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A Cognitive-Behavioral Program for Improving Self-Esteem in At-Risk Adolescents

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ABSTRACT

Youth who have experienced adverse events in childhood are more likely to experience negative health outcomes. Increased exposure to adverse experiences such as abuse or neglect are associated with increased risk for outcomes such as smoking, obesity, sedentary lifestyle, depressed mood, and attempted suicide. These outcomes may be mediated through the development of more positive coping strategies. Currently, there are no group programs for young adolescents that are designed from a cognitive-behavioral perspective that aim to improve self-esteem in this population. Cognitive Behavioral Therapy (CBT) has been found to be effective at reducing symptoms of depression, anxiety, and other mental health issues through teaching both cognitive and behavioral skills. CBT has been found to be most effective with this age group when behavioral skills are emphasized. The present program development model includes weekly group therapy sessions designed to be implemented in a school or clinical setting to produce an effective, novel approach to treating at-risk adolescents with low self-esteem. Plans for program evaluation are included.

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I: Introduction

Introduction to Topic

Adolescence is a phase of life that is fraught with both body and psychosocial changes. Youth are expected to form a sense of identity during this time, figuring out their view of themselves, as well as how they fit into the world. For some adolescents, this endeavor is complicated by difficulties at home and difficulties in their relationships with caregivers. For the purposes of this paper, "at-risk" is defined as anyone who has experienced an Adverse Childhood Event, as defined by Felitti et al. (2019). These events include child physical, sexual, or emotional abuse; emotional or physical neglect; mother treated violently; household substance abuse; mental illness in the household; parental separation or divorce; or a criminal household member. Studies have found that exposure to these adversities increase the likelihood of difficulties in adulthood, including many health problems associated with decreased longevity (Felitti et al., 2019). It has also been theorized that a mechanism for this relationship between adversity and poor health outcomes is the use of unhealthy coping tools, such as alcohol or drug abuse. As such, it is imperative that treatment and prevention efforts focus on intrapersonal skills that could mediate the effects of adverse childhood events on the lives young people.

Self-esteem has been widely studied in the psychological literature, and it has been conceptualized as either a global view of the self or a trait-specific view of the self. For the purposes of this paper, it will be defined as an overall regard for the self. Crocker (2012) posited that people each construct their own self-worth based on a set of contingencies that hold different weight for different people. For instance, some adolescents might have self-esteem that is more contingent upon athletic performance

than other people. With the construct of self-esteem organized in this way, it follows that early life experiences have a significant (and sometimes detrimental) effect on how individuals structure their own views of themselves. Self-esteem is also correlated with many other mental health disorders, although low self-esteem is not a disorder in and of itself. The cognitive model of self-esteem explains that one's view of the self is perpetuated by a series of thoughts, followed by behaviors that confirm those views.

Cognitive Behavioral Therapy (CBT) has been shown to be effective at treating myriad mental health conditions, including many that are associated with low self-esteem. CBT teaches clients tools that can be used to challenge thoughts and change behaviors in meaningful ways in order to improve individuals' lives and allow them to break out of unhealthy patterns of cognition. Although CBT has been used with success in adolescent populations, it has largely been utilized in individual therapy for youth. However, CBT has been successfully utilized to improve self-esteem in group settings with other populations (Beattie & Beattie, 2018). In addition to improving self-esteem, a group program for adolescents may serve to increase social support and add to the positive experiences in the lives of at-risk adolescents.

Purpose

This doctoral project aims to design a group treatment program to be utilized for the improvement of self-esteem in at-risk adolescents. It combines the cognitive behavioral treatment model of self-esteem that was developed by Fennell (Fennell, 1998) with a group therapy approach, which may be more accessible than individual therapy for adolescents. In addition, this project serves as the basis for expanding research into treatment and prevention strategies for youth who are at-risk for further mental and

physical health difficulties. This program may be particularly useful in a school setting, although it is designed to be used in any setting where adolescents and their families can seek mental health services.

Statement of Significance

Adolescents who have experienced adversity are at risk for poor life and health outcomes. This program development project provides a treatment that may prevent some of these negative outcomes by intervening during adolescence. Although CBT has been shown to be an effective treatment for depression and anxiety, which may both be related to self-esteem, the author has not found any programs in the literature for the improvement of self-esteem in at-risk adolescents that utilize this CBT model of treatment. Therefore, this program adds to the available group treatments for low self-esteem in a novel way. This program has potential to impact the lives and functioning of adolescents who may not have any other access to learning these skills, and it may increase their future use of cognitive behavioral coping skills.

II: Literature Review

Methods for Literature Review Search

The literature review was primarily conducted utilizing databases and literature from the Eastern Kentucky University Libraries, including the following databases: Academic Search Complete, PsycARTICLES, PsycINFO, PsycTESTS, Child Development and Adolescent Studies, Dissertations and Theses Global, DSM-5, EBSCOhost, Google Scholar, JSTOR, Psychology and Behavioral Sciences Collection, ScienceDirect, Sage Journals Online, and Web of Science. Search topics included self-esteem, self-concept, and self-worth in adolescent populations. The search was broadened to include research relating to self-esteem in adults and other populations. Research regarding outcomes related to Adverse Childhood Events was explored, and those findings were compared to research relating to self-esteem as a potential mediator. Research on different measures and models of self-esteem were also included in this review, as well as evaluations of group programs for adolescents. The search was also broadened to include Self-compassion due to its association with self-esteem.

Models of Self-Esteem

Throughout the history of psychology, researchers have been intrigued by the implications of self-esteem. It is seemingly connected with a host of psychological disorders and other maladaptive behaviors (Crocker & Park, 2012). According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), 21 different disorders are associated with lowered levels of self-esteem, relative to the general population. It is described in either a diagnostic way or as an associated feature, risk factor, or consequence (Kolubinski, Frings, Nikčević, Lawrence, & Spada, 2018). Starting in the

1960's, researchers developed scales to measure self-esteem, and increasing self-esteem was touted as the next cure-all for psychological ailments. However, decades of research eventually led people to believe that the benefits of high self-esteem were initially overstated, and psychologists lost interest in the construct (Crocker & Park, 2012). However, more recent research examining self-esteem has demonstrated that perhaps a more important way to understand self-esteem is through researching the components of individuals' own measures of self-esteem: contingencies of self-worth (Crocker & Park, 2012). Other research on self-esteem, depression, and anxiety has found that the relationship between self-esteem and these disorders is reciprocal in nature. This adds support for Fennel's cognitive model, which views low self-esteem as the consequence of a maladaptive cycle of thoughts and behaviors (Kolubinski et al., 2018).

Understanding models of self-esteem can help to clarify the direction of the present program. Self-esteem is a complex construct which can be conceptualized in multiple ways; however, it should be noted that research has clarified much of the organization of thought surrounding this topic. For instance, most researchers agree that there are components of self-esteem that are domain-specific, and that those domains of self-esteem load onto a more global self-esteem. Understanding self-esteem as a construct can also help to clarify possible individual differences in the development and maintenance of self-esteem. Not only is it important to understand the mechanisms by which self-esteem is developed, but it is important to understand how these mechanisms might affect different individuals in different ways. Having an understanding of this construct as a whole can also guide efforts to measure self-esteem, which can help to inform the practice of choosing group members who might benefit most.

