

Cognitive Behavioural Counselling in Action



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What is Cognitive Behavioural Counselling?

Since the first edition of *Cognitive Behavioural Counselling in Action* (Trower, Casey and Dryden) was published in 1988, there has been an almost exponential growth in the development and applications of cognitive behavioural therapy (CBT). Within the UK, it is now government policy to make CBT widely available for a number of common emotional disorders. As part of this rapid growth, there are now many introductory texts, academic papers and case studies available. In fact, one would be forgiven for arguing that a second edition of *Cognitive Behavioural Counselling in Action* was unnecessary. However, the task facing counsellors and therapists has become more rather than less difficult because of this growth. New and rival theories and therapies have created the potential for confusion, and CBT arguably lacks theoretical clarity as a therapeutic system (Mansell, 2008a,b; Trower, in press). In our experience trainee counsellors and therapists often raise questions and problems while developing their competence in CBT that remain unanswered and unresolved, despite the proliferation of introductory texts and training courses. Our intention is to address these issues in this second edition. We do so by retaining what is helpful in the first edition, but also by addressing the difficulties that counsellors and therapists often have in developing their effectiveness in CBT.

In this edition we have therefore updated the CBC model and practice from the first edition, to include many of the key later developments in

CBT, and to address some of the basic principles of psychology that we consider either omitted or insufficiently addressed elsewhere. It is again designed for a wide range of problems but the less severe and complex of these problems.

There are two parts to this edition. The first is the Basic Guide, which aims to provide a clear and up-to-date evidence-based guide to CBC which takes the practitioner step-by-step through the actual process when face to face with the client, from initial contact to termination. The second part addresses how CBC can be applied to specific emotional problems.

Introduction to Cognitive Behavioural Counselling

An Integrated Approach

We have explicitly drawn our main inspiration for the second edition from the cognitive models of the two ‘founding fathers’ of CBT – the late Albert Ellis (Rational Emotive Behaviour Therapy or REBT) and Aaron T. Beck (Cognitive Therapy or CT) who continues to have a profound influence on the field. These models are similar in major respects; indeed Beck acknowledges Ellis’s influence on his early formulation of CT (Beck, 1976, 2005). However, there are also important differences and the two models have different strengths.

Both the Beck and Ellis models can be summed up at the most general level by the proposal that people are not disturbed by events themselves directly but by the way they interpret those events – the famous principle attributed to the ancient Greek Stoic philosopher Epictetus.

In various of his many writings Beck proposed that emotional disorders are characterised at the ‘surface’ level by negative automatic thoughts (NATs) which intrude into clients’ conscious minds often involuntarily, and negatively distort their perceptions and memories, leading to emotional and behavioural disturbances. A NAT might, for example, be a negative prediction that ‘I will fail the test’.

Then clients have certain ‘dysfunctional assumptions’ at the second or intermediate and less conscious level, which are conditional propositions, for example ‘*If I fail at something, then I am a failure*’.

At the third or deepest and least consciously accessible level are negative ‘core beliefs’ which are unconditional and accepted as truths about the self, the world and the future, such as ‘I am a failure’.

The dysfunctional assumptions and core beliefs are components of cognitive schemas often established early in life which are activated by certain internal or external triggers, like a 'key in a lock' as Beck puts it. Once activated the schemas can lead to the cognitive distortions, and self-maintaining vicious cycles can then ensue. So in the above example, an exam will trigger a schema that contains the core belief 'I am a failure' and the dysfunctional assumption 'If I fail I will be a failure', the schema giving rise to NATs such as 'I will fail the test'.

Ellis's model similarly proposes that emotional disturbances are the consequence (C) of Beliefs (B) about adverse events (A), but differs from Beck in how he identifies beliefs. Ellis identified two types of Belief, namely inferences, which are if . . . then propositions which could be true or false, and evaluations, which are good–bad judgements. Ellis asserted that it is only certain specific rigid and extreme evaluations that he specified in his theory that can generate emotional disturbances.

We have drawn on the conceptual and empirically grounded strengths of both models in CBC. One of the strengths of Beck's CT that we have drawn on is the focus on NATs. Capturing NATs in ordinary everyday thinking is a task most clients can usually identify with, and helping them learn how to capture or 'catch' the NATs enables them to get a handle on the otherwise extremely elusive disturbance-inducing thoughts, and also to begin the process of decentring from them – both functions being essential for cognitive change. Another strength is the therapeutic process Beck originated in accessing the toxic beliefs and images embedded in the schemas out of which the NATs arise, and the methods by which these beliefs are restructured in cognitive therapy.

On the other hand, we have also drawn on some of Ellis's unique contributions, particularly the distinction between inferences and evaluations, between the specific irrational and rational beliefs and between healthy and unhealthy, qualitatively distinct, negative emotions. Lack of clarity in these two areas can, we believe, translate into confusion in assessment, formulation and intervention for both counsellor and client.

