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Cognitive therapy in the treatment of low self-esteem

Melanie J. V. Fennell

Beck's cognitive therapy originally developed as a short-term treatment for depression (Beck *et al*, 1979). It has been shown to be effective with a range of other disorders including panic disorder, generalised anxiety disorder, social phobia, eating disorders and sexual dysfunction (Roth *et al*, 1996). It is promising in the treatment of yet more disorders, many of which have traditionally been thought relatively impervious to psychotherapy, for example, bipolar disorder, chronic fatigue and psychosis (Clark & Fairburn, 1997). However, not everyone responds well to short-term cognitive therapy. In particular, it has been proposed that people with multiple, chronic problems that are apparently expressions of personality, rather than temporary responses to adverse life experiences, require more extended therapy (Beck *et al*, 1990).

Low self-esteem (often a major focus of interest in other psychotherapies) has been relatively neglected in cognitive therapy. This is perhaps because it is neither a specific psychiatric disorder nor a personality disorder. Rather, it emerges as an aspect of, consequence of or vulnerability factor for many presenting problems. For example, a negative self-image is central to depression (aspect), but characteristically evaporates as mood lifts. Alternatively, self-denigration may occur only once a specific disorder, such as generalised anxiety disorder, has persisted over time (consequence) and may improve on its own as the presenting problem is addressed. Low self-esteem may predispose to a range of other difficulties (vulnerability factor), such as depression and suicidality, eating disorders and social anxiety. Here it may hinder progress in treatment and persist even after presenting problems have been successfully resolved.

I aim: (a) to introduce practitioners unfamiliar with the approach to the concepts and methods of cognitive therapy; (b) to show readers more familiar with cognitive therapy how a cognitive model may be helpful in understanding low self-esteem (Fennell, 1997); (c) to outline a cognitive–behavioural treatment programme, which follows logically from the model and integrates methods from the treatment of specific disorders with recent developments in cognitive therapy for personality disorders; and (d) to provide some sense of how the model and related treatment methods may apply in practice, through an illustrative case example.

The model and treatment programme have not yet been empirically evaluated. However, as noted above, research has repeatedly demonstrated the efficacy of the cognitive treatments for anxiety and depression on which it draws, and has supported the proposed relationships between cognition, affect and behaviour in both anxiety and depression (Clark & Steer, 1996).

Cognitive model of emotional disorder

Beck's cognitive model of emotional disorder (Beck, 1976) suggests that, on the basis of experience, people form conclusions (beliefs and assumptions) about themselves, other people and the world (predisposing factors). When experience is negative, these conclusions are also negative. Some core beliefs are descriptions of how things appear in the eyes of the person, for instance, 'I am no good', 'people cannot be trusted' and 'life is a struggle'. These may be experienced as statements of fact, rather than opinions formed on the basis of experience. Other beliefs (dysfunctional assumptions) are more like

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guidelines for living, standards of performance or rules and regulations that allow the person to operate in the world, given the perceived truth of the core beliefs (e.g. 'I must always do everything to the highest possible standard, no matter what the cost'). All may be well until the person encounters an event or series of events (precipitating factors or critical incidents) in which he or she is unable to meet the requirements of the dysfunctional assumptions (e.g. the perfectionist fails at a crucial task). This leads to activation of the belief system, giving rise to negative, distorted automatic thoughts. These are thoughts which pop into the mind rather than being a product of reasoned reflection. They are negative in emotional tone and contain biases or exaggerations (e.g. over-generalisation from specific incidents or jumping to conclusions). Negative automatic thoughts directly influence mood, body state and behaviour. The perfectionist who has failed may feel anxious and depressed, experience physical signs of stress and begin working even harder. Unfortunately, changes in mood and body state and attempts to right the situation may feed back into continuing negative thoughts (maintaining factors). So the perfectionist's low mood makes him or her more likely to think negatively, while attempts to work even harder result in increasing fatigue and strain which may confirm the sense of failure. A vicious circle is established which becomes increasingly difficult to break without professional help.

Concepts and methods

In treating relatively acute disorders, such as depression or anxiety, cognitive therapy is typically offered for 6–20 sessions. Treatment is based on a thorough assessment, normally using standard questionnaires as well as a detailed clinical interview. Information is gathered on current thoughts, emotions and behaviours, living circumstances, the events that precipitated the onset of the presenting problems and, where possible, predisposing experiences and beliefs (these may not become evident until later in therapy). An individual cognitive case conceptualisation is drawn up (see Fig. 1), which both guides treatment and changes as new information emerges and new understandings are reached.

