning</td>
<td>2.41 (clinical case)</td>
<td>Functioning</td>
</tr>
<tr>
<td>Risk</td>
<td>1 (clinical case)</td>
<td>Risk</td>
</tr>
<tr>
<td>Total</td>
<td>2.21 (clinical case - moderately severe)</td>
<td>Total</td>
</tr>
<tr>
<td>PHQ-9</td>
<td>Score: 9 (mild depression)</td>
<td>Score: 5 (mild depression)</td>
</tr>
<tr>
<td>SES</td>
<td>Score: 16 / 30</td>
<td>Score: 22 / 30</td>
</tr>
</tbody>
</table>

The CORE-OM demonstrates that Jane was considered a ‘clinical case’ in all dimensions which was ‘moderately severe’ at the start of therapy; at the end of therapy, Jane was classed as ‘healthy’ on all dimensions. Jane progressed from the more severe of the ‘mild depression’ category to the least severe on the PHQ-9. Jane progressed from 16 to 22 out of a maximum 30 on the SES showing an increase in self-esteem. In summary, Jane’s wellbeing, functioning and self-esteem have improved, whilst the problems, risk and depression have decreased, providing evidence that CBT was successful for this client.

The end of therapy was mutually agreed, with Jane expressing her confidence in being in charge of her own recovery. Jane was discharged from the service but was aware that she could request re-referral to the service in the future should she need further support.

8. Complicating factors

One key challenge was language. Although Jane had proficient English skills, occasionally there were times when she did not fully comprehend the therapist (e.g. with the aforementioned CORE-OM). This challenge was overcome by becoming a focus of therapy in a number of ways, as Jane felt “stupid” when she didn’t fully understand and we were able to explore this and modify the core belief through cognitive restructuring. Sensitivity had to be taken when addressing this area, with the therapist gently checking understanding and modifying their language to avoid confusion. By handling this challenge,
Jane felt “understood” and as if she had a voice.

Whilst it seems that there has been improvement in Jane’s presentation, it is important to acknowledge limitations. Jane was experienced as trying to please; therefore, the positive outcomes could have reflected unhelpful strategies (avoiding conflict, withholding feelings, try to please others) rather than true improvement. It is important to acknowledge this and draw tentative conclusions. In addition, although outcome measures and self-reporting suggests that there was improvement in Jane’s difficulties, though we can never definitively state whether this is due to therapy or other uncontrolled, external factors.

9. Access and barriers to care

There were no identified tangible access issues or barriers to care. However, the client was of Spanish origin and Jane relayed to the therapist that there is more societal stigma surrounding mental health and the uptake of services in her culture. It was important that the therapist was sensitive to this so that this did not become a barrier to engagement. Language differences were an obstacle on a number of occasions, particularly with psychology-specific terminology (for example on the outcome measures). It was imperative that the therapist ensured clarity and comprehension so that Jane continued to access care.

10. Follow up

Relapse after therapy is considered to be a potential risk (Roth & Fonagy, 1996). The literature shows that follow up or ‘booster’ sessions are effective against relapse (as suggested by Beck, Rush, Shaw & Emery, 1979) though these could not be offered due to therapist departure. Therefore, we are not likely to know the long term outcome unless Jane presents to the service again; we can only hope that positive psychological change will last for Jane and that she will be resistant to future setbacks.

11. Treatment implications of the case

Choice of Therapy

In line with the literature review, this case provides support for the successful treatment of depression and low self-esteem using cognitive and behavioural techniques. Cognitive restructuring and behavioural experimentation were useful techniques within this framework, alleviating Jane’s depression. As previously suggested, successful treatment of depression also tends to raise self-esteem, and this was demonstrated in this case which included tackling the critical internal voice and negative interpretation bias towards the self. Jane’s progress appears to fit in well with the literature on CBT for depression and low self-esteem, suggesting that it has been successful in this instance.
**Therapeutic Process**

Jane was experienced as motivated and trying hard which at first left the therapist feeling pleased. However, care had to be taken as within Jane’s formulation, we identified strategies she implemented such as avoiding conflict, withholding feelings and always trying to please others. Jane was gently encouraged to speak openly about her experiences; through this process she appeared to gain confidence and the relationship became more genuine. It seemed that just by the therapist listening and Jane expressing her feelings and opinions, she was moving towards her goals by improving her assertiveness. This relational modelling assisted Jane to test out new ways of interacting, and she transferred this skill relating to others outside of the therapy room.

**Possible Rationale for Change**

Client factors, therapist factors and therapeutic factors are likely to be responsible for change. Firstly, Jane displayed qualities that have been shown to correlate with better outcomes: highly motivated; psychologically minded; completed homework tasks; and attended sessions. Secondly, the therapist attempted to establish a good rapport by utilising listening skills, empathy and collaborative working. This had a positive impact upon engagement and is hypothesised as an agent of change. Finally, the type of therapy has been shown to be effective for Jane’s presenting difficulties and the therapy goals she set were in line with a CBT approach. These factors are the likely reasons for psychological change, and offer treatment implications with regards to other cases.

From this case, there are a number of implications for future work. Firstly, it is important to discuss stages of therapy more explicitly from the start. In this case, it would have prepared Jane better for the ending and given her clearer expectations. The collaborative and thorough formulations conducted with Jane proved to be very effective: building rapport, focussing goals and balancing difficulties with strengths, and this will be implemented in therapy with other clients. Finally, it would be beneficial to the therapist to work with similar presentations to Jane’s in the future, to consolidate what has been learnt and to extend skills further.

Jane appeared to be motivated to make changes throughout therapy. Life after therapy is likely to have seen Jane enjoying improved relationships, mood, self-esteem and assertiveness.

**12. Recommendations to clinicians and trainees**

From the basis of this case, the therapist proposes the following recommendations:

- Consider the use of CBT for treating cases of depression and/or low self-esteem.
- Explore cultural differences with the client in the early stages of therapy, and ascertain the impact this may have upon engagement with services and their understanding of therapy.
- Conventional formulations of presenting difficulties may be hard for clients to tolerate and prove distressing. Consider
constructing a collaborative formulation for resilience factors as standard.

- In this case, audio recordings were taken with client consent and reviewed in between sessions. This provided an excellent learning opportunity and enabled the therapist to generate alternative hypotheses from information which may have been missed in the session.

- The use of outcome measures documented psychological change which was beneficial for both clinician and client. Introducing routine use of measures can enable the clinician to evaluate practice whilst providing the client with tangible evidence of progress.

- Carefully consider the effect of the client’s existing strategies on therapy. In this instance, reflection and supervision were essential for identifying unhelpful strategies, e.g. trying to please and withholding feelings, which could impact upon the effectiveness of therapy.

- As with all work completed during training, it is important that therapists recognise their own limitations as trainees. This involves operating within competence, through appropriate use of supervision and the evidence base to inform work carried out.

Potential Conflicts of Interest

The author declares no conflict of interest.

Acknowledgements

Many thanks to Dr. James Reilly, for providing me with excellent supervision on this case and supporting me in the write up of this report.

Author’s biography

Bethany Larham lives in the North West of England and is a trainee clinical psychologist doing a Doctorate at the University of Liverpool. Bethany is passionate about working in the field of Clinical Psychology, and has particularly enjoyed roles in Child & Family Services and Adult Mental Health. Bethany has a degree in Psychology and Criminology, a Postgraduate Certificate in Psychological Therapies and a Postgraduate Diploma in Public Health (Analysis).

References


