broad-based training programmes (Haldane *et al.*, 1979; Margison, 1980; Lieberman *et al.*, 1978).

The possible harmful effects of therapy have attracted relatively little attention. Active treatment methods are often evaded or resisted by patients, but their potential for serious harm is relatively low. Interpretive methods, on the other hand, where transference plays a large part, can leave patients worse off (see, for example, Bergin, 1966) and the ways in which such harm may be done must be borne in mind. Meares and Hobson (1977) provide a useful discussion of this issue, offering a description of the "persecutory therapist" under six headings. The distortions of the therapist's relationship they describe are often justified by theoretical beliefs. The six features of negative therapist-patient interactions which they identify are summarized as follows:

(a) *Intrusion* into the patient's personal space can occur by crude interrogation, by premature intuitive understanding, and by forcing the confession of secrets.

(b) *Derogation* is a term used to cover various ways in which a therapist can denigrate his patient, seriously damaging his self-esteem.

(c) *Invalidation* of experience occurs when the therapist does not respect everything that his patient says and responds by explaining away or categorizing, rather than by elaborating and amplifying affects, images, and memories.

(d) The *opaque therapist*, in attempting to maintain an impersonal neutrality, denies his involvement in a two-person situation with its rhythm of intimacy and distance.

(e) The *untenable situation* renders the patient helpless, confused, and unable to explore and learn; it is promoted by lack of clarity about the structure of therapy; by the imposition of impossible requirements; by giving conflicting messages; and by making conflicting demands.

(f) The *persecutory spiral* is an escalating, destructive interaction in which both therapist and patient are, or feel, persecuted. Potent factors are "all-knowing", authoritarian, rigid and sectarian attitudes and beliefs regarding psychotherapeutic theory and technique.

To these various acts of commission, Older (1977) under the title "Four Taboos That May Limit the Success of Psychotherapy" considers common rigidities whereby therapists may fail their patients. The four he considers are, firstly, the fear of any physical contact because of the dangers of sexual involvement and the general difficulty in physical expression in our culture; secondly, the avoidance of embarrassing topics; thirdly, not allowing the noisy expression of emotion; and fourthly, an unwillingness to vary durations of the patient's sessions in response to the occasional patient's need to work through a problem to its conclusion.

14
Aids to Self-scrutiny and Self-help

My work as a psychotherapist has evolved over the years in a number of directions. I have become more varied in the methods I use, I have become increasingly explicit about what I am doing, and about the ideas underlying my approach and, in talking to patients, I use the word "work" much more often. Over this period, I seem to find my patients less perplexing and less exhausting, and their changes more predictable and more rapidly achieved. While this could be the result of the accumulating illusions, rather than the skills, of greater age, I prefer to believe that it is because I am better at providing the conditions and concepts that patients need in order to change themselves. In this chapter, I want to describe some of the ways in which people can be helped to think clearly and differently about themselves and to learn new ways of acting outside the therapy situation. Some of these ways may be useful to people not in therapy, as aids to self-exploration and problem-definition.

One of the main threads running through the book has been an emphasis on the description of the aims of treatment as being the revision of self-perpetuating errors or failures in procedures. The value of these descriptions is that they direct attention away from the surface manifestations of symptoms, moods, and unwanted behaviours to the underlying modes of thought and action that perpetuate difficulty.

People do not usually reflect on their procedures in this way, and they often lack concepts with which to engage in such reflection. As I became clearer about these concepts, I found myself sharing them with many patients, and after a time I decided to give to most of my patients, during the assessment period, a "personal therapy file" which described in some detail the ideas I was operating on, and which invited them to apply these ideas to their own difficulties. In such cases, the last assessment session was devoted to a discussion of the aims and methods of treatment, based on what they, in their way, and I, in my way, had concluded over the first sessions.