The first objective is to help patients break out of the vicious circles which maintain their difficulties. Painful emotions and maladaptive behaviours are presumed to result from negative biases in the patient's thinking. The task is to help patients become aware of thoughts or images that enter their minds in upsetting situations ('What went through your mind just then?'), and to teach them to question,

re-evaluate and test the validity of those thoughts. The cognitive therapist's prime tool is 'guided discovery', a collaborative process of inquiry which helps patients to explore evidence for and against their ideas, to search for alternative perspectives, and to examine how realistic and helpful these are by carrying out experiments in the real world and observing the results. It is not up to the therapist to point out patients' errors of interpretation and to suggest alternatives, but rather to teach self-observation, self-questioning and openness to experimentation. These are skills which will allow patients to discover alternative perspectives for themselves. The objective initially is to bring about changes in thinking on a day-to-day basis, with corresponding changes in emotional state and behaviour. At a later stage, attention turns to dysfunctional assumptions and core beliefs. A similar process of guided discovery is used to question and reformulate dysfunctional assumptions, and to question the validity of core beliefs and arrive at more balanced views. Ultimately, the aim is not only to help patients to resolve current difficulties, but also to reduce their vulnerability to future problems (for further details on the practice of cognitive therapy for emotional disorders see Hawton *et al*, 1989).

Cognitive model of low self-esteem

It is proposed that the cognitive model of emotional disorder, with some elaborations, is directly relevant to the understanding of low self-esteem (the following account should be read in conjunction with Figure 1, and is illustrated in the case example below). It is suggested that the essence of low self-esteem lies in global ('me as a person') negative core beliefs about the self, which derive from an interaction between inborn temperamental factors and subsequent experience, for example, neglect, abuse, bereavement or an absence of sufficient warmth, affection and praise. Dysfunctional assumptions then function as 'escape clauses' which allow the person to feel more or less happy with him/ herself, so long as he or she is able to do as they require (be perfect, be loved, be in control, etc.). However, well-being and confidence remain fragile, because the dysfunctional assumptions and the behavioural strategies to which they lead 'wallpaper over' negative core beliefs, rather than undermining and changing them.