In brief, NATs can be thoughts or images, can be dysfunctional assumptions or core beliefs in Beck's terminology, or can be inferences or evaluations in Ellis's. Dysfunctional assumptions can be inferences or evaluations. Some core beliefs in Beck's system are one type of evaluation – those that are equivalent to self, other, life or future 'downing' in Ellis' system. In each of these cases, we believe it is important to be clear whether the client's NAT or dysfunctional assumption is an inference or an evaluation, and we give guidance on this in the relevant tasks in the Basic Guide.

How do you Feel?

This is probably one of the most important questions the counsellor will ask her client, so we think it may be helpful to invite you, as a counsellor, to answer the same question as part of our introduction to the CBC journey.

Just before you answer this question, stop and observe what you are doing. Be aware of the senses and processes you are using to determine your response. Normally, we spend most of our time oblivious to our emotional experiences or at least not consciously aware of them. Behind the scenes our emotions tend to power us along, enabling us to overcome obstacles we face and helping us to recognise when something we like or dislike happens. We typically only become aware of our emotions when they are particularly intense or problematic. Otherwise they are functional, beneficial and consistent with our experiences. Distress tells us that something is wrong, and we become aware of the discomfort or the behaviour associated with our emotional response to an experience. So, how do you feel?

If you started to consider your response to this question, you may have drawn on information from a range of sources. You may have considered what has been going on in your recent experiences or perhaps turning your attention to something that is due to happen to you in the near future. You may have heightened your awareness of your physical sensations, checking whether you are tense, relaxed, alert, or perhaps tired. You may have thought about what you are doing and what this tells you about your emotional experiences. You may have immediately started to think about what you are feeling, trying to locate some capsule of here and now experience. If you are currently having problems in life, you may have already been more acutely aware of your emotional experiences. You might feel anxious or concerned about some event in your short- or mid-term future. You might feel depressed or sad about something that has happened recently. Perhaps you feel hurt, shame, anger, envy or a range of other emotions. You might even be feeling more than one, right now. The answer to the question is in our view the key to understanding the cognitive behavioural approach to counselling and psychotherapy. If you can answer this specific question accurately, we think you are more than halfway towards understanding how you can use this knowledge to help the clients you work with.

When you first read the question 'How do you feel?', you might have responded in a habitual manner. Consider how many times you have asked this question within your everyday life. There might be variations, such as

'How are you?', 'Are you well?', but most of the time when we ask such questions we are not usually expecting others to reveal their physical well-being, offering you a specification of every ache or pain. No, usually we are enquiring about the other person's general well-being. Most people respond to this question in a habitual manner. Responses such as 'Fine', 'OK' or 'Good' are commonplace. However, when you as a counsellor ask this question of a client, you are not typically doing this as a standard aspect of a greeting. You are also not expecting the client to respond habitually, in their usual manner. Usually when a counsellor asks this question of a client, the counsellor expects the client to reveal something of their internal world, their current status or perhaps the problem they are experiencing. As a counsellor it might be necessary to place some context around the question, such as 'And how do you feel about that?' But when you ask this question in this context you are expecting the client to undertake the same process that we asked of you. We wanted you to reflect on and respond with your current emotional experience.

We are asking this question 'How are you feeling?' not only to stimulate thought, but also to show you just how difficult this question can be to answer. In the remainder of this chapter, step-by-step we will introduce the cognitive behavioural model of human emotions used in CBC. We feel strongly that this model can help you to understand how all of us, clients included, experience problems in a manner which we believe will enable you to facilitate real change for your clients.

One reason why the 'How are you feeling?' question is difficult to answer is because human emotion is complex. It is not just 'feeling', which is only one component of emotion. Emotion can be construed as a broad theoretical construct which encompasses an activating stimulus event of some kind, an appraisal process and a response, which is both the feeling and the closely associated actions tendencies (see Scherer, 2009 for a detailed account of the component process model of emotion). For the purposes of CBC, emotions can be viewed as capsules of experience, where the capsule is the ABC model used in CBC.

Formulating Emotions – the ABC Model of CBC

At the heart of CBC is the use of an ABC formulation of here and now emotional problems. Using an ABC structure is nothing new; it has

featured in nearly all forms of the cognitive therapies in one form or another, and was first developed by Albert Ellis. Our core model is an integrated approach, using the fundamental principles of both Beck and Ellis, as we feel this is the most straightforward method that is both comprehensive and easily understood by counsellors and clients alike. The model is also in keeping with the understanding of emotions across the therapeutic and cognitive science literature (see Figure 1.1).



FIGURE 1.1 *A basic model of the relationships between events, cognition and emotion*

In the ABC model, the event is represented by A, which stands for Activating Event; and serendipitously also for Adverse Event or adversity; cognition is represented by B, or Beliefs; and emotion is represented by C, Consequences. Therefore, the central tenet is that Activating Events (A) lead to Beliefs (B) that in turn produce emotional and behavioural Consequences (C). It is important to note, that people do not experience As, Bs and Cs in an apparent temporal sequence. Rather, the ABC is an emotional episode which is experienced as a whole. However, for change to occur, it is important to identify the components and understand the relationships between them in order to carry out the necessary cognitive restructuring that is the *raison d'être* of all forms of CBT.

