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Brief CBT for Work-Related Anxiety and Self-Doubt in a Young Medical Social Worker: A Case Report

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Abstract:

- ***Background:***

Healthcare and social-service workers are often exposed to institutional adversity, such as power imbalances, perceived corruption, and personal financial strain, that can erode their sense of professional efficacy. This case report describes a brief, cognitive-behavioral intervention for work-related anxiety and self-doubt in a young medical social worker in a Philippine tertiary hospital.

- ***Case Presentation:***

AJM, a 24-year-old woman, was referred through the hospital's employee wellness clinic after her supervisor noticed excessive worry, self-doubt, reluctance to ask for help, and higher stress than peers carrying a comparable workload. Her difficulties had followed a ten-month stint in government social work, during which she experienced entrenched power imbalances and daily exposure to corruption, and was expected to shoulder work-related costs from her own salary. A confrontation with a demanding patient reactivated these memories and temporarily impaired her work functioning.

- ***Intervention and Outcome:***

She received three sessions of supportive, cognitively oriented therapy over roughly two weeks, centered on cognitive reframing, resilience-building, behavioral experiments in help-seeking, and structured homework (journaling, self-reminders, and questioning of doubts). By the second session she reported improved emotional regulation and had begun to seek support from her supervisor; at an informal check-in about six weeks after the first consult, she reported continued gains in how she approached her work. No standardized measures were administered; outcomes rest on self-report and clinical observation.

- ***Conclusion:***

The case suggests that a brief, formulation-driven cognitive-behavioral approach, delivered within an employee wellness service, may help workers whose self-doubt is rooted in earlier institutional adversity. As a single uncontrolled case, it is hypothesis-generating rather than confirmatory.

Keywords: *Cognitive-Behavioral Therapy; Workplace Adversity; Self-Efficacy; Medical Social Work; Employee Wellness; Philippines; Case Report.*

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I. INTRODUCTION

Workers in the helping professions carry a particular kind of occupational load. Beyond long hours and heavy caseloads, they are routinely asked to act on behalf of vulnerable people inside systems that may be under-resourced, hierarchical, or ethically compromised. When such workers witness or are pressed into practices that conflict with their values, the resulting distress can go beyond ordinary stress and burnout (Chaves-Montero et al., 2025). A recent review of social workers found that heavy workload and workplace victimization predicted emotional exhaustion, whereas resilience and social support were protective (Chaves-Montero et al., 2025). The related construct of moral injury, distress that follows perpetrating, failing to prevent, or witnessing acts that violate one's moral beliefs, has likewise been linked to poorer wellbeing and mental health among healthcare workers (Thibodeau et al., 2023), and perceived

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organizational neglect has been among the circumstances most consistently reported across regions during COVID-19 (Xue et al., 2022).

In the Philippines, medical social workers occupy a demanding position in this regard. They are frontline mediators between hospital resources and patients who frequently have limited means, and they may be confronted by anger, entitlement, or appeals to influence when those resources run out. For early-career workers who have previously served in strained public institutions, these encounters can reactivate earlier experiences and the beliefs formed around them, such as "I am ineffective," or "leaving was a sign of weakness."

Local data point in the same direction. In a study of 364 healthcare workers at a tertiary government hospital in Metro Manila conducted during the COVID-19 pandemic, higher job demands were associated with depression, anxiety, and stress (Hilvano-Cabungcal & Bonito, 2025).

Cognitive-behavioral therapy (CBT) offers a practical framework for such difficulties because it links situations, appraisals, emotions, and behaviors, and because it can be delivered in a short, skills-focused format suited to workplace clinics (Beck, 2021). Evidence for CBT-based stress management among healthcare workers remains of low certainty, with benefits over no intervention emerging after the first month (Ruotsalainen et al., 2021). Published accounts of how brief CBT is used with employees in Philippine hospital settings remain limited. This report therefore describes a single case managed in a hospital employee wellness clinic, with the aim of illustrating how a brief, formulation-driven approach was applied and what the course of treatment looked like. It follows the CARE guidelines for case reports (Riley et al., 2017).

II. CASE PRESENTATION

➢ *Patient Information*

AJM is a 24-year-old heterosexual woman and a licensed social worker employed as a medical social worker in a private tertiary hospital in Metro Manila. Identifying details have been altered or generalized to protect confidentiality.

