Overcoming Low Self-Esteem: Practitioner Guide

THE TALKING THERAPIES UK PRACTITIONER GUIDES



Overcoming Low Self-Esteem: Practitioner Guide

Delivering the programme as guided self-help

A practitioner guide · 8 contacts · to accompany the workbook

TALKING THERAPIES UK

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First edition, 2026.

This guide accompanies the Overcoming Low Self-Esteem programme on the Talking Therapies UK self-help platform and its workbook. It is drawn from the programme and is kept current with it: whenever the programme changes, the guide is set again.

Revised and expanded edition, November 2026: the approach and its evidence, written practitioner notes and a worked example for every contact, the module's own teaching set out for the practitioner, and the answers to every sorting task and quiz.

Revision 5. This printing was set on 8 November 2026 from the programme as it stood that day.

A note on clinical responsibility. This guide supports qualified practitioners delivering guided self-help within their competence, their supervision and their organisation's policies. It does not replace clinical judgement, and its thresholds are guidance: where your service's policy differs, follow your service's policy.

Set in Poppins and Roboto, the Talking Therapies UK typefaces.

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How to use this guide

This guide is for qualified practitioners who support clients through the Overcoming Low Self-Esteem programme as guided self-help: a short supported contact after each of its 8 modules, with the client working through the programme or its workbook in between.

Part 1 sets out the model the programme is built on, what the research shows, and who the programme is for. Part 2 covers what every contact needs: your part in guided self-help, how to structure a contact, how to review each kind of worksheet, what to do when the work is not being done, how to adapt the programme, the check-ins and when to step up, and risk. Read Parts 1 and 2 before you begin with a client.

Part 3 has a chapter for each contact, to read before that contact: what the client has read in the module, why the skill matters, the messages to reinforce, a plan, the questions to ask, a worked example with dialogue, how to review the week's worksheets with their answers, and what to do when the skill is hard, how to adapt it and its cautions. Part 4 covers ending the work, supervision, and the checklist.

The guide follows the programme as it stands on the platform, so its plans name the programme's own modules, teaching and worksheets, and it is set again whenever the programme changes.

What this guide covers

- The model the programme is built on, and what the research shows
- Who the programme suits, how to assess for it, and when it is not enough on its own
- Your part in guided self-help, and how to structure each contact
- For each of the 8 contacts: what the client has read, why it matters, a worked example with dialogue, a plan, and the worksheets with their answers
- What to do when a skill is hard to learn or use, how to adapt it, and its cautions
- Keeping the work going, adapting the programme, the check-ins and stepping up, and risk at every contact
- Ending well, supervision, and a checklist for delivering the programme as designed

PART 1

The approach and the evidence

The model the programme is built on, what the research shows, and who the programme is for.

In this part

- Chapter 1, The model behind the programme: low self-esteem as a learned set of beliefs, Fennell's cognitive model and its maintenance cycle, and how the eight modules are built
- Chapter 2, What the research shows: the evidence for CBT based on Fennell's model, for its components, and for the link between self-esteem and depression, with its limits

CHAPTER 1

The model behind the programme

What low self-esteem is

Self-esteem is the set of beliefs a person holds about themselves: about their worth, their competence and their acceptability to others. Low self-esteem is not a diagnosis, and it is not the same as a passing loss of confidence after a setback, which most people know. The programme is written for the more lasting pattern, in which a negative view of the self has become the lens through which ordinary events are read, and has been so for years. People with this pattern often function well by outside measures. They hold down demanding jobs, look after others and are thought of as capable and kind, while privately believing that they are not good enough and that sooner or later others will see it.

Module 1 makes the distinction the practitioner should keep in view throughout: low self-esteem is a learned set of beliefs, not a fixed characteristic and not the truth about the person. This is not a reassurance. It is the working premise of the cognitive model, and it is what makes the problem treatable. Beliefs that were learned can be examined, and beliefs that are examined can change.