Not every patient is suitable for this approach; a few make little use of the file and in some cases I do not even offer it, or I give only certain pages of the file,

describing the most relevant concepts. If it makes sense to the patient to use these sheets, then the overarching framework of understanding offered by the concepts and methods suggested, and the active participation in the therapeutic work called for, provides early relief to the patient's sense of helplessness and a basis for continued self-generated work. Some other written instructions and test procedures which may also be helpful to patients and may save time to therapists will be discussed later in this chapter, after the personal therapy file has been presented in the following sections.

PERSONAL THERAPY FILE

Introduction

These sheets are offered as a way of helping you think about the problems we shall be dealing with in your therapy. People seek therapy because of a wish to stop doing or experiencing things they do not like but cannot control, or because they cannot achieve some aims or life purposes. In the former case, one needs to see what it is that prevents one learning different ways; in the latter case, one needs either to revise or abandon unrealistic aims, or learn better procedures for attaining realizable ones. In living our lives, we are continually making sense of the world around us, especially of the people in it, and are pursuing the aims and expressing the beliefs and values that are important to us. Most of this goes on without the need for us to be consciously aware of our mental processes, but when things go badly it is helpful to be able to reflect, so that we can recognize how we cause ourselves trouble or why we fail to solve our problems. In both small-scale actions (like planning the morning shopping) or large scale ones (like maintaining a relationship or pursuing a career) the basic procedures involved are similar. They can be described as eight stages; we will consider these and note (in brackets) how we may create problems for ourselves at any stage.

(1) We consider whether the situation is suitable for our purposes; sometimes our purposes are determined by the situation (problem: always looking on the dark side, not seeing things clearly).

(2) We consider our ability to influence events (problem: over- or underestimating our capacity; belief in luck or magic).

(3) We consider if the aim will produce a bad reaction from ourselves (guilt) or from others we care about (problem: overstrict criteria for self-acceptance, unreasonable self-blame; seeing others as harsh).

(4) We consider the ways in which we might pursue the aim (problem: lack of skills or experience; narrow definition or polarization of the alternatives).

(5) For each possible way, we consider whether it will work (problem: pessimistic predictions) and what will be the consequences (problem: unrealistic expectation of blame or guilt).

(6) We select a means and proceed (problem: relative incompetence).

(7) We reflect on how we did (problem: exaggerating failures; overgeneralizing from failures; not allowing our success; unrealistic fears that others are hurt or angered).

(8) We review the whole process and revise or confirm the aim, the assumptions, and the means (problem: abandonment of reasonable aims, failure to revise procedures).

With this sequence in mind, read the sheet that follow describing common patterns of difficulty; these suggest some ways of thinking about these issues, which you may find useful. You may be given one or two additional "tests" with the same purpose in mind.

Negative beliefs, defensiveness symptoms

Note any of the following that apply to you.

(1) Negative beliefs, e.g. undue self-criticism, guilt, unrealistically low opinion of capacities, unreasonable need for reassurance from others, unreasonable need for self-proof, not seeing your ability to influence your life.

(2) Defensiveness: some problems arise because we don't know what we feel or what our life and our past mean to us. Are you someone who is liable to forget important events, or blot out unpleasant feelings? Do you tend to see in others things that are really aspects of yourself? Do you find yourself blocking or avoiding doing what you really wish to do? Do you feel as much in control of your life as other people seem to be?

(3) Symptoms: do you have any of the following?

(a) Prolonged or repeated unreasonable depression or anxiety.

(b) Physical symptoms that seem to be related to how your life is going.

(c) A tendency to avoid situations (on irrational grounds).

(d) A tendency to carry out acts that you don't really intend.

Traps (thoughts, acts, and social strategies)

Traps are what one cannot escape from. Certain kinds of thinking and acting that are self-perpetuating are called traps. An example in the realm of thinking would be depressive assumptions about one's capacity that lead to anxiety and impaired performance, followed by a negative evaluation of the performance and overgeneralization from this, leading to depressive assumptions about one's capacity (see the description of the stages on the first page). A common self-perpetuating *behaviour* is phobic avoidance: initial anxiety about entering a situation which causes anxiety is subsequently anticipated with anxiety and this leads to avoidance; avoidance relieves the fear, but does not challenge the irrational expectation of danger and, hence, maintains the avoidance behaviour.