➢ *Presenting Concerns*

AJM's supervisor referred her after observing a pattern of excessive worry and self-doubt related to work. Although she was considered competent, she tended to keep her work to herself, was reluctant to ask for help, and reported more stress than her colleagues, despite having a similar workload. She sought consultation on her own accord after a patient shouted at her while demanding free accommodation and claiming to know people in government. This incident brought back her earlier experiences in public service, and she experienced marked anxiety symptoms and was temporarily unable to perform her duties.

➢ *Relevant History*

After earning her degree in social work, AJM worked as a general social worker in a faith-based organization that rescues sexually abused children and provides foster care. She was stable and well regarded there, and was offered a supervisory role within the year. She declined it, citing her lack of a license; she later sat for and passed the licensure examination. Rather than remain, she chose to enter government service, and was successful.

She spent ten months in that role and described it as the most difficult period of her career. She reported institutionalized power imbalances, daily exposure to corruption, and being expected to shoulder part of the costs of running her office and caring for the children under her supervision from her own monthly salary. It was during this time, by her account, that her belief in her own efficacy began to fall away. Seeking an exit, she found a position at her current hospital, but she interpreted the move as a form of weakness, as though she had given up. These beliefs about her performance and efficacy accompanied her to the new workplace and became noticeable during her initial work validation.

Table 1 Timeline of Consultation and Treatment Contacts

Date	Event
March 30, 2026	Initial consultation; intake and formulation; first session
April 6, 2026	Session 2
April 14, 2026	Session 3
May 14, 2026	Informal check-in at her workstation
After session 3	Further sessions as needed

III. ASSESSMENT AND CASE FORMULATION

➢ *Clinical Impression*

At intake, AJM presented with a moderate level of anxiety and mild depressive tendencies, assessed through clinical interview. No standardized measures were administered, so severity ratings reflect clinical judgment alone. Her presentation was understood as a work-related anxiety picture marked by excessive worry (GAD-like symptoms) with secondary low mood, rather than a primary mood disorder. No formal diagnosis was assigned, and the symptoms are described as GAD-like rather than as a confirmed disorder.

➢ *Cognitive-Behavioral Formulation*

The following formulation was drawn from the intake and session material.

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- Predisposing factors: a prior history in government service, where she experienced bullying and institutional pressure that she was nonetheless able to overcome, together with early-career responsibility in emotionally heavy settings (child protection and foster care).
- Precipitating factors: ten months in public service marked by power imbalances, observed corruption, and personal financial outlay for work needs; later, a hostile encounter with a patient invoking political connections.
- Core and intermediate beliefs: "I am not effective at my work," and "leaving government means I am weak or gave up." These beliefs predicted that asking for help would expose inadequacy.
- Maintaining factors: keeping work to herself and not requesting help (a safety behavior that prevented disconfirming evidence); a freeze response under added stress; and self-critical interpretation of her own career choices.
- Protective factors: demonstrated resilience in overcoming earlier workplace bullying, good performance as observed by her supervisor, a stable earlier work record, successful licensure, an ability to reflect on her experience, and willingness to seek help.

Together, these elements describe a cycle in which a trigger resembling past workplace abuse activated beliefs about inefficacy, led to anxiety and freezing, and was followed by withdrawal from support, which in turn kept the beliefs in place.

IV. INTERVENTION AND COURSE OF TREATMENT

Treatment was delivered by the author, a clinical psychologist working in the hospital's employee wellness clinic, in three sessions over about two weeks. The approach combined cognitive reframing, supportive techniques, resilience-building, and between-session practice. Table 2 summarizes the sessions.

