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

ourselves and our situation, and how we would like to see them. When we perceive a discrepancy between our reality and what we want, we experience one of the emotions such as sadness, anxiety, anger, or sexual desire, which rouse us to action. When such action successfully closes the gap between what we want and our reality, by the revision of one or the other, or when our perception is of a satisfactory match, we experience positive emotions such as contentment or joy (see Katz, 1980; further discussed at the end of this chapter).

Positive emotions signal no mismatch: they are not accompanied by obvious physical sensation indicating the need for action, while mental functioning is experienced as fluent. Negative emotions, on the other hand, represent a call to action, and are accompanied by the physical changes that prepare the body for action and by mental changes in the direction of concentration or restriction, or sometimes disruption.

The power, or impact, of a script-reality discrepancy will obviously depend upon its place in the hierarchy of our life aims. A mismatch at the self-identity level of the PSM (e.g. "my life is out of control") is clearly more powerful as a source of emotion than one at the strategic level (e.g. "I cannot manage my relationship with my employer") and much more powerful than one at the tactical level (e.g. "I cannot mend my typewriter"). Generalizations up and down the hierarchy can occur, however, so that one may be cheered up by getting the typewriter to work on the one hand, or too depressed to do a simple repair job on it on the other. These generalizations represent the revisions of self-efficacy assumptions.

The physiological changes accompanying emotion are to some degree specific to the emotions, but the recognition of emotional states is also dependent on one's understanding of the situation and its meaning. Cultural differences in the sorts of discrimination made between emotional states are considerable and, within cultures, particular families may develop idiosyncratic rules for the naming and expression of feelings. In some cases, the physical symptoms accompanying emotion may be mislabelled, e.g. as hunger, and their personal meaning may not be realized. Non-recognition of feeling states in this way is a common attribute of patients with anorexia nervosa and other serious eating disorders (Bruch, 1973). A reverse instance is the mislabelling of physical symptoms as emotion: the pallor and rapid pulse following drinking too much coffee can make one feel anxious, unless one remembers how much coffee one has drunk (see Schachter and Singer, 1962).

ABNORMAL EMOTIONAL STATES

We have considered so far emotions as being the result of schematic mismatches between reality as perceived and as desired, and have noted their function in initiating appropriate action. The persistent failure to resolve such perceived mismatches is one source of dysphoric mood states, notably depression and anxiety. Another important and common source of persistent mood states is the unresolved conflict between aims and self-judgements: in terms of the PSM, schematic discrepancies

between aim scripts and self-identity criteria. Harshly critical self-evaluations, unrealistically high criteria for self-acceptance, or the sense that success is forbidden or must be paid for are all potent sources of persistent negative mood states. These long-term emotional states derived from internal conflict can become a further source of difficulty by impairing cognitive functioning and provoking feelings of self-doubt or incapacity. In other cases, the avoidance of conflict is achieved by the abandonment of important life aims with a consequent restriction of experience and possibility, as in the snags described in the last chapter. The sense of emptiness or purposelessness which follows such abandonment of important aims becomes a further source of despair.

The importance of such conflict is recognized fully only within psychoanalysis, but in some respects the psychoanalytic view of emotion is a narrow one. Emotion, identified with the id and regarded as being concerned with the primitive "pleasure principle", is regarded as actually or potentially disruptive, to be controlled by the ego. Schachtel (1959), in an important critique of this position, saw Freud's pleasure principle as being a reductive account of emotion in both infant and adult. To the tension-relieving "pleasure principle" affects described by Freud (more properly labelled as effects of the "unpleasure principle") which he labelled as "embeddedness affects", and equated with the torpor of the infant after a feed, Schachtel proposed the addition of another class: the activity affects, related to the experience of achieving mastery over the world, and manifest in the infant's eager exploration of his environment. In terms of the PSM, Schachtel's "embeddedness" affects represent mismatches solved by the actual or fantasized reliance on external sources, rather than upon action. Many emotional states in adults, especially the usually neglected positive affects, can be seen to exist in two forms, discriminated along this embeddedness/activity distinction. Thus, Schachtel contrasts the magical joy of fantasy wish-fulfilment, which is often accompanied by the fear of envy, with joy reflecting an active turning towards the world, and he makes a similar distinction between magical hope and the active exploration of reality. Among negative affects, he regards anxiety, especially in the established mood state of angst, as the classical example of an embedded affect, representing the passive expectation of incapacity in the face of reality, as opposed to the active mobilization of resource. These views of Schachtel represent an important revision of psychoanalytic thought, and, in the emphasis on activity and on the positive integrating effect of emotion, are in line with the cognitive model proposed here.

We will conclude this theoretical account of emotion by considering once more the cases of Anne and David.

David

In the case of David, the original impulse to consult the Careers Adviser had come from his uncertainty about his future plans, and from a sense of not being sufficiently in control of his own decisions. In effect, therefore, he was mildly unhappy to

recognize a mismatch between a perception of himself as he was and as he would like to be, namely, competently in charge of his life. He acted appropriately to try to resolve that. Patricia's departure, however, presented him with an abrupt and disruptive mismatch between his expectations and reality. His sense of the purpose of his life and of where it was centred had been taken for granted for a long time. When Patricia left, he felt lost, without purpose, sad, and angry. These emotions came and went according to how he thought about the situation: despair or depression at the though of a future that now seemed meaningless, grief at the loss of his closest relationship, self-reproach that he had not cared for the relationship better, anger at Patricia's act and at the way in which she had done it. Attempts to win her back were soon abandoned and he was left, therefore, with the task either of replacing her, which was the solution he had adopted at the end of his previous relationship, or of forming his purposes and definitions upon some other base.

Anne

Anne's experience of her thoughts being out of control confronted her with a version of herself that was contradictory to a very important basic aim, namely to remain sane, stable, under control, and unlike her mother in every way. Although the original symptom, which was probably chemically induced, was short-lived, uncontrolled rumination about possible brain-damage, or about the probability that her symptoms (or the fact of worrying about them) might be a harbinger of, or a cause of, a future breakdown, served as continuing reminders that she was *not* under control; and the anxiety that flooded her when she had that thought was itself a further contradiction to the stable self-definition she had successfully defended up until that point in time. Anxiety erupted whenever she was confronted with this discrepancy between her experience and this centrally important self-definition.

PHYSICAL SYMPTOMS OF EMOTIONAL ORIGIN

The physical symptoms accompanying psychological and emotional difficulty can be divided into three groups differing in origin and significance: arousal symptoms, hysterical symptoms, and psychosomatic symptoms.

Arousal symptoms arise when schematic mismatches elicit the physiological changes that occur in nature, either in preparation for fight or flight, or as signals (such as the raised hair that frightens off the enemy). These symptoms include changes due to autonomic nervous system activity such as pallor or flushing, palpitations or sweating, and changes in muscle tone leading to weakness or tremor or, if persistent, to fatigue or tension symptoms. When these changes occur inappropriately, due to one's misconstruction of the situation (PSM 2a) or of one's own state (PSM 2b, 2c), or when the arousal is appropriate but the response that might alter the situation (e.g. by dealing with the threat) is not proceeded with, then awareness of the symptoms (PSM 6b) can lead to secondary anxiety, such as the fear of collapse

or the fear of loss of control. With repetitions, this secondary fear, which may be associated with a particular situation, or which may be evoked by particular thoughts or images, becomes a sufficient cause of the symptoms. In understanding such symptoms, attention must be paid to the circumstances of their origin, the situations in which they occur, and the thoughts that precede or accompany them, so that one can identify the nature of the abandoned act and consider the accuracy with which the self and situation have been construed.

Hysterical symptoms (which have become increasingly rare in western cultures) represent the translation of an idea or wish, that is not acceptable, into a physical symptom, such as loss of voice, writer's cramp, or the paralysis of a limb. The unacceptability of the idea of wish may relate to the anticipated responses of others, or, more frequently, to one's own self-judgements. In essence, rather than the person saying "I will not", the symptoms announce that "he cannot"; in terms of the PSM the aim is not abandoned, but the means is, unconsciously, inhibited.

Eileen

Eileen sought a psychiatric opinion a year after the onset of her symptoms, which consisted of headache, panicky feelings, and attacks of cramp and numbness of the right hand. She was a highly achieving postgraduate student who said she felt like "an exhausted dog chasing an inexhaustible electric hare". In recent months, her ability to produce written work had diminished and she was now entirely blocked, and feeling depressed and ashamed. During the previous year she had had a full neurological investigation which had proved negative, and she was currently attempting to arrange endocrinological investigations, still seeking an organic explanation for her troubles. From childhood onwards, Eileen had been her teacher's golden girl, working frenetically and achieving high grades up to the end of her undergraduate career. Her angrily critical self-judgements, as I saw it, were based upon her early perception that only achievement could win her father's respect and then only at the cost of her being seen as unfeminine. Failure, unless justified by illness, was therefore unthinkable, and the desire to give up could only be expressed through the symptoms, just as her rejection of this explanation was initially expressed by "forgetting" to get off the train to come to her third appointment.

Psychosomatic symptoms, with varying degrees of complexity, combine the symbolic expression of denied feelings with forms of self-restriction or self-punishment, and with ways of obtaining or justifying care from self or others. The symbolic nature of symptoms is often apparent from the way in which popular speech incorporates them in expressive phrases such as: "It sticks in my gullet"; "I can't stomach it"; "You make me sick"; "You are a pain in the neck (or elsewhere)"; "Why don't you piss off". Many of these metaphors suggest a bodily image of taking something in, refusing something, or expelling something, and they serve to support the psychoanalytic notions about the child's early cognitive development in

which the experiences of taking in and rejecting food, and of retaining and expelling urine or faeces, are linked with, or become the coin of, a developing sense of himself in his relationship with his mother.

In addition to serving this symbolic function, symptoms of this sort can also be seen as the expression of a substitute aim. In terms of the procedural script, symptoms can represent the abandonment of an intention at the stage of judging the anticipated consequences, and its replacement by a revised aim. This revised aim, as Freud pointed out, represents a compromise combining elements of gratification and elements of punishment. The punishment lies in the abandonment of the first aim and in the discomfort of the symptoms. Some symptoms seem to occur primarily as punishment, e.g. Saturday morning migraine that deprives the obsessionally driven person of a well-earned weekend. But some gratification usually accompanies symptoms of this sort, commonly in that they are the occasion for "deserving" care from oneself or from others, or sometimes simply that they represent payment, and therefore serve to relieve guilt.

James

James, a 36-year-old solicitor, consulted on the advice of his doctor when full audiological investigation had failed to demonstrate any physical cause for a constant whistling in his ears. The symptoms had started one day, six months before, and on enquiry it seemed that the day in question was one in which he had had an angry exchange with his adolescent stepdaughter at breakfast followed by an awkward and unsatisfactory meeting with colleagues during the day. He was the middle of three sons of a judge; his eldest brother was a successful barrister, and his younger one was a "charming alcoholic". James described himself as a quiet, unassertive person. He felt satisfied with his career, though he felt he would not equal his father's or elder brother's achievements. James was unwilling to acknowledge the psychosomatic nature of his symptom until he kept a diary on my suggestion, which showed a consistent pattern. Over a brief period, his symptoms became worse in relation to an interview with an awkward client, seeing a film about the crushing of a slave revolt in which he identified strongly with the slaves, having an unsuccessful argument with his wife, and being unable to refuse an invitation from the firm's senior colleagues to a social occasion he did not want to attend. On the basis of this, and only after a further consultation with an ear, nose, and throat specialist, he was finally able to acknowledge that the noise, which had become a signal of his wish for quiet and care, should really be regarded as a call to action and assertion. In this way he was helped to recapture the appropriate arousal function of the unacknowledged emotion that was concealed by his symptom. The underlying dilemma here was between being *either* assertive, nasty, and liable to provoke rejection *or* being placatory and nice. The aim to be nice, however, was incompatible with the aim of getting his own way. The evolution of the symptoms in terms of the PSM is given in Table 4.1. After some therapy, James became more assertive and less anxious, at

which point his wife, who had chosen him for his niceness, became depressed; this snag was eventually resolved through conjoint therapy.

Psychosomatic symptoms can become incorporated into very complex systems of self- and other-control, often combined with magical thinking of the type we have

Table 4.1 Symptom as "compromise formation" between incompatible aims

Stages			Compromise aim
1.	(i) *To get my own way*	(ii) *To be nice*	*To be looked after* (because I have a buzzing in my ears, and deserve care and can't be expected to be assertive).
2a	Other people are stronger than me.	People like it.	
b		I know how.	
c	Being assertive is like my (envied, disliked) father and brother.	It is like I prefer to be.	
3.	Tentative plans to assert.	Placate.	
4a	Unlikely to be effective.	It will work.	
b	Will provoke dislike, rejection, and I'll feel bad.	Others will like me.	
5.	Incompetent performance.	Placatory act.	
6a	Failure.	I was nice, but I did not get my own way.	
b	People don't like me being pushy, anyway I failed.		
7.	I've a buzzing in my ears.	I've a buzzing in my ears.	

Stages

1. Define aim.
2. Consider general assumptions about
   a) possibilities for pursuit of aim,
   b) capacity to pursue aim,
   c) permissibility of pursuing aim (judgements of self and others).
3. List possible action plans.
4. For each plan, consider
   a) can it be carried through?
   b) what consequences will follow carrying it through?
5. Choose preferred plan, and act.
6. Consider
   a) how effectively plan was carried through,
   b) what were the consequences of carrying it through?
7. Evaluate the sequence; reaffirm or reverse the aim and/or the assumptions.

considered in relation to obsessions; e.g. anorexia and bulimia can combine the ritual repetition of the experience of self-deprivation or of greed and punishment with a controlling dependency on, and defiance of, concerned others.

In the smooth course of an untroubled life, unpleasant emotions initiate acts that resolve the discrepancies that gave rise to them, and pleasant emotions provide a secure base from which to respond to new events or develop new aims. As lives are not untroubled for long, the unavoidable pains and difficulties we encounter usually test out, and in some way find wanting, our capacities to pursue our purposes and solve our problems. To conclude this chapter, we will consider two major sources of long-term emotional difficulty: the experience of loss and the experience of sexual intimacy.

LOSS

Losses occur inevitably through the course of life. One may lose important other people; one may lose one's place or one's prospects in the social world, one may lose one's skills and resilience due to illness or age and, with the passage of time, whether or not these other losses occur, one feels one's future inexorably shrinking and one loses one's illusions. Some of these losses occur at transitions which also mark new departures, which can make the element of loss difficult to acknowledge. Perhaps this is most marked in the case of parenthood for women: the birth of the first child, especially for working-class women, often involves a massive restriction of the social world, and an end to financial independence. The effect of this may only be overcome by the time a second loss is faced as the children leave home. The most severe loss, however, and the one most thoroughly studied, is that of bereavement.

Of the negative emotions, sadness about loss is the most difficult one to cope with because there is no act that can serve to close the gap between the desired and actual situation: the schematic discrepancy is permanent. In the case of bereavement, replacement is impossible, even though certain roles or functions can be repeated. What is called for in the bereaved individual is acceptance, which involves the revision of all those aims and purposes of life which concerned the lost person. The end of the 4-year relationship with Patricia presented David with such a task, as we have seen, although this was clearly a less severe experience than bereavement by death after longer-term attachments.

The fact that sadness cannot provoke effective action in most cases, probably accounts for some of the characteristic features of normal mourning in its early stages, notably the searching and restlessness and the almost universal use of denial in the form of continuing thoughts, images, or even hallucinations implying that the dead person still lives. Other features of mourning reflect the fact that sadness is not the only emotion felt; we seek always to attribute causality, and most deaths are, unless seen in a religious light, random and meaningless events. Rather than accept this, it is common to attribute blame to oneself, to the dead person who has

abandoned one, or to the doctors and nurses who failed to care or cure. The attribution of blame to self or other will be a larger feature where hostility, acknowledged or denied, was a part of the relationship, and is particularly liable to cause trouble in the case of the deaths or disasters of parents during late childhood and adolescence. In these instances, the normal angers and assertions of the child (which, in the psychoanalytic view, are seen to carry over some of the child's omnipotent assumptions from infancy) can be interpreted, often unconsciously, as having contributed to, or caused, the death or illness of the parent. This may result in incomplete mourning, because the death cannot be fully acknowledged, or in expiatory self-punishing or self-restricting acts (PSM 2c), a common source of the snags described in the last chapter.

The completion of mourning involves both the recognition that the death has occurred, and the revision of life plans acknowledging that fact. Where the dead person has been a central source of external validation, completion of mourning allows one, in some sense, to take into oneself the values that were accorded by the other. If one cannot let the death be true, which is more likely to be the case where guilt and hostility are active but not acknowledged, this process cannot be completed, and the external source may be located in objects linking one with the dead or in a shrinking world of memories, which effectively closes off the possibility of further change or growth.

Loss will be an issue in most therapies, most obviously where past loss is the source of difficulty. These losses may be of people or of illusions, or may follow from the recognition of past restrictions: such mourning for the self is both painful and freeing. The therapist's job is to guide the process of ending therapy in such a way that that loss, and, symbolically, past losses, can be acknowledged and mourning completed.

Not only therapists are involved in the issue of loss. Doctors, nurses, social workers, ministers, and others likely to be in contact with the bereaved, need to be aware of the ordinary mourning process. Our society offers impoverished rituals and many social pressures reinforce the unhelpful prolongation of denial. Those in touch with the bereaved, or with those coping with other losses, such as physical disability, need to know how to allow the expression of grief and anger, how to support the process of acceptance, how to encourage the development of new aims, and they need to recognize those who need psychotherapy to overcome the effects of incomplete mourning.

PROBLEMS RELATED TO SEXUAL INTIMACY

It sounds cynical, but it is probably true to say that if you see somebody weeping it is as likely that the cause is love as that it is loss. The reason for this is to be found in the unresolvable paradoxes involved in our simultaneous wish to be both free and dependent, both separate and joined, and to the fact that how we deal with that paradox is deeply coloured by the particular history of our own slow growth from

the total dependency of infancy to the precarious autonomy of adulthood. That autonomy is most at risk where we are most exposed, and it is in our sexual relationships where exposure is most possible, most desired, and most feared, and where our sense of self and other is expressed in physical language as was our first experience of ourselves and of the other in infancy. It is not surprising that our primitive strategies for self-definition and defence, our primitive needs to control the other and fears of being controlled by the other, find their expression in sexual relationships, where schematic discrepancies between consciously desired aims and unrecognized wishes and prohibitions are common.

Such issues are present throughout adult life, but the main concerns vary with age. In late adolescence and early adult life, self-proof may be a larger concern than intimacy, and sexuality may be a game, involving little personal exposure. This unconcern serves as a defence against the threat posed by intimacy in someone whose sense of self is still uncertain or largely other-dependent. An alternative adolescent pattern is that of total immersion, or fusion with the other. Through this, the normal late adolescent separation conflicts with parents, which are defining of personal identity, are evaded by reconstituting dependence on, and definition by, a peer. David's first involvement, shortly after leaving home at 17, which lasted for 4 years and was rapidly replaced by his relationship with Patricia, may have contained some aspect of this.

Once intimacy is sought, and some committed relationship is made, the implications of dependency become a major preoccupation. The forms in which these issues are manifest will reflect the way in which dependency and autonomy were experienced in childhood and upon the resulting central self-identity scripts, and upon how far the self is stably constituted. To the extent that autonomy is felt to be threatened, efforts to control the other, directly or by withdrawal, will be exercised. In many instances, the conflicts arising from these issues are not faced; the craving for, and the conventional myth of, easy positive relationships in which each person sustains his life while caring for, and being cared for by, the other, makes it hard to acknowledge the almost inevitable experience of disillusion and disappointment, competitiveness, hostility, or envy. The denial of these feelings, and hence the avoidance of the acts that might resolve the issues, can contribute to depression, combining elements of sadness and anger, and to psychosomatic symptoms. The psychotherapy of these conditions in adults leads on to the consideration of self-identity and relationships scripts and, hence, to disturbing the patterns of existing relationships.

If the myth is not sustained, and if mixed feelings are acknowledged, then the battle-lines will be drawn up, sometimes in ways determined by sex-role stereotypes, sometimes in ways clearly repeating the issues of the individual's own child-parent experiences. A common spiral that can develop in this is that, under stress, both partners feel more childlike and hence seek more care, while becoming less parent-like and hence giving less care. To endure such conflict involves a capacity to acknowledge negative feelings that our culture does not support, and the retreat into mood states or symptoms may seem preferable. For the therapist involved in helping such struggles, the task is both to recognize this, and to understand the mutual projections which are normally built into such relationships. Joint therapy, based upon an object-relations approach, is probably the best solution.

The conflicts of later life, whose frequency is reflected in the soaring divorce rates, are partly the final surfacings of these earlier issues, and partly the expression of the firmer individuality and autonomy of the partners. This healthier process is accompanied by the reassertion of aspects that have been denied in the service of the relationship (and often, also of parenthood) or that have been recognized in the other but effaced in the self. Issues of this sort may arise at an earlier stage now than was the case in the past, as the impact of feminism upon marriage has encouraged greater self-awareness and greater reluctance to accept self-abnegating definitions. Once conflict is acknowledged, the choice lies between a return to collusion and denial, or a progression, bound to be painful, to the fullest possible acknowledgement of the reality and individuality of the self and of the other; sometimes only at the cost of the relationship.

Common sexual difficulties, in my view, are nearly always expressions of these personal (self-identity) and relationship (strategic) difficulties, rather than being either causes of, or independent of, these higher-order issues. The most severe sexual problems such as fetishism, perversions, and major confusions of sexual identity, reflect radical problems of self-identity, and the understanding of these owes much to the developmental aspects of psychoanalytic theory. The common problems of absent or incomplete sexual capacity (erectile impotence, premature ejaculation in the male; varying degrees of frigidity and orgasmic failure in women) are statements about how the self or the other is seen. Problems present from the first sexual experience are likely to reflect combinations of ignorance and of negative self-evaluations and judgements. Problems arising in the course of a relationship are likely to express feelings about the relationship. (In older subjects in particular, physical disorders such as neurological disorders and diabetes need to be excluded.)

Behavioural approaches to the treatment of sexual problems are based upon the simple premise of reinforcement strategies. Some, which to me seem humanly and ethically very undesirable, make sexual availability contingent upon other behaviours, such as work about the house, or time spent together. Others serve more simply and more positively to remedy ignorance and overcome inhibition by encouraging plain speaking and providing a vocabulary for it, by teaching how to give, and ask for, pleasure, and by breaking the failure-anxiety-failure cycle by a regime of slowly increasing sexual activity short of intercourse. Ostensibly, such approaches operate, in terms of the procedural sequence model, at the tactical level, by extending the repertoire of means and by replacing negative predictive evaluations with positive ones. In fact, however, such programmes include, implicitly or explicitly, the modification of self-identity scripts by challenging such self-statements as "I am not, and may not be, a sexual person".

Because sexuality is an expressive act of considerable symbolic weight, development of a more satisfying, more self- and other-regarding, sexual relationship may influence favourably other aspects of the relationship; but, by the same token, unresolved interpersonal issues may make such a solution unattainable, in which case sexual difficulties will persist until the other problems are resolved. These other difficulties often include fundamental issues about identity, related to particular family experiences, and represented in conflicts between sexual aims (PSM 1) and self-judging scripts (PSM 2c). Sexual guilt may be less prevalent now than it was in Freud's Vienna but it can hardly be said to have been eliminated. Sexual difficulties which develop in the course of a relationship are expressive acts; although the patient will often say, "I cannot", the impotence, frigidity, or other symptom, is saying in effect, "I will not". The real task for the couple, which they will often fall back from, is to understand and remedy the reason for this negative statement. The long-term negative emotional states commonly accompanying unsuccessful marriages represent, for each of the couple, a mismatch between the desired and perceived other. This is often complicated by contradictions (mismatches) between different aims in relation to the other who therefore, in fulfilling one aim, inevitably frustrates another. To understand the complexity and persistence of these problems, the phenomenon of projective identification, to be discussed in the next chapter, is an important concept.

DISCUSSION

The paper by Schachter and Singer (1962) on the "Cognitive, Social and Physiological Determinants of Emotional States" provides experimental evidence on the relation between physiological changes and emotion, and concludes that the labelling of the physiological changes accompanying emotion is determined largely by the accompanying cognitions (see also Schachter, 1964). Attempts to develop more comprehensive theories of emotions in cognitive terms have been made by a number of writers. Kelly (1955) and, among Kellians, McCoy (1977) have attempted to develop a systematic account of emotions on a cognitive basis. I find the definitions emerging from this work to be unsatisfactory. To a man about to be run over by a steam-roller, the description of fear as "awareness of imminent incidental change in one's core structure" (core structure referring to the construct system) would not adequately cover the situation. However, Kelly usefully defines the often neglected form of anxiety which accompanies the loss, or threat of loss, of cognitive control. In Kelly's terms, anxiety is the awareness that the events with which one is confronted lie outside the range of convenience of one's construct system.

Beck (1976) discusses emotion in terms of his concept of the "personal domain", by which he means the self and those things, people, and values, identified with the self. In his somewhat entrepreneurial view, for example, euphoria implies expansion, and sadness implies loss to the domain. Anxiety is a response to the prospect of loss, anger arises out of a sense of the domain being deliberately attacked by another. Beck does not consider the relation of intrapsychic conflict to emotion at all and, to a greater or lesser extent, this restriction is true of most other cognitive and behavioural writers.

Plutchik (1980) offers an account of emotion, drawing on ethology, and emphasizing the importance of cognition. In his view, an emotion is a chain, starting with the cognition of an event which evokes a feeling leading to a behaviour having some appropriate biological goal. The objectives of emotionally provoked behaviours are variously to seek protection, to remove obstacles, to incorporate, accept, or reject, reproduction, to recall or replace a needed other, to orient, and to explore. His view therefore links emotions explicitly to aims. This author also offers a useful circumflex model of primary emotional terms and of mixed emotions, based upon studies with the semantic differential.

The fullest account of emotions from a cognitive viewpoint is that provided by Katz (1980) whose paper was a major source for this chapter. Emotions, as we have discussed, signal a schematic matching or discrepancy; they are cognitive and biological events, labelled in ways determined by our personal and cultural histories.

The importance of bereavement and loss has long been recognized in the psychoanalytic literature and their influence on morbidity has been extensively researched by epidemiological means. The experience of bereavement and the indications for professional help are lucidly described by Parkes (1975).

There is an extensive behaviourist literature on the treatment of "sexual dysfunction" and associated marital problems, much of it stemming from the work of Masters and Johnson (1966) (e.g. Gurman and Rice, 1975; Bancroft, 1975; Crowe, 1979). