The ABC Model Revisited
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This chapter considers and elaborates a personal construct model, first described by Tschudi (1977), that allows exploration of a problem faced by an individual by considering the disadvantages and advantages of the problem and of the person's desired alternative to the problem. The personal construct psychology view of choice, including choice of symptoms, will first be described. Other personal construct methods of exploring dilemmas and conflicts will then be considered, before describing the ABC model. The clinical applications of this model will be outlined, and illustrated by a case example. Recent elaborations of the model in the exploration of decisions and in considering problems at a systemic level will also be discussed.

Choice

It is a central tenet of personal construct psychology (Kelly, 1955/1991) that people's actions are based, at some level, on the choices that they make. This centrality of choice to Kelly's theory derives from the bipolarity of personal constructs, in that each of our constructs presents us with the alternatives of construing an element of our life (for example, an event, another person, or oneself) in terms of one or the other of the construct's poles, or perhaps neither. The choice which the individual makes is, in Kelly's view, an elaborative one, in that the alternative chosen is the one that offers the best prospect for anticipating events.

While this may provide a vision of the individual smoothly negotiating his or her way through life, by simply choosing at each crossroad the turning leading towards greater anticipation, the reality is that choices are rarely this
Advantages and Disadvantages of the Symptom

Although it might appear self-evident that one “choice” that is straightforward is whether to retain or relinquish a particular symptom, the persistence of our clients’ symptoms, or of their seemingly self-destructive behavior, provides a clear indication that this is not the case. This issue has been addressed by writers from a range of theoretical perspectives. For example, Freud (1959) proposed that symptoms may provide clients with “secondary gains,” Greenwald (1973) illustrated the “payoffs” of symptoms, some systemic therapists indicated the “function of the symptom” in protecting the system from some other problem, and Mowrer (1950) described the “neurotic paradox” of behavior which is “at one and the same time self-perpetuating and self-defeating.”

Kelly (1969, pp. 84–85) dismissed the notion of the neurotic paradox, taking the view that “Within the client’s own limited construction system he may be faced with a dilemma but not with a paradox.” For example, as Fransella (1970) demonstrated, for all its unpleasantness, the symptom may still essentially be the client’s “way of life” in that it appears to present his or her best current option for providing meaning and anticipating events.

ABC Model

Tschudi (1977) first described this model in the chapter “Loaded and honest questions,” where A, B, and C denote three interrelated constructs. A – conveniently referred to as the problem construct – is the starting point,
and both poles – positions – on this construct are easily accessible. We might say that they are on a manifest level, where one position, a1, is problematic, and the other, a2, represents a desired position, DP. In clinical applications the problematic position, PP, has generally been referred to as the symptom but the more general term PP may be more convenient for applications in other fields. It is usually straightforward to elicit PP, for instance asking “what, specifically, is bothering you?” For clinical applications the approach is especially relevant for problems of long standing where there is a history of unsuccessful attempts at solution. Some obvious examples of an A construct are a1 depression, can’t have orgasm, feelings of social incompetence, and drug dependence, where a2 would be not depressed, have orgasm, social competence, and drug free. The poles should, of course, be expressed in the client’s own language and sometimes it may be necessary to help the client to specify the problem further by asking for more subordinate constructs.

The B construct represents elaboration of A, where b1 represents negative consequences of a1, and b2 positive consequences of a2. Eliciting B usually fairly straightforward, and indeed it is sometimes so obvious that it can be ignored.

Quite often there is an underlying C construct which defines the dilemma and prevents movement from a1 to a2. The undesired a1 may also have desirable consequences, c2, and conversely a2 has undesired consequences, c1. In Hinkle’s terms, this structure is an implicational dilemma, and being made aware of C may point to more therapeutic steps to bring the person out of the dilemma. Such an approach is not only useful in therapeutic settings but also more generally.