Table 2 Summary of Sessions, Focus, and Homework

Session	Date	Focus	Homework or action
1	March 30, 2026	Intake and assessment; cognitive reframing and supportive techniques	Encouraged to ask her supervisor for help
2	April 6, 2026	Past experiences of workplace abuse; the freeze response under added stress	Daily journal
3	April 14, 2026	Self-doubt about work abilities; cognitive reframing and resilience	(1) Daily reminder that she had thrived in government and could therefore manage elsewhere; (2) when doubts arise, sit with them and question them; (3) find humor in her earlier experience

The first session combined cognitive reframing with supportive work, and its most concrete behavioral step was to open up to her supervisor about the support she needed. This worked as a behavioral experiment against the belief that asking for help is a sign of inadequacy. The second session returned to her earlier experiences of workplace abuse and her freeze response, and introduced daily journaling to help her notice and record thoughts and reactions. The third session targeted self-doubt directly. The reminder that surviving government service was itself evidence of capability was intended to counter her belief that leaving signified weakness, while the instruction to sit with and question doubts followed the CBT principle of treating thoughts as hypotheses to be tested. Finding humor in her earlier experience was used to help her regain some psychological distance from it. After the third session, contact was kept on an as-needed basis.

➢ *Outcomes and Follow-up*

By the second session, AJM reported that she was handling her emotions better and approaching her work differently. She had gradually opened up to her supervisor and had received the support she needed in her tasks. This was an early and meaningful change, since reluctance to seek help had been one of the most visible features of her presentation.

On May 14, 2026, about six weeks after the first consultation, the author met her informally at her station in the service clinic. She reported doing well and expressed appreciation for how the sessions had helped her change her mindset toward work. No standardized re-assessment was conducted, and there was no formal follow-up beyond the contacts described above.

No adverse events occurred during or after treatment, and by the author's account she is now doing well. The outcomes described here rest on the client's self-report and the clinician's observation, and are discussed as such below.

V. DISCUSSIONS

This case illustrates how long-standing beliefs about one's efficacy can be shaped by institutional adversity rather than by any real deficit in performance. AJM was seen by her supervisor as competent, yet she interpreted her move out of government service as weakness and treated every new demand as a test she might fail. Seen through a CBT lens, her reluctance to ask for help functioned as a safety behavior: it protected her from imagined exposure, but also kept her from learning that support was available and acceptable.

Two features of the treatment appear worth noting. First, the earliest behavioral step, approaching her supervisor,

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doubled as a behavioral experiment and was followed by reported improvement by the next session, which suggests that targeting help-seeking early may be a high-yield focus in similar presentations. This fits reviews of social workers, in which social support and resilience emerge as protective against emotional exhaustion (Chaves-Montero et al., 2025). Second, the homework reframed her past as evidence of strength ("if you thrived in government, you can survive anywhere") rather than as a source of shame. This is consistent with CBT's emphasis on testing appraisals against evidence, and it may also be relevant to moral-injury-type distress in healthcare workers, for which evidence-based interventions are still lacking (Thibodeau et al., 2023).

The case also points to the potential value of hospital employee wellness clinics as an accessible, low-threshold point of care for staff in demanding roles, particularly where a supervisor is attentive enough to notice and refer.

➢ *Limitations*

This report has several important limitations. It describes a single case without a comparison condition, so improvement cannot be attributed to the intervention rather than to time, workplace changes, or supervisor support. Treatment was brief, and follow-up was informal and short. Symptom severity was judged clinically and not with validated instruments, so change cannot be quantified. The treating clinician is also the author, which introduces potential bias, and because she was seen in her own workplace's clinic, she may have been cautious about what she chose to report. Finally, findings from one Filipino medical social worker cannot be generalized to other professions or settings.

VI. CONCLUSION

In this case, a brief CBT-informed approach, centered on cognitive reframing, behavioral experiments in help-seeking, and structured homework, was associated with reported improvement in a young medical social worker whose work-related anxiety and self-doubt were rooted in earlier institutional adversity. Controlled studies and case series using standardized measures are needed to test whether this approach is effective and to refine it for Filipino healthcare workers.

➢ *Patient Perspective*

The patient's own account was not formally recorded for this report. At an informal check-in, she expressed appreciation for how the sessions had helped her change her mindset toward work.

➢ *Informed Consent and Ethics Statement*

The patient gave verbal informed consent for the publication of this report, and identifying details were altered or generalized. An exemption from formal ethics review was granted for this single de-identified case report. The report was prepared in line with the Data Privacy Act of 2012 (Republic Act No. 10173) and the CARE guidelines. The author's only relationship with the patient was that of her treating clinician; there was no supervisory, personal, or other relationship between them.

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