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CASE STUDY

Self-concept therapy across diverse clinical profiles: Insights from three complex clinical cases

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ABSTRACT

Ensuring clients' emotional safety is essential for preventing dropout and supporting effective psychotherapy. Self-Concept Therapy (SCT) targets the reconstruction of a healthy self-concept and has shown utility in treating trauma, attachment difficulties, and personality disorders, as well as in promoting stabilisation and dropout prevention. This study compares three cases to illustrate treatment protocols based on the three layers of self-concept (true self, emotions/thoughts, and behaviours) and to examine key therapeutic factors. The cases included: (1) a woman in her 30s with attachment difficulties and diagnoses of neurodevelopmental disorder and borderline personality disorder; (2) a man in his 30s suspected of child abuse and presenting with high intimacy avoidance and narcissistic traits; and (3) a woman in her 30s with hypochondriasis. In each case, SCT was applied using tools tailored to the client's symptoms and concerns, including psychoeducation, imagery, psychodynamic techniques, body-oriented interventions, and approaches integrating transpersonal concepts. Across therapy, clients showed improvements in depression, anxiety, compulsive symptoms, and attachment style. The findings suggest that SCT can support individuals with developmental and personality disorders in recovering a healthier self-concept and reducing attachment-related anxiety. Its capacity to provide a secure therapeutic base also appears to reduce the risk of dropout among clients at high risk of discontinuing treatment.

Keywords: attachment; borderline personality disorder; dropout prevention; self-concept therapy; treatment outcomes

Dropout remains a persistent challenge in psychotherapy, with rates reported as high as 50% in some clinical contexts (Swift & Greenberg, 2012). Clients who disengage prematurely not only fail to achieve therapeutic gains but may also experience a reinforcement of helplessness and treatment avoidance (Wierzbicki & Pekarik, 1993). Dropout risk is particularly elevated among individuals with personality disorders, complex trauma, and attachment difficulties, precisely the populations for whom sustained therapeutic engagement is most critical (Barnicot et al., 2011). Fostering mental state stabilisation early in treatment is therefore regarded as a key factor in both retaining clients and improving outcomes.

One approach considered central to this stabilisation process is the cultivation of a healthy self-concept. Self-concept formation is strongly influenced by social interactions (Rosenberg, 1981), and the internalisation of others' evaluations plays a crucial role in shaping it over time (Rosenberg, 1981). When self-concept is unstable, individuals are prone to deep anxiety and self-distrust, which can reduce overall mental health functioning (Relojo, 2016; Zeigler-Hill et al., 2024). This fragility is particularly pronounced in individuals with personality disorders, for whom a destabilised sense of self is both a symptom and a barrier to engagement (Luyten & Fonagy, 2015). Among individuals with diverse psychiatric disorders, a fragile self-concept tends to heighten abandonment anxiety and avoidance of intimacy, both of which obstruct treatment. The instability of self-concept is also closely linked to difficulties in emotion regulation, making self-reappraisal challenging and sustaining vulnerability to dropout. Despite the centrality of self-concept to a range of psychiatric presentations, mainstream therapeutic approaches such as cognitive behavioural therapy and dialectical behaviour therapy have focused primarily on symptom and behaviour change, with comparatively less attention paid to the repair of self-concept and internal identity (Landa et al., 2019).

Several theorists have addressed the structure and development of self-concept in ways that inform clinical practice. Lewin (1935) divided personality into an "inner personal region" and a "perceptual-motor region", holding that the former is relatively insulated from environmental influence and that

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self-concept changes and develops over time. Horney (1950) conceptualised the "true self" as the accumulation of a healthy conscience, representing an individual's authentic potential. Winnicott (1960a, 1960b) similarly distinguished between a true and false self, arguing that psychological health depends on access to the former. In clinical terms, the suppression of the true self in response to invalidating environments has been linked to the development of borderline pathology, chronic shame, and relational dysfunction (Masterson, 1988). More recently, Fosha (2000, 2005) proposed the "Core State", encompassing positive emotional experiences such as love, empathy, and joy, which she regards as conceptually consistent with the True Self described by Winnicott and Horney. Together, these perspectives converge on the view that therapeutic progress depends substantially on restoring access to a stable, authentic sense of self.