Critical incidents which lead the person to believe that he or she might not be able to meet the
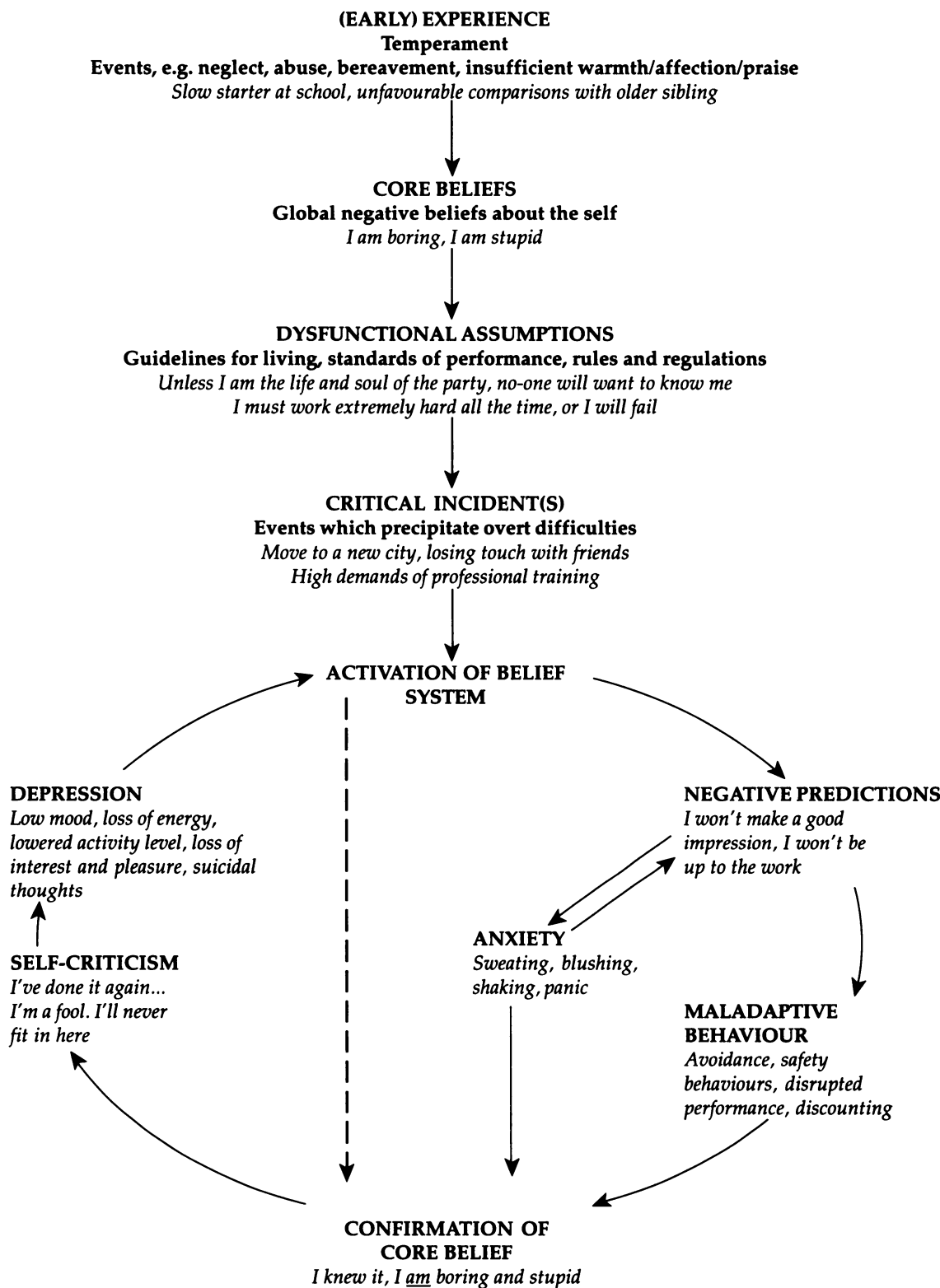
(EARLY) EXPERIENCE
Temperament
Events, e.g. neglect, abuse, bereavement, insufficient warmth/affection/praise
Slow starter at school, unfavourable comparisons with older sibling

CORE BELIEFS
Global negative beliefs about the self
I am boring, I am stupid

DYSFUNCTIONAL ASSUMPTIONS
Guidelines for living, standards of performance, rules and regulations
Unless I am the life and soul of the party, no-one will want to know me
I must work extremely hard all the time, or I will fail

CRITICAL INCIDENT(S)
Events which precipitate overt difficulties
Move to a new city, losing touch with friends
High demands of professional training

ACTIVATION OF BELIEF SYSTEM

DEPRESSION
Low mood, loss of energy, lowered activity level, loss of interest and pleasure, suicidal thoughts

SELF-CRITICISM
I've done it again... I'm a fool. I'll never fit in here

NEGATIVE PREDICTIONS
I won't make a good impression, I won't be up to the work

ANXIETY
Sweating, blushing, shaking, panic

MALADAPTIVE BEHAVIOUR
Avoidance, safety behaviours, disrupted performance, discounting

CONFIRMATION OF CORE BELIEF
I knew it, I am boring and stupid

Fig. 1   A cognitive model of low self-esteem

requirements of the assumptions (i.e. an element of uncertainty), precipitate negative predictions, which in turn lead to symptoms of anxiety. These may then produce further predictions (e.g. 'I am going to lose control'). Performance may genuinely be disrupted (e.g. stammering, clumsiness). In addition, the person may engage in a range of maladaptive behaviours, including outright avoidance and more subtle self-protective manoeuvres ('safety-seeking behaviours'; Salkovskis, 1991). These are designed

to prevent the predictions from coming true, but in fact contribute to the persistence of the problem. Even if to the detached observer all has gone well, success may be discounted as a product of luck, or a 'near miss' where disaster was only narrowly averted. Thus, whatever the actual outcome, the person with low self-esteem experiences the incident as confirmation of the original belief about the self. This often provokes self-criticism (negative automatic thoughts about the self) and then depressed mood, sometimes intense and persistent enough to meet diagnostic criteria for major depression. Depressed mood in turn maintains activation of the system, increasing the frequency and credibility of negative predictions and self-critical thoughts. The model suggests that confirmation and subsequent self-criticism and depression may occur without preceding anxiety (the dotted line in Fig. 1), if the critical incident is taken to mean that standards set by the dysfunctional assumptions have definitely not been met, that is, no element of uncertainty is involved.