The cognitive model

The programme is built on the cognitive account of low self-esteem set out by Fennell (1997), which applies Beck's model of emotional disorders to the self and draws on cognitive therapy for depression and for anxiety, together with work on core beliefs. The model describes low self-esteem in layers. At the deepest is the bottom line: a short, absolute and global belief about the self, such as "I am not good enough", "I am unlovable" or "I am a burden", usually formed early

and rarely put into words. Above it are the rules for living, conditional policies that allow the person to function despite the bottom line by keeping it out of sight: “if I do everything perfectly, no one will see that I am not good enough”; “if I always put others first, they will not reject me”. Above the rules are the anxious predictions that arise whenever a rule is threatened, and the self-criticism that follows whatever happens.

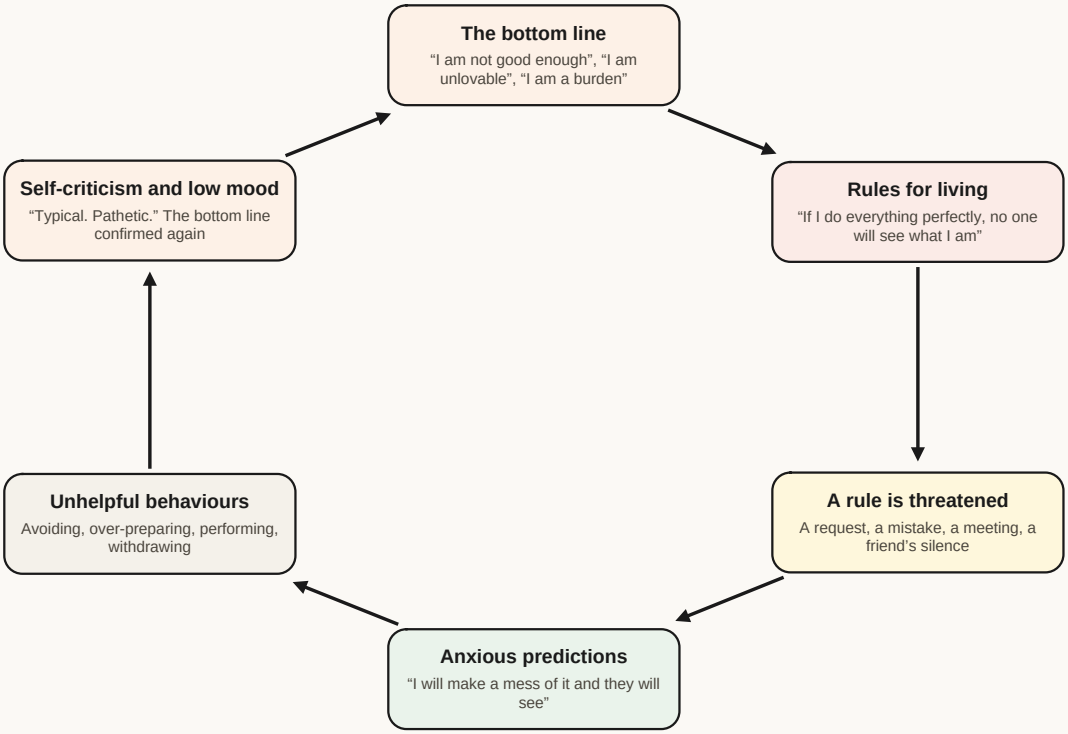


FIGURE 1.1 How low self-esteem keeps itself going
The maintenance cycle described by Fennell. The bottom line gives rise to rules for living; a situation that threatens a rule brings anxious predictions; the person avoids, over-prepares or performs; whatever happens, the self-critical verdict follows; and low mood confirms the bottom line, which is never put to a fair test.