Self-Concept Therapy (SCT) draws on this theoretical lineage, integrating the work of Lewin, Winnicott, Horney, and Fosha with principles of Eastern philosophy to conceptualise the self as a three-layered structure comprising the True Self, personality and emotions, and behaviour (Fujisaki, 2025). SCT incorporates mindfulness, compassion, and transpersonal concepts to reduce rigid attachments to distorted self-images and promote the regeneration of a healthier self-concept. Treatment is delivered across three phases, progressing from the establishment of the True Self as a secure base, through experiential awareness of emotions, to the restructuring of thoughts and behaviours. This phased structure allows therapy to proceed at the client's pace, reducing the risk of emotional overwhelm and premature disengagement. Initial research has demonstrated a significant reduction in dropout among clients scoring high on personality disorder scales, a group typically considered at elevated risk of therapeutic regression (Fujisaki, 2025). However, the mechanisms through which SCT achieves these effects, and the extent to which its benefits generalise across diverse clinical presentations, remain insufficiently understood.

Despite these promising findings, SCT has not yet been examined across varied clinical presentations in sufficient depth to identify the client-side and therapist-side factors that determine its effectiveness. Case study methodology is well suited to this purpose, as it allows detailed examination of therapeutic processes across individuals with distinct symptom profiles (Fishman, 1999). This paper presents three cases involving clients with neurodevelopmental tendencies, narcissistic and borderline personality features, obsessive-compulsive traits, suspected abuse history, hypochondriasis, and attachment-related difficulties. The aim is to illustrate how SCT adapts to different presentations, to clarify factors contributing to its effectiveness, and to examine its role in supporting psychological stabilisation and preventing dropout.

METHOD

Design

This study employed a multiple case study design to examine the application of SCT across three clients with distinct clinical profiles. Case study methodology was selected for its capacity to capture the complexity of individual therapeutic processes and to identify context-specific factors that contribute to treatment outcomes (Fishman, 1999). SCT conceptualises the self as a three-layered structure comprising the True Self, personality and emotions, and behaviour, and aims to restore each layer to a healthier state progressively from the centre outward (Fujisaki, 2025). Treatment is delivered across three phases: establishing the true self as a secure base, developing experiential awareness of emotions, and addressing thoughts and behaviours. Therapy progresses at the client's pace and incorporates psychoeducation, imagery, body-oriented techniques, and where appropriate, transpersonal approaches.

Participants

Three clients were referred to the SCT programme due to concerns about personality disorders and elevated risk of dropout. All were middle-class and highly educated. Client details are summarised below.

Client A was an Asian woman in her 30s diagnosed with ADHD, ASD, BPD, and depression. She was in full-time remote employment and had a history of attachment difficulties linked to emotionally inconsistent parenting. She was prescribed Lexapro (10 mg/day), with no changes during the therapy course. Therapy comprised 54 sessions of 50 minutes, held once every one to two weeks.

Client B was a man in his 30s with no prior psychiatric history, referred following a child protection concern. He presented with anger dysregulation and difficulties controlling physical

outbursts towards his child. Therapy comprised 28 sessions of 50 minutes, held approximately weekly.

Client C was an Asian woman in her 30s diagnosed with depression and hypochondriasis. She reported persistent health-related anxiety that had intensified following the COVID-19 pandemic. She was prescribed an SSRI (10 mg/day), which was gradually reduced and discontinued by the end of treatment. Therapy comprised 21 sessions of 50 minutes, held fortnightly.

Therapist

The therapist was a licensed female clinical psychologist with more than 30 years of clinical experience, working in an Asian country. Her orientation is primarily humanistic.