Cognitive therapy

Cognitive therapy for low self-esteem integrates concepts and methods from well-validated short-term work with acute anxiety (Beck *et al*, 1985) and depression (Beck *et al*, 1979), and more experimental ideas and interventions from recent developments in the treatment of personality disorders (Beck *et al*, 1990). Treatment is designed to target elements in the cognitive model of low self-esteem (Fig. 1) in a systematic sequence, although the exact sequence of events and the emphasis given to components will vary. Some key interventions are summarised in Box 1.

   As with anxiety and depression, therapy normally starts with a focus on maintaining factors, identifying, questioning and testing the cognitions that drive the vicious circle (i.e. negative predictions and self-critical thoughts) through a combination of cognitive and behavioural methods. Focused cognitive–behavioural work provides a foundation for examining how dysfunctional assumptions are both unreasonable (asking more than can realistically be expected) and unhelpful. More realistic and helpful alternatives are then formulated, and put into practice in day-to-day situations. Finally, attention turns to modifying the negative core beliefs about the self which the model suggests form the heart of low self-esteem.

   The overall goal is to encourage realistic self-acceptance, 'warts and all'. It is proposed that negative core beliefs about the self are maintained by two complementary processes: biased perception

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Box 1. Some key interventions

Overall treatment objectives
To weaken old, negative core beliefs about the self
To establish and strengthen more positive, realistic new beliefs about the self (a balanced view)
To encourage kindly self-acceptance, 'warts and all '

Understanding the problem
The cognitive model – developing an individually tailored case conceptualisation

Modifying the perceptual bias
Directing attention to positive qualities, assets, skills, strengths
Keeping regular written records of examples of positive qualities, etc. on a day-to-day basis
Seeking evidence (past and present) which is inconsistent with negative core beliefs about the self
Recording incidents inconsistent with negative core beliefs about the self
Acting against the old belief and observing the results (behavioural experiments)

Modifying the interpretative bias
Re-evaluating the evidence (past and present) that apparently supports the old belief
Questioning associated negative automatic thoughts (e.g. self-criticism) on a daily basis
Testing negative predictions through regular and frequent behavioural experiments
Breaking down black-and-white thinking through continuum work
Re-evaluating dysfunctional assumptions and formulating more realistic and helpful alternatives

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and biased interpretation (Padesky, 1994). Biased perception means that information which is not consistent with the pre-existing belief tends to be ignored, screened out or forgotten. In contrast, information which is consistent with the pre-existing belief is readily perceived, processed and stored. Biased interpretation means that incoming information is distorted to fit the Procrustean bed of the pre-existing belief. So, a compliment is taken as insincere and a practical problem is interpreted as a sign of incompetence. The methods used to change core beliefs are designed to help the patient to become aware of and correct these complementary processes,

both by actively directing attention to strengths, assets and qualities, and by examining past and present experiences held to support the old belief (work on specific self-critical thoughts lays a foundation for this). The end result is both to weaken and undermine old beliefs, and to establish and strengthen more realistic and helpful alternatives.

Treating low self-esteem in the context of personality disorder

Even patients whose problems date back to childhood (as is common, for example, in social phobia) may work successfully within the limited time period of classical short-term cognitive therapy, especially if they have the qualities summarised in Box 2. The interventions described above can produce substantial change within a matter of weeks. With more complex cases, however, it may take some months for patients even to begin to perceive anything positive about themselves, or to consider entertaining a more kindly view.

When treating low self-esteem in the context of personality disorder, the objectives of cognitive therapy are essentially the same, that is: to help patients to bring about desired changes in their current thinking, emotions and behaviour, and to undermine and find alternatives to underlying dysfunctional assumptions and beliefs about the self. However, certain modifications to treatment are usually advocated (Beck et al, 1990) in response to problems presented by these patients, some of which are outlined below. These modifications are mainly based on clinicians' attempts to overcome the shortcomings of traditional cognitive therapy with this difficult population, and have not as yet been subject to systematic empirical testing.

