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Cognitive Therapy for Low Self-Esteem in the Treatment of Depression in an Older Adult

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Abstract. Low self-esteem is an underlying component of depression and psychological therapy may first need to address deeply entrenched negative self-evaluations in order to challenge and reduce the rigidity of core beliefs (Fennell, 1997). Hall and Tarrier (2003) developed an effective brief intervention aimed at reducing low self-esteem in patients with psychosis. Subsequent anecdotal evidence suggested that this intervention may also provide positive results in an older adult population with depression. In this case study, the intervention was implemented with a 79-year-old woman who was experiencing anxiety symptoms and depression with suicidal thoughts. Following implementation of the self-esteem intervention, significant improvements were obtained. This paper offers preliminary evidence that this novel intervention can be used successfully with older age clients and provides a positive and engaging therapy for depression.

Keywords: Low self-esteem, anxiety, depression, cognitive therapy, older adult.

Introduction

Fennell (1997) suggests that low self-esteem is a collection of long-standing, fixed schemata unrelated to mood that facilitate susceptibility to depression. She explains that, as a consequence of developing negative self-schemata, standards or rules for living are put in place in order to maintain high self-esteem. However, when these standards can not be achieved, negative self-beliefs may be activated, resulting in depression. Fennell (1997) therefore notes that the provision of classical cognitive therapy, designed to challenge the content of negative

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thoughts arising as a result of depressed mood, may leave undetected broader and enduring issues of low self-esteem.

A short-term cognitive therapy for the treatment of low self-esteem in psychotic patients was devised by Tarrier (2001) and evaluated by Hall and Tarrier (2003, 2004). The intervention appeared effective in increasing levels of self-esteem and social functioning. Following the research trial, the authors (PH, NT) suggested that this novel technique may also be successful with other disorders such as depression with older adults (PH) and in social anxiety (NT).

This case report describes the implementation of the intervention with a 79-year-old woman who presented with depression and anxiety. For reasons of confidentiality, the client will be referred to with a pseudonym of "Ruth".

Client background

Ruth was born into a large family. She married at aged 22 and had two children in the following 4 years. At this point she discovered that her husband was being unfaithful and although this continued throughout their marriage, the couple had two further children together. Ruth's husband was very critical towards her however, and she experienced continuous emotional and physical abuse. He contributed little to the family income and Ruth had to work long hours in order to provide for their children. Following a stroke in 1994, Ruth's husband discharged himself from hospital and allowed only Ruth to care for him. This continued for 6 years until he died after a second stroke. Over the next few years, Ruth became increasingly socially isolated as her neighbours died or moved away.

At this time Ruth was hospitalized due to severe anxiety symptoms (there were no symptoms of depression identified initially) and she was referred to a Psychological Therapy Service for Older Adults. Shortly after her return home, a second admission to hospital was initiated when Ruth presented to the Accident and Emergency department with suicidal thoughts.

During the psychological assessment period, Ruth acknowledged that being in an abusive marriage had eroded her self-esteem and that this was central to her difficulties. She was aware that she had developed strategies for protecting herself from this by utilizing her social skills and keeping herself busy but that these had recently not been accessible to her due to isolation and minor health problems.

Psychometric assessment

The Beck Depression Inventory II (BDI-II; *Beck, Steer and Brown, 1996*), Beck Anxiety Inventory (BAI*; Beck, Epstein, Brown and Steer, 1988*) and the Self-Concept Questionnaire (SCQ; *Robson, 1989*) were administered to Ruth pre and post intervention. Both the BDI-II and the BAI were administered during the initial assessment period as a measure of the severity of Ruth's symptoms. Following the development of a formulation and rationale for treatment, these measures were repeated in Sessions 8 and 13 in order to monitor change. The SCQ was also used in Sessions 8 and 13 as a pre and post intervention measure for self-esteem.

Case conceptualization

The origins of Ruth's difficulties, predisposing and precipitating factors involved in her presentation are shown in Figure 1. This series of events illustrates how depression can result from and be maintained by underlying low self-esteem.