Measures

Five standardised self-report measures were administered at pre- and post-treatment: (1) the State-Trait Anxiety Inventory (STAI; Spielberger et al., 1970) assessed state and trait anxiety across 40 items on a 4-point Likert scale; (2) the Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977) measured depressive symptom frequency and severity across 20 items, with a clinical cut-off of 16; (3) the Narcissistic Personality Inventory, Short Version (NPI-S; Oshio, 1998; Raskin & Hall, 1979;) assessed narcissistic traits including superiority and need for admiration (4) the Inventory of Obsessive Personality (IOP; Takebayashi, 2002) measured obsessive-compulsive personality traits across four subscales; and (5) the Experiences in Close Relationships, General Others (ECR-GO; Brennan et al., 1998; Nakao & Kato, 2004) assessed abandonment anxiety and intimacy avoidance in general interpersonal relationships on an 8-point Likert scale.

Ethical considerations

This study was conducted with the approval of the Counselling Centre Ethics Review Committee and in accordance with the Declaration of Helsinki and the APA Ethical Principles of Psychologists. Written informed consent was obtained from all participants prior to inclusion. Clients were informed of their right to withdraw at any time without penalty. Identifying information was altered where necessary to protect confidentiality, without affecting the integrity of the case descriptions.

RESULTS

All three clients completed their respective treatment courses without dropout, with each demonstrating measurable improvements in symptom severity and self-concept stability across the phases of SCT.

Client A

Initial phase (Sessions 1–21)

Client A presented as cheerful and talkative from the outset, though her presentation masked significant emotional dysregulation and relational instability. She described a childhood in which she had acted as confidant to a perfectionistic and emotionally demanding mother, while her father remained disengaged. She reflected that conflicts with others had consistently destabilised her emotionally, and that she had at times become involved with multiple men simultaneously.

When asked how well she maintained boundaries with others, she acknowledged a stark division: "I'm defensive with 99% of people, but with the remaining 1%, my partners, I become overly involved". Her emotional regulation was underdeveloped, and dependency on romantic partners frequently led to interpersonal conflict. SCT was introduced to support the development of a stable self-concept, appropriate boundary setting, and emotion regulation skills. Following psychoeducation on self-concept and Phase 1 imagery work, she responded with evident relief, stating that she felt "both surprised and relieved" to recognise that she also possessed a core self-filled with love and affirmation. Psychodynamic work centred on her deceased grandfather, the one figure she experienced as consistently supportive, and focused on internalising a felt sense of being loved.

Middle phase (Sessions 22–42)

Client A began working through unresolved conflicts with her parents. She described her mother's tendency to impose her own preferences, recalling a childhood incident in which she had asked for a specific item of clothing, only to be told it did not suit her. When invited to articulate what she would have wanted to say to her mother, she stated that she would have told her not to impose her wishes on her. Despite this progress, dependency in her romantic relationship persisted and conflicts escalated. Interventions drawing on SCT Phases 2 and 3 focused on emotion regulation

strategies, cognitive management, and the consolidation of a more stable sense of self.

Final phase (Sessions 43–54)

Client A ended her relationship with her partner and reflected on the change with clarity, noting that she could no longer understand what had drawn her to him and recognising that she had been dependent on him. Difficulties with a controlling supervisor at work were identified as echoing earlier relational patterns with her mother, and more adaptive coping strategies were explored. She ultimately changed jobs. SCT work in this phase also addressed her relationship with her father. Despite having always felt emotionally distant from him, she was able to recall moments of genuine connection, including times they had played video games together, and acknowledged that there had also been enjoyable aspects of their relationship.

By the end of therapy, her emotional state was largely stable. Session frequency was gradually reduced, and treatment was concluded following a six-month follow-up period.