In understanding the relationship between the research and definitions of self-esteem, one must define the various ways in which self-esteem has been conceptualized in the literature. Self-esteem has been defined in numerous ways, with many researchers and theorists agreeing that self-esteem can be viewed as a hierarchy with evaluations of one's own behavior at the bottom, evaluations about one's functioning in certain domains in the middle, and a global self-evaluation at the top (Coelho, Marchante, & Jimerson, 2017). Additionally, the terms self-concept, self-esteem, and self-worth are largely used interchangeably within the literature. Although self-concept has a more general connotation, and self-esteem and self-worth imply a positive regard for self, studies on these topics do not typically differentiate them clearly. Therefore, the terms may be used interchangeably throughout this paper.

Global or Trait Self-Esteem. Global self-esteem refers to a general, overall level of self-esteem that is conceptualized as a baseline for an individual. This view of self-esteem conceptualizes it as a generally stable construct (Fuller-Tyszkiewicz et al., 2015). When viewed in this way, self-esteem is less meaningful as a focus of change, and it certainly would not be an acceptable target for intervention. However, Crocker asserts that individuals' constructs for self-esteem are highly varied (Crocker & Park, 2003). Although the definition becomes less exact and less useful if we talk about it purely in "global" terms, there is some merit to the idea that self-esteem is at least partially tied to personality and thus a relatively stable factor within a person. This inherent way of viewing the self in a more negative or positive light could be considered a global self-esteem.

Domain-Specific Self-Esteem. A domain-specific model of self-esteem posits that self-esteem should be defined as the way in which people view their own functioning in different areas of life (Boden, Fergusson, & Horwood, 2008). For example, people may view themselves as very academically proficient, yet socially inept; this would be described as high academic self-esteem and low social self-esteem. Others view domain-specific self-esteem areas as components of a global self-esteem (Boden et al., 2008). Most research that has been done on self-esteem uses a global model, making it difficult to ascertain the impact of domain-specific self-esteems on later life outcomes (Boden et al., 2008).

The domain-specific model of self-esteem comes from the belief that self-esteem can be separated into different areas of life and functioning. For most people, each domain is assigned a different weight, or value, which is discussed further in the section about contingencies of self-worth. This theory of domain-specific self-esteem is reflected in numerous measures, which assess self-esteem by asking questions about several different aspects of internal life. According to Crocker (2002), these domains of self-esteem contribute to a global self-esteem, but not vice versa (Fuller-Tyszkiewicz et al., 2015). One study of Australian adolescent girls, which sought to understand the influence of body-image on self-concept, found that measures of *state*-based body satisfaction varied more throughout one week than did measures of *trait*-based self-esteem. This means that global (or trait) self-esteem varied less within individuals over time than the more volatile state-based self-esteem. This finding is consistent with previous research that has shown domain-specific self-esteem to be less stable over time (Fuller-Tyszkiewicz et al., 2015).

Contingencies of Self-Worth. According to Crocker and Park (2012), those who are particularly susceptible to depression or anxiety have formed stringent contingencies of self-worth, which are analogous to maladaptive core beliefs in a cognitive model. For example, a person may believe "I am worthless if the person I love does not love me". This would likely cause an individual's self-perception to be very fragile, as people have little control over other people's feelings and behaviors. People with more external contingencies of self-worth may also be more susceptible to these emotional disorders due to the likelihood that there are more fluctuations in these external contingencies. Rather than viewing self-esteem as either contingent or not contingent, Crocker and Park suggest that all people inherently base their self-esteem on something. We all learn that we must do things or be certain ways in order to have value. This is important, because it means that self-esteem is largely constructed from previous learning and can vary greatly between individuals. This view of self-esteem also has implications for the development of self-esteem in at-risk adolescents. When people experience invalidating or abusive environments, they learn to have these maladaptive contingencies of self-worth, and thus, have more fragile self-esteem (Crocker & Park, 2012).

According to Crocker (2002), self-esteem is largely based on how people, as individuals, define it for themselves. While many studies have shown a link between low self-esteem and adverse life outcomes, few have shown any causality. She argues that people develop different bases (contingencies) for their own self-worth, including things like physical attractiveness, family support, or school competence. People then spend their time and energies in pursuit of success in these areas that satisfy their desire for high self-esteem, sometimes to the detriment of other fulfilling areas of life. Crocker proposes

four possibilities for developing a less costly way of seeking self-esteem, including "engaging in self-affirmation, abandoning dysfunctional contingencies, developing non-contingent self-esteem, and shifting goals from seeking self-esteem to more altruistic, compassionate, and other-oriented goals (Crocker, 2002)."

Self-Compassion. Self-compassion and self-esteem have been found to be highly associated constructs (Crocker & Park, 2012). Kristin Neff's Self-Compassion Scale measures people's view of themselves along three dimensions including "how they emotionally respond to pain or failure (with kindness and less harsh judgment), cognitively understand their predicament (as part of the human experience and as less isolating), and pay attention to suffering (in a mindful and less over-identified manner)(Neff et al., 2018)." Self-compassion is a way of treating oneself like a friend, with a focus on self-kindness, common humanity, and mindfulness (Neff et al., 2018). Self-compassion removes some of the weight off of individuals' contingencies of self-worth, because it directs people to view specific situations as less powerful indicators of self-worth. For example, if one earns a failing grade on a math exam, it may be a harsh blow to self-esteem if academic achievement is an important contingency of self-worth. However, people who practice self-compassion would be less likely to have harsh thoughts about themselves. They would see the failing grade as something that most people have had to endure and they would practice mindfulness (focusing on the present, and less on the past or future). Self-compassion skills could be one method for improving self-esteem in at-risk adolescents because of the focus on cognitive skills that promote positive coping.

A Definition of "At-Risk"

This project focuses on "at-risk" youth because this population is largely underserved. By definition, these young people have faced and are facing adversity in their lives, and this project aims to improve quality of life for these youth. According to the well-known study on Adverse Childhood Events (ACEs Study), exposure to childhood abuse or household dysfunction is associated with an increased risk for health problems in adulthood. For the purposes of this project, "At-Risk" will be defined as an individual who has experienced one or more of these events in childhood. These adversities include child physical, sexual, or emotional abuse; emotional or physical neglect; mother treated violently; household substance abuse; mental illness in the household; parental separation or divorce; or a criminal household member (Greger, Myhre, Klöckner, & Jozefiak, 2017). Exposure to these adversities in childhood appears to have a cumulative effect on health outcomes, with more exposure to these experiences associated with increased risk for outcomes such as smoking, obesity, sedentary lifestyle, depressed mood, and suicide attempts (Felitti et al., 2019).

The link between these events and later health outcomes appears to be due to certain unhealthy behaviors like smoking, drinking, or having many sexual partners, which function as maladaptive coping mechanisms for stressful life circumstances. Thus, they are linked to these adverse childhood events (Felitti et al., 2019). Presumably, one way to decrease health risks in this at-risk population is to introduce more positive coping tools early in life, so that these young people will be less likely to adopt these health-risk behaviors. The aim of the group program outlined in this paper is to encourage the development of the healthy cognitions and coping tools that may impact the health

choices of at-risk adolescents. Greger et al. (2017) found that global self-esteem is an important mediator in the association between adverse childhood events and later psychopathology. This means that increasing self-esteem at this crucial point in adolescence could be important for increasing later well-being and allowing individuals to develop healthy coping strategies (Greger et al., 2017). Through this group, individuals will be presented with healthy ways of viewing themselves and their environments, in order to build resilience in the face of these adverse childhood events.