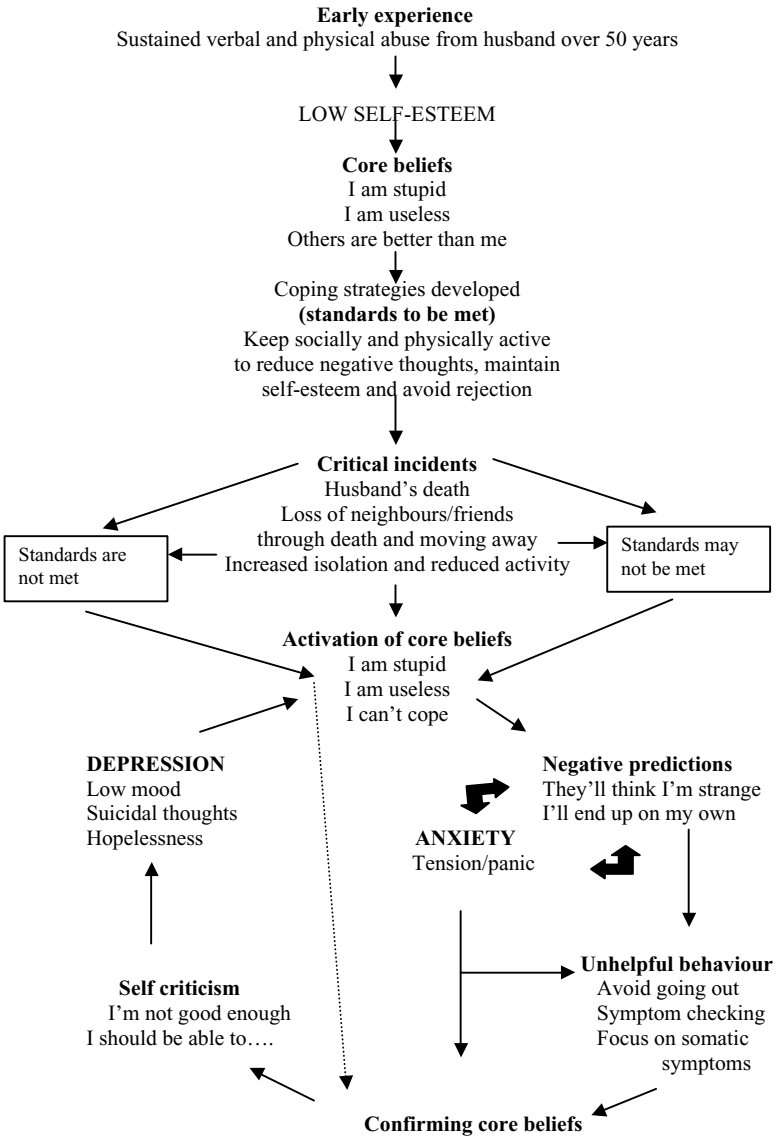

Figure 1. Cognitive formulation of factors contributing to low self-esteem, depression and anxiety

Intervention

Rationale for intervention

The hypothesis that Ruth's depression was a result of her enduring low self-esteem was supported by Ruth's own view of her difficulties and the comprehensive clinical assessment. A standard cognitive therapy approach would have focused on the inherent negativity of Ruth's

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thought processes and it was felt that this therapeutic route may not have adequately addressed Ruth's long-established low self-esteem. Moreover, Ruth's mood was already low and she had little access to any social network for support outside of therapy sessions if she later felt distressed by anything discussed. It was therefore perceived as possibly detrimental to Ruth's mood to prolong sessions that focused on "problems". The structured and positive focus of the cognitive intervention developed by Hall and Tarrier (2003, 2004), together with Ruth's reluctance to discuss her negative thoughts, therefore made this a preferred choice of intervention.

Outline of sessions

Following a comprehensive psychological assessment, the self-esteem intervention developed by Hall and Tarrier (2003, 2004) was delivered by one of the authors (LC) in six sessions. In four of the sessions, Ruth was asked to identify two positive qualities and to generate evidence to support each of these. Although Ruth initially found it difficult to identify positive self-qualities, these could be raised during discussions about her past achievements and coping strategies. Ruth was able to recognize that she was a good cook and generated several items of evidence for this quality; for example, that her children had always enjoyed the meals she had cooked for them and were always eager to know what she would be cooking the next day and that her friends would often comment that she was a "fabulous cook". Ruth also identified that she was hardworking and provided evidence for this in her extensive employment history and the housework involved in looking after her husband and four children.

One session additionally focused on the way in which low self-esteem affects thoughts, feelings and behaviour, and the resultant negative cycles that are created. The converse was also illustrated whereby positive self-beliefs can activate more positive feelings and behaviours. The final session focused on evaluative issues.

Results

Re-administration of the psychometric measures following intervention revealed improved scores all within the "non-clinical" range. During the assessment period Ruth's depression as measured on the BDI-II increased from a score of 24 at the initial assessment to 30 prior to intervention. It may be hypothesized that this was due to the necessary focus on "problems" during this time. Following the intervention, however, Ruth's depression score reduced substantially to 6, which is below the threshold indicative of clinical depression. At initial assessment, Ruth's anxiety score was high at 22 as measured on the BAI and prior to intervention this score remained high at 20, but again reduced substantially following the intervention to a score of 6. In addition, Ruth's pre-intervention self-esteem score on the SCQ was 93, well below the mean (137) for a "normal" population. Post-intervention this score also improved to 173, which is outside the clinical range.

At the end of therapy Ruth stated that she felt *"more like my old self and more able to cope*". Ruth was making an effort to keep herself active but felt able to relax when she needed to. She had been discharged from hospital and was functioning well on a daily basis.

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Discussion

Following the intervention, there was a substantial improvement in all psychometric measures, which may have been due to a number of factors, including her reduced isolation, her increased level of assistance from mental health services, and her increased self-confidence. It is difficult to evaluate whether Ruth's improvement was due to the psychological therapy or to other care she received from various professionals. However, Ruth reported that she felt the therapy had been helpful to her in understanding the development and maintenance of her depression. She had adopted a cognitive model to understand her difficulties and she felt confident in breaking down the different elements of her psychological problems into thoughts, feelings and behaviour.

A traditional cognitive therapy approach to depression may have resulted in an equally successful outcome. However, Ruth reported that focusing on her strengths had increased her belief in her positive qualities and that this had enhanced her state of wellbeing.

Implementation of the intervention was easily achieved as the original written protocol was accessible and explicit in its direction. Little adaptation would be needed to enable this to be used successfully with other client groups experiencing similar difficulties.

In summary, a brief time-limited intervention for enhancing self-esteem provided a beneficial approach to working with a client with very long-term difficulties. Moreover, the focus of this innovative therapeutic approach was on the positive attributes of the client and offered a refreshing and inspiring change to other cognitive therapies that focus on problems and negatives.

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