Client B

Initial phase (Sessions 1–12)

Client B was under supervision from the child guidance centre due to suspected child abuse. He described his son as a difficult child and disclosed that he had slapped him on one occasion. When asked what he believed had triggered his anger, he attributed it primarily to carrying what he perceived as a disproportionate share of household and childcare responsibilities. Psychological assessment indicated slightly elevated narcissistic tendencies and low tolerance for ambiguity, suggesting that frustration arose when domestic routines did not proceed as expected. Initial interventions focused on reviewing household responsibilities and providing psychoeducation on self-concept. Role-playing exercises were used to practise open-ended communication with his child.

Middle phase (Sessions 13–16)

Phase 1 imagery work helped Client B identify his true self, and Phase 2 body and emotion awareness exercises were introduced. A turning point arose around his son's school refusal. Client B disclosed that his son had begun refusing to attend school, finding it less stimulating than his cram school, and acknowledged that he privately agreed with this view. The therapist encouraged him to consider the broader developmental purposes of school attendance, including socialisation, learning to navigate unfair situations, and establishing daily routines. Client B engaged with this reframing and subsequently discussed it with his son, after which the school refusal gradually decreased. Daily SCT homework records supported him in recognising and regulating his negative emotions more effectively.

Final phase (Sessions 17–23)

Client B intensified work on emotion observation, cognitive restructuring, and reflection on core beliefs about himself and his family. He identified a strong belief that he must be perfect and that expressing emotions was shameful and reported holding similarly rigid expectations of his son. Exploration of the origins of these beliefs revealed a childhood marked by loneliness. He recalled that because his younger brother had been frequently ill, his parents had spent considerable time at hospital, leaving him feeling isolated. He reflected that from an early age he had overexerted himself in order to gain parental attention and approval.

By the end of treatment, Client B demonstrated greater awareness of his emotional triggers, reduced rigidity in his expectations of his son, and improved capacity for reflective communication. No further incidents of physical outbursts were reported during the treatment period, and supervision from the child guidance centre continued alongside therapy.

Client C

Initial phase (Sessions 1–4)

Client C presented with long-standing health anxiety, describing a pattern of spending hours online researching potential illnesses in response to minor physical sensations. She also reported over-involvement in her children's hygiene and persistent self-criticism following moments of anger towards them. She described herself as having been highly sensitive to bodily changes since childhood and recalled her mother as strict, frequently angry, and at times physically punitive. She reflected that fear of criticism had shaped much of her early development.

When asked how her mother's influence affected her currently, she identified a painful pattern of replicating the critical style she had experienced, despite her conscious wish to parent differently. Early sessions focused on recognising existing adaptive strategies, and the therapist introduced a playful approach to daily tasks as a way of reducing

anxiety. SCT was introduced, and psychological assessment confirmed high obsessive-compulsive tendencies, abandonment anxiety, and intimacy avoidance as the primary clinical challenges.

Middle phase (Sessions 5–10)

Phase 1 imagery work focused on Client C's true self, and Phase 2 homework involved daily emotion monitoring. Exploration of early relational experiences with her mother clarified the origins of her health anxiety. She came to recognise that her excessive worry about illness had developed as a response to her mother's critical environment, in which feeling unwell had felt like a personal failing. Guided by the therapist, she developed a set of self-affirming responses to draw on when health-related anxiety arose, including reframing physical symptoms as normal bodily signals rather than signs of failure. Following these interventions, she became able to observe her symptoms from a more distanced perspective and her frequency of online health searching reduced.

Final phase (Sessions 11–21)

Phase 3 work focused on reconstructing anxiety-related cognitions and addressing trauma-linked thinking patterns. Client C developed a written collection of self-affirming statements, which she placed in a jar for her family to draw from daily. This approach engaged her children positively and supported her own sense of calm.

A later recurrence of physical discomfort prompted renewed fear of death, which was explored directly in session. She disclosed uncertainty about what follows death and expressed particular distress when considering this in relation to her children. Encouraged to explore how others approach mortality, she returned to subsequent sessions with reflections that allowed her to tolerate existential uncertainty more readily. As her fear of death diminished, her health-related preoccupations also reduced. Trauma-related cognitions subsided and her emotional state stabilised. Her prescribing physician judged pharmacotherapy no longer necessary, and post-treatment psychological assessment confirmed clinical improvement. Therapy was concluded with a follow-up plan in place should symptoms recur.