Prevalence of Low Self-Esteem in Adolescence

Although not all adolescents can be considered "at-risk" by this definition, adolescents are almost universally confronted with issues pertaining to self-concept and self-esteem. Adolescence is a time when numerous biological processes cause a shift in development, which understandably causes one to stop and take notice of one's body and self. Hormonal changes regulate new body processes, like menses and hair growth, among other body changes. If these biological changes are not enough, adolescents must also struggle through big changes in social settings. This is a period during which many young people can expect to change schools and friend groups, all while trying to figure out their own identity and place in the world. Therefore, it is no wonder that research has shown that adolescents are particularly vulnerable to low self-esteem (Fuller-Tyszkiewicz et al., 2015). These normal issues of development can be further complicated by experiences of adversity in a child's home life, so it is foreseeable that unhealthy habits can be established at this time.

Another frequent issue in adolescence is the experience of bullying or peer victimization. Although not all children or adolescents experience this, it is certainly

more common in this time of life, when individuals are surrounded by peers. One literature review suggests that about one in four school-age children will experience bullying during their school careers (Swearer & Doll, 2001). According to Swearer and Doll (2001), the experiences of bullying and/or victimization are inextricably intertwined with children's ecological factors, such as their home life and relationships with parents and siblings. Children who are subjected to abuse at home may be more likely to learn maladaptive ways of dealing with bullying and thus more likely to continue to be victims of bullying. In contrast, children who witness violence at home may be more likely to engage in violent behavior at school. It should also be noted that bullying is not as dichotomous as many believe, with one child always acting as the bully and the other always the victim. Often, children fluctuate between these two roles (Carrera, DePalma, & Lameiras, 2011).

There are few, if any, times in life when people are less in control of their surroundings and peer groups than during adolescence. In one examination of the qualitative experiences of bullying, authors found that many youth who experienced this victimization reported self-esteem issues. Their meta-analysis also found that individuals who were bullied more frequently were more likely to have decreased self-esteem. In line with other research linking Non-Suicidal Self-Injury (NSSI) to low self-esteem, authors of this meta-analysis found that victims of bullying were at increased risk for depression, anxiety, NSSI, and suicidal ideation. It is also notable that some of these self-esteem related reports demonstrated the cognitive model of self-esteem, with reports of peer victimization translating directly into thoughts of the self as worthless. Overall, it is clear

from this meta-analysis that decreased self-esteem is a frequent result of being bullied in adolescence (Hutson, 2018).

There is also evidence that this cycle of victimization continues on into adulthood. One study found that mental and physical health outcomes in individuals' mid-twenties were related to an increased likelihood that those who were victimized as youth would continue to be victimized and bullied in the workplace (Brendgen, Poulin, & Denault, 2019). This highlights the need to target youth who are at greater risk for bullying and victimization in order to potentially end this cycle early in individuals' lives. Changing children's cognitions about themselves and working toward developing positive coping strategies in adolescence could potentially have an impact on later physical and mental health.

Children are also particularly vulnerable to decreased self-esteem when they are dealing with changing schools or peer groups. One study in Brazil found that lowered self-esteem was more highly correlated with school transition in early adolescence. This association was clear, due to the fact that the middle school transition occurs between fourth and fifth grade in Brazil. Their results were consistent with the idea that there is something inherently stressful about school transitions that could lower self-esteem, perhaps temporarily, at this time (Coelho et al., 2017). Since adolescence is already a time of change and increased risk for lowered self-esteem, it makes sense that this group be targeted for intervention, when these issues are especially salient.

Outcomes Associated with Low Self-Esteem in Adolescence

There is an established association between self-esteem and numerous adverse life outcomes, such as mental illness, substance abuse, self-harm, and other social issues (Boden et al., 2008). This may be due to either causality, or a common factor (such as childhood adversity) that causes both low self-esteem and these other adverse outcomes. Low self-esteem has been associated with increased levels of anxiety among adolescents, as well as increased likelihood of depression after a stressful life event (Boden et al., 2008). This finding is consistent with Greger et al.'s later finding, establishing self-esteem as a mediator between adverse childhood events and later well-being (Greger et al., 2017). In adolescents specifically, low self-esteem has been associated with increased risk of substance abuse, especially among "troubled" adolescents. In contrast, high self-esteem has been demonstrated to be a factor in the avoidance of substance use in adolescence (Boden et al., 2008). Self-esteem has been positively correlated with the quality of friendship and marital relationships, with no gender differences. One study of heterosexual dating couples even found that lower self-esteem predicted lower rates of self-disclosure in relationships, which eventually led to the dissolution of those relationships (Boden et al., 2008). All other outcomes aside, self-esteem has been shown to be highly correlated with life satisfaction, which is often a factor in why people present for therapy services in both adulthood and adolescence (Boden et al., 2008). Since life satisfaction plays such a strong role in people's behaviors, it follows that interventions targeting self-esteem may be beneficial in improving not only psychological health, but physical health as well.

Results of one longitudinal study in New Zealand found that low self-esteem at the age of 15 was clearly associated with previous stressful life events and circumstances, including abuse, socioeconomic disadvantage, and mental health or behavioral problems prior to the age of 15 (Boden et al., 2008). However, it was also concluded that self-esteem was not associated with any life outcomes when adjusting for confounding factors, with the notable exception of later suicidal ideation.

Boden's New Zealand study also found that even after adjusting for confounding variables, self-esteem at the age of 15 was predictive of life satisfaction and peer attachment at ages 18, 21, and 25 (Boden et al., 2008). Low self-esteem during adolescence is not always a problem that simply resolves on its own, and intervention could be beneficial in developing new cognitive habits that foster high self-esteem.

Self-harm. One impetus for research into the treatment of self-esteem stems from the desire to decrease the likelihood of self-harm in adolescents. Self-harm is very common in adolescents, with a non-suicidal self-injury lifetime prevalence rate of 18% (Abdelraheem, McAloon, & Shand, 2019). Self-harm typically begins in adolescence, and studies have shown that this behavior corresponds to hormonal changes that come with puberty, rather than chronological age (Abdelraheem et al., 2019). Although self-harm in and of itself warrants intervention, one must also consider that risk of suicide goes up dramatically with the presence of previous self-harm. Thus, the link between low self-esteem and self-harm should not be ignored. Tatnell et al. (2014) found that non-suicidal self-injury was partially mediated by self-efficacy and self-esteem, meaning that these factors were found to directly impact NSSI. Although self-esteem can be identified as one potential mediator of NSSI, it should be noted that research conducted in this field

highlights the multifactorial nature of the development of NSSI (Abdelraheem et al., 2019). Multiple factors go into the development of this dangerous behavior, including adverse childhood experiences (Felitti et al., 2019).

Targeting self-esteem in interventions will certainly not put an end to NSSI in adolescents; however, fostering a healthy view of the self may add to resiliency factors in adolescence and young adulthood. This could decrease risk of NSSI. According to Abdelraheem et al. (2019), interventions targeting self-esteem in this population could also serve to illuminate the strength of the association between NSSI and self-esteem. Although the impact of self-compassion on self-harm has not been studied, self-compassion has been shown to reduce the negative emotions associated with bullying and peer victimization (Abdelraheem et al., 2019). Thus, interventions to increase self-compassion may be helpful in alleviating some of the stress that can lead to NSSI.

