of the fundamental one: psychoanalysis offers a set of compounded metaphors of energy, location and conflicting entities, while cognitive psychology describes the storage, retrieval, organization, and putting into operation of information. The PSM offers a very simple account, but should not be taken to constitute an invitation to accept a naive simplification of human experience. At each stage of the sequence, procedures may be coherent or contradictory, and any aspect of the process may be consciously recognized and under conscious control; consciously recognized but not under control; not consciously recognized but capable of being made so; or unconscious and inaccessible either inevitably or as the result of unconscious, conflict-reducing, cognitive strategies. Each procedure is shaped by the particular past history of the individual, and many will be limited by the persistence of assumptions or strategies rooted in earlier life stages. In the general assumptions of Stage 2, and the range of methods considered in Stage 3, will be found the results of the whole personal and cultural history of the individual. The simple PSM serves to locate these complex influences in relation to the individual's life; any understanding we may have of them, from whatever source, will serve to flesh out the bones of the model.

As regards the cognitive view of unconscious mental processes, Oatley (1981) suggests a six-fold classification, as follows.

(1) The unconsciousness of unconscious inferences. The perceptual processes whereby we make sense of our perceived world may be understood, but we do not have introspective access to them and cannot alter them.

(2) Unconsciousness as confusing inner and outer — as in dreams, hallucinations or misattributions due to using schemata to structure experience inappropriately.

(3) Unconsciousness as being without an appropriate schema.

(4) Unconsciousness as being unaware of the origin of our interpretation, due to the persistence of "implicit theories" based on forgotten (often infantile) learning.

(5) Unconsciousness of other people's meanings, usually due to false assumptions of similarity to one's own.

(6) Unconsciousness as being stuck within some too rigid theory.

3

Defences, Dilemmas, Traps, and Snags

In the ordinary course of life, most of us develop a reasonably accurate view of ourselves and others, a realistic range of purposes, and a repertoire of effective means; but for all of us sometimes, and for some of us always, our means prove ineffective and our aims unattainable in important ways. In order to overcome our failures to solve potentially soluble problems, we need to know about the ways in which our normal problem-solving and aim-fulfilling scripts work and about how the processes can go wrong.

The emphasis on aims in the PSM should not be taken to imply that only conscious logical action is important, or that only deliberate thought and action can produce change. An important part of psychotherapy for some people is that it provides permission for, and the opportunity for, non-logical thought, e.g. through dreams or the exploration of fantasy. Indeed, one aim of therapy may be a richer contact with those aspects of thought and feeling that can be called non-rational, mystical, or creative. In guiding patients through such experiences, however, the therapist needs to have a clear model of what kind of process he is intervening in. Many patients are out of touch with their feelings and confused about the personal meanings of their experience, and are hence unable to recognize and pursue the full range of potential human aims. Their state represents one of the end results of restrictions imposed on the self by the self, or by the terms of relationships with others. In this and ensuing chapters we shall be considering common ways in which personal meanings become confused and intentional scripts "go wrong".

The procedural sequence is a sequence of mental operations, each one of which must be completed satisfactorily if the aim is to be achieved. Abandonment of an aim may take place appropriately if it is seen to be incompatible with other aims or if it is judged correctly to be beyond one's powers to attain, or if the situation is recognized accurately as being unpropitious. In the same way, the absence of an available means or plan of action, or the correct evaluation that the proposed means would be — or, after execution, have been — ineffective, undesirable, or costly, will

lead either to the modification of the various judgements made and procedures used, or to the abandonment of the aim. The last step in the procedural sequence (the stage of reviewing evaluations and modifying assumptions and purposes) represents the learning process, whereby more accurate perceptions, more appropriate assumptions, and more effective actions, may be developed.

In considering why intentions are inappropriately abandoned or modified, and why the problems in the way of their attainment are not solved, we must consider all the ways in which the procedural sequence might be interrupted or diverted. If there is no realistic reason for abandoning an aim (and this is the defining criterion for neurosis and for the sort of problem that we are considering), then there must be a false reason; and if there is a false reason which is not corrected, there must be a factor at work which makes the error self-perpetuating: understanding these self-perpetuating processes is essential if we are to interrupt them.

In considering this issue of failed or abandoned procedural sequences, we are not concerned with isolated acts or events, but rather with those that recur. We need, therefore, to look at every stage of the sequences, including the last, at which learning does, or does not, take place. We will start by looking at each stage in the sequence in turn, in order to consider how it might contribute to difficulty, before moving on to the various forms of self-perpetuating problem that are clinically important and which usually involve several stages in the script.

CAUSES OF INAPPROPRIATE AIM ABANDONMENT AT DIFFERENT STAGES

Stage 2

(a) At the stage of considering assumptions, the understanding of the possibilities of the situation may be subject to specific, systematic distortion e.g. through a negative, depressive bias or through the denial of the meanings of particular aspects of reality.

(b) As regards self-efficacy, negative beliefs about one's capacity to influence events, or the assumption that the "locus of control" is largely in others, will inhibit effective action. Unrealistically positive self-evaluation can also lead to inappropriate acts.

(c) The criteria which define and judge the self may prescribe limits to the roles and capacities available to the individual, or may apply harsh, unrealistic, critical conditions for the maintenance of self-esteem. Specific aspects of the self, in the form of certain acts, attitudes, or qualities, may be undeveloped or forbidden expression. Negative responses to self-assertions from others may be anticipated consciously or unconsciously (see below: Snags).

Stage 3

At the stage of the listing of possible action plans, an individual may possess only a narrow range because of restrictive past experience, or because his ability to draw on analogous experience may be limited, or possible acts may be conceived of in terms of two contrasted, polarized alternatives (see below: Dilemmas).