Pre- and post-intervention assessment scores

Table 1 presents pre- and post-intervention scores for all three clients alongside total session numbers. For the STAI and CES-D, scores exceeding the clinical cut-off are marked with †. NPI-S, IOP, and ECR-GO scores are expressed as Z-scores, with values significantly above the mean marked ▲ and those significantly below the mean marked ▼ (▲/▼ indicate $p < .05$; △ indicates $p < .10$). For the ECR-GO, paired t-tests were conducted on pre- and post-intervention scores, with statistically significant differences marked * ($p < .05$).

Table 1

Clients' Psychological Test Scores and Total Session Time

Client	STAI (Pre/Post)	CES-D (Pre/Post)	NPI-S (Pre/Post)	IOP (Pre/Post)	ECR-GO (Pre/Post)	Total Session Time
Client A	State: 32/30 Trait: 31/28	28†/15	Sense of superiority: 28/28 Need for attention and admiration: 15/14 Assertiveness: 35/31 Total: 78/73	Obsessive thoughts: 23/22 Certainty-seeking: 18/17 Contamination fear: 8/5 Ambiguity reduction: 13/9	Abandonment anxiety: 3.5/3.3 Intimacy avoidance: 4.1/3.8	54
Client B	State: 32/30 Trait: 30/28	3/2	Sense of superiority: 38△/40▲ Need for attention and admiration: 23/24 Assertiveness: 36△/38▲ Total: 97/102	Obsessive thoughts: 25/22 Certainty-seeking: 20/20 Contamination fear: 7/3▼ Ambiguity reduction: 12/9	Abandonment anxiety: 3.0/2.8 Intimacy avoidance: 5.3△/3.8*	28
Client C	State: 30/25 Trait: 55†/33	24†/4	Sense of superiority: 25 Need for attention and admiration: 34 Assertiveness: 22 Total: 81	Obsessive thoughts: 33/23 Certainty-seeking: 28▲/12 Contamination fear: 12/7 Ambiguity reduction: 11/9	Abandonment anxiety: 4.3/3.0 *Intimacy avoidance: 5/3.8*	21

Note 1: STAI = The State-Trait Anxiety Inventory; CES-D = Center for Epidemiologic Studies Depression Scale; NPI-S = Narcissistic Personality Inventory; IOP = Inventory of Obsessive Personality; ECR-GO = Experiences in Close Relationships-General Others

Note 2: Above cutoff; ▲Significantly above the mean ($p < .05$); ▼Significantly below the mean ($p < .05$); △Marginally above the mean ($p < .10$); *Significant difference between pre- and post-intervention ($p < .05$, paired t-test)

Across all three clients, post-intervention scores showed meaningful reductions in anxiety, depression, and attachment-related distress. Client A showed marked improvement in both abandonment anxiety and trait anxiety. Client B demonstrated reductions in narcissistic tendencies and obsessive personality traits alongside improved ambiguity tolerance. Client C showed the most pronounced changes, with clinically significant reductions in health anxiety, obsessive tendencies, and abandonment anxiety, consistent with the discontinuation of pharmacotherapy by the end of treatment.

DISCUSSION

The three cases collectively illustrate how disrupted early attachment relationships can impede the development of a stable self-concept, contributing to the range of clinical presentations observed. In each case, parent-child relational difficulties were prominent, and improvements in self-concept were associated with reductions in symptom severity across diverse diagnostic profiles.

These findings are consistent with established research linking insecure attachment to self-concept vulnerability. Attachment anxiety correlates with low self-worth and excessive dependency, whereas attachment avoidance is associated with inflated self-perception and intimacy avoidance (Mikulincer & Shaver, 2007). Bartholomew and Horowitz's (1991) two-dimensional model of self and other representations demonstrates how attachment style structures the internal working models through which individuals evaluate themselves and others. Clinically, both anxiety and avoidance dimensions have been shown to contribute to conditional self-worth, depression, anxiety disorders, and personality pathology (Collins & Read, 1990; Mikulincer & Shaver, 2019).