Cognitive rigidity

Some patients believe their low opinion of themselves reflects simple fact: that they really are useless, unlovable, etc. These beliefs are likely to be associated with intense emotion, and sometimes extensive avoidance. Consequently, work at the level of specific presenting problems may have minimal impact. It may first be necessary to help the patient to entertain the possibility that beliefs are opinions, not facts, as a way of introducing some flexibility into the system. Even then, such patients will take longer to consider and work on alternatives to their negative views.

Multiple problems

Patients often present with a mass of problems, and find it hard to define any of them precisely, establish priorities or focus on one at a time. This makes systematic problem-focused work difficult and can leave both therapist and patient feeling overwhelmed. It may help to draw up a coherent conceptualisation at an early stage, to explain the development and maintenance of problems and how they relate to underlying beliefs and to each other.

Difficulties in the therapeutic alliance

Patients often report significant interpersonal difficulties, based on beliefs about themselves, others and relationships (e.g. 'I must never allow anyone to see my true self', or 'people are out to attack and exploit me'). Patients may therefore be reluctant to discuss their difficulties openly and prone to misinterpret the therapist's behaviour. This, in turn, may result in activation of the therapist's own negative beliefs and dysfunctional assumptions, and thus prevent the development of a warm, equal collaborative alliance. Relationship issues must then be addressed in their own right, using the same cognitive theoretical framework that is used to address any other problems in the patient's life (Safran & Segal, 1990). Therapy can then function as a 'laboratory' in which the patient may safely experiment with new ways of relating, before transferring learning to the outside world.

Box 2. Characteristics in people likely to respond to short-term cognitive therapy

Acceptance of the cognitive model of emotional disorder as relevant to their own experience

Belief that change is at least theoretically possible, and acceptance of the possibility of alternatives to their negative views

Ability to recognise and describe thoughts and feelings with minimal training

Low to moderate level of disability

Willingness to try out cognitive–behavioural methods in practice, and to experiment with new ways of thinking and behaving, both within therapy sessions and in between-session self-help assignments

Ability to form an equal, collaborative therapeutic alliance

Non-verbal meanings

Patients with long-standing problems often have vivid, painful memories of childhood experiences when beliefs about themselves, others and the world are crystallised out. Perhaps because they were formed early in life, these beliefs may not have any readily definable verbal content. This has two implications for therapy. First, it may be necessary to work on changing meanings assigned to experiences in the distant past. Second, imaginal and experiential methods, often drawn from Gestalt therapy, can supplement more purely verbal and behavioural techniques to identify and change meanings that the patient may never have put into words (Hackmann, 1997).

Chronicity

Patients whose difficulties are lifelong have often accumulated a substantial body of experience which apparently supports their negative beliefs about themselves. This is especially so where the beliefs have resulted in extreme disability (multiple episodes, absent or unsatisfactory personal relationships, failure to establish a successful working life, etc.). In this case, hopelessness about the possibility of change may be intense, undermining willingness to engage actively in the process of therapy and even contaminating the therapist. Treatment may also need to include teaching interpersonal and work skills from the most basic level.

The existence of long-standing, strongly held negative core beliefs does not necessarily indicate a need for long-term treatment (Fennell, 1998). Many patients with such beliefs respond well to 6–20 sessions of competently administered cognitive therapy. This is of practical importance, given limited resources. However, taken together, the difficulties outlined above sometimes mean that cognitive therapy must be extended over a longer time period (18–24 months is sometimes advocated). For a population which makes heavy use of services, this may be an acceptable investment, provided it can be shown to be more effective than more short-term alternatives both after treatment and over long-term follow-up.

Case example

Peter was referred by his general practitioner because of his social phobia, of several years' duration. Peter had not responded to anxiolytic medication. He had recently developed panic attacks and was becoming increasingly depressed and suicidal.

The cognitive conceptualisation of Peter's problems is presented in italics in Fig. 1. In childhood, he was seen as slow and dull in comparison to his bright, socially adept elder brother. This led to two core beliefs about himself: 'I am boring' and 'I am stupid'. His dysfunctional assumptions, adopted during adolescence and reflecting his strategies for maintaining self-esteem, were: 'Unless I am the life and soul of the party, no one will want to know me' and 'I must work extremely hard all the time, or I will fail'. These allowed him to feel more or less happy with himself in his final years at school and at university, so long as he could do as his strategies required. However, they left the underlying beliefs about himself intact. Problems arose when he moved to a new city to pursue a professional career. The work was very demanding, and at the same time he lost contact with old friends. This combination led to activation of his core beliefs about himself.