The ABC model is summarized in Figure 4.1. Using Ecker and Hulley’s (1996, p. 16) terminology, the C construct represents “the pro-symptom position.” This is said to be a “compelling personal meaning,” containing “the truest emotional significance of the symptom,” which sometimes may be “vital necessary, so it may not simply stop or be disallowed.” In Kellian terms, C may thus exemplify a core construct. Unlike Ecker and Hulley, we prefer not to think of c2 as “unconscious” but rather regard it as generally latent (Tschudi, 2009), and invoke the Kellian concept “level of cognitive awareness.” In some cases c2 may be at a high level of awareness. People who want to stop smoking are generally painfully aware of the advantages of smoking, and similarly for many other cases of drug dependence. More commonly, however, c2 is at a low level of awareness, and a challenge for the therapist is to ask what Dawes (1985, p. 190) describes as “the seemingly absurd question ‘what are the advantages of remaining as you are, and then the disadvantages of changing?’” When advantages are not at all obvious, as for instance with severe depression, considerable therapeutic tact and skill are necessary to get at possible underlying advantages. Being depressed may, for instance, be a person’s only way of getting attention, or in other cases it may be felt as necessary to preserve social sensitivity by being “sadder but wiser.”

If the therapist feels that going straight at “advantages of PP,” and/or “disadvantages of DP” does not represent a viable challenge for the client there are several alternative ways of getting at the C construct. An obvious approach is to “soften” the question, for example:

This may sound a strange question but I wonder if there may be any disadvantages of DP in addition to the advantages, and indeed if there may be any advantages of PP as well as the obvious disadvantages.

The therapist may simply ask:

What prevents you from getting to a2?

As a less direct approach, “but” is an elegant way of getting at c1, for example:

You tell me you want DP, might there still be a “but” lurking here?

An “as if” frame (as in Kelly’s 1995/1991 “invitational mood”) might also be useful:

Suppose you were at DP. How would the world then look like? What else would then be different? Are there any disadvantages here?

If this approach is taken, the therapist might use hypnotic techniques to help the client as fully as possible enter the DP world.
Personal Construct Methodology

It may also be possible to “help” the client with suggestions, provided that it is clear that the client is perfectly free to reject them. For example, if the client does not appear to comprehend that there may be any advantages of depression, the therapist might say:

For example, when you are depressed could it be that there are fewer demands on you?

Any such suggestion should represent an educated guess, for example from the client’s nonverbal behavior, and not primarily be guided by the therapist’s preconceived theory.

There are cases where there do not seem to be any advantages of the problem, what Tschudi (1977) referred to as “behavioral deficiencies.” As discussed by Tschudi and Sandsberg (1984), these might be cases for a more symptom-focused approach such as traditional cognitive-behavioral therapy. Essentially, the therapist would concentrate on getting to DP, using anything relevant in the book. If it fails the attempted therapy (which may well be carried out by a therapist from another school than the Kellian therapist) may be seen as part of a diagnostic venture, providing a vantage point for what prevented movement to DP. Finally there may be cases where any possible disadvantage of DP may be a chimera, as in our final example from Sierra Leone.

Frances (2004) has noted that sometimes there may be an unfortunate tendency to “force” constructs into a mould with a positive and a negative pole. Both poles may in general have both positive and negative implications, and she uses “open – closed” as a personal example (see Figure 4.2). When there is no general preference for either pole the two diagonals correspond to B and C constructs, and both have by definition a positive and negative pole. There is, however, no basis for distinguishing between B and C as in the ABC model. Since the ABC model starts with the premise that the person is at a non-preferred pole it has a different focus, and it is thus not clear if Frances’ (2004) approach should be seen as “elaborating Tschudi’s model a little” (p. 106). We do, however, find it important to draw attention to Frances’ approach since in some cases this may invite a general question such as “when there are both advantages and disadvantage to both positions, are you sure you really want to change?” This may help the client to contextualize applicability of the poles, and this may be especially useful for generally stated constructs, such as “sociable”/“not sociable.”