In Client A, attachment anxiety manifested as abandonment fears and relational dependency, consistent with the borderline presentation. Her invalidating maternal relationship had led to repeated suppression of her authentic self in favour of an externally compliant role, in line with Winnicott's (1960a, 1960b) concept of the false self. SCT provided a framework for reconnecting with her true self, which gradually reduced her reliance on external validation through romantic relationships.

In Client B, obsessive tendencies and narcissistic traits reflected a self-concept organised around performance and external approval, rooted in childhood experiences of perceived neglect. Obsessive symptoms have been conceptualised as strategies to avoid an undesired self-image through rigid self-evaluation and compulsive control (Mancini & Gangemi, 2015), while narcissistic pathology reflects a grandiose self-image maintained over a fundamentally vulnerable self-concept (Kernberg, 1975; Kohut, 1977). Both patterns share dependence on contingent self-worth, in which self-esteem is sustained only through success or praise and collapses under failure or criticism (Crocker & Wolfe, 2001; Pincus & Roche, 2011). SCT targeted this underlying vulnerability, though challenges in this case are discussed further below.

In Client C, hypochondriacal symptoms were understood as a compensatory response to feelings of helplessness instilled through critical maternal parenting, consistent with Fujisawa and Shiranami's (2002) suggestion that obsessive symptoms may function to restore a sense of safety in the face of perceived personal inadequacy. The therapeutic reframing of physical symptoms as normal bodily signals, combined with externalisation techniques that created psychological distance from self-critical patterns (Keeling & Bermudez, 2006), supported a more stable and self-affirming self-concept. The therapist's proposal that C approach parenting as an opportunity to nurture her own childhood self also proved clinically productive. Research suggests that for individuals with complex childhood trauma, the parenting role can serve as a site of identity reconstruction and healing (Chamberlain et al., 2021), and that cultivating equanimity in parenting can enhance parental efficacy while contributing to the interruption of intergenerational trauma cycles (Eads et al., 2025).

Dropout prevention was a central aim of SCT in all three cases, and none of the clients discontinued treatment prematurely. This is clinically notable given that dropout rates in BPD treatment range from 15% to 77% (De Panfilis et al., 2012), with an average of 22.3% across psychotherapy modalities and 28.2% in outpatient randomised controlled trials (Barnicot et al., 2021). Predictors of dropout in this population include younger age, high hostility, and a history of suicide attempts (Barnicot et al., 2011; Goodman et al., 2013), and the quality of the therapeutic alliance is consistently identified as a critical factor (O'Keeffe et al., 2022; Steuwe et al., 2023).

In Client A's case, the early establishment of a secure therapeutic base through Phase 1 psychoeducation and imagery work appeared to support sustained engagement. Data from a broader SCT cohort suggest that 93% of clients reported increased relief and reassurance following Phase 1 psychoeducation on the three-layer model of self-concept, indicating that this component may have particular utility in enhancing early treatment motivation (Fujisaki, 2025).

In Client B's case, retention was supported by a deliberately non-directive therapeutic stance. Given his elevated intimacy avoidance and narcissistic tendencies, an approach that minimised directives and prioritised inquisitive, supportive engagement was adopted to avoid triggering defensive withdrawal. Campbell et al. (2009) have noted that narcissistic traits can increase dropout risk, and the therapist's careful management of the alliance appeared to mitigate this risk. External compliance pressure from the child guidance centre may also have contributed to retention, though this raises questions about the degree to which engagement reflected genuine therapeutic motivation.

In Client C's case, the relatively low dropout rates associated with hypochondriasis treatment generally (Hedman-Lagerlöf et al., 2023) were consistent with her sustained engagement. The progressive reduction and eventual discontinuation of pharmacotherapy across the treatment course further indicated meaningful clinical improvement beyond symptom management alone.

While all three cases demonstrated clinical improvement, the findings also highlight important limitations and challenges in the application of SCT. The most notable complication arose in Client

B, where narcissistic traits, specifically sense of superiority and assertiveness, increased over the course of treatment despite overall reductions in attachment avoidance and obsessive tendencies. This finding warrants careful consideration.

Several explanations are plausible. The Phase 1 SCT emphasis on affirming one's essential self may have been overgeneralised by Client B to justify his attitudes towards his son rather than fostering genuine self-acceptance. Alternatively, the increase may reflect a short-term fluctuation consistent with the dynamic nature of narcissistic functioning, which research has shown can shift between grandiosity and vulnerability across therapeutic and developmental contexts (Henttonen et al., 2022; Orth et al., 2010). Longitudinal evidence suggests that narcissistic traits as measured by the NPI can change across the lifespan, and short-term exacerbation during intervention is not uncommon (Edelstein et al., 2010). In this case, extended treatment until a reduction in narcissism could be achieved would have been preferable, and closer monitoring of narcissistic functioning throughout therapy is recommended for similar presentations.

More broadly, SCT has no specific contraindications and has demonstrated utility across a wide range of presentations including depression, anxiety, trauma, attachment difficulties, personality disorders, and neurodevelopmental conditions (Fujisaki, 2025). However, its effectiveness cannot be assumed to be uniform. Cases involving pronounced defence mechanisms, significant treatment resistance, complex comorbidity, or substantial environmental stressors may present greater challenges. The therapist's capacity to select appropriate interventions across SCT's diverse toolkit also requires sufficient training, and proficiency in each technique demands time and practice. That said, since SCT techniques can be acquired progressively, competence in Phase 1 alone enables meaningful clinical application across a broad range of clients.

CONCLUSION

This study examined the application of SCT across three clients presenting with distinct but overlapping clinical profiles: a woman with borderline personality disorder, neurodevelopmental conditions, and attachment difficulties; a man suspected of child abuse with narcissistic traits and anger dysregulation; and a woman with hypochondriasis and obsessive tendencies. In each case, SCT was adapted to the individual's presentation, and all three clients completed treatment without dropout, with post-intervention assessments confirming measurable improvements in anxiety, depression, and attachment-related distress.

The findings suggest that SCT's focus on reconstructing a healthy self-concept offers a clinically useful framework across a range of diagnostic presentations, including those not traditionally associated with self-concept-oriented approaches. The early introduction of Phase 1 psychoeducation on the three-layer model of self-concept appeared to provide a stable therapeutic foundation, supporting self-acceptance, treatment motivation, and dropout prevention. These findings are particularly relevant given the high dropout rates documented in the treatment of borderline personality disorder and related conditions.

At the same time, the case of Client B highlights that SCT does not produce uniform outcomes across all dimensions of functioning. The observed increase in narcissistic traits during treatment underscores the need for careful monitoring and tailored intervention in clients with prominent narcissistic features and suggests that longer treatment courses may be warranted in such cases. Several methodological limitations should be acknowledged. The case study design, while well suited to exploring therapeutic processes in depth, does not permit causal inference or generalisation beyond the cases presented. All three clients demonstrated relatively high intellectual and introspective capacity, which may limit applicability to populations with lower cognitive or reflective functioning. The absence of a comparison condition means that observed improvements cannot be attributed solely to SCT, and reliance on self-report measures introduces the possibility of response bias. The single-therapist design raises the possibility of therapist-specific effects, and the culturally specific clinical context warrants caution in extrapolating findings to other settings.

Future research should examine SCT across a broader range of ages, cognitive abilities, cultural backgrounds, and diagnostic profiles. Quantitative comparative studies with other psychotherapeutic approaches would help clarify the specific contribution of SCT to observed outcomes, and

longer follow-up periods would strengthen conclusions about the durability of treatment gains.

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