Stage 4

(a) At the stage of the anticipation of performance, there may be a systematic over- or underprediction of the likelihood of success by the available means; this will be influenced by the general assumptions about self-efficacy and about the situation.

(b) At the point of considering the consequences of a plan, either the outcome or the means may be seen to conflict with basic assumptions and values; or there may be a realistically or unrealistically based anticipation of negative responses from others.

Stage 5

At the point of deciding on the means and operating them, the performance, for whatever reason, may fail to achieve the desired end.

Stage 6

(a) During the process of retrospective evaluation of performance, the effectiveness of the act as performed may be underestimated or overestimated.

(b) In the same way, the retrospective evaluation of the consequences of the act may be distorted by bias of a positive or negative sort.

Stage 7

Finally, in reviewing and evaluating the procedural sequence, the aim, or the process, whether realistically understood or seen in a biased way, may be judged in such a way that basic assumptions about the self and the situation may be revised in ways diminishing the likelihood that the attempt will be made to pursue the aim again.

THE DEFENCE OF DENIAL AND REPRESSION

We will now consider two of the classical defence mechanisms as described in psychoanalysis, namely denial and repression. The function of these defence mechanisms is to reduce anxiety and conflict. (In psychoanalytic terms, they serve to defend the ego against unmanageable aspects of reality or against id–superego conflicts.) Denial represents the failure to acknowledge the meaning and implications of a situation; it can operate with varying intensity from minor distortions due to idiosyncratic interpretations, through the editing out of the most uncomfortable aspects, to an extreme inability to face obvious meanings. In terms of the PSM, denial represents the reduction of conflict between an aim and the perceptions and

assumptions reviewed in Stage 2 by means of distorting or selectively ignoring aspects of the latter. In repression, the aim or the means available for its attainment are not acknowledged.

Rosa

An example of denial is provided in the account of Rosa, a 30-year-old Italian woman who had described, in her first psychotherapy assessment session, two events in her life which would be expected to be very distressing, but which she had met, it seemed, with calm indifference. These events were her premarital pregnancy and her husband's suicide. During the (tape-recorded) second session she returned to these issues, and I asked her, "What happens to the feelings?". She replied:

> I've thought about it; I wonder why. I must explain something: I was passing through the churchyard and there were graves there and I could see them. I didn't feel anything but crossing the road was very difficult because my eyes were sore and tears were coming down. I thought that my eyes had something sensitive to the sun, though it wasn't very sunny. Once I visited the cemetery again at visiting time for about 1½ hours; my tears was coming down, I didn't cry. Again I thought the marbles were white and there was snow on the ground and because of the white my eyes were irritable. Then these sorts of things happened always related to death in some way, and then I thought, "it is a real tear".

Denial is located in the situation-scanning stage of the PSM. The original aim is made subservient to a more dominant aim — that of preserving a manageable degree of conflict or discomfort. In repression, the meaning of the situation is similarly distorted, with an additional "forgetting" of the aim or with the exclusion from the repertoire of possible means of certain actions that might achieve "forbidden" outcomes. Here, too, there is a continuum from minor blocks on memory and action through to the quite specific exclusion of certain situation–action procedural scripts.

The more general statement about denial and repression is that they represent extreme ends of a spectrum of restriction on, or distortion of, aspects of the procedural script. As Haan (1977) points out, the healthy equivalents representing coping strategies rather than defensive ones, are concentration for denial, and suppression for repression. These modes are healthy because they represent adaptive, consciously reversible behaviours which heighten the capacity to pursue aims, whereas the defences of denial and repression achieve the aim of anxiety-reduction only at the cost of reduced accuracy in the understanding of the situation and a reduced range of available action.

We will now consider three classes of self-perpetuating difficulty, which I have described under the heading of traps, dilemmas, and snags (Ryle, 1979a).

TRAPS

The concept of the trap is intended to suggest circularity or self-perpetuation. The basic sequence of a trap is that an unwanted or inappropriate belief leads to a form of action intended to correct it but, in fact, serving to maintain or reinforce it. The circularity of traps derives from the feedback to the early stages of the PSM of judgements from the later stages. Simple traps involve only feedback from Stage 6 to Stage 4, whereby the prediction of an unsuccessful act, based on the judgement that earlier acts were unsuccessful or disallowed, leads to poor subsequent performance or to avoidance. However, more general considerations (Stage 2) may influence, or be influenced by, these detailed procedures, and actions may be further impaired or diverted by revisions (Stage 7) of the basic judgements about the possibility and permissibility of desired acts.

A clinically familiar example of the trap is a phobia. A simple model of phobic behaviour is that the false perception of danger in the situation or object for which the phobia is felt (PSM 2a), linked with the sense that there are no means adequate to cope with it (PSM 2b), leads to the abandonment of aims involving facing the situation. If an attempt is made to overcome the fear but the execution fails (PSM 6a) or leads to symptoms of fear or panic (PSM 6b), the assumptions of danger and of incompetence (PSM 2) are heightened, reinforcing the initial perception of danger. Repeated experiences of this sort have the further effect of redefining the self as a phobic person, and this can lead to the abandonment of further attempts to confront the feared situation (PSM 7). The identity of the self as phobic, once established, may colour a number of the strategic relationship scripts enacted by the individual; this can be seen as a form of secondary gain from the symptom, to use the psychoanalytic term. Primary gain, in the psychoanalytic view, lies in the fact that the original avoidance served a purpose in that it prevented the carrying out of some other, often unacknowledged, forbidden intention (PSM 2c); e.g. the phobic, housebound wife, according to some psychoanalysts, avoids exposure to men other than her husband, and achieves the primary gain of avoiding the (often unconscious) temptation to infidelity. The initial cause is often less hidden, however: feelings of incompetence, an incompletely developed sense of autonomy (PSM 2b), and the example of inappropriate fears in other family members may all play a part in the initiation of symptoms. The sequence: experienced fear— anticipated fear— fear on exposure but fear relief on avoidance— avoidance, is a trap sequence maintained by the experience of symptoms whenever exposure is attempted.