Self-monitoring helped Peter to identify the negative predictions fuelling his anxiety socially and at work, for example: 'I won't make a good impression' and 'I am going to make a mess of this assignment'. These triggered a range of anxiety symptoms, including sweating, blushing and shaking. He was certain that his anxiety was obvious, and predicted that others would think badly of him because of it. To prevent his predictions from coming true, Peter engaged in a variety of self-protective manoeuvres. Sometimes he avoided social situations altogether. At other times, he would read the newspaper so as to have something interesting to say, drink heavily before going out in order to relax and spend hours perfecting work assignments. Sometimes he had genuine difficulties, for instance, his mind would go blank when his boss asked him a question. On other occasions, he in fact performed perfectly well, but in retrospect would discount this (e.g. 'they were just being polite' or 'well, I managed a good cover-up there, but next time...'). The end result, to his mind, was confirmation of his beliefs about himself that he was stupid and boring. This led to streams of self-criticism. Combined with hopelessness about improving his situation, this triggered clinical depression including not only low mood but also loss of energy, lowered activity levels, loss of interest and pleasure, and suicidal thoughts. This state was sometimes reached without intervening anxiety, for example, when his boss criticised a report he had written.

Peter received 16 weekly sessions of cognitive therapy, and three, monthly follow-up 'booster' sessions. Treatment began by identifying links between anxious predictions and safety behaviours, and considering how these operated together in specific situations to maintain his anxiety (Clark, 1997). He predicted, for example, that unless he

made every effort to be bright and witty, people would not want to know him. He was asked to consider whether this idea was generally true (review of the evidence), or whether in fact he knew people who were not particularly bright and witty, but none the less had an active social life. Even though he did, he still believed that for him personally being bright and witty was essential. However, he agreed to carry out a behavioural experiment. He went out with friends and, instead of striving to be the life and soul of the party, listened quietly to the conversation. There was no sign that people did not want to know him, and in fact one friend commented that she had enjoyed his company. This became the first of a series of experiments which gradually undermined both his specific predictions about what would happen in particular situations, and also his overall assumption that to be acceptable he must always act in this way. This gave him confidence to conduct similar tests on his predictions that unless he spent hours perfecting every assignment at work, he would be unable to do his job. He agreed to adopt a 'good enough' standard, and discovered to his surprise that he was able to work more efficiently because the time taken to complete assignments was reduced. Again, this changed his feelings and working practices on a day-to-day basis, and also diminished the assumption that he must work extremely hard all the time in order to succeed. Peter also learned to identify self-critical thoughts, and to question them ('What's my evidence for that?', 'What would I say to another person in that situation?'). Once he had mastered these skills and could see change occurring, his depression lifted.

The combination of changes in thinking and behavioural experiments showed how strategies Peter had adopted to meet the requirements of his dysfunctional assumptions and improve his self-esteem actually had an adverse impact, confirming his poor opinion of himself. This observation formed the basis for formulating more realistic and helpful alternatives: 'being relaxed and spontaneous brings me closer to people', and 'enough is as good as a feast'. These were consolidated over treatment and throughout follow-up through further behavioural experiments (acting in accordance with the new rules, and observing the outcome). At the same time, work began on modifying Peter's negative core beliefs about himself. The idea that he was stupid was tackled by reviewing supporting and contrary evidence. Most of the evidence in favour of the belief was located in the distant past, though he still tended to see failure to perform exceptionally as a further sign of stupidity. Detailed exploration revealed that, while he had undoubtedly been slow to develop at school, a combination of specific difficulties with reading (which was resolved), poor

teaching and shyness were a better explanation for this than stupidity. Changing this belief also involved some imagery work, as Peter had vivid, painful memories of feeling stupid as a little boy which emerged in similar situations in the present and were not affected by purely verbal interventions. Peter imagined himself speaking to his child self, telling him that his difficulties were not his fault, and that he was actually intelligent and would do fine in the end. This reduced the pain of the memories, and they became less powerful and less frequent.