The ABC Model Revisited

Preferred aspects

- Honest, inclusive
- Private, happy with self

OPEN

- Indiscreet, gullible
- Isolating, exclusive

CLOSED

Least preferred aspects

Figure 4.2 An example of both poles of a construct having positive and negative implications. Source: adapted from M. Frances (2004) The preference axis – ambiguity and complexity in personal construing. Personal Construct Theory and Practice, 1, 104–107, Figure 1, © 2004. Reproduced by permission of Prof. Dr Joern Scheer.

In the clinical setting, having used the ABC model to identify the positive and negative implications of the client’s problem position, various therapeutic options may be identified. These may include the following:

1. Controlled elaboration of the dilemma: Use of the ABC model allows the therapist to reframe the client’s problem in terms of a dilemma, which may be further elaborated by various means, including ladder, grid method, or the use of “empty chair technique” in which the chairs represent the contrasting poles of the dilemma (Feixas and Säul, 2005).
2. Find a way to combine a2 and c2: The client may, for example, be asked to role play, or write a characterization of, someone who can combine these characteristics, or to think of someone he or she knows who is able to do so. As described by Feixas and Säul (2005), this might include the therapist designing, and asking the client to play, a fixed role of the resolved dilemma. Such approaches may facilitate the elaboration of ways in which the client may integrate options which previously may have been seen as incompatible.
3. Take a step from anywhere in the network that seems likely to lead to change: This may be a small step towards a2, during which the therapist helps the client to maintain their position at c2 (e.g., encouraging an
agoraphobic client to make longer and longer journeys from the house, while not, as feared, losing her capacity to care for her husband. Alternatively, it may be a step towards c2, as in a case described by Tschudi (1977) of a client for whom depression (a1) allowed her to avoid sexual intercourse (c2) with her husband, where she could have been encouraged by the therapist either directly to say “no” to intercourse when she did not want this or deliberately to play being depressed at such times.

4. Reframe constructs involved in the dilemma: This may be illustrated by a case described by Greenwald (1973) in which a professor who used “indecent exposure” (a1) as a way of expressing contempt for the establishment (c2) was encouraged to view his behavior as doing no more than validating establishment views of radicals as being perverts. Such an approach may lead to what Ecker and Hulley (1996) term an “experiential shift.”

5. Acceptance of the “problem”: While the therapeutic focus is generally likely to be on reconstruction of c2, the positive implications of the problem, in some cases therapy may lead to a “reverse resolution” (Ecker and Hulley, 1996) in which the client effectively decides that a1 is no longer a problem. For example, the client may come to appreciate that other people regard a1 as a problem but that he or she does not.

Whatever the specific therapeutic approach adopted, the aim will essentially be to help the client to replace “loaded” by “honest” questions. We shall now consider a case which illustrates how the ABC model may be used to guide the therapeutic procedures adopted with a client.

Case Example

Over the years, Tom had been through the therapeutic mill, having been in both individual and group analytic psychotherapy and, most recently, a social skills group. This group had been included in a study of social skills training, which indicated that the low level of improvement of the clients was quite comprehensible in that their repertory grids showed that for 80% of them, social competence carried some negative implications (Winter, 1988b). Their constructions suggested that they construed the “social skills” in which they were being trained as associated with selfishness, contempt, and deceit. Tom was the client who had shown the most negative

outcome in the social skills groups, during which he displayed considerable deterioration on symptom measures and, on a repertory grid, an increase in the perceived distance between himself and his ideal self and an increasing tendency to construe assertive extraverts as “demanding and aggressive.” This deterioration continued in the six months following the group. In his view, “the group didn’t help at all. I’m not lacking in social skills. The problem is the feelings behind the social skills.”

We (DW and Tom) decided to commence personal construct psychotherapy, and to apply the ABC model to explore “the feelings” (or at least the constructions) “behind the social skills.” The ABC (see Figure 4.3) focused upon his major complaint of inability to be assertive. Although “stands up for himself and asserts his opinions” was presented by him as his desired state and was therefore regarded as the positive pole (a2) of the A construct, the situation was not so simple in that, on being asked for the contrast pole of this construct (a1), he said that this was to be “reasonable.” As indicated in Figure 4.1, he was only able to indicate one positive implication of being assertive, namely that it “relieves tension” (which thus became the b2 pole of the B construct), as opposed to being “mixed up inside and withdrawn” (b1). However, he listed three negative implications of standing up for himself and asserting his opinions (i.e., c1 poles of C constructs), which he saw as likely to lead to being “perceived as a pain in the neck,” risking “losing an argument,” and possibly becoming “personally attacking or physically violent.”

After delineating the negative implications of assertiveness, Tom spontaneously observed that they were “invalid” since he was always unassertive and reasonable and yet was not seen as “a good bloke.” To capitalize on this apparent insight, and with a view to facilitating redefinition of the C constructs, DW explored with Tom why being reasonable was not bringing
him the rewards that he had anticipated. The following interaction ensued (Winter, 1987, p. 114):

DAVID (D):
Could it be that in some way you’re being too reasonable?
TOM (T):
Yes.
D:
What is it about being very reasonable that people might dislike?
Could be boring perhaps. Frustration I suppose. I’m thinking of an answer. I don’t know really. Irritating probably … So people prefer me to disagree because it makes life more interesting. It gives them an opportunity to be something, to assert their point of view. Perhaps I imagine people are too like myself, don’t like arguing.
T:
Maybe, also if you’re reasonable all the time, in some way the other person is forced into being unreasonable by contrast.

This has happened.

Tom also admitted that, although he saw losing an argument as likely to lead to “inner anger” and depression, his current strategy of avoiding assertion and consequent arguments hardly seemed to be relieving his depression. In addition, he said that there was no evidence that he could become attacking or violent.

As a further therapeutic strategy, we used “time-binding” (Kelly, 1955/1991), attempting to identify the historical roots of the constructions revealed in his ABC as a precursor to limiting them to the time and events from which they were derived. This is similar to one of the therapeutic steps recommended by Greenwald (1973), in which one finds the context for the “primary decision” since while the decision might be found to have been highly functional at that time, this may not be the case later in life. In response to this approach, Tom recalled incidents from his childhood involving his mother, a depressive, socially phobic woman who rarely spoke, but who became physically violent on the rare occasions when she did assert her opinions. He accepted that several of his constructions concerning assertiveness once served a purpose in helping him to anticipate his mother’s unpredictable behavior, but were now anachronisms.

Subsequently, he began to make larger and larger steps towards assertiveness by experimenting with alternative constructions and behavior, aided by the use of a fixed-role sketch (Winter, 1987). Post-treatment assessment showed a marked reduction in the severity of his symptoms, and of the negative implications for him of extraversion and assertiveness, as well as more favorable self-construing.

Further Directions

Exploring decisions

The ABC model can be applied clinically, or indeed in other settings (Murray-Prior and Wright, 2001), to explore decisions rather than a more circumscribed focus upon the implications of a client’s symptom. Such work may be seen as facilitating the operation of Kelly’s (1995/1991) “Circumspection – Preemption – Control Cycle” by, for example, helping the respondent to circumspect concerning the issues involved in the decision.

An example is provided by the case of Paul, a young man who had been referred for treatment of post-traumatic stress disorder. When he was a schoolboy, Paul had killed his father. However, he said that he still did not know the reasons for the “big event,” as he referred to what he had done, and said that he had “encapsulated it and put it on a shelf.” Since he clearly felt very threatened by the prospect of taking the big event off the shelf, Paul and DW explored this choice by applying the ABC model. The A construct was “leave the event on the shelf” versus “take it off the shelf.” As indicated in Figure 4.4, positive implications (b2) of taking the event off the shelf were that this would be likely to improve his memory,