Obsessive–compulsive phenomena may be similarly understood. The aim of the compulsive act or thought is to avert danger; in so far as the danger is unreal, the act is a magical one. The simple model involves a false perception of danger, as in the phobia. The intention to confront the anxiety and avoid the obsessive act, which is what recovery demands, is difficult or impossible to pursue because of the knowledge, based on repeated experience, that to do the act is possible and is effective in relieving anxiety. If the danger feared carries symbolic "moral" meaning to it, its

control by means of the magical compulsive act serves as a protection against the external danger (PSM 2a) or against the forbidden act (PSM 2c) which it might otherwise call forth. The identity of compulsive person is in due course acquired, and may acquire secondary meanings, as in the case of phobias. The fact that compulsions to do with cleanliness (which, according to tradition, is next to godliness) are common, suggests that the primary gain of obsessive–compulsive states includes the magical control of guilt-provoking thoughts or wishes. In psychoanalytic terms, the compulsive act is a reaction formation, that is to say, it is an act repeatedly performed as being the reliable alternative to other forbidden (id) acts. In terms of the PSM this represents a restriction at the third stage, based on a false dichotomy or dilemma (see below).

Robert

This may be illustrated by a case history. Robert, aged 21, had suffered from panic attacks, a marked travel phobia, and extensive, severely restricting, obsessional–compulsive symptoms for the past 5 years. Medication had eased but not abolished his symptoms. He was the only child of highly achieving, controlling, perfectionist parents. His symptoms began soon after he had defied his parents by refusing to stay on at school at the age of 17. At about the same time, both his grandfather and his aunt had had surgery for intestinal obstruction and both had been left with colostomies, whereby the bowel empties through a surgically constructed opening in the abdomen wall. The colostomies seemed to have become symbols of loss of control, and were associated in some way with his own sense that his assertion of his independence had been a "shitty thing to do". He developed extensive rituals, including counting, special ways of going through doors, up and down stairs, getting dressed, and washing, and he became obsessively preoccupied in public places with the possibility that the people he saw there might have colostomies. At times he became concerned with the fate of his garbage, becoming unable to part with it, so that at those times his room was lined with plastic containers full of waste paper and kitchen refuse. Along with this, he began to have the feeling that he did not really exist, and would have to look repeatedly in the mirror to reassure himself. Robert had left home at 18 to live with a girlfriend and in that relationship his symptoms enabled him to be highly controlling. He was unable to travel or spend a night without his girlfriend's presence, and, if she were away for more than a few hours, she was required to telephone. Robert's symptom, therefore, continued to punish him for, or prevent him from, repeating self-assertions, while sustaining him in a controllingly dependent role with the girlfriend.

Some forms of depression can be regarded as a trap. The basic depressive vicious circle may be summarised as follows. Harsh self-identity criteria, a low estimation of self-efficacy, and a negative evaluation of the situation together determine negative predictive evaluations and negative judgements about the consequences of particular acts. This can lead to the abandonment of the intention, or to unconfident,

diminished performance. In so far as performance is diminished or absent, the sense of reduced self-efficacy is further reinforced; alternatively, some success may be achieved but success may seem forbidden, conflicting with self-identity judgemental scripts, so that the self-criticism is reinforced. This cycle may be initiated in a number of ways, for example: by the experience of repeated failure, for which responsibility is taken; by the impairment of performance due to illness; by exposure to unfamiliar and more difficult tasks; by an increase in the harshness of the conditions set for the maintenance of self-esteem as a result of guilt for some act, either committed or anticipated; or by physiological changes affecting energy levels and concentration, as a result of physical illness or of manic-depressive illness.

It is important to understand the relation of this psychological model of depression to endogenous depression (unipolar in bipolar manic-depressive illness). It is assumed that, in such illnesses, which may be apparently spontaneous or provoked by childbirth, the primary disturbance is physiological. This affects the organization and execution of tasks and these changes are experienced subjectively as a loss of energy and concentration, without in every case an accompanying depressed mood. The experience of incompetence, however, can lead to depression by lowering the sense of self-efficacy in general, and by leading to the progressive abandonment of aims, as failure is increasingly predicted. Moreover, as self-esteem is normally rooted to some extent in the perception of the self as competent, guilt will be added to the picture; in some cases, denial may operate and lead to the making of quite unrealistic, grandiose (hypomanic) claims.

In the treatment of this kind of depression, therefore, it is important to relieve the physiological changes with drugs, where this is possible, and to try to protect the patients from unreasonable self-blame for their diminished performances. At the same time, as soon as any physical recovery begins, the depressive spiral of hopelessness and predicted helplessness needs to be challenged by the encouragement of appropriate activity, by the imposition of accurate estimations of achievement, and by teaching patients to monitor and block their depressive thinking, along with any other appropriate psychotherapeutic methods.