Eating Disorders. Additionally, disordered eating has been associated with a broad range of early adverse experiences (Vartanian, Smyth, Zawadzki, Heron, & Coleman, 2014). One study investigated the mechanism by which these adverse events are related to disordered eating and found that early adversity was related to lower intrapersonal resources (like self-esteem) and lower interpersonal resources. This supports previous research that suggests that intrapersonal resources can decrease the risk of developing body dissatisfaction (Vartanian et al., 2014). Satisfaction with one's own appearance also plays a role in self-liking, which is one component of self-esteem (Lázaro et al., 2011). Girls who believe they are overweight tend to desire thinness, which can result in the development of eating disorders. Low self-esteem has been found to be a risk factor for disordered eating (Lázaro et al., 2011). In a study examining the effects of a self-esteem

group intervention in adolescents suffering from disordered eating, participants were shown to have improvements in self-concept related to weight and shape after completion of the group. Those who were classified as having anorexia nervosa also recovered weight throughout the group, demonstrating the health benefits of this targeted intervention for this population (Lázaro et al., 2011). Overall, research shows that adverse childhood events are related to the stunted development of intrapersonal resources, like self-esteem. This can lead to issues such as body dissatisfaction and disordered eating.

Treatment Programs Targeting Adolescent Populations

Adolescence is typically regarded as a time that is fraught with change, including many biological, social and psychological stressors. One treatment movement called Positive Youth Development (PYD), focuses on the trajectories of adolescents, (Freire, Lima, Teixeira, Araújo, & Machado, 2018). This framework focuses on adolescent strengths and helping this population gain tools to help them take control of their personal development. The key features that have been identified in the positive development of adolescents can be organized into the "Five Cs Model," coined by Bowers in 2010. These components are competence, confidence, connection, character, and caring/compassion (Freire et al., 2018). One Portuguese study of a PYD program with a sample of 99 participants examined the impact of such a program on youth, as well as any gender differences in its impact. The program lasted for eight weeks, with one 90-minute session each week. Researchers found that participants had increased levels of global self-esteem and life satisfaction at posttest when compared to a control group. Their program used several methods of improving these factors in youth. Notably, they used a "Three good things" activity to promote positive self-image, as well as other activities that focused on

identifying existing positive qualities and strengths (Freire et al., 2018). Results of this study also showed that girls experienced more improvement on the measured constructs than did boys. Authors theorized that this may be due to the social, group nature of the program, as development of social skills have been documented to differ by gender (Freire et al., 2018). Thus, in designing the present program for the improvement of self-esteem in at-risk youth, it may be prudent to arrange activities in a way that balances sharing of ideas with individual reflections during group time. Boys may also benefit from more directed and structured discussions within this group setting.

A Cognitive Model of Self-Esteem. Although CBT has been shown to be effective in treating many disorders, such as depression, anxiety disorders, and personality disorders, its use in treating low-self-esteem has been under-researched. This is likely due to the fact that low self-esteem, in and of itself, is not classified as a psychological disorder. Self-esteem may be thought of as either a predisposing factor, or simply a corollary factor in many psychological disorders. For example, in depression, people may experience low self-evaluations that resolve after their depression lifts. However, others may develop psychological disorders with low self-esteem as a predisposing factor (Fennell, 1998). According to the cognitive model of emotional disorders, people form beliefs and assumptions about the world which usually form based on past experiences. If those experiences are negative, they may form negative beliefs about themselves or the world in general (Fennell, 1998). This is an especially important point when thinking about adolescents and the development of their worldviews. When one is exposed to adversity in childhood and adolescence, one may believe things like “I am no good,” or “people are not trustworthy” (Fennell, 1998). These beliefs about the way in which the world

operates eventually give rise to automatic thoughts, which emerge in response to situations. These thoughts often bypass any reasoning abilities that people may or may not possess. When people's minds are inundated with these automatic negative thoughts, they become susceptible to lowered mood (Fennell, 1998). Kolubinski (2018) states that Cognitive Behavioral Therapy aims to establish a more positive system of beliefs by "re-evaluating negative predictions, reducing physical symptoms of anxiety, changing behavior, shifting a perceptual bias, and reducing self-critical thinking through cognitive restructuring and behavioral experiments."

Cognitive therapies aim to remedy these thought processes that stem from core negative beliefs, inviting clients to explore the evidence related to those automatic thoughts (Fennell, 1998). In doing this, a clinician not only addresses the automatic thoughts themselves, but lays the foundation for addressing life in a more reasonable and balanced way. Fennel hypothesizes that low self-esteem can be developed as a function of negative core beliefs about the self, which are developed as a result of an interaction between biological tendencies and an environment of abuse, neglect, or simply invalidating experiences (Fennell, 1998). The Centre for Clinical Interventions in Australia has developed a workbook for the improvement of self-esteem, however, it is aimed at adults and formatted for individual use (Lim, Saulsman, & Nathan, 2005). Although this workbook does not offer modules that are suitable for adolescents, many aspects of this individual program can be used to inform the development of the present program, including the topics of each weekly session.

Groups with adolescents. Although the aim of the current program is to address self-esteem in adolescents from a cognitive-behavioral perspective, examples of similar

programs are few or nonexistent in the literature. However, many programs have been implemented to address other areas of functioning in adolescents. One such program that was implemented in Spain addressed factors that predicted positive outcomes in a community intervention program for at-risk adolescents. Their program focused on fostering development of community involvement in youth. In examining their program implementation methods, researchers concluded that having a facilitator with less professional experience, attending larger groups, having a high level of family involvement, and performing fewer modules with fewer extra activities predicted higher attendance rates. They also found that these implementation factors predicted more positive task orientation, self-concept, social realization, and problem-solving competencies. Interestingly, they also found that younger age was associated with increased community involvement (García-Poole, Byrne, & Rodrigo, 2019).

One dissertation project was found that targeted middle-school aged girls and focused on positive youth development. However, this study was highly limited in validity because no measures of self-esteem or outcomes were used to assess the program besides interviews with a small sample of participants. Although this program was not empirically studied, the author noted that participants reported that the group helped them to feel connected socially, which benefited their well-being (Haney, 2014).

Section III: Program Design

Program Overview

Although some group programming exists to improve general outcomes for at-risk youth, there are no groups, to the author's knowledge, that focus on improving self-esteem from a cognitive behavioral perspective in adolescents. Evidence suggests that at least part of the reason for poor health outcomes over the lifespan for at-risk youth is due to poor coping skills, which lead to poor health choices. Cognitive Behavioral Therapy focuses on both cognitive and behavioral skills that can be useful for treating and preventing depression, anxiety, and other common mental health concerns. These skills may be not modeled or taught at home, due to parents' own difficulties with legal, financial, or drug use problems. Therefore, this program may offer an opportunity to teach skills that can be used throughout a child's life, that they may not have the opportunity to learn otherwise.

Although some programs exist that focus on development of positive self-esteem with respect to body image, these programs appear most appropriate for larger-scale use with entire classrooms. For example, the Dove: Confident Me series of workshops offers a set of classroom-based teaching tools that are meant to be applicable to many or all students. It teaches about the role of the media in creating unattainable beauty standards, as well as healthy ways to think about outer beauty (Diedrichs et al., 2015). While some of these issues of focus may be salient for youth who have experienced adversity, they may not be the most important factors in the self-concepts of these at-risk youth. Especially for adolescents who have experienced abuse or neglect, their feelings of worthlessness are rooted in deeper views and core beliefs that would be more

appropriately addressed in a smaller group setting, where more personal experiences can be discussed.