More complex social behaviours of this sort include the following:

(a) The social isolation trap — feeling underconfident about ourselves, we fear that others will find us boring or stupid, so we avoid contact with them and do not

respond to friendly moves. As a result we come to be seen as unfriendly and then are, in fact, socially isolated, from which we conclude that we are boring or stupid, and feel still less confident.

(b) The placation trap — feeling uncertain about our worth or value, or anxious about our right to be assertive, we seek to please other people by doing what they want or what they seem to want. As a result we end up being taken advantage of by others, which makes us either childishly angry or guilty or depressed; hence, our sense of uncertainty about ourselves is maintained or increased. One important issue here is concerned with the distinction between assertion and aggression. A fear of being destructive makes many people invite destruction. In the placation trap in particular, it is common for one's self-effacement to invite or allow abuse, and one's consequent resentment can lead to childish anger. Observing oneself to behave so unreasonably reinforces one's belief that aggression is impermissible. However, tantrums are neither assertive nor effectively aggressive. In being assertive we do no more than make a claim to exist. In being aggressive we give the other person less claim than we do to ourselves. In most circumstances, assertion based on mutual respect is perfectly acceptable; those few people who (aggressively) do not allow us our proper assertions must either be fought (aggressively) or avoided. The image of birdsong provides a useful metaphor here. Most birdsong serves to define territory; by singing, the bird announces its claim to its piece of ground. Most of the time, rivals respect this and fighting only occurs if the line is crossed. People often need to be instructed in the art of "singing on the boundary".

Self-monitoring

Any symptom, unwanted thought, or unwanted behaviour that comes and goes, or varies in intensity, can be better understood as a result of self-monitoring, and this can also very often help one gain control. Many of the problems listed on the previous pages may be worth studying in this way. Here is the way to proceed:

Each time you notice that one such change has occurred, think about (a) the trigger — whether it was an event outside in the world, or a thought or image in your mind; (b) the subsequent thoughts or images in your mind, or the conversation you have with yourself following the triggering event. We often fail to notice or to recall thoughts and images of this kind. It is helpful for 2 or 3 weeks to concentrate on them by spending a little time each day noting down any triggers and the following thoughts that have occured in relation to the symptoms, actions, or mood changes of which you would like to have better control. By writing them down, you will learn to recognize more clearly what causes them, and you will almost certainly find that you imagine situations or consequences much more extreme that those existing in reality. Often one's moods or acts reflect this imagined situation rather than the real one. By noting down these negative thoughts you will begin to distance yourself from them, and by learning to recognize them as they occur you will achieve much more control over them.

From time to time, take a look at the record from two points of view: first of all, note down regularities or recurrences; and secondly, evaluate the realism or otherwise of the judgements and predictions made. From the first you will probably be able to form for yourself a more general view of what causes trouble; for example, does it always occur around issues of rejection or separation, or in relation to acts of assertion? From the second, you may come to recognize a recurrent process of spiralling into catastrophic imagining. This recognition can help you thereafter to tell yourself to stop these imaginery spirals and attend to the real situation that you are in. The purpose of this exercise is to learn to recognize, and then to redefine or relabel, an aspect of your experience or action. For example, the passive experience of depression or the compulsive repetition of overeating can become recognized as your reaction to particular experiences or as the consequences of particular ways of thinking about yourself. Once you have defined situations or the thoughts associated with your unwanted experiences or acts in this way, the possibility of alternative action becomes available. At this point you may move on from monitoring and redefinition to exploring and elaborating different ways of acting, and this may be aided by developing explicit alternative self-instructions. Initially these self-instructions may be essentially negative, for example "do not dwell on catastrophic thinking" or "think about what you are feeling and do not go to the cupboard for another slice of bread". As soon as possible they should be extended to the trying out of more positive and relevant acts designed to further your real wishes and aims.