<table>
<thead>
<tr>
<th>a1</th>
<th>leave the big event on the shelf</th>
<th>a2</th>
<th>take it off the shelf</th>
</tr>
</thead>
<tbody>
<tr>
<td>b1</td>
<td>has memory lapses faulty reasoning poor relationships with other people</td>
<td>b2</td>
<td>improve memory programming patch thinks about relationships at different levels more proactive</td>
</tr>
<tr>
<td>c2</td>
<td>don’t worry about it move forward</td>
<td>c1</td>
<td>get depressed about it might decide I’ve screwed up terribly badly and that my life’s down the tubes (dead end) might kill myself because I can’t deal with it</td>
</tr>
</tbody>
</table>

and, using a metaphor from his hobby of computing, that it would allow him to develop a “programming patch” rather than having “faulty reasoning.” As well as being likely to improve his interpersonal relationships, taking the event off the shelf would, in his view, lead him to be “more proactive,” in contrast to his current “directionless” (b1) state, which he saw as being due to a “big block of bad goo sitting in my brain.” Negative implications (c1) of taking the event off the shelf were that it might lead him to become depressed, and that he might decide that his life had reached a dead end, perhaps literally because he might kill himself.

After considering these implications, Paul said that he knew that he had to risk looking at the big event. In view of the possible risk of suicide, DW and Paul explored the sources of support that might be available to him during this process, and he identified one friend to whom he felt that he could turn for help. Subsequent sessions involved small steps towards taking the “big event” off the shelf, using repertory grid technique and any material that might aid his recollection of the event, including newspaper reports and culminating in the file of his court case. As described elsewhere (Winter, 2006), Paul began to remember some of the circumstances of the event, his construing of which was shown by repertory grid technique to have become much more highly elaborated. Coupled with this, he made major changes in both his personal and professional life.

**Systemic ABCs**

The way of thinking in the ABC model may also be useful in areas quite different from therapy. So far we have construed the “symptom position” on the problem construct A as a position which a person, P, experiences as painful and thus wants to move away from (towards a “desired position”). We have implicitly taken it for granted that it is not necessary to consider the wider network of persons who are affected by P’s actions. When, however, the wider network is considered there are many situations where P can be described as being on a “problem position” but does not experience any wish to change. Yet, there may be overriding social considerations which imply that life would be substantially better for one or more persons if P could move away from the PP, the “problem position,” toward a “desired position,” DP. This will now be illustrated by two quite different examples.

1. **Restorative justice and dehumanization**

   In severe conflicts there is often a pattern where one party holds an extremely negative view of the other, and this may imply a wish to inflict harm on the other. Conferencing in restorative justice (Tschudi, 2009) provides an excellent arena for illustrating how this can be dealt with in a peaceful way such that positive cooperation can come to replace the negative emotions. As an example we consider a conference described by Neimeyer and Tschudi (2003). The background was that Jill, a 24-year-old unmarried woman with a six-year-old child, had been driving while drunk and accidentally fatally hit a 16-year-old girl, Pat. This filled Jack, Pat’s father, with a consuming depression and anger. His prime motivation for joining a conference was to inflict harm on Jill, who was then in prison. Jill, however, wanted to participate to tell how sorry she was.

   The facilitator, John McDonald, talked with all participants (also friends, family and prison officials) before the conference. In his notes he wrote that Jack’s opinion about Jill and her family was that:

   they were not intelligent people. In fact they were the sort of people who went around making other people’s lives a mess. Jill spent her life at the pub with her useless family, she was ugly and overweight and spent time in a psychiatric institution. (McDonald, 2000, personal communication, p. 4)

In Kellian terms he made no attempt to “construe the construction processes” of Jill. In terms of how Kelly’s (1955/1991) Sociality Corollary may be phrased (Tschudi and Rommetveit, 1982), he did not want to “join in a viable social enterprise” with her. Put otherwise (Tschudi and Reichelt, 2004), in Buber’s terminology, he wanted the relation to be I–it and had no wish to move towards I–Thou.

Schematically, Jack’s position may be illustrated in ABC form (see Figure 4.5), where it should be clear that we impose a normative interpretation

![Figure 4.5](null)  

Jack’s suggested ABC.
of the A positions, implying that for Jack it will in the long run be more healthy to move in the "social" direction. We also assume that the advantage (c2) for Jack of his I-it relationship with Jill, and the all-consuming emotions associated with this, was that it provided him with a "way of life" (Fransella, 1970) that allowed him to fill a "void" and thus avoid anxiety.

As John McDonald told all the participants, the aim of the conference was:

to talk about what happened, get to hear how we've been affected. We look at what might happen (if anything) to make things easier for each other and whether anything might be learned from the tragedy. (McDonald, 2000, personal communication, p. 3)

A remarkable outcome of the conference was an agreement that Jack and Jill should work on a joint program to reduce drunk driving, addressing various schools, thus exemplifying "a viable social enterprise." Jack was thus moving towards an I-Thou position.

This raises the question of what made this possible. On a quite general level what we might describe as the "ecology" of the conference is important. People sit in a circle, and there is thus no trace of any hierarchical structure. Furthermore, there are no tables, only chairs, and notetaking is discouraged. This maximizes paying attention to all details of the other participants. While there is a general script for a conference, emotional outbursts as well as interruptions are certainly permitted.

When strong negative emotions towards the other reign it is as if an empathic wall (Nathanson 1986, 1992) stops one from discovering the basic humanity of the other. As Martin Buber (1961, p. 27) once put it, "Each of us is encased in armor whose task is to ward off signs." There is a large literature about conditions for dehumanization, for instance how special programs may be devised for soldiers to make it easier for them to kill what are just the "enemies." Much less is known about the reverse process, how to break through the armor.

From this point of view conferencing may be seen as a "laboratory" specially fitted for bringing about and registering such breakthroughs. When exploration of vital issues with free display of response is encouraged conditions are optimal for display of a common humanity.

Probably a "breakthrough" should resonate with deeply felt personal experience. At some occasions there may be events which call forth a joint human response, what we have called "collective vulnerability," as in the following incident from the conference which we have described:

the critical turning point of the conference came when Jack passed around a graphic photograph of the scene of the accident that had been taken by the police, providing a vivid portrayal of the disaster that all participants had in common. As the photo slowly made its way around the room, a reverential silence fell over the group, punctuated only by the occasional sob of a participant. This, in the words of the facilitator, was the point of the emergence of "collective vulnerability," experienced as a shared physical deflation. Joined in the poignant recognition of the frailty and brevity of life, a new sense of coherence within the community of conference participants was cemented. The sense of connection seemed to reach out and embrace Pat herself. With shared sadness but conviction, the group then turned toward forging an agreement. (Neimeyer and Tschudi, 2003, p. 180)

After the conference Jack admitted that part of him sought to reconnect with his daughter through Jill. Before this, however, several things had happened which paved the way for the turning point. For instance it turned out that Jill was not the only one responsible for the accident. Several of her family who were present had seen that she was drunk when driving and could firmly have stopped her from driving. It is here of interest that in a related form of conferencing from Hawaii, &o pono pono, participants are often asked both about sins of omission - "What could you have done to prevent the happening?" - and commission - "What have you done that have contributed to the happening?" A variety of such examples appeared during the conference. Furthermore, Jill's uncle and Jack had extensive conversation about the nature of causality, and this served to underscore a wide distribution of responsibility.

In terms of the ABC model this may be taken to illustrate that as steps towards the desired position occur there is a concomitant reconstruction of C. The void in the wake of Pat's death was no longer filled with hatred and despair (c1) but Jill's humanity was discovered - they were "in the same boat." While much remains before one can say that Jack has regained a totally meaningful life the goals stated by John McDonald above, "to make things easier for each other" and seeing "whether anything might be learned from the tragedy," were reached.

2. Institutional care and respecting dignity From a normative point of view we take for granted that respect for, and fostering of, human dignity is a superordinate desired position, DP (Tschudi, 2009). From this point of view lack of respect for human dignity will always be a "problem position," PP. In
many cases there may, however, be administrative, or cultural/ideological values which buttress a more or less pronounced violation of dignity. In such cases an administrator may actually prefer PP, while we shall take the normative point of view, which we take for granted will by and large coincide with the interests of the “victims” of the official policy. The crux of implicative dilemmas in such cases is that the administrator will see advantages of PP, e.g., providing order (c2), and conversely disadvantages of DP, for instance extra costs, or just a disorderly, perhaps chaotic environment. Braithwaite et al. (2007) have provided a large set of examples from the aged care setting which may be taken to illustrate such dilemmas. They list a set of superordinate values as “social independence, freedom of choice, homelike environment, variety of experience, privacy and dignity,” where we regard “dignity” as a useful superordinate construct pole.

As a final example, one of us, DW, had a moving experience when acting as part of a delegation to the only psychiatric hospital in Sierra Leone. At this hospital, which had been looted by the rebels during the civil war that had ravaged the country, there was no electricity, little equipment, scarcely any qualified staff, and on the ward which DW “adopted” many of the residents were chained to the beds or walls. What can one do in such a situation, where extremely limited resources might seem to be the reason for an inertia in which there appears to be no alternative to an environment which is not conducive to human dignity? In the present terminology DW went right for DP, the “desired position,” and asked the residents “what do you want?” Would it be possible to “bypass” whatever had “prevented movement” to DP, and, indeed, to show that this (in ABC terms, c1, involving chaos and overstretching of resources) was merely a chimera? It turned out that a general wish of the residents was to have music. A cassette player was bought, some of the nurses provided cassettes, and the immediate consequence of the music was that the residents started to dance! This applied also to the ones tied to the beds and walls, most of whom were then promptly unchained and danced, holding their chains, with the staff. A simple program of regular music groups was then put into place on this ward, and corresponding programs, for example of board games involving staff and patients, were introduced by DW’s colleagues on other wards. It is hoped that one of the functions that these programs will serve will be to make staff more aware of the humanity of the residents, and to be a powerful means of invalidating any derogatory constructions concerning people with mental health problems.

On a more recent visit to the hospital, DW used the ABC model with the senior staff member on each ward to explore, and facilitate discussion of, their views concerning chaining of the residents. For example, as indicated in Figure 4.6, this method enabled one staff member to identify restriction of freedom and various physical problems as disadvantages of chaining, whereas its perceived advantages were denying residents access to (prohibited) drugs and avoiding harm and trouble. In contrast, worryingly, another staff member was unable to think of a single negative implication of chaining!

Instead of losing hope in unpromising situations such as these, the attempts to facilitate some viable movement, taking into account the constructions of all the stakeholders in the situation and the positive and negative implications of change for them, including economic constraints, remind us of Mary Kaldor’s (2006) concept of building “islands of civility” in wartorn societies. This might be tied to Braithwaite et al.’s (2007), and Parker’s (2002) “triple loop learning.” The first loop would be to make programs such as that described in the last example self-sustaining, the second loop would be that by way of word of mouth a successful program will be adopted at similar locations, and the third loop would be to write about it in such a way that it inspires healthy development in other areas.

Although we may appear to have strayed some distance from the ABC model, we hope that this chapter, by demonstrating the importance of taking seriously the obstacles to and facilitators of change of all the participants in seemingly hopeless situations, will go some way towards the third loop!
Conclusion

Over 30 years since it was first devised, the ABC model remains a valuable, noncomputerized means of assessing aspects of construing relating to problems and obstacles to their resolution. Its utility has been demonstrated to extend beyond the exploration of clients’ symptoms and the selection of therapeutic approaches to a range of other possible applications. These include examination of the problems not only of individuals but of social systems.

References