The differential diagnosis of neurotic and endogenous depression is not easy because severe neurotic depression may provoke physiological changes of the kind associated with endogenous depression, whereas endogenous depression may make longer term neurotic problems manifest. In practice, any depressed person, who is not physically ill from some other cause, who is showing marked impairment of concentration or energy, alterations in appetite or major changes in sleep rhythm, especially where early morning waking is a feature, should be considered for antidepressant medication. If there are strong reasons to suppose that life events have provoked the depression, for example, by exposing the ineffectiveness of some procedural script, or by exacerbating a conflict between aims and self-judging scripts, then the effects of supportive, explanatory, and interpretive therapy, and the use of some active methods may be tried as the first therapeutic methods, and in some cases these will give rapid relief. It is important to exclude physical illness as a cause

of depression. Once this is done, mild cases, not apparently explicable psychologically, or anyone who is severely depressed, with retardation of thinking and talking, agitation, and marked self-blame, may be helped by anti-depressant medication. This should be given in adequate dosage for an adequate time, and not in the small, unsustained regime all too frequently prescribed. Psychotherapists whose patients become depressed during treatment will be reluctant to use medication, as the depression will often be seen to arise as a result of dealing with important issues in the therapy; but transference emotions may serve to trigger mood swings in manic-depressive patients, and during such swings patients may be inaccessible to psychological methods. It is clear that non-medical psychotherapists will need to treat depressed patients in co-operation with doctors.

David

In the case of David, although there was a family history of depression in his father which might suggest a predisposition to manic-depressive illness, the onset of his depression was closely related to Patricia's departure and was clearly a reaction to it. As a result of the upset caused by this, by the time I saw him he was some weeks in arrears with his work, and had failed in a minor examination. He had therefore suffered a reduction in academic performance as a result of depression from another source. In discussing his situation, he showed a pessimistic and unrealistic estimation of his chances of catching up; that is to say, his predictive evaluation of performance was biased by his mood. Moreover, in discussing his past academic record, he reported several assessments and comments from his tutors which suggested a quite satisfactory situation but he discounted these as being based on kindness rather than judgement. In this it seems likely that David's retrospective evaluations of performance were also negatively biased due to his depressed mood.

In another form of trap, related to the defence of regression (in psychoanalytic terms), anxiety about long-term goals, e.g. about being sexually attractive, may lead to short-term strategies, such as comfort-eating, that replace those actions needed to solve the problem or achieve more important aims. Often, these actions actually hamper the achievement of the more important aims, e.g. overeating causing obesity. Regressive behaviours of this sort represent the pursuit of diminished goals, usually goals related to the satisfaction of basic (childish) needs. In "bulimia nervosa", which is marked by cycles of binge-eating followed by self-induced vomiting, this regressive satisfaction is followed by the ritual emptying out that is at once relieving of guilt and productive of shame and self-disgust, paving the way for further depression and further resorting to regressive comfort-eating.

Another important group of trap behaviours are those in which the undesired state of the self, or assumptions about the self, are maintained by the reactions provoked from others. At the level of strategic scripts concerned with relationships, these traps are usually the manifestation of negative assumptions about the self, typically as being weak or dangerous or without value, and of unrealistic judgements of the other, typically as being critical, rejecting, or harsh. Restrictive beliefs about what constitutes permissible behaviour or negative predictions about the likely responses of others to what one wants to do may also play a part. A common example is the belief that to be self-assertive will inevitably provoke rejection. These beliefs can lead to forms of relating to others which serve only to heighten or sustain them.

Two common examples are the social isolation trap and the placation trap. In the former, the shy person feels boring and expects rejection; in company, he avoids eye contact and responds brusquely and awkwardly to conversational approaches. He is then perceived as aloof or hostile, and people tend to avoid him, from which he concludes that his initial poor sense of himself is clearly shared by others. In the placation trap, a person who fears that his assertion will lead to rejection tries to please everybody, only to find that this leads to his own needs being ignored, so he comes to feel misused and resentful, and may end up by acting in childish ways with ineffective forms of aggression in inappropriate circumstances, behaviours which both he and others may indeed find unacceptable. These judgements, in turn, can reinforce both the lack of confidence in the self and the sense that assertion does not pay.

Other traps are acted out upon the body. Scratching the skin, which makes it itch, and causes further scratching, or compulsive hair-pulling, are examples of physical acts which are also expressive of self-attitudes. Such acts are often associated with issues of guilt and self-punishment, although this may not be known consciously. Self-cutting, for example, often produces relief; it would seem to represent the enactment of self-punishment which eases or obviates guilt. Many other symptoms, some of which will be considered in the next chapter, serve to maintain the individual in an unsatisfactory state that combines some gratification with restriction or punishment.

DILEMMAS

A dilemma operates at Stage 3 of the procedural sequence. It puts restrictions upon action by defining the possibilities narrowly: typically, as lying between equally undesirable alternatives, thus preventing the individual from freeing himself to try out a range of other possible courses. Two situations can be envisaged: in the first (a false dichotomy), the choice is restricted, seeming to lie between two courses. Sometimes either may be pursued, sometimes one is chosen, although it is unsatisfactory, because the only apparent option is even less desirable or more frightening. In the second, the dilemma is seen in the form of "if, then" (a dilemma of false association) so that the course which is desired is seen as unattainable because it is felt that to pursue it has negative connotations for the self-description. Reaction formation, which is part of the obsessive-compulsive syndrome, can be seen as an example of a false dichotomization of possibilities between the compulsive act and the feared alternative.