Dilemmas

We very often continue to act in certain ways, even when we don't particularly enjoy what we do, because other possible ways seem as bad or worse. Yet there may in reality be many other ways of acting; it is just that our particular personal history has given us a narrow view of what is possible, or a narrow range of strategies. Dilemmas can be described briefly as "either/or", e.g. *either* in firm control of one's feelings *or* in chaotic confusion; or as "if/then", e.g. *if* feminine, *then* submitting to others.

In the "either/or" dilemma, the choices seem to lie between two courses: A and B. Not to do A implies necessarily doing B and vice versa. Restricted by such a dilemma one may alternate between A and B or, if one of the two is worse, say B, then one will be confined only to doing the other, A. In "if/then" dilemmas, to follow a desired course, C, is seen necessarily to imply an associated unwanted quality, D; seeing it this way, one may choose to give up C altogether, even though it is otherwise an appropriate and important aim.

Some dilemmas operate to restrict the ways in which we see it possible to relate to other people. Others are to do with how we control and look after ourselves. Think about ways in which you may restrict your options in this way. It may help you to look through the list of common dilemmas on the next sheet. Note any dilemma that you think may restrict the ways in which you go about your life.

Common dilemmas

(i) *If* caring for someone, *then* giving in to them.
(ii) *If* depending on someone, *then* controlling them.
(iii) *If* caring for someone, *then* controlling them.
(iv) *If* depending on someone, *then* giving in to them.
(v) *Either* dependent and controlling *or* caring and submissive.
(vi) *Either* caring and controlling *or* dependent and submissive.
(vii) *Either* involved with someone and vulnerable *or* detached and controlling.
(viii) *If* dependent, *then* guilty.
(ix) *Either* cut off and hence lonely, *or* emotionally involved and hence scared, confused, angry.
(x) *If* loved by another, *then* feeling trapped.
(xi) *If* feminine, *then* passive.
(xii) *If* masculine, *then* unemotional.
(xiii) *If* I win people's praise or approval by trying to please them or do what they want, *then* I feel childish/guilty/trapped/resentful.
(xiv) *Either* assertive and rejected by others *or* compliant and and abused/hurt by others.
(xv) *If* competitive, *then* feeling depressed, under stress, rejected by others.
(xvi) *Either* anxiously self-reliant *or* dependent and feeling childish/trapped/resentful.
(xvii) *If* I try to be perfect, *then* I feel depressed and angry and often blocked; if I don't try to be perfect, then I feel guilty, dissatisfied, anxious.
(xviii) *If* I get what I want, *then* I feel childish and guilty; *if* I don't get what I want, *then* I feel angry and depressed.
(xix) *Either* I keep feelings bottled up and feel cut off, depressed, *or* I express feelings and risk rejection/hurting others/making a mess.
(xx) *If* I must, *then* I won't (obligations from others, or even my own plans, are sensed as oppressive and I block, postpone, evade, and do not meet them).
(xxi) *If* not structured by tasks or by relationships with others, *then* I feel anxious, out of control.
(xxii) *Either* I spoil myself and am greedy, *or* I am self-denying and self-punishing.

It is obvious from the list that many dilemmas are familiar to most of us to some extent, representing as they do inescapable paradoxes of human life. They are sources of trouble when they are extreme and unresolved.

Snags

Many people have to deny or dismantle the gains, achievements or assertions which they make in their lives, and people wanting to change themselves often find that they are unable to take advantage of the gains they make. The process underlying this is a snag, as in, "I want to get better but the snag is . . .", but snag also stands for Subtle Negative Aspects of Goals. Such prohibitions on succeeding or doing or being may have external origins, for sometimes parents, spouses, lovers, or friends

resist or seem unable to cope with one's changes. Often, however, the prohibitions are more subtle and are more in our own minds, not always consciously. Such self-prohibitions often relate to the need to avoid guilt. The guilt is usually quite irrational, stemming either from misinterpretations made early in life or from the experience of external prohibitions, of the sort described above, during childhood or adolescence.

Do you think in your own case there is any tendency to avoid success, deny success, or dismantle it, or any need to restrict your pleasure or interest in life, or to pay for it? If there is, do you have any idea where this might come from, taking account of the ideas put forward above?