Let us consider the example of anxiety at the idea of having to give a presentation, a not infrequent anxiety, and the main problem in our illustrative Case Example in the Basic Guide. In the ABC model it is not the event of having to give a presentation at some point in the future (at A) that causes the emotion of anxiety (at C). Rather the inferences and evaluations made by the individual (at B) create the specific emotion and its associated Action Tendencies. The As can be past, present or future, Bs can comprise inferences (or memories, images or predictions) and evaluations (dysfunctional and functional), negative emotions can be functional (or healthy) or dysfunctional (unhealthy) and are closely associated with action tendencies (urges to act) and actual actions. As noted above, the client who feels anxious at the idea of having to give a presentation

is unlikely to experience first a reminder of the event of giving a talk, then an inference and evaluation, and then the emotion in a temporal sequence like this. If this were within our everyday awareness we would already know how to help ourselves and question our beliefs. The problem is these experiences happen so quickly that our emotions usually seem to occur automatically and simultaneously when the A occurs, particularly in anxiety and anger. The ABC offers a memorable method of enabling your client to formulate their problems and so be prepared to commit to working to change.

A summary of the ABC model in CBC is presented in Figure 1.2. The basic premise is that as humans we encounter adversities (Activating Events at A), about which we infer beyond the available data and then evaluate those inferences (Beliefs at B), which in turn leads to our experience of emotion and our urges to act (Consequences at C). Also evident in Figure 1.2 is the connection from C to A (this is depicted as a dotted line because it is not always the case a C leads to an A). Many problems do feature this cyclical relationship (see Beck and Emery, 1985, for an explanation of the vicious cycle effect in anxiety disorders and phobias, and Chapter 6. For example, for many people with anxiety problems, anxiety would occur at C in the ABC model. This C then becomes a new A, so people then go on to make further inferences and evaluations about their experience of anxiety, which might lead to more anxiety or depression or anger, depending on the nature of the inferences and evaluations. In CBC this is a meta-emotional experience, a feeling about a feeling, and this can often have a debilitating impact on the individual, and be one of the factors that maintain a problem for very long periods of time. Meta-emotional experiences (to be distinguished from metacognitive

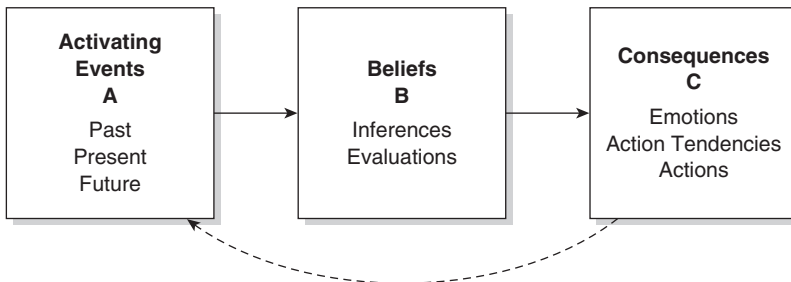


FIGURE 1.2 *The ABC model in CBC*

beliefs, which are beliefs about beliefs) are common across the emotional problems and in subsequent chapters we will show you how to consider this in your assessment process. Of course, meta-emotional problems can continue for many levels. For example, it is possible to feel anger, then shame, then anxiety and each of these can be understood in terms of interconnected ABCs, which can become self-maintaining vicious cycles. Examples of how this may manifest clinically are presented in Chapters 12 to 17.

An Emotional Life – or the C in the ABC Model

Developing understanding and knowledge about emotions has been a central theme in psychology, philosophy, cognitive science, counselling and psychological therapy. Some 20 years before Sigmund Freud established what we now know as psychotherapy, the psychologist William James was interested in why human beings experience emotion and how. He developed a theory that humans know what they feel when they are acting in accordance with their emotional experiences. In his often quoted example, he described how we would know we are scared of a bear because we may find ourselves running from the bear. The act of flight tells us that we are afraid. James (1890) had developed a behavioural-cognitive model of emotion. However, his thesis was limited by failing to address everyday emotional experience and our ability as humans to change what we feel. The difficulty lies in that James failed to explain why we ran from the bear in the first place. Therefore, this is an A–C model, where the emotion was caused by the adversity faced at A. This is all too common in clients, who often arrive at counselling holding an A–C model of their problems, such as how somebody acted made them angry, depressed, ashamed and so on.