The belief about being boring was tackled in a different way. Peter believed initially that anything less than '100% scintillating' was boring, with no intervening stages. On a continuum with 0% scintillating (i.e. boring) at one end and 100% scintillating at the other, he initially rated himself at close to 0%. However, after exploring what 100% and 0% scintillating actually meant (always having jokes and funny stories and never being unconfident or at a loss what to say, versus never having anything to say and being unable to join in any conversations), he realised that he was probably nearer 50%, even when making no attempt to shine. He also concluded that being with someone who was scintillating 100% of the time would be exhausting. This reminded him of a university friend who appeared genuinely close to 100% and made him feel more like an audience than a participant in conversations, and of a girlfriend who broke up with him because she felt he never took anything seriously and she could not get close to him. Peter then began to recollect instances where he was able to be himself without any negative responses from others, and where he behaved in a way that showed intelligence and common-sense. This combination of re-thinking the old beliefs and day-to-day change led to the formulation of new beliefs, which he saw as more accurate once all the evidence was taken into account: 'I am likeable just as I am' and 'I am an intelligent person who sometimes does stupid things'. By the end of treatment, Peter rated his confidence in his old core beliefs at 0%, and the new alternatives were close to 100%. He no longer met criteria for social phobia or major depression, and reported that he was handling his work and social life with confidence and pleasure.

Referring patients for cognitive therapy

Low self-esteem is associated with a wide range of presenting problems. Additionally, the model and

associated treatment programme contain elements from cognitive therapy of anxiety, depression and personality disorder. Ideally, referrals should be made to therapists with knowledge and supervised experience of working cognitively with a range of psychological problems, including long-term difficulties associated with high levels of distress and disability. Unfortunately, at present very few psychiatrists (particularly at consultant level) have enough training and supervised experience in cognitive therapy to work effectively with these patients. However, cognitive therapy is widely available from clinical psychologists. Also, increasing numbers of nurse behaviour therapists working in hospital and community settings now receive training in the approach. The British Association of Behavioural and Cognitive Psychotherapies (BABCP; inquiries to Howard Lomas, Executive Secretary, 23 Partridge Drive, Baxenden, Accrington, Lancashire BB5 2RL), a multi-professional organisation, holds a register of accredited cognitive–behavioural practitioners, including therapists operating in private practice. Patients with less severe problems may also benefit from cognitive therapy self-help texts which address low self-esteem (McKay & Fanning 1992; Young & Klosko, 1993; Butler & Hope, 1995; Greenberger & Padesky, 1995). A 'homework' assignment of reading a relevant chapter from one of these, and perhaps monitoring and making a note of situations, thoughts and emotions relating to low self-esteem, can be a helpful rough-and-ready way to assess how likely a patient is to respond to cognitive therapy. Broadly speaking, patients who complete the assignments and who feel the cognitive model of emotional disorder has direct personal relevance to them are likely to take to cognitive therapy and make good use of it. Conversely, patients who have serious doubts about the relevance of the model and/or fail to complete the assignments may be less suitable, at least for a short-term focused approach.

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Multiple choice questions

1. From a cognitive perspective, low self-esteem is:
   a a personality disorder
   b an acute psychiatric disorder
   c an aspect of, consequence of or vulnerability factor for a range of psychological problems
   d a product of unconscious conflicts.

2. Negative core beliefs about the self are:
   a irrelevant to the successful treatment of low self-esteem
   b a result of previous experience and influence current thoughts, feelings and behaviour
   c a bi-product of biochemical disturbances
   d the end product of behavioural deficits and excesses.

3. Low self-esteem is perpetuated by:
   a a vicious circle comprising cognition, affect and behaviour, which results in persistent activation of negative beliefs about the self
   b behavioural avoidance strategies
   c symptoms of anxiety and depression
   d interpersonal and environmental stressors.

4. Cognitive therapy for low self-esteem aims to:
   a help patients to break out of the vicious circle
   b undermine old negative core beliefs about the self
   c establish a new, more positive and realistic view of the self
   d understand how the problem developed and what keeps it going.

5. Cognitive therapy for low self-esteem:
   a can be done by anyone with basic book knowledge of cognitive therapy
   b is not available within the National Health Service
   c should only be given by therapists with sound knowledge of the approach and supervised

experience of working cognitively with a range of psychological problems
   d should always be carried out in combination with psychotropic medication.

MCQ answers				
1	2	3	4	5
a F	a F	a T	a T	a F
b F	b T	b F	b T	b F
c T	c F	c F	c T	c T
d F	d F	d F	d T	d F