In considering external snags, it is helpful to list the changes you hope to achieve in yourself and to imagine the reaction such changes might provoke in those people close to you. Although in principle these people are probably all in favour of you getting better and doing what you want to do, it may be the case that the response of some (most often family member, lover, or spouse) is less clear and positive. There may, in fact, be quite powerful instructions implied by some relationships, based on attributions of identity (such as "he's always been such a gentle person . . .") or upon family myths ("in our family we never . . ." or "you are the one who always . . ."). Such views often restrict our sense of ourselves and they certainly do not define all the possible ways we might be. In some cases, as we change, these others will prove more able to accommodate to the new version of us than we expect; in other cases, there will be a rearguard action, and sometimes we are confronted with such major opposition that we have to choose between the change we desire and the continuation of the relationship.

Internal snags are more difficult to locate because they are sensed as being part of our nature and are based usually upon unacknowledged and irrational guilt. If, in your life, you can trace a pattern that could be described as one of having avoided, damaged, or paid for, your successes or for your existence, or if you habitually sell yourself short, hurt or deprive yourself, then you should suspect that you are "snagged". The guilt underlying a snag is often unconscious. Common sources are the illnesses, deaths, or disasters of parents or other family members during childhood or adolescence, for which one has assumed magical responsibility; or the experience of having been actively envied, commonly by parent, brother, or sister. If you can see that such a process is at work undermining your life, or if you can see that you act *as if* you were guilty, whether or not you experience guilt, you will begin to understand that your self-sabotage is arbitrary and undeserved. You will, however, have to recognize and fight against a tendency to forget that you know this, and a continuing tendency to give away the gains you make, because snags are subtle and persistent.

THE SELF-ESTEEM SOURCES TEST

In this section I am going to describe a simple test procedure which can be self-administered and self-scored, the aim of which is to identify trap behaviours. The test investigates the sources one relies upon for the maintenance of self-esteem. The

acts we perform and the things needed from others to feel good about ourselves vary from person to person, and are not all equally effective. The aim of the Self-Esteem Sources Test is to guide one's examination of one's sources and of the costs and benefits attached to them. Going through this procedure often leads to the recognition of the fact that some of the sources one relies upon bring little benefit or high costs, so that acts intended to make one feel better are persisted in and, in fact, make one feel worse.

SES Test — page 1: Description and Instructions

The purpose of this test is to explore the sources you depend on to feel good and secure in yourself. People differ greatly in this respect and there are no right or wrong answers; the answers you give should be as accurate and undefensive as possible.

Thirty-eight possible sources are listed on SES Test page 2. Go through this list (taking time over each item, as you may not have thought about yourself in these terms before) and when you recognize an item that applies to you, circle its number. You can add other sources that are important to you, in the blanks (39–42, or more if you wish).

The second part of the test is an examination of the costs and benefits of these various *sources*. First pick out the fifteen items that are most important to you. In judging importance consider how much effort you put into them, and how much it would matter to you if they ceased to operate. Now turn to SES page 3 and list the numbers of these 15 in the space indicated at the top of the page. Fourteen possible effects or *consequences* are listed, and you may add further ones if you wish. Indicate the degree to which each of these possible consequences follows upon each of the 15 *sources* by giving a rating of 1 – 5 (see rating instructions). This part of the test should be completed fairly quickly, rating all the sources on each possible consequence in turn.

SES Test — page 2: In order to feel good about myself I need, or tend, to

1. Be a helpful and caring person.
2. Feel I am competent at my work.
3. Be tolerant and forgiving.
4. Avoid close emotional involvement.
5. Make certain I am not caught out.
6. Be loved by my family (i.e. parents, brothers, sisters, children).
7. Try to do what others want.
8. Be praised for what I do.
9. Behave badly in order to be reassured by the forgiveness of others.
10. Criticize or undervalue others.
11. Be a social success.
12. Be part of a group of friends giving mutual support.