The cycle explains the most puzzling feature of low self-esteem, which is that it survives a lifetime of evidence against it. When a rule is threatened, the person predicts the worst, and then avoids, over-prepares, performs a role or withdraws. If things go badly, the bottom line is confirmed. If things go well, the credit goes to the over-preparation or the performance, and the bottom line is untouched. Either way, self-criticism completes the circuit and the low mood that follows colours the next situation. The belief is never put to a fair test.

A recent refinement of the model by Rimes, Smith and Bridge (2023) keeps this structure and adds two points that are useful in the contacts. The first is that the core beliefs fall into two broad domains, personal adequacy (worth, success and status) and social connection (being liked, accepted and included), and that beliefs about how others see the person matter as much as beliefs about the self. The second is a fuller list of what keeps the beliefs going: corrective behaviours, compensatory strategies, constant monitoring of one’s own standing, safety-seeking, rumination and unhelpful ways of managing mood. Clients often recognise themselves in the list more readily than in the original cycle.

How the programme works on the model

The programme works from the surface down and then back up. Module 1 introduces the layers and sets goals, and module 2 traces the origins and maps the client's own cycle. Module 3 is the deepest piece of work: putting the bottom line and the rules into words. Modules 4 to 6 work on the cycles that keep the bottom line alive: anxious predictions tested by behavioural experiments, the inner critic met with self-compassion, and the depressive talk and withdrawal that low self-esteem so often brings, met with behavioural activation. Module 7 builds the alternative, a new bottom line and a positive data log that gathers the evidence for it, and module 8 turns the work into a plan for the months ahead, when much of the change in self-esteem actually happens.



FIGURE 1.2 The eight modules and what each works on
The programme begins with the patterns closest to daily life and works down to the bottom line, then builds the alternative. Modules 1 and 2 set out the model and its origins, module 3 brings the deep structure into words, modules 4 to 6 work on the cycles, and modules 7 and 8 build and protect a more balanced view.

How the modules are built

Each module has an introduction, one to three teaching sections, a sorting exercise that gives the client practice in recognising the module's ideas in other people's examples, a practical worksheet, a closing summary with practice for the week ahead, and a reflection, "Taking this forward", which asks what the client most wants to keep, when it will be hardest to use, and what exactly they will do then. The programme takes four check-ins: the PHQ-9, the Work and Social Adjustment Scale and the CORE-10 in module 1, and the PHQ-9, GAD-7, WSAS and CORE-10 in modules 4 and 8. The CORE-10 is a ten-item measure of general psychological distress designed for routine use in the psychological therapies (Barkham et al., 2013), and it suits this programme because low self-esteem often brings distress that the depression and anxiety measures catch only in part. Take the GAD-7 at assessment too, and consider the Rosenberg Self-Esteem Scale (Rosenberg, 1965), ten statements rated on a four-point scale and scored from 0 to 30, higher

scores meaning higher self-esteem; it is short, widely used, and measures the thing the client came to change. The worked examples in this guide follow one composite client, Erin, through all eight contacts.

What the practitioner adds

The programme carries the teaching. The practitioner's part has three particular demands in low self-esteem. The first is to notice the cycle running in the contact itself. Clients with low self-esteem often apologise for their worksheets, predict that they have done them wrongly, discount whatever went well and assume the practitioner is disappointed. Each of these is the model in action, and naming it gently, as an example rather than as a criticism, is often the most useful thing a contact does. The second is to resist the pull to reassure. Telling a client that they are clever, kind or worthwhile is well meant and almost always fails, because the bottom line filters the reassurance out, or files it under "she has to say that". The programme's method is to help the client gather and weigh their own evidence, and the practitioner's questions should serve that. The third is to model the stance the programme is building: interested, warm, accurate, and unimpressed by the critic's verdicts. Chapter 5 shows how a thirty-minute contact can hold all three.