Other programs focus on the social support aspect of group intervention, which will also be a focus of this group. Social influences are important to foster in this age group, since changes in schools and peer groups have such a notable effect on self-esteem (Coelho et al., 2017). Establishing a weekly group of individuals who have experienced similar adversities can serve as a way for these youth to make friends and a support system of people who can relate to them. However, the goals of this group intervention reach beyond the social impact. This group aims to introduce youth to cognitive and behavioral methods of improving and maintaining a healthy view of the self. While the social benefits of the group may be limited to the duration of the group, the skills learned can be used throughout the lives of these individuals.

Proposed Treatment Model

According to Fennell's Cognitive Model of Low Self-Esteem, the treatment that follows should be staged in a way that allows the client to gradually understand the concepts. This is especially helpful to remember when working with adolescents, as too much information too soon may be confusing. The proposed treatment program allows participants to learn one concept at a time, practicing as they go. This way, clients are able to apply each concept and fully understand it before moving on to the next piece. In addition, the facilitator serves to correct any misunderstandings of the material and lead participants toward helpful practice of their new skills.

Behavioral skills are a key part of conducting cognitive behavioral therapy with children and adolescents (Webb et al., 2019). This program incorporates behavioral skills

and methods of practicing that aim to help this population succeed. A system of rewards is also incorporated throughout the program so that participants will be motivated not only to continue attending group sessions, but to continue practicing their skills at home. Each group member will receive a binder to hold weekly worksheets, as well as a log of weekly activities. For each activity that participants complete successfully, they will earn a point. After each session, participants can redeem three points for a small prize from the Self-Care Box, which should be filled with small items like individually-wrapped candies, chapstick, stress balls, etc. Participants will have the opportunity to earn three points per session, although they may not earn all three in one session. Points are awarded for 1) completing their worksheet, 2) practicing the weekly activity, and 3) scheduling and completing one self-care activity.

Homework is an essential piece of this group program, as the program aims to undermine core beliefs. Since these fundamental views of the self are so ingrained, they require practice to change (Fennell, 2007). This change cannot be attained in one-hour weekly group meetings alone. Participants must practice these skills on their own in order to change their ways of thinking and behaving; this is why homework completion and practice are so heavily reinforced. In addition to the prizes as reinforcement, participants will likely experience intrinsic rewards for implementing these changes in behavior and cognition. If these group sessions take place in a school setting, they may be limited to a typical 50-minute class period. However, if time allows, group play activities may be included at the end of each session in order to add enjoyment and reinforce attendance. In a school setting, the opportunity to leave class in order to attend group will likely be reinforcing in and of itself.

Session 1. The first session of the intervention will focus on allowing participants to orient to the group. The session will begin with information about the limits of confidentiality, and the clinician will answer all questions that participants have regarding these limits. This group targets individuals who have likely experienced traumatic (and thus reportable) events, so it is important to make certain that all group members understand the obligations of the clinician to report events that have not been reported before. Parents or guardians will have already signed informed consent, and group participants will have already signed an assent form. Individuals will introduce themselves to other group members, and it is recommended that each participant be asked to share something about themself. Another focus of this first session will be on establishing and creating rules for behavior in group. Group participants will be asked to contribute to this list of rules, so that all members feel that the group is a place where they are safe and heard.

After this brief (about 20 minutes) orientation to the group, the clinician will introduce the concept of self-esteem. The content of this session focuses on the definition of low self-esteem, so that participants have a greater understanding of the goals of the group. In addition, group members will each be asked to complete a self-esteem questionnaire, which is discussed more thoroughly in the section titled "Treatment Outcome and Evaluation". The activity for this group session will be a worksheet that asks participants to both describe themselves in words and draw a picture of how they see themselves. This worksheet can be found in Appendix A. After completing the activity, participants will be asked to discuss what they notice about their self-evaluations.

Homework for the week will be to write down three personal goals for their time in the group.

Session 2. The second session will focus on education about the development of low self-esteem, with group discussion about the effects of adverse childhood events. This session will also inform participants about contingencies for self-worth, as defined by Crocker (2003), and focus on understanding their own contingencies for self-worth. The group facilitator will explain the common bases for people's self-worth, including others' approval, appearance, defeating others in competition, academic competence, family love and support, being a virtuous or moral person, and the love of a higher power or deity (Crocker, Luhtanen, & Cooper, 2003). This will also be a time for the facilitator to explain how each person weights these sources of self-esteem differently. Participants will be asked to complete a worksheet that will help them think about their own contingencies for self-worth. After all members have had enough time to work on this, they will be asked to discuss their most important contingency with the group, if they feel comfortable doing so. The clinician will discuss the development of core beliefs, which are the basis of development of self-esteem (Fennell, 2007). These core beliefs cause us to formulate rules for living, which are very similar to our contingencies for self-worth. When these contingencies are unachievable or out of our control, self-esteem is more fragile. The facilitator will help participants evaluate whether or not their self-esteem is attainable, based on their values.

Session 3. Session three will focus on using cognitive behavioral methods for combatting symptoms of anxiety or depression that often accompany and perpetuate low self-esteem. Group discussion will center around the behavioral ways that a cycle of low self-esteem

can be perpetuated. Understanding the difference between facts and opinions is essential to this topic. The facilitator will lead group in the discussion of the difference between these two and will ask for examples to practice differentiating. Discussion about why and how these opinions are formed will be a main part of group discussion. For example, a person may think "I must always get every chore completed on time or else I am bad." This belief may be formed based on past experiences, like the reactions of caregivers in this situation. However, participants will practice finding evidence for their beliefs. Group members will also be introduced to the idea of self-compassion and treating oneself as you would treat a friend. This concept is especially relevant for members of this group, who have likely experienced more hardship than others. Group members will be asked how they care for themselves mentally as well as physically, with a discussion about self-care. Homework for this session will include scheduling two positive events for the week and writing about the activities in a journal.

Session 4. At the start of session 4, participants will share something about one of the positive events that they had scheduled for the previous week. If they were able to follow through with it, they will report how it went and how it made them feel. If they were not able to do any of the events that they had planned, they will discuss why they were unable to do it, and a plan will be discussed to help them overcome barriers or choose an activity/event that is more feasible. Session four will again focus on how our thoughts and behaviors can perpetuate a cycle of low self-esteem, because a main goal of this program is to teach participants that many aspects of self-concept formation are in their control. The clinician will teach the participants about biased expectations, which cause us to overestimate the chance that bad things will happen, exaggerate how bad things are,

underestimate our abilities to handle difficult situations, and ignore other factors (Lim et al., 2005). Often times, people will think "that thing would go terribly if I tried to do it," which decreases the likelihood that they will try to do whatever it is that they want to accomplish. In order to combat this avoidance that typically goes along with these negative thoughts, participants will be asked to test out their biased expectations. In group, individuals will be asked to examine their own biased expectations about a particular event or type of event. These will be discussed with the group and the clinician will facilitate understanding of the cognitive model of self-esteem. Homework for this session will be to carry out a behavioral experiment to counter a negative thought, and then write about how it went in a journal. In order to carry out this experiment, participants will put avoidance aside, and jump right into the difficult action. Examples might be asking someone to a school dance, asking a teacher if there is anything that can be done about a late assignment, or trying out for a sports team. All of these activities create an intimidating scenario for individuals who expect that they will fail, especially if that failure confirms to them that they are incompetent or ineffective. For these experiments, participants will first define the situation. Then, they will write out their expectations about what will happen. Then, on a scale of one to 10, with 10 being the most, they will rate how strongly they believe that their predictions will come true. They will also identify and rate their emotions. After they complete the activity, they will write about what happened and how it went, including their emotions and thoughts about it. Results of their experiments will be discussed at the start of the next group.