13. Feel that I am sexually attractive.
14. Be placatory, avoid arguments.
15. Try to make up for what I feel is wrong with me.
16. Look good (e.g. clothes, make-up, etc.).
17. Disarm others (e.g. by weakness, sexuality, etc.).
18. Depend upon a stronger person.
19. Assert myself in work or social situations.
20. Think about what I hope to be or achieve.
21. Get intensely involved in people or activities.
22. Deprive or punish myself.
23. Know that I can make others want me sexually and/or emotionally.
24. Identify with and/or participate in something larger than myself (e.g. politics, religion, etc.).
25. Think about where I come from (e.g. family, class, country, etc.).
26. Give myself treats (e.g. food, comforts, presents, etc.).
27. Make others envy me.
28. Show I don't have to do what others want or expect.
29. Be active and productive all the time.
30. Control those I am emotionally close to.
31. Never show angry feelings.
32. Feel expert at the things that really concern me.
33. Feel properly valued and regarded for what I do.
34. Compete successfully with others.
35. Be loved by my spouse/lover.
36. Feel self-reliant.
37. Have others grateful to or dependent on me.
38. Be rejected or disliked by most people.
39.
40.
41.
42.

(*continued overleaf*)

SES Test — page 3

Ratings: 5 applies very strongly; 4 definitely applies; 3 may or may not apply; 2 does not apply; 1 very definitely does not apply.

Consequences	*List the numbers of the SESs that matter most to you here:*															
1. I feel calm																
2. I feel trapped																
3. I feel guilty																
4. I feel strong																
5. I feel hopeful																
6. I feel free																
7. I feel depressed																
8. I get what I want																
9. I feel under stress																
10. I feel confident																
11. I feel lonely																
12. I feel happy																
13. I feel childish																
14. I feel angry																
15.																
16.																
17.																
18.																

SES Test — page 4: Scoring Instructions

Go through the list of consequences and mark those you regard as indicating positive outcomes; for most people these are those numbered 1, 4, 5, 6, 8, 10, and 12. Mark these rows regarded as positive with a pencil or magic-marker line. Now go through each source in turn, adding up for each the total positive score. Now do the same for the consequences which you regard as negative (omitting any outcome you see as neutral or unimportant).

From these two sets of figures identify those sources that yield the highest negative and/or the lowest positive total scores. On the basis of this, consider why it is that this is the case, and why it is that you still rely upon sources that, at least in present terms, are unhelpful.

INTERPRETATION OF SES TEST

Anne

Anne's SES test was completed after her second assessment session. She had neither added nor omitted any consequences but she had rated all sources as 2 on the outcome *I feel angry*, so this was not included in the scoring. (This rating suggests a difficulty in acknowledging anger.) The highest potential positive score was therefore 35 for positive, and 30 for negative outcomes. The lowest positive scores (values in brackets) were in respect to the items: *control those I am emotionally close to* (16), *feel properly valued and regarded for what I do* (16), *be loved by my family* (16), and *identify with and/or participate in something larger than myself* (14). The highest negative scores were for *be a helpful and caring person* (19), *be loved by my family* (18), and *compete successfully with others* (18). We can see that, although at that time Anne could not directly acknowledge her difficult feelings for her family and did not know how much she tended to be controlling in relationships, and although she still prized perfectionist and ambitious work attitudes, the SES test recorded her awareness in detail of the low benefit and high costs attached to these ways of pursuing her two central aims of being loved and being successful.

David

David's SES test was similarly revealing. The lowest positive scores (22) and highest negative scores (15 and 17) were recorded for *I like to feel needed in some way by certain people* and *get involved intensely in people or activities*; both these refer to issues which, it will be remembered, played an important part in his predicament.

In a study of twenty-eight patients who completed the SES test during assessment, the outcomes attached to various commonly selected sources were classified as positive, negative, or mixed (for this purpose a more complex scoring system was used but the results produced are essentially the same as those coming from the

method described above). Mixed consequences were those where the outcomes included high ratings for both positive and negative effects. Self-dependent sources like *being competent, expert,* and *self-reliant* gave largely positive outcomes, although assertion was negative or mixed in effect in half the cases. Other-dependent sources such as *being praised, being properly valued,* and *feeling sexually attractive* were associated with largely positive outcomes, but *being placatory* and *avoiding arguments* were predominantly negative in effect, and *being a helpful and caring* person was negative or mixed in a third of subjects. *Being loved by family* or *being loved by spouse or lover* had unmixed positive consequences in only one third of this patient population.

The explicit recognition of the effects of acts designed to reinforce self-esteem is aided by this simple procedure; faced with high-cost or low-gain procedures, one can begin to consider whether the sources should be abandoned or whether their terms and implications should be revised.

SIMPLE BEHAVIOURAL TECHNIQUES

To complete this chapter, we will consider some simple behavioural methods. The following descriptions could serve as a bases for a self-administered programme or for a professionally supervised one.

(a) Relaxation

Relaxation requires practice. Some people can relax "all at once" by letting their whole body go limp and heavy. For others, relaxation is best achieved piecemeal, by learning to relax one part of the body at a time, either by tightening and then loosening a particular group of muscles, or by thinking of a part such as a limb or the neck and imagining it to be heavy and loose. Try out which method suits you best and practice it daily. While relaxing, breathe more slowly and deeply than usual. It may help you to memorize, or even tape-record, the self-instructions that you find most useful in achieving relaxation. The ability to achieve relaxation voluntarily can help one cope with tense situations, even if one does not achieve complete relaxation under those circumstances.

(b) Rehearsal

Some people find it helpful to imagine feared situations before entering them. To do this requires you to be good at relaxing. Try to imagine the feared situation in as vivid detail as possible, and similarly try to recreate your reaction to it. As soon as you begin to feel tense or anxious, then turn your attention to the induction of relaxation; once you are relaxed again, return once more to imagining the situation. Repeat this process several times. Rehearsal in this way can be built into programmes of graded exposure to feared situations (see below).

(c) Self-instruction

Linked with this rehearsal in imagination of a situation and your response to it, you can also rehearse ways of dealing with it. These can take the form of reassuring statements about the absence of real danger, reminders of the immediate goal and of your long-term intentions of losing symptoms, or recollections of the satisfaction of previous situations which you have coped with. Sometimes it helps to carry written reminders of these into the actual situation, or to use objects or phrases as talismans to take with you. As well as such reassurances, try to prepare effective ways of coping with the situation, and rehearse simple reminders of these ways.

(d) Paradoxical intention

The quickest way to get over a fear about having symptoms is to try to have the symptoms. This approach works very well for some people with situationally-provoked anxiety or panic. The method involves you in determining to have the symptoms as soon as you enter the situation or, if you begin to have the symptom, in attempting to have it as thoroughly as you can manage. The paradox is that this usually prevents the symptom developing; even if that is not the case, the situation is no worse than usual, so nothing has been lost. The explanation is that you cannot deliberately lose control. For symptoms which are maintained by performance anxiety (such as insomnia, impotence, inability to urinate in public toilets), the instruction is to enter the situation with the express intention of *avoiding* the performance (sleep, intercourse, urination). Increasingly prolonged and frequent exposure under these conditions leads, in the end, to the anxiety diminishing to the point at which the rule to avoid attempting the performance is broken.

(e) Overcoming avoidance behaviours

If you avoid situations because of physical symptoms, and if you have any doubt about whether the symptoms you experience are dangerous, seek medical advice. The ordinary symptoms of fear or panic, however extreme, are never dangerous to a healthy person, but could put a strain on someone with physical disease. Once you are sure on this point, proceed with a graded programme of exposure as follows. To begin with, prepare a detailed list of all the situations you avoid or have difficulty in entering, and list them in order from the least difficult to the most difficult. On the basis of this list, go through a programme of exposing yourself to increasingly difficult situations. For each exposure set a clear goal and do not proceed to a more difficult situation until that goal has been achieved. Each exposure may be preceded by rehearsal in imagination as described above, if you find that helpful. However, the essential fact is that recovery from avoidance behaviours depends upon staying in the feared situation. The more fearful the situation entered, and the longer you stay in it, the quicker the effect. To start with, however, do not be over-ambitious about the difficulty of the situation but do aim to stay in it as long as possible. Remember that you will certainly have some symptoms, remember that you can

leave if you have to, but try to stay in as long as possible, preferably until you are bored, not scared. In putting yourself through such a programme, get rid of "props" such as being accompanied by other people or dogs, depending upon carrying walking-sticks or cases, or hiding behind newspapers. If you depend upon these to cope with a given situation, your next task should be to cope with the same situation without these "props". Similarly, if you use alcohol or tranquillizers you should aim to manage a situation without them before you attempt any more difficult situations. If you do use drugs, take them 2 to 3 hours before you go into the difficult situation so that the effects of the drug will wear off while you are in that situation and give you the experience of mastering your fear on your own. After each exposure, record the place and duration and some measure of how bad you felt and for how long. If you have a friend who knows about your programme, show him the record from time to time. If you have a set-back, which is likely, enter a less difficult situation as soon as possible and proceed to increase your range again from that point. Your record will show you how, over time, you do make progress and also how the intensity and duration of fear subsides, and it will prevent your becoming discouraged by inaccurate, negatively biased self-evaluations.

The above description applies particularly to phobic avoidance, but the overcoming of obsessive–compulsive behaviours is based on essentially similar methods. Rituals are ways of controlling fear, and to overcome them involves accepting exposure to fear without the magical reassurance of the ritual act. The seeking of reassurance from others can itself become a compulsion, and the co-operation of close others in withholding such reassurance and in supporting resistance to the compulsions is an important back-up to the individual's programme of graded exposure.

DISCUSSION

Interest in self-help aids has been confined to the behavioural and cognitive tradition, where it represents a logical extension of the use of specific homework assignments in therapy. Psychoanalysts, with their emphasis on unconscious mental processes and on the transference as the agent of cure, would clearly be sceptical. Little good evidence exists for the effectiveness of the behavioural self-help literature (Glasgow and Rosen 1978). I have no evidence for the effectiveness of the material described in this chapter beyond the reports of my patients, many of whom have found them useful in maintaining and extending the understandings reached during sessions.

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Afterword

Just as a patient, in the act of telling his story to a psychotherapist, may discover that he understands more than he knew, so an author in the act of writing may clarify and extend the ideas which prompted him to write. While my original aim has been largely achieved, and while my approach has largely followed what I originally envisaged, I am aware of a number of shifts in emphasis that have resulted from the act of writing this book. These are not easily conveyed because they are somewhat paradoxical. In many respects the book makes a larger and more definite claim than I had anticipated and yet, at the same time, I have the sense that experienced practitioners will read much of it with a sense of familiarity. I think this is a reflection of the fact that therapists are often more flexible and various and less restrained in action than they are in their theoretical writing. Some of the positions I have discussed or dismissed polemically may seem to such people windmills rather than giants. The gap between acts and the accounts given of acts is, however, one that needs closing, and if I have contributed to that closure I am satisfied. I have argued throughout the book that a main function of therapy is the provision to patients of accurate, usable accounts of how they think and act, and the attempt to do the same for therapists seems appropriate.

No attempt is made to proclaim a New Therapy; I think it is unfortunate that inflated claims are nearly always made for new ideas or approaches in the field of psychotherapy; current enthusiasm for cognitive psychotherapy seems to be a contemporary example of this. In my own view, it is impossible for any one contribution in this field to dispose of all the issues, and exaggerated claims such as are expressed most baldly on the dust-jackets or in publishers' advertisements serve only to delay the evolution of a more coherent theoretical base for the field. In this book, I have offered an account of practice that is largely derived from psychoanalysis, behaviourist and cognitive therapies, and the suggested name of cognitive–analytic therapy declares this derivation; but I am aware that there are many other therapeutic methods I have not discussed that may also have their