CHAPTER 2

What the research shows

Why low self-esteem matters

Low self-esteem is distressing in its own right, and it is also a risk. Sowislo and Orth (2013) brought together longitudinal studies that measured self-esteem and later depression or anxiety: 77 studies of depression and 18 of anxiety. For depression the pattern favoured what they called the vulnerability model: low self-esteem predicted later depression more strongly than depression predicted later self-esteem. For anxiety the two effects were roughly balanced, each predicting the other. The practical implication is the one the authors drew: if the vulnerability effect is causal, work that raises self-esteem may help to prevent depression as well as to relieve present distress. For the practitioner it means that a client presenting with low self-esteem and mild low mood is a client whose mood deserves monitoring, and the PHQ-9 at each check-in is not a formality.

CBT for low self-esteem

The evidence for CBT built on Fennell's model is encouraging and still limited. In a small randomised trial in primary care, Waite, McManus and Shafran (2012) allocated 22 adults with low self-esteem to ten sessions of individual CBT with accompanying workbooks, based on Fennell's formulation, or to a waiting list. At the end of treatment the treated group had higher self-esteem, better overall functioning and lower depression than the waiting group, and fewer met criteria for a psychiatric diagnosis; the waiting group responded in the same way once treated, and the gains were maintained eleven weeks later.

Kolubinski and colleagues (2018) reviewed every study of an intervention based on the Fennell model they could find: eight studies, seven of which could be combined, with 821 participants. Weekly sessions, most of them in groups, produced large improvements from before to after treatment in self-esteem and in depression; one-day workshops produced smaller improvements three months later. The authors were careful about the limits. Most of the studies had no control group, attrition ranged from 9 to 49 per cent, follow-up was short, all the studies were conducted in the UK and most participants were women, and they questioned how far these interventions differ in practice from CBT for depression. The fair summary is that the approach consistently helps the people who complete it, that the best controlled evidence is small, and that guided self-help following the same model is a reasonable first step for the mild to moderate presentations this programme is written for.

The components

Several of the programme's components have their own evidence. Behavioural experiments, the method of module 4, are a core technique of cognitive therapy across disorders, and Bennett-Levy and colleagues (2004) set out how they are designed, run and reviewed; the programme's account follows theirs. Behavioural activation, the method of module 6, is an effective treatment for depression in its own right: a meta-analysis of 26 randomised trials with 1,524 participants found it clearly superior to control conditions (Ekers et al., 2014). The positive data log and the new

bottom line of module 7 come from Padesky (1994), who described the log as a daily record of everything consistent with a new and more adaptive belief, and who reported something every client starting the log should hear: belief in the new view usually rises slowly, perhaps to 5 or 10 per cent after a month or two, and the log often needs to be kept for six months or more before the new belief feels solid.

Self-compassion, the alternative stance of module 5, was defined by Neff (2003) as having three components: kindness to oneself rather than harsh judgement, a sense of common humanity rather than isolation, and mindful awareness of painful feelings rather than over-identification with them. A meta-analysis of fourteen studies found a large negative association between self-compassion and symptoms of depression, anxiety and stress (MacBeth and Gumley, 2012). The association is correlational, but it supports the programme's emphasis. Gilbert (2009), describing compassion-focused therapy, offers a clinical observation that explains why the work can be hard: in people with high levels of shame and self-criticism, the threat system tends to dominate and the soothing system is harder to reach, so that kind or balanced thoughts can be understood logically without being felt. Clients who say "I know it in my head, but I don't believe it" are describing exactly this.

What the research does not show

No trial has tested this programme in its present form, and there is no NICE guideline for low self-esteem, which is not itself a diagnosis. In NHS Talking Therapies services it is usually addressed within the treatment of depression or an anxiety disorder, and some services offer groups built on the Fennell model. The programme applies the model faithfully and is suitable for guided self-help where low self-esteem is the main difficulty and its severity is mild to moderate. The stepping-up guidance in Part 2 and in module 8 is the safeguard for the clients for whom it is not enough: those whose low self-esteem sits alongside major depression, the effects of trauma or abuse, an eating disorder, or a relationship in which the low view of themselves is being actively reinforced.