Let us modernise James's example. Replace the bear with poverty, the behaviour with resignation and the feeling with depression. Now we have a common dilemma. So common, that in the UK, the Department of Health has recently invested heavily in its Improving Access to Psychological Therapies (IAPT) programme (Department of Health, 2007) to help people who are depressed or anxious. If we apply James's theory, then people living in poverty would know they are depressed if

they noticed their behaviour – that that they had given up, withdrawn, resigned themselves to their lot. This behaviour is unlikely to address the key problem of being poor. Withdrawal and resignation rarely generate income or motivate us in any way. In fact this is as good as seeing the bear and just lying down. In that case we would just have to hope that the bear gets bored and walks away, not giving in to its hunger. People all over the world live in poverty or conflict and most are not depressed or resigned. Certainly they have negative feelings about it but still face up to their problems as best they can. A minority will feel depression and give in, rendering themselves stuck, unable to escape their very own bear. Poverty rarely stops being a problem of its own accord. So, if our behaviour or environment determines our emotions, how come people feel and behave differently when presented with the same problem? The answer to this lies in understanding how you feel.

Healthy vs. Unhealthy Emotions

The primary aim of CBC is to help our clients overcome *unhealthy* negative emotions such as anxiety and depression, and the associated self-defeating and dysfunctional behaviours, in their reaction to genuine adversities, and instead to respond with *healthy* negative emotions like concern or sadness, and functional behaviours that help to solve rather than exacerbate problems. We will show in the Basic Guide that ascertaining the client's emotional problem and their corresponding goal is one of the key tasks undertaken in CBC. There is a clear rationale for this focus.

The two founding fathers of CBT, Beck and Ellis, agree on the core aspects of human nature. They assume that human beings share common goals in life. As Ellis put it, beyond basic survival, adaptation and reproduction, all individuals are motivated to pursue every day goals such as relating, working and achieving – and having fun. Simple though it is, this paradigm provides the necessary starting point to begin an understanding of human distress and misery. With these goals in mind, we set about life, striving to achieve our basic aims through forming relationships, gaining knowledge and skills, and learning how to maximise our happiness. However, life does not always facilitate our goals. We encounter events that are adverse and challenging. In the vast majority of cases our 'healthy' negative emotional reaction to such adversities actually motivates us to strive to overcome adversity in order to achieve our goals. However, from

time to time we turn our healthy negative emotions into unhealthy disturbance about such events, and this disturbance forms the basis of what Albert Ellis referred to as Unhealthy Negative Emotions and Aaron T Beck considered to be symptoms of mental disorder. Either way, they are emotional experiences that lead to dysfunctional behaviour that serves to further block our basic goals or paralyse us in the face of an event.

Following this reasoning, we propose that the *problems* for CBC are these unhealthy negative emotions and dysfunctional behaviours (rather than the adversities *per se*) and the *goals* for CBC are to develop healthy negative emotions and associated functional behaviours. Examples of healthy negative emotions that facilitate our efforts to overcome difficult experiences have been clearly described in Rational Emotive Behaviour Therapy (REBT). Some of the adaptations of the original Cognitive Therapy (CT) (Beck, 1976) typically follow a diagnostic or quasi-medical model, and conceptualise problematic emotions and behaviours as symptoms of a mental disorder. Emotions are considered to be symptoms that manifest as a consequence of some underlying disorder. In CBC we depart from this conceptualisation, as it does not readily permit the fundamentally important distinction between healthy and unhealthy negative emotions.

We have found that by not helping clients distinguish between healthy and unhealthy negative emotions, we may be leaving them at a disadvantage when faced with adverse experiences. For example, suppose we help a client with an anger problem. In the diagnostic system, the client is suffering from an anger *disorder*, and the anger is a symptom to be eradicated or reduced. So our goal is to help the client to feel less angry, more relaxed and less explosive in response to their trigger stimuli. On occasion this approach might be acceptable and appropriate. However, what if the reduction of arousal renders the client vulnerable to future transgression or even abuse and does not aid them to act functionally to address their current challenge in life? If you have ever been in a relationship, you may have had the experience of feeling angry towards that individual on occasion. Imagine if that person frequently treated you badly, ignored your requests for leniency and sought to dominate you. You seek help for your anger and learn methods to reduce your physiological arousal so that you do not experience the same, often overwhelming, level of emotion. Then in an ideal state completely free of all traces of anger, you might then develop skills in assertion. But what then gives you the courage to address the problem? In this instance, we would encourage the client to develop

a feeling of healthy anger (Chapter 14), that gives them the courage to face the transgressor but in a safe and controlled manner. This approach helps clarify the emotional goal from the beginning and is the rubric used in CBC in action.

We think there is a qualitative as well as a quantitative difference in emotions. So in CBC the aim is to change the quality (or nature of the emotion) rather than simply the quantity (intensity). All emotions have a purpose, and the purpose of negative emotions is to alert us to problems, prepare us to deal with the problems and directly motivate our behaviours (Frijda, 1986). However, while healthy/functional negative emotions are adaptive, indeed essential to our well-being, unhealthy/dysfunctional negative emotions tend to be maladaptive and can maintain or even worsen problems. To aim to reduce dysfunctional negative emotions while neglecting to facilitate healthy, functional emotions can only be with the aim of helping clients to feel less, which may not be adaptive. In CBC the goal is different, we want clients to feel and be more adaptive, not return them to a state of non-arousal, or at its worst a state of under-arousal, but to feel *differently*. Box 1.1 contains an example that illustrates this point.

Box 1.1 Reflecting on Anxiety

Take a Moment to Reflect

Try to recall the last time you felt anxious about some upcoming experience in which you wanted the outcome to be good for you. This might have been a job interview, a presentation, an exam, a trip to the dentist, a date, etc. Once you can recall such an event and the feeling associated, recall what you did or wanted to do. You may have wanted to cancel the interview or date, you may have sought reassurance that things would turn out just fine, you may have tried really hard to distract yourself or reduce your arousal to make the idea of the event more manageable. In the run up to the event do you over- or under-prepare? How did your anxiety help you? Probably, not a lot and might have made itself even worse. Now think about how you felt just before the event actually started. You might have been sitting in the waiting

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room, waiting for the audience to go silent, or waiting for the date to show up. Had the reassurance or relaxation strategy worked? Or were you still feeling anxious about the imminence of the event? Now recall how you felt as the event actually took place. Did you immediately start to enjoy the experience, or were you preoccupied with your performance or thoughts about what other people might think of you or what might happen next? And after the event, did it go as well as you had wanted it to, or could you have performed better?

Now try to recall a time when you felt profound concern about an upcoming event. This might have been an interview, the health of a loved one, a task at work, a date, etc. You probably really wanted the outcome to be good for you or those you care about. The experience of profound concern probably was not comfortable, but did you even think about avoiding the event or the problem, or were you motivated to try to deal with the problem? Probably this motivation was intrinsic – you did not even have to think, just act.

Now contrast the two. Would you rather approach a potential threat (to your self or your image of yourself) feeling anxious and wanting to avoid, preoccupied with exaggerated thoughts about the potential negative outcomes, or would you rather be concerned and cautiously propelled towards facing up to the threat? You decide.

Emotions that are functional (healthy) tend to implicitly motivate us to act in a way that is adaptive to the problem we face. Dysfunctional (unhealthy) emotions, on the other hand, are inherently counter-adaptive or self-defeating; no matter how compelling they might feel at the point of experience. It is these dysfunctional emotions that form the first part of the model used within CBC. They are the Consequences (C) that define the nature of the problem experienced by the client. Distinguishing dysfunctional and functional emotions is not difficult to do intuitively but not so easy to put into words. We provide a guide in Table 1.1 (a more in-depth treatment of the distinctions is provided in Dryden, 2008). Within CBC we use these distinctions to help and encourage clients to identify and replace a dysfunctional emotion with the more functional alternative. This might involve a reduction in arousal, but rarely would the client be helped to feel nothing about an

TABLE 1.1 *Dysfunctional and functional emotions*

Dysfunctional	Action tendency	Functional	Action tendency
Anxiety	Avoidance of the threat	Concern	Approaching the threat
Depression	Withdrawal into self	Sadness	Communicative of feelings
Dysfunctional anger	Seek vengeance or hold it in (thereby not addressing the problem)	Functional anger	Assert self about the transgression
Hurt	Sulk and wait for the other to approach	Sorrow	Openly communicate feeling
Shame	Hide or shrink away from others	Disappointment	Face up to others
Guilt	Begging for forgiveness or denial of wrongdoing	Remorse	Asking for forgiveness or taking a penalty
Invidious envy	Seek to obtain the desired thing, no matter what	Benign envy	Working hard to obtain that which is desired

adversity they face as, put simply, it is almost never to their benefit to do so. Consider the experience you reflected on earlier (see Box 1.1). How would you have actually benefited from feeling almost nothing about the experience? You might have failed to prepare for the experience or, even worse, not cared about the outcome. The counsellor is best advised to be mindful of this when discussing problems and goals with their client. The notion of dysfunctional (or unhealthy or disordered) and functional (or healthy or ordered) emotions is not unique to REBT, but is also a paradigm adopted in cognitive science (Power and Dalgleish, 1997).

Functional vs. Dysfunctional Action Tendencies

When we feel an emotion we invariably experience an urge to act or may spontaneously act. In CBC the urge to act is called an Action Tendency. Each of the unhealthy and healthy feelings has an associated action tendency. Broadly speaking, the unhealthy feelings lead to dysfunctional (such as avoidance) Action Tendencies and the healthy feelings lead to functional (such as approach) Action Tendencies. Let us consider the experience of shame to illustrate. When we experience shame we simultaneously experience an Action Tendency to shrink away, to jump into some hole, to avoid the gaze or scrutiny of others, we want more than anything to escape. When we experience disappointment our Action Tendency is different, we tolerate the scrutiny and make use of what

was learned for self-improvement. The counsellor uses this information in a number of ways. The Action Tendency can be understood so that the client is encouraged to act differently, become more self-enhancing than self-defeating. The counsellor might also use the Action Tendency to help the client describe their feeling where they might otherwise find it difficult to describe the feeling in words.

Life is a Challenge – or the A in the ABC Model

In trying to achieve our basic human goals, we encounter the challenges of life. These challenges are adverse to us and are often the events that commence the activation of our emotional experiences. Such adversities may take the form of setbacks, transgressions, hardships and opportunities. They may emanate from ourselves, other people, the world around us or the future. No matter how privileged, virtually all humans will encounter adversities. Within the CBC model, challenges and adversities are Activating Events (A).

Activating events can trigger different types of emotional response, and though never directly cause the response; experience can mislead us – and our clients – into believing that they do. Indeed, some As seem to be the direct cause of the individual's emotional experience. Consider the arachnaphobe who sees a spider crawling towards them. Their panic and extreme behavioural response might seem almost automatic. But the spider does not cause the response. Similarly other people cannot make us angry, though they can certainly act in ways that we can make ourselves angry about. Unfortunately, when all of us experience emotional problems we rarely jump to the conclusion that we are distressing ourselves. Therefore, when many clients first enter the therapeutic relationship they rarely immediately report emotional responsibility, an awareness that they are creating their emotional problem. Rather, they typically attribute their emotional response to the activating event. It follows therefore that the client has not been able to work their way out of their problem, as with this account in mind, their emotions can change only if the event alters or disappears.

The presentation of the model of CBC does not explicitly focus on the history and genesis of the problems for the client at this stage – the As of

the past. Rather, to begin with we will present an episodic, cross-sectional (or horizontal) model for formulation, and focus on the As of the present. We are not discounting a consideration of history, rather we prefer at first to concentrate on the here and now experiences of the client. This is not because an individual's history is unimportant, but because the cognitive model does not hypothesise that the answers to a client's problems lie in resolving the issues of their past. Therefore, within the CBC model, historical events that continue to present as problematic for the client are conceptualised as a form of activating event at A which the client is carrying with them in their memories into the present. We will of course demonstrate in later chapters how to make use of the CBC model within longitudinal (or vertical) formulations that incorporate the individual's experiences and learning histories.

It is not possible to produce a list of the typical activating events for all clients, though themes do emerge in the literature. For example, depression is usually associated with loss or failure (Beck, 1976; Beck et al., 1979), anxiety with threat (e.g. Wells, 1997), and anger with transgression (DiGiuseppe and Tafate, 2007).

Making Sense of Life – or the B in the ABC Model

Men are disturbed not by things but by the views which they take of them

This statement by the second-century Greek philosopher Epictetus is often quoted in books on CBT because the phrase neatly presents the key conceptual element of cognitive theory. By views, Epictetus is referring to the thoughts and beliefs we have about our experiences. It is these thoughts and beliefs that put the B into the ABC model.

In CBC beliefs at B are separated out into inferences and evaluations. Both are important in mediating the experience of emotion and they have a particular relationship. Put simply, inferences about the activating event establish the cognitive frame and the evaluations provide the emotional heat. However, the relationship is not unidirectional, as having evaluated an inference we might then go on to make further inferences.

Inferences

Thoughts that are inferences and images tend to be fleeting in our minds, though they can also become persistent and habitual. Beck (1976) refers to these experiences as Negative Automatic Thoughts. However, inferences are not necessarily negative until they have been evaluated. In CBC an inference is a judgement about an event (real or imagined) that goes beyond the available data. Images may be associated with inferences or may exist separately and may take the form of visual or other sensory memory episodes or imagined scenes about the future. For example, if a client is anxious about presenting their work to an audience, their anxiety is likely to be amplified when they are reminded of the upcoming event, such as a programme of presentations arriving through their letterbox. At such a moment the individual may infer that their presentation will go badly (despite them being keen for it to go well). They might infer 'people will find out that I do not know what I'm talking about!' This is an inference because the event at the moment the inference is made about the future and by definition goes beyond the available data in the present as there is no way of knowing what judgements the audience will arrive at until after the event has occurred (and even then the task to identify their genuine reactions would be a significant challenge). Thus, a future-oriented inference is often a prediction or forecast about the event. Similarly, the client might receive the programme of the day and experience an image of themselves standing in front of a disinterested or critical audience, a room full of derision and frown. Such an experience, whether inference or image, may seem automatic in response to the trigger stimulus of the activating event, because they are sudden and often intrusive. However, the inference might also be deliberate. In the example of depression, an individual may spend considerable time dwelling on a particular loss or failure, inferring the reasons that might lie behind that experience.

Inferences, in mainstream cognitive-behavioural therapy, tend to be the focus of considerable therapeutic attention. Because inferences go beyond the evidence available, their truth can be questioned. For example, if a client infers that nobody likes them, the counsellor could ask them to consider any examples of times when people have liked them. In so doing the counsellor is gently encouraging the client to challenge the truth of or evidence for the inference. Inferences also tend to generate further inferences, as we seek to understand our experience of an

adversity. Taking the client who infers that nobody likes them, it is likely that this will have stemmed from a previous inference about a significant other not liking them, which in turn may have been generated after an inference that the significant other has acted badly towards them and so on. In the Basic Guide we will demonstrate techniques to uncover inference chains. For now, consider the following example from a clinical session, where the client was angry at the way the receptionist had spoken to them:

- Counsellor: So, when you first approached the receptionist he did not immediately acknowledge you, rather he was looking at the computer screen?
- Client: Yeah. They couldn't even be bothered to look me in the eye (inference)!
- Counsellor: And then what happened?
- Client: I said 'Hello, I've got an appointment at 10 o'clock' and they ignored me again (inference). They just think I'm not important (inference), just like how everyone else treats me (inference), nobody respects me (inference).

As we can see from the above example, inferences are often experienced assertions or statements of fact. However, it is important for the counsellor to help the client recognise that inferences are assumptions, as they infer (or assume) beyond that which is actually known.

In CBC inferences (or images) are necessary but not sufficient for an emotional experience. In order for an emotional problem to occur the inferential thought has to be evaluated further. We will come to evaluative beliefs shortly. However, it might be helpful to offer a metaphorical example to illustrate our point. If you are baking a sponge cake, you will require a set of ingredients, which usually you mix together, often adding one after the other. At the end of mixing, however, you do not yet have a cake, but you are getting there. What you need in order to produce a sponge cake is heat, and this comes from placing the mixed together ingredients in an oven. The ingredients may vary dramatically, as there are many types of sponge cake, but heat is required before it becomes a cake. Here we would argue that the ingredients are akin to inferences and the evaluations are the heat.

The following transcript from a supervision session is used to further illustrate this point.

- Trainer (or supervisor): Supposing you have a client who expresses the phrase 'Nobody loves me', how do you think this person would feel?
- Trainee (supervisee): (Answering instinctively, perhaps biased by their own judgements) I think they would feel depressed.
- Trainer (or supervisor): How did you come to that conclusion?
- Trainee (supervisee): Well, it's not very nice is it? You know, believing that nobody loves you, especially if you carry on thinking like that, it would really get you down.
- Trainer (or supervisor): OK, and how do you think that client might act?
- Trainee (supervisee): Give up, mope about, maybe just withdraw from interpersonal relationships.
- Trainer (or supervisor): And would that behaviour help them discover any evidence to contradict their judgement that nobody likes them?
- Trainee (supervisee): No, not at all. They might become like an emotional hermit. That might make it hard for other people to get to know the client and then decide that whether they like that person or not. Though I have to say, it would be kind of hard to genuinely like someone who adamantly believes that nobody likes them.
- Trainer (or supervisor): And I guess it would be easy to see how that goes full circle. But I'm interested in why you quite easily came up with the notion that the *idea* of having nobody like you, even if the reality were true, that nobody did, would *make* you feel depressed.
- Trainee (supervisee): So let me see if I get your point. Are you saying that even if nobody likes the client (which is unlikely, but remains possible), then they might feel something other than depression?
- Trainer (or supervisor): Well, not quite so fast. First let's think about how your client, or anyone for that matter, might depress themselves about the idea that nobody likes them. Is it automatic, so that whenever any human thinks 'nobody likes me' they feel depressed?

- Trainee (supervisee): I don't think so. I guess it's an unpleasant thought, and we are all social animals. It would make life very hard for us and so we might just give up, overwhelmed with depressed affect.
- Trainer (supervisor): Let me help you. Having concluded that 'nobody likes them' your client might make themselves feel depressed, but I think it is possible that they might also make themselves feel other emotions about the same thought. Can you think of how else they might feel?
- Trainee (supervisee): Sure. They might feel ashamed of themselves for being unlikeable. They might be angry with other people for not treating them better. They might be anxious about some social event that they have to attend. They might feel guilty about something that they might have done that led other people to not be as friendly towards them.
- Trainer (supervisor): OK, now that sounds more like your average human being! So what determines how they feel if the same thought, or more accurately, the same inference, can lead to all sorts of different emotions and corresponding behaviours?
- Trainee (supervisee): Well I guess their past experiences, both in the distant and proximal history of the client.
- Trainer (supervisor): I'm interested to understand why you think this.
- Trainee (supervisee): Well, it's quite obvious really. Most of the models make reference to early life experiences in the formation of beliefs. So I guess, if the client had bad experiences as a child, perhaps received criticism from a parent, then they might become sensitised to people not liking them and might conclude that nobody does, distorting their perception of reality.
- Trainer (supervisor): Let's try and think about all that guesswork and speculation. You are right that many formulations often refer to the impact of early learning experiences on the formation of beliefs. You pointed out, as many do, that the experience of negative feedback or criticism might have occurred.

- Trainee (supervisee): Well yeah, of course.
 Trainer (supervisor): If someone else had experienced exactly the same feedback and criticism during their life (both in terms of distant and proximal events), would it be possible for that individual to depress themselves even more about their judgement that nobody likes them than your client?
- Trainee (supervisee): I guess so, I can't think of why not.
 Trainer (supervisor): So how might they do that?
 Trainee (supervisee): Well it can't be just their early experiences, because you are asking me to think that these are the same for both people. I guess, you could depress yourself more if you added more kind of emotional weight to the observation or inference.
- Trainer (supervisor): And how would you do that?
 Trainee (supervisee): Well by making a different evaluation of the inference that nobody likes me. So one person might think that's really bad and another might think it's bad but not the worst thing that could happen. I guess this would then distort, or magnify, the inference.
- Trainer (supervisor): OK, good!

Inferences, as judgements that go beyond the available data, can be either true or false. When counselling clients, you will invariably encounter inferences that are obviously false. For example, if a client infers that their wife 'absolutely hates everything about me', then it is possible to establish that this cannot be entirely true, hence is false. However, for some inferences the case is less clear, especially where predictions of the future are involved (such as in anxiety-related problems). Take, for example, an inference that a woman might reject a romantic advance. These inferences are therefore difficult to challenge effectively. Hence in CBC we propose focusing attention at least as much, if not more, on the evaluations drawn by the client.

Evaluations

As the transcript above demonstrates, the CBC model asserts the importance of the beliefs that evaluate the inferences about the event. It is

these evaluations that create the emotional distress in the here and now, not the inferences alone. The inferences only assert what is true or false. Evaluations assert our likes and dislikes, loves and hates; in other words our preferences. The experience of evaluations is just as rapid as that of inferences. Humans seem to intuitively accept the evaluations they make such that they are experienced as real or true.

To illustrate the importance of evaluations, let us return to the anxiety felt about giving a presentation. The event, inference, evaluation, emotion and action tendency can be considered in two forms:

- 1 Receiving a programme through the letterbox, Jill infers 'people will find out that I do not know what I'm talking about', and this inference is evaluated 'which will be true and that will be terrible', leaving Jill anxious and with an impulse to pretend to be ill so that she does not have to endure the experience.
- 2 Receiving a programme through the letterbox, Jill infers 'people will find out that I do not know what I'm talking about', and this inference is evaluated 'and even if that does happen it will be bad, but not the end of the world!', leaving Jill concerned (having challenged both evaluations and has conviction in the truth of the second) and with an impulse to adequately prepare for the experience.

So, what was the difference between the two forms? In the first, Jill evaluates the inference as being terrible, while in the second, Jill evaluates the inference as being bad but not terrible. Changing the evaluation of the inference produces a different emotional and behavioural outcome.

Evaluations are defined as cognitions that assert a value judgement that an event or experience is good or bad, in contrast to inferences, which assert a proposition that could be true or false, though clearly evaluations can be true or false as well. Most of the time we are not aware of the evaluations that occur frequently in life that are not associated with emotional distress. Think about your favourite food. Imagine the smell, texture and taste. Do you like what you imagine? Of course, the answer is yes, as we asked you to think about your favourite food, but because of this we knew that this would be associated with an implicit evaluation of the food being good. As humans, we just know. Similarly, when we distress ourselves and our evaluations are exaggerations of the badness (as opposed to an appraisal that is more consistent with reality) we remain equally convinced that we are right. Therefore the primary task in CBC is to help the client challenge their evaluations on various grounds and in various ways.

Evaluations can take many forms. In REBT there are four types of dysfunctional or 'irrational' negative evaluations: demands, awfulising, low frustration tolerance and self/other/life downing. All of these implicitly or explicitly take the prefix 'absolutely', making them both rigid and extreme, for example, absolutely must or must not, absolutely awful, absolutely intolerable and absolutely worthless. For each of these there are four functional or 'rational' alternatives, namely strong preferences, relative badness, high frustration tolerance and self, other, life acceptance. In CBT a number of the common cognitive distortions are also evaluative rather than inferential in nature: shoulds/oughts/musts, over-generalising, magnifying (and minimising) and labelling. Evidently, there is a similarity between the two approaches, and we make use of all them in CBC. The types of evaluations and goals for intervention are defined in Table 1.2.

TABLE 1.2 *Types of evaluation and targets for intervention*

Evaluations leading to disturbance	Target for intervention
Demands: absolute shoulds, oughts, musts, needs	Flexible preference/desire
These can be focused on how a person (self or other) must behave/think/feel or how life must be	Evaluating according to what one desires or wants rather than on what must be
Extreme Magnification	Badness-rating
Evaluating an experience or inference as so bad/negative/terrifying that it is truly awful or a catastrophe	Evaluating the experience of inference on a continuum rather than at one end of the continuum
Global Labelling	Acceptance
Self/other/life downing evaluations that rate a person or conditions in their entirety based on one aspect of the person or situation	Evaluating self/other/life as undefinable, incapable of having their entirety described in one way
Frustration Intolerance	Frustration Tolerance
Evaluating an experience or inference as unbearable such that the individual has no way of coping with that experience	Evaluating an experience of inference as uncomfortable but bearable and worthy of the struggle

This chapter has introduced the rationale and overview of our integrated ABC model for use in formulating client problems. There is far more to this model, such as vicious cycles and complex chains that help the counsellor attend to more longitudinal factors in the client's presentation, which we will come to in the Basic Guide section that follows. The Basic Guide section also presents the tasks of CBC.