At the strategic level, dilemmas are concerned with the terms of relationships and with their associated costs. Such dilemmas can usually be seen to be derived from childhood and family roles; they are manifest in adult relationships, where mutuality would be appropriate, often representing the imposition of roles appropriate to parent–child interactions. Common examples may be summarized as follows. *If* dependent, *then* submissive; *either* dependent *or* in control; *if* caring, *then* submissive. Issues of this sort frequently link up with cultural notions about the appropriate male and female differentiations. For example, a woman brought up in the old tradition, which could be summarized as "*if* feminine, *then* passive" will have difficulty in feeling feminine while being assertive. People restricted by such dilemmas often select partners prepared to play reciprocal roles or they will endeavour to mould their relationships within their familiar terms.

At the level of the self, dilemmas are expressive of conflicted self-attitudes; here too, issues of control are common, notably the "*either* in control of feelings *or* risking going crazy" dilemma, in its various forms; but particular histories can generate highly individual and complicated dilemmas. A list of common ones is given in Chapter 14. For a psychoanalytic discussion of these issues see Kris (1977).

It is clear that everyone is faced with dilemmas; life presents them inevitably and few of us can find easy resolutions to them. The brief descriptions given later of neurotic patients' dilemmas in these terms do not necessarily imply that is by virtue of having such dilemmas that these individuals are neurotic. What is true is that neurotic individuals seem to have such dilemmas in more extreme forms, or it may be that they have been forced to face some of the painful consequences of them due to the breakdown of previously matching or collusive relationships (Ryle, in press). In therapy, or problem-solving, the important task is to identify these dilemmas that are serving to restrict the capacity of the individual to solve his particular problems. Having identified such dilemmas, one can proceed to generate alternatives beyond those possible within the terms of the dilemma. To put this differently, the concept of the dilemma is a way of describing explicitly the premises (at PSM Stage 3) from which the problem-solver is addressing his problem. These premises seem self-evident to the person with the problem because they are his familiar terms, but they will usually turn out to be idiosyncratic and narrow, and to recognize this can lead to a fruitful redefinition.

Anne

Anne exhibited a relationship dilemma, in which the alternatives were seen to be between being *either* helpful, controlling, and sane, *or* dependent, weak, and potentially crazy. This dilemma did not dominate all her relationships, however; with her husband, one friend and, in time, with me, she was able to accept that a dependent role could be safe. Anne showed a second dilemma in relation to work, in which the choice had always seemed to be between *either* stressful striving for perfection *or* guilty failure, alternatives which left out the possibility of working from interest, ambition or pleasure towards realistic ends.

David

In the case of David, there seemed to be a similar underlying relationship dilemma, probably related to his early separation from his mother, which could be expressed as "*if* dependent, *then* not in control", and in most of his relationships he aimed to be in a position of amiable control.

SNAGS

The word "snag" implies complications and difficulties, and it can also be seen to stand for Subtle Negative Aspects of Goals. Here, we are concerned with the individual who fails to pursue what he wants to do or be, as if the outcome would be dangerous, forbidden, or otherwise undesirable (PSM 2c and 4b). This prediction is seldom conscious and (unlike traps) is not maintained by symptoms or by the responses of others; often, the abandoned aim is forgotten. To the extent that the "as if" is false, a person can be freed to act more as he wishes by being helped to recognize his "snag". At the tactical level, such predictions are manifest in countless acts of self-diminution, but the understanding of them comes from studying the strategic and self-identity levels. In external snags, the predicted consequence of pursuing desired life aims is of adverse responses from others.

The whole of family and marital therapy, and the application of systems theory approaches to such therapies, has grown out of the very well-validated observation that the problem or sickness of one is often — perhaps nearly always — an aspect of the emotionally significant group of which he is a member. The individual who does not live his life fully may do so because he believes that another, or others, cannot permit it. Sometimes he has directly experienced the adverse responses of others, or has had more or less direct prohibitions issued by them; but such knowings are usually concealed within family or interpersonal confusions or myths. Individual psychotherapy in the psychoanalytic tradition, with its preoccupation with history and the "inner world" and the transference, has often underestimated the importance of such current emotional forces. The way in which the other indicates prohibitions may be through direct threats of abandonment, rejection, or punishment; or through illness, either physical or psychiatric, or through attributions. In such cases, the individual cannot change until such relationships have been clarified, revised, or broken. In many cases, however, it turns out that the extent of the adverse response anticipated from the other has been exaggerated and, in reality, the other accommodates to the changes in the individual without too much difficulty. Here, patients in individual therapy need to be helped to test out realistically what responses their changes do evoke, and to deal with the effects of such changes upon others.

Internal snags are the consequences of self-identity judgemental scripts that deny one the right to pursue one's aims or be oneself. Their effects are often manifest in widespread prohibitions on success or enjoyment, and their existence is seldom

recognized by the individual restricted by them. It may take time for a therapist to discern the operation of internal snags: this recognition may be through seeing the way in which the patient dismantles, or arranges to pay for, or be punished for, the gains made in therapy. (This is the negative therapeutic reaction of psychoanalysis). The existence of snags of this sort should be looked for where such dismantlings, punishments, or restrictions are seen to recur. There are common antecedents of such snags in the patient's history which can alert the therapist to look out for them. Many are derived from the child's omnipotence, which can lead him to assume unrealistic responsibility for illnesses, deaths, or failures of other family members. The case of Peter in Chapter 9 is an example of this. Another common source can be the exposure in childhood to the active envy of a parent, brother, or sister.

It is as if the person with the snag is saying to himself: "All that I might have, do, or become, will be at the cost of . . . I can avoid this or I must pay for it by failing, by not enjoying my life, by undoing achievement, or being ill . . . "; but he is not conscious of this process of guilt and expiation.

Because such self-prohibitions are seldom fully conscious, the recognition of their patterns is an important step in reducing their force. Once recognized, patients will often name the snag, for example, Win, described at the end of Chapter 9, called hers her "gaoler". The recognition of the debate that is going on between such irrationally determined negative voices and the ordinary assertions of the self, and the clarification of the way in which the restrictions of the self may have been falsely attributed to others, opens the way for a challenge, but the change may be slow because, like everything else positive, the understandings and the gains of therapy may also have to be or paid for dismantled. In terms of the PSM, the experiences of adverse outcomes (Stage 6) and the experiences that such outcomes are avoided by abandoning the aim, leads to the elimination or "forgetting" of the aim (Stage 1).

David

In David's case, I was alerted to the possibility of a snag by his self-deprecation and depressive thinking about his academic work, and at the end of the first session the following interchange took place.

AR: I don't know how far the issue of success was an issue before your father's breakdown, as the issue of dependency obviously was; but I do know it's very common for people who have a family catastrophe at that time of entering the adult world to feel guilty. The coincidence in time of one's growth and the illness, death, or whatever, of a parent gets some kind of magical connection in one's mind. As if your entering into manhood was at the price of your parents' marriage and of your father's severe mental illness.

DAVID: Which isn't true.

AR: Which isn't true, but if you feel that, then one way of paying is never to have the life you might have.

DAVID: Yes, I can see that.

This somewhat brusque introduction of the notion of the snag was returned to and discussed more extensively in later sessions; later in therapy David recognized another source (see Chapter 5).

Anne

In the case of Anne, throughout childhood and adolescence a snag was imposed by the family, although the avoidance of plain speaking and the family myth of mother's immense vulnerability meant that it was difficult for Anne to see her role and her yielding to mother's alleged needs as being other than normal and appropriate. Mother's illness was always described as being due to biochemical disorders, by the father. Anne was only allowed to pursue those aspects of her own intentions which did not conflict with this set of assumptions, and these "rules" had become part of her own self-identity script.

DISCUSSION

The PSM is compatible with a number of behavioural and cognitive/behavioural models. The relation of some of these models (of depression, of attribution, of learned helplessness, of self-efficacy, of cognitive therapy, and of generalized expectancies) to the procedural script model is summarized in Table 3.1 a, b, c. These models, in turn, are similar to the various behavioural and cognitive/behavioural models reviewed by Whitehead (1979) in which she showed that attention was focused on four issues: depression as behaviour; depressed behaviour as maintained by the absence of positive reinforcement; depression as reflecting the absence of a sense of being able to control the environment; and depression as reflecting a negative view of the self and of circumstances. Beck's (1976) work on depressive thinking, and its control by monitoring, represents the recognition and correction of negative evaluations of performance. The model of depression proposed by Rehm (1977) and of learned helplessness by Roth (1980) are more systematic studies of the same area, which are fully compatible with the model proposed here. Roth, for example, writes as follows, in discussing her refinement of the theory of learned helplessness:

> The current model is also unique in its consideration of influential factors at each of three stages of a subject's movement, from objective contingency to learned helplessness deficit. 1. Objective non-contingency— perception of non-contingency. 2. Perception of non-contingency— further expectancy of non-contingency. 3. Expectancy of non-contingency— learned helplessness . . .

In simpler terms, a failure to control or influence events is correctly perceived (Stage 6) but overgeneralization from this means that future attempts are expected to fail (Stage 4); this may be further generalized to the general assumption of 'learned helplessness' (Stage 2).

The PSM can also take account of the work on the locus of control and

Table 3.1a Six theories in relation to the Procedural Sequence Model

Procedural Sequence Model	*Rehm (1977) (Depression)*	*Roth (1980) (Learned helplessness)*
1. Define aim.		
2. Consider general assumptions about:		
a) possibilities for pursuit of aim;	Selective monitoring of negative aspects;	
b) capacity to pursue aim;	negative evaluation of efficacy;	
c) permissibility of pursuing aim (judgments of self and (others)	self-derogation; failure to self-reward.	
3. List possible action plans		
4. For each plan, consider:		
a) can it be carried through?		Prediction of non-contingency;
b) What consequences will follow carrying it through?	Selective monitoring of immediate over delayed consequences.	
5. Choose preferred plan, and act.		Ineffective action
6. Consider:		
a) how effectively plan was carried through. b) what were the consequences of carrying it through?	Inaccurate attribution of responsibility for outcome. Overgeneralisation of failure.	Objective non-contingency resulting in perception of non-contingency (attribution and over generalization)
7. Evaluate the sequence; reaffirm or revise the aim and/or the assumptions.		Prediction of future non-contingency.

Table 3.1b

Procedural Sequence Model	*Beck (1976) (Cognitive therapy)*	*Rotter (1978) (Generalized expectancies)*
1. Define aim.		
2. Consider general assumptions about:		
a) possibilities for pursuit of aim;	Selective monitoring of negative aspects;	Understanding, trusting; discriminating between others reduced;
b) capacity to pursue aim;	negative evaluation of efficacy;	ability to control, especially in long-term, reduced;
c) permissibility of pursuing aim (judgments of self and others)	Self-derogation, stringent criteria.	
3. List possible action plans.		Limited view of range of possible actions.
4. For each plan, consider:		
a) can it be carried through?	Capacity to influence events underrated.	
b) what consequences will follow carrying it through?		
5. Choose preferred plan, and act.		
6. Consider:		
a) how effectively plan was carried through;	Overgeneralization from failure.	
b) what were the consequences of carrying it through?		
7. Evaluate the sequence; reaffirm or revise the aim and/or the assumptions.	Failure increases negative assumptions about situation and efficacy.	

Table 3.1c

Procedural Sequence Model	*Försterling (1980) (Attribution)*	*Bandura (1977) (Self-efficacy)*
1. Define aim		
2. Consider general assumptions about:		
a) possibilities for pursuit of aim;	External locus of control assumed;	
b) capacity to pursue aim;	effects of acts on outcomes under-estimated.	Self-efficacy influenced by performance, vicarious experience, persuasion.
c) permissibility of pursuing aim (judgments of self and others).		
3. List possible action plans.		
4. For each plan, consider:		
a) can it be carried through?	Effectiveness of own acts underestimated.	Efficacy assumptions determine prediction and influence performance.
b) what consequences will follow carrying it through?		
5. Choose preferred plan, and act.		
6. Consider:		
a) how effectively plan was carried through;	Faulty deductions from outcome; underestimate responsibility for outcome.	Failure reinforces low self-efficacy; success enhances self-efficacy.
b) what were the consequences of carrying it through?		
7. Evaluate the sequence: reaffirm or revise the aim and/or the assumptions.	Belief in external locus of control reinforced.	Level of self-efficacy as perceived influences Stage 2.

expectancy (Rotter, 1966, 1978) and of Bandura's (1977b) recent writing on self-efficacy.

While they are compatible with the procedural sequence model, these cognitive and behavioural approaches are incomplete. In so far as self-evaluative processes are considered in them, they are largely concerned with performance and only marginally with personal meanings and judgments. While Rehm (1977) does discuss the issue of self-punishment and self-reward, she considers these only in terms of "maladaptive modelling or reinforcement schedules". Here, as in the other works, the self appears variously as the object of negative behaviours, the object of negative evaluations, as the more or less effective executor of acts, or as a proper object of monitoring and control; but no serious attention is paid to the structure of the self or to who, or what, it is that rewards, punishes, measures the power of, or controls, this self. The issue of the self will be considered more fully in Chapter 5, but at this point it must be said that many phenomena, including several of the clinical states discussed in this chapter, cannot be explained adequately unless it is assumed that the self includes both an executive and a conceptualizing and judging aspect. This is most notably true when there is a conflict between aims and judgements, or where the avoidance or relief of guilt by expiation of self-punishment becomes a salient aim. The understanding of these issues is one of the important contributions of psychoanalysis.

Another inadequacy of these approaches is in their neglect of defences and of the influence of early psychological development. Beck (1976), for example, who is probably the most influential clinically, avoids any discussion of guilt or conflict. He considers that emotional difficulties arise from the individual's "distortions of reality based on erroneous premises and assumptions" and does not consider the role of denial or repression, despite the fact that satisfactory accounts of them are available in cognitive terms, e.g. in the writings of Loevinger (1976) and of Haan (1977).

Because of the circularity of trap phenomena (including depression, phobias, and obsessive—compulsive behaviours), intervention in any part of the trap circle may be therapeutically effective, and therapies based on these incomplete models may therefore work by modifying either behavioural or cognitive stages in the circular sequence. Moreover, the therapeutic situation also serves indirectly to relieve guilt and accord positive value to the individual. There will, however, be a proportion of cases in whom the full understanding of the more complex circular processes in terms of the PSM will be needed for therapy to be effective.

Some of the ideas presented in this chapter deal with phenomena familiar to many in psychoanalytic terms as repression, denial, regression, and reaction formation (Anna Freud, 1936). What is proposed, however, is not a simple translation of these terms, but rather a more general consideration of how intentions, including those seeking "outlets" for "drives", may be blocked, modified or diverted; how the meaning of experience may be idiosyncratic, narrowed, distorted; and how choices of action may be restricted. The psychoanalytic concept of the dynamic unconscious, whereby unacceptable memories, ideas, or impulses are actively denied

access to consciousness, is re-described in these terms as cognitive strategies involving selective forgetting, schematic isolation, or replacement of action plans by alternative plans. These strategies serve to reduce conflict between competing plans and values, to reduce the distance between desire and possibility, and to avoid challenging the conditions imposed by self-evaluative criteria. They are therefore the adult internal equivalents of devices used visibly by children to cope with unpleasantness or conflict. (For example, my grandson, not quite 3, brought home a note from his nursery school, announcing its intended closure; he put the note in the cupboard and shut the door, announcing, "Now you can't see my broken school." On another occasion, he wanted to bite his sister; he was prevented and was reminded of how his wish was unkind, given that she had recently given him a piggyback; he dealt with this discrepant fact by saying, "Can't 'member.").

In psychoanalytic terms, it is the conflict between the primitive urges of the infant and parental authority, as internalized, that sets the tone for how subsequent "drive–defence conflicts" are resolved. As a corollary of such a view it is claimed that interpretation of the regressive transference offers the only real key to cure in neurotic problems. In contradistinction to this view, the PSM allows one to see how the effectiveness of intentional scripts can vary in a number of ways, and how the scripts an individual operates with will always show some degree of simplification, distortion, or restriction. Moreover, although some areas of exploration or development may be blocked because of early conflict-reducing strategies, it is by no means clear from clinical work that this occurs to a total extent, and there is very often evidence that the later experiences of childhood and adolescence have served to shape the individual scripts. This later distortion can occur, both through the definition of certain thoughts or behaviours as "no go" areas (e.g. Anne was brought up never to argue with the definition of her mother's behaviour as due to illness) and, perhaps more importantly, by leading to the development of scripts that are perfectly effective and sensible strategies for dealing with the family situation, but which prove inflexible and restrictive in the larger world. These successful but restrictive strategies are often obvious to the therapist but have not been recognized fully by the person; or they may be seen by him as self-evident, or as an aspect of personality rather than as constituting a limitation on possibility. The recognition that such strategies are operating can often lead to their revision, without the need for prolonged, extensive interpretive work.

There are important clinical implications in the different account offered by the cognitive model. Are the detailed "not-knowings" which characterize repression and denial, the *causes* of the deformation of self-identity scripts, or are these defensive devices made necessary by ineffective higher-order scripts? In the classical psychoanalytic view, it is by the analysis of ego-defences against forbidden impulses, dating back to childhood and seen as presenting in the transference, that recovery takes place, implying the former version. However, there is evidence, including some from psychoanalytic sources, that memories so recovered during the treatment process may bear little relation to the actual early experience (e.g. Kris, 1965; Kennedy, 1971; Gill, 1978). In practice, psychoanalysts are divided in how far they attempt to reconstruct childhood, as Gill (loc. cit.) discusses, but the trend is towards a focus on the here-and-now, and most writers seem to agree that the understandings gained in the transference and the safety offered by therapy permit the derepression of (or, more probably, the construction or reconstruction of) memories, more often than the recovery of memories promotes a new understanding.

If this is the case, it seems likely that *any* extension of the patient's self-understanding and self-control (i.e. any increase in his ego-strength) would have a similar effect in reducing his need for defences, and analytical approaches for treatment are clearly not the only means of achieving these. Behavioural and cognitive treatments are often effective in this regard, but I believe that a more elaborated cognitive approach is better.

The most effective way to reduce defensiveness is to improve the patient's control over his life, and here, while successful behavioural change or cognitive modification can be helpful, I believe that the sharing of explanatory concepts upon which these and other treatment methods are based is valuable. The concepts of the trap, dilemma, and snag (first proposed in Ryle, 1979b) are descriptive of important malfunctionings of the procedural script; their purpose is not only to guide the therapist, they also direct the patient's attention to the essential nature of his difficulty. In teaching a person a way of understanding his processes, one is enabling him to overcome the obstacles to learning. Minsky and Pappert (1972), in urging the usefulness of computer analogues for thinking, wrote that "learning to learn is very much like debugging complex computer programs. To be good at it requires one to know a lot about describing processes, and manipulating such descriptions." In sharing with a patient a suitably complex model of how his procedures are faulty, we make it clear to him that the point of our various therapeutic methods, whether behavioural, cognitive, interpretive, or whatever, is precisely to help him develop more satisfactory procedures, and we at once alter his experience of his difficulties in ways that increase his sense of possibility and responsibility.

The relation of cognitive control styles to therapy (Klein, 1970), in particular with children, is discussed from a psychoanalytic viewpoint by Santostefano (1980) in ways that have some bearing on this chapter. The function of cognitive controls is to integrate inner information about feelings, drives, and fantasies with information about the outer world (in terms of the PSM, to integrate aims with the perception of the situation and self-identity criteria). Individuals differ, for example, in being undifferentiated or distinct in their body and ego tempo regulations, narrow or wide in their intentions, relevant or random in the selectivity of their attention, global or complex in their discriminations and crude or elaborate in their categorizations. Santostefano reports the relationship of these aspects of functioning to psychological difficulty in childhood, arguing that personality development requires satisfactorily established cognitive controls. Where these are absent in a child in therapy, development of more satisfactory ones may require successive working through of the issues in the modes, first of physical activity, then of fantasy, and only finally in

language. He suggests therefore that "cognitive control therapy" may need to precede defence analysis, and notes that problems in cognitive control are quite extensive and not confined only to issues which are the subject of drive/defence conflict.

Extending this view to the field of adult psychotherapy, it would seem equally important to pay attention to cognitive features in all cases, and particularly helpful to develop as quickly as possible a discriminating, well-focused, and adequately complex way of thinking about the problem being dealt with. The dilemma, trap, and snag formulation put forward in this chapter serves precisely to mobilize better cognitive understanding in this way. For some people, however, action and fantasy work may be especially useful in modifying maladaptive processes, and the active methods of therapy to be discussed later (teaching self-monitoring, rehearsal in imagination, graded exposure) may be more accessible than more verbal or conceptual approaches.

4
Emotions and Symptoms

In the last two chapters the essential features of the PSM have been described, and some ways in which it serves to describe common neurotic difficulties have been considered. We need now to consider further the sources of aims (the question of motivation), the nature of the emotions, and the nature of the symptoms that so frequently accompany neurotic difficulties in living.

Many colloquial descriptions of human activity, and some psychological ones, offer a dualistic model whereby we are "motivated" by some force which is separate from, but in some degree controlled by, us. Such accounts are unhelpful because they contribute to what Schafer (1975) called "disclaimed action" or what, in the vernacular, might be called "copping out". It is easier to say, "I want to get on with my work but somehow I lack motivation" than it is to say, "I choose not to work". In psychotherapy, where one is concerned above all to extend the patient's sense of his capacity to choose and act, the challenging of this kind of conceptualization is important. In terms of cognitive theory, the idea of motivating forces is redundant once we accept that human activity is, essentially, meaningful, that is to say that man is inevitably and always concerned with the extension of his cognitive understanding and control of experience, and with the active exploration of his world. We bring to the world our curiosity, our biological drives for food, drink, and sex, our innate need for attachment to others, and we learn from the world, above all from the social world, how to satisfy these and how to pursue our complex, culturally determined desires and intentions.

A COGNITIVE THEORY OF EMOTION

If we are to pursue our aims, we must be able to recognize how far, at any given time, our state and situation correspond with, or conflict with, these aims. Emotions are understood in cognitive terms in relation to this issue; they are the subjective accompaniment of our recognition of the current match between how we see