Session 5. Session five will begin with some time to discuss the homework. It is likely that participants will have varying levels of success with their experiments; however, the

main goal of this discussion is to help participants understand that there are different measures of success. Even if an experiment did not go perfectly, it is likely that participants overestimated the negative results before carrying out the experiment. All of these assumptions will be discussed in the group. Any avoidance of the homework will also be processed. The focus of the fifth session is on addressing negative automatic thoughts. We will discuss the utility of these thoughts in our lives, especially the misperception that this negative self-talk will in some way motivate us to do, or be, better (Neff et al., 2018). In order to combat these negative self-evaluations, we will talk about self-compassion. In group discussion, we will practice identifying these negative self-evaluations and finding more constructive and adaptive things to say to ourselves. Homework for this session will include a journaling activity to help participants identify their own negative self-talk. Participants will write down at least five negative self-evaluations that they make throughout the week, and then write a more self-compassionate thought to replace it.

Session 6. Time will be devoted to going over the previous week's homework at the beginning of the session and participants will have the opportunity to talk about how it affected them to notice some of their negative self-evaluations and use self-compassion. They may begin to notice that their negative self-talk is due to some unhelpful rules that they have for themselves (Fennell, 2007; Lim et al., 2005). This session will focus on the development of more realistic and helpful rules and assumptions (Fennell, 2007). When people deal with low self-esteem, it naturally follows that they develop rules that aim to protect this fragile self-concept. For example, a person may think "I must make everyone happy, or else I am a worthless person." As a result, the person tries very hard to please

others. If and when this proves to be difficult or impossible, the view of the self as a worthless person is confirmed(Lim et al., 2005). Participants may have a difficult time identifying these unhelpful rules by which they have been living. The facilitator may start by asking which areas of participants' lives have been particularly difficult. Are they struggling to make or keep friends? Are they having difficulty with school anxiety? This will help clients find a starting place for identifying some of these unhelpful rules. The facilitator may also assist participants in putting those rules into words if they have difficulty understanding the "If I do this, then this will happen," format. This discussion would be incomplete without mentioning helpful rules. According to Lim et al. (2005), a helpful rule is "balanced and flexible." For example, the aforementioned unhelpful rule could be made more helpful by changing it to "I should try to get along with others, but even when people aren't happy with me, I have inherent worth." This rule is much more helpful because it is flexible, and it does not lead to a person feeling worthless for something they cannot always control. For homework, participants will write about one of their own rules that they wish to change.

Session 7. The seventh session will begin with a review of participants' homework. Then the clinician will discuss the development of balanced core beliefs (Lim et al., 2005). Through previous sessions, participants have worked on challenging the thoughts and assumptions that arise from negative core beliefs about themselves. Fennell calls this "the Bottom Line," and it is a generalized assessment of the self (Fennell, 2007). Now that participants are familiar with the experience of challenging their thoughts, they can be more receptive to challenging these basic beliefs about themselves. They have practiced making changes and can now feel more confident that their beliefs are not always facts.

In group discussion, members will be asked to identify one of these negative core beliefs. The facilitator should ask questions like "what does that thought/rule/assumption say about you as a person?" This will help clients clarify these core beliefs. Discussion should help clients think through how these beliefs came about. Many participants will have experienced mistreatment from others, and the words or actions of abusers may have contributed. Participants will complete a worksheet during this session that asks them to change a core belief to a more balanced version. This new version should be helpful, and it should be something that they *are*, not something that they *are not*. On the worksheet, they will be asked to draw themselves again, this time reflecting how this new belief makes them feel. Discussion should also revisit the participants' contingencies for self-worth and the practice of self-compassion. How have new contingencies shaped this new belief about the self? How does practicing self-compassion help you to strengthen this new belief?

Session 8. Session eight will focus on practicing the skills needed to maintain healthy self-esteem. The discussion will focus on behavioral ways to reinforce these new beliefs. In order to strongly believe in a new self-evaluation and "bottom line," participants must live as if they believe it. This will mean stopping avoidant behaviors that stem from the old beliefs. It also means treating yourself kindly and making sure to engage in pleasant activities. Group discussion should center around brainstorming ways that participants can strengthen their healthy self-esteem, as well as any barriers to this maintenance. This week for homework, they will create a log of pleasant activities that reinforced healthy perceptions of themselves.

Session 9. In session nine, participants will discuss their plans for the future, when they no longer have the structure of the group. It is important for clients to think through their plans and possible setbacks before they are on their own so that they feel confident that they can handle challenges going forward (Fennell, 2007). Group members will be asked to talk about possible challenges and any worries that they may have about the future and their own ability to handle it. In every session, it is important to remind clients of the skills that they have learned, including self-compassion. As such, the facilitator should note that participants will experience setbacks with their own self-esteem, mood, or level of anxiety. However, skills take time and practice to perfect and learn how to apply. This group is an excellent starting point and introduction to valuable skills, but clients must practice these skills going forward in order to make them habitual ways of thinking and behaving. Assure clients that even when they feel like they are, as Fennell (2007) put it, "back to square one," they will always have the knowledge of how to get started again. Clients will write their own plans for the future for homework after this session.

Session 10. Session ten will be devoted to celebrating the successes and personal growth achieved in the group. This session will not have a formal lesson but will be a time for group members to socialize with each other and wrap up the program. At the start of this session, the clinician will facilitate discussion that encourages reflection, asking group members how they believe they have changed as a result of the group experience. After brief discussion, participants will be invited to talk or play games if they choose. Participants will be encouraged to exchange information if they would like to keep in contact after completion of the group. This group may include appropriate snacks and drinks to add to the celebration. Participants will also be given the same series of surveys

that they were given at the beginning of the group, which will be used to evaluate the program.

Program Materials, Staffing, and Costs

One benefit of implementing this program is that it requires few materials. Costs associated with program implementation include drawing and coloring materials to be used for worksheets and activities, paper and printing of handouts, any games used for end of session free time, and staffing. Many, if not all, of these materials can be provided by the organization in which the group is held. For example, if implemented at a school, there would likely be a copy machine for the clinician to use, as well as drawing materials.

The largest cost of program implementation is staffing. Ideally, the program will be facilitated by two staff, one of whom should hold at least a Master's level degree in counseling, psychology, or social work related field. A background education in facilitating group therapy is a basic qualification that will allow this group to run smoothly. This background is also essential for managing any potential legal or ethical issues that may arise during the course of this program. It is recommended that there be two group facilitators so that there will always be at least three individuals present for group meetings, even if only one participant attends. It also allows one staff person to focus on the lesson, while the other manages any handouts or materials. In addition, facilitators can model appropriate behavior and conversation skills in group, which might otherwise go unrepresented. However, if necessary, this group can easily be facilitated by one clinician.

Clinician and Participant Characteristics

Clinicians providing this group should have the basic knowledge and skills required to facilitate a meaningful and beneficial group experience for participants, as noted above. These therapists should be well-trained in Cognitive Behavioral methods and have an excellent understanding of CBT. It may also be acceptable for a clinician to be a student in training who practices under the supervision of a qualified professional. Clinicians should have experience working with children and adolescents. Working with this age group comes with unique challenges, and clinicians must be open to approaching clients with respect and unconditional positive regard. A background in working with issues of interpersonal trauma is also helpful experience for clinicians facilitating this group. Participants have likely experienced traumas that have led to self-esteem problems, so knowledge of how these experiences can affect individuals is necessary to effectively work with these individuals.

Participants chosen to be group members of this treatment should undergo a careful screening process. As defined previously, this group is intended to serve middle-school-aged individuals who fall into an "at-risk" category. However, it is important that individuals are not currently experiencing an abusive or neglectful situation, as this requires more immediate resources for help. A primary concern is safety, and individuals must live in a safe home situation in order to fully participate in this group treatment. However, it should be noted that individuals who may participate in this program often have problems with their self-image that are exacerbated by invalidating home environments. These are not necessarily classified as abusive or neglectful situations. One goal of this group is to create more resilience within individual participants, and this

would include these individuals who may be seen as having a relatively unstable home life. Individuals who have a history of aggression toward peers may not be appropriate for this group; however, such individuals may participate with the understanding that any physical aggression would mean immediate removal from the group. Additionally, individuals with intellectual functioning within the average range would be best suited to this group, due to the cognitive approach; however, individuals with lower perceived intellectual functioning may still gain valuable skills through this group.

Treatment Outcome and Evaluation

A thorough program evaluation is necessary to determine the effectiveness of this intervention. The goal of this project is to implement a program that will make a difference in the way that at-risk youth view themselves. To measure effects of the treatment, a series of pretest surveys will be given to participants in order to assess their functioning prior to the start of the group. Another set of surveys and assessments will be given after the last session, and at 3 months follow-up. These assessments will include the Rosenburg Self-Esteem Scale (RSES), which was developed from a sample of over 5,000 adolescents in 1965. Although this scale is dated, its 10-question format is easily understood by adolescents, and its content remains relevant. It is also widely used in self-esteem research and would thus yield more comparative and useful results. Questions are designed to give a picture of global self-esteem (Rosenberg, 1965). Stakeholders would hope to see improvement in scores on the RSES from pretest to posttest, as well as maintenance of those improvements at the three-month follow-up.

Another goal of this program is to teach basic CBT skills so that the clients can utilize them going forward. The Skills of Cognitive Therapy (SoCT) measures clients'

understanding and use of these skills, as well as the therapists' perception of clients' skill use(Jarrett, Vittengl, Clark, & Thase, 2011). For this group application, it may not be useful to measure the therapists' observations, as the group may not give the facilitators a clear enough view of each individual's skills. For this reason, only the client version is recommended. This measure will be given at pretest, posttest, and follow-up as well. This measure will also be useful in helping to establish a possible mechanism for improvement from this group. The SoCT is included in Appendix B.

In addition to the RSES and the SoCT, a qualitative survey will be administered following the program to assess the participants' views of their experiences in the group program. This survey will ask questions that assess participants' engagement and attendance, participants' attitudes toward the program, and their perception of its efficacy in alleviating low self-esteem issues. These surveys may be used to further develop this program so that it is more enjoyable and useful for participants. An example of this survey is included in Appendix B.

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10.1037/ccp0000393.supp (Supplemental)

Appendix A

Handouts and Worksheets (by session number)

Points Log:

	Completed Worksheet?	Practiced?	One Self-Care Activity?
Session 1			
Session 2			
Session 3			
Session 4			
Session 5			
Session 6			
Session 7			
Session 8			
Session 9			

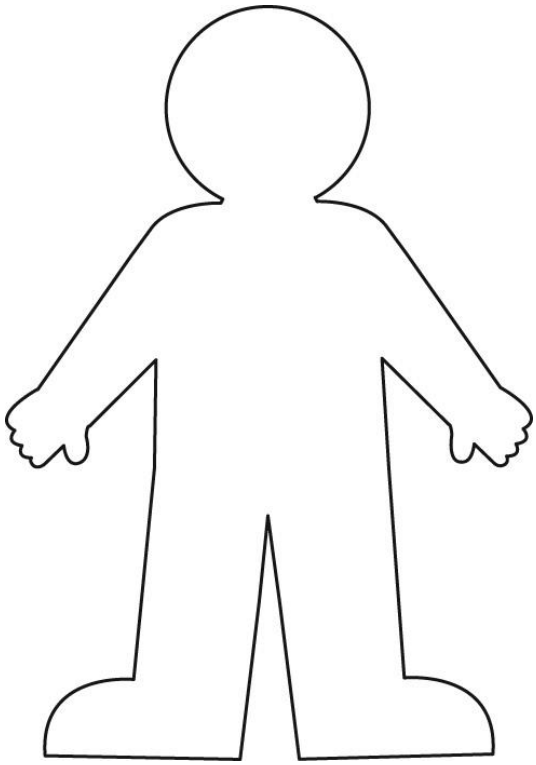
Worksheet, Session 1
How do you see yourself?

Before we get started talking about self-esteem, take a moment to write down a description of yourself.

I am...

_____
_____
_____
_____
_____
_____
_____
_____
_____

Now, draw a picture of yourself. Try to show the things you described.



Worksheet, Session 2
What makes you feel worthy?

(Complete before session) What are your goals for yourself during this group?

1._____
_____
_____
2._____
_____
_____
3._____
_____
_____

What are the effects of low self-esteem on your life?
_____
_____
_____
_____
_____
_____

Think about the things on which you stake your own self-worth. What is most important to you? Of the following things, which would make you love yourself, if you had it? What would be second on your list? Keep ranking until you put them all in your own order.

_____ Getting good grades

_____ Being liked by other people

_____ Being attractive

_____ Winning/being better at things than other people

_____ Having love and support from family

_____ Being good or doing good things

_____ Having a spiritual/religious sense that you are loved

Positive Event 1

What:

_____
_____

When:

_____
_____

Where:

_____
_____

Tell us about it!

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Positive Event 2

What:

_____

_____

When:

_____

_____

Where:

_____

_____

Tell us about it!

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

What are biased expectations?

Biased expectations are faulty assumptions about what might happen. Usually, these assumptions make us think that bad things are definitely going to happen, that things are just terrible, or that we aren't good enough to handle what might happen. Biased expectations also cause us to ignore many of our strengths and our abilities.

Let's put our expectations to the test!

Step 1: Define the situation. What are you going to do? Who is involved?

_____
_____
_____
_____

Step 2: What do you think is going to happen? How will things turn out for you?

_____
_____
_____
_____

How much do you believe that this is how it will go? Circle one.

1 2 3 4 5 6 7 8 9 10

Definitely won't happen like that — Definitely will happen like that

Step 3: What emotion are you feeling about the situation? How intense is that feeling?

Emotion:_____

1 2 3 4 5 6 7 8 9 10

Tiny feeling — Huge feeling

Step 4: Go out and try it! It might be nerve-wracking to dive in and try something that you think will go poorly, but examining the results will help you understand what you might have gotten wrong about the situation in the first place! Once you have given it a shot, come back here and answer a few questions about what happened.

Describe what happened:

_____
_____
_____
_____

Which parts of it went like you expected it to go?

_____
_____
_____
_____

Which parts of it went differently than expected?

_____
_____
_____
_____

How are you feeling about it now? Describe your emotions.

_____
_____
_____

Any other thoughts?

_____
_____
_____
_____

Worksheet, Session 5
Treating Yourself Like a Friend

What is Self-Compassion?

Self-Compassion is treating yourself the way that you would treat one of your friends. Sometimes we are really critical of ourselves. Why do we criticize ourselves when we would never treat our friends that way? Well, we might think that criticisms will help us do better next time. In reality, all that negative self-talk leaves us feeling down and unable to try again.

So, what should we do about it? Treat ourselves kindly and with compassion! The first step toward changing our judgmental thoughts about ourselves is to identify those thoughts. This week, identify times when you make a negative evaluation of yourself and write down the thought. Next, come up with a more self-compassionate thought to replace it. If you get stumped, ask yourself, "What would I say to my friend?"

Negative Self-Evaluation	Replacement Thought
1.	
2.	
3.	
4.	

Worksheet, Session 6
Forming Helpful Rules

We all create rules to live by. When those rules are difficult or impossible to follow, we set ourselves up for failure. When we fail, we feel bad about ourselves. However, we can change those rules and form new ones with a bit of practice!

What is one rule that you want to change?

_____
_____

Why or how did you come up with that rule for yourself?

_____
_____
_____
_____

What parts of it are unrealistic or unhelpful?

_____
_____
_____
_____

What parts of it are good?

_____
_____
_____
_____

Keeping the good parts of your rule, how could you change it to make it more balanced, flexible, and helpful to you?

_____
_____
_____
_____

My new rule:

_____
_____

This week, practice applying this helpful rule whenever you can!

Worksheet, Session 7
The Bottom Line

What is your new bottom line?

_____

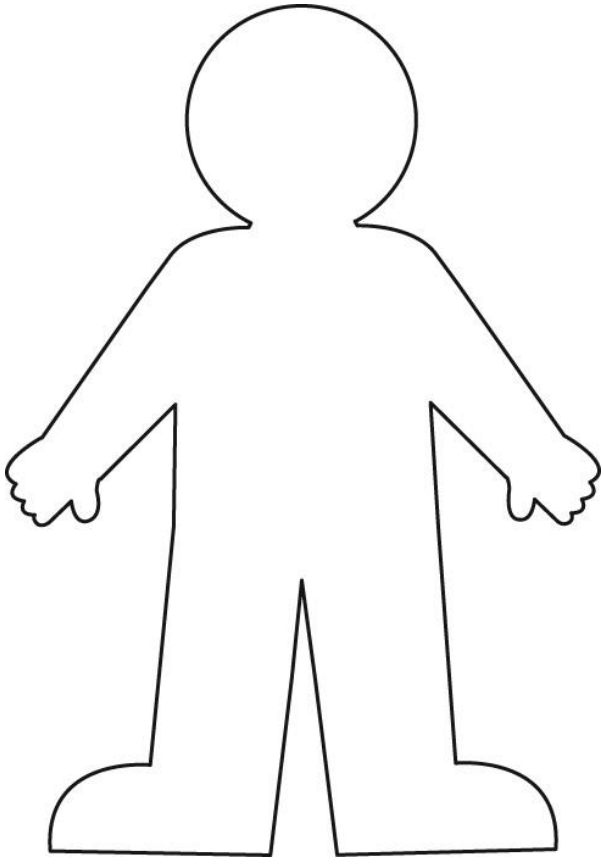
How strongly do you believe it right now?

1	2	3	4	5	6	7	8	9	10
Don't believe it at all									Completely believe it

What can you do to strengthen this new belief?

_____
_____
_____

Draw a new picture of yourself. This time, draw how the new belief makes you feel.



Worksheet, Session 8
Nourishing New Beliefs

It can be hard to believe in the new beliefs about yourself, but we have gained the skills to keep strengthening those beliefs. One way to strengthen a more positive view of yourself is to engage in fun activities that make you feel worthy. This week write down each pleasant activity you do that makes you feel like the new "bottom line" is true.

1. _____
   _____
   _____

2. _____
   _____
   _____

3. _____
   _____
   _____

4. _____
   _____
   _____

5. _____
   _____
   _____

6. _____
   _____
   _____

7. _____
   _____
   _____

Worksheet, Session 9
My Plan for the Future

How did your problems with low self-esteem get started?

_____
_____
_____

What kept those problems going?

_____
_____
_____

What skills or techniques did you learn in this group?

_____
_____
_____

How will you continue using those skills?

_____
_____
_____

What might cause you to start thinking badly about yourself again?

_____
_____
_____

How would you know that you aren't feeling well/mentally healthy?

_____
_____
_____

What would you do to change that?

_____
_____
_____

Appendix B

Measures and Scales for Program Evaluation

Skills of Cognitive Therapy—Observer [Patient] Version

Directions: For each statement below, circle the number that best indicates how often the patient [you] used tools or skills from cognitive therapy during the past month, where:

1 = Never
2 = Almost Never
3 = Half the Time
4 = Most of the Time
5 = Always or When Needed

1. The patient [I] understood that his/her [my] thoughts, feelings, and behaviors can contribute to his/her [my] depression.	1	2	3	4	5
2. The patient [I] examined his/her [my] underlying assumptions (or schema) and how they contributed to his/her [my] depression.	1	2	3	4	5
3. The patient [I] identified automatic negative thoughts and completed thought records.	1	2	3	4	5
4. The patient [I] scheduled and participated in activities which improved his/her [my] mood.	1	2	3	4	5
5. The patient [I] looked for alternative explanations when he/she [I] had negative thoughts.	1	2	3	4	5
6. The patient [I] weighed the evidence for and against negative thoughts.	1	2	3	4	5
7. The patient [I] tested negative automatic thoughts or beliefs by setting up experiments.	1	2	3	4	5
8. The patient [I] stated his/her [my] thoughts in ways that could be tested.	1	2	3	4	5

Post-Treatment Qualitative Survey

Thank you for participating in this group program! We would appreciate it if you would answer the following questions about your experience in the program. This information will be kept confidential and it will help us make the group better for future participants.

1. How would you rate your self-esteem before this program?

1	2	3	4	5
Awful				Great

2. How would you rate your self-esteem after this program?

1	2	3	4	5
Awful				Great

Please circle the best fitting response.

1= Strongly Disagree 2=Disagree 3=Neither Agree nor Disagree 5=Strongly Agree

3. I learned something that I will use in the future.

1 2 3 4 5

4. I feel like my self-esteem has improved as a result of this program.

1 2 3 4 5

5. I do not feel like my self-esteem has improved as a result of this program.

1 2 3 4 5

6. I would recommend this group to a friend who is struggling with low self-esteem.

1 2 3 4 5

7. I enjoyed participating in this program.

1 2 3 4 5

8. Overall, this group was a good experience.

1	2	3	4	5

9. The reward system helped me stay on track.

1	2	3	4	5

10. The facilitators treated me with respect.

1	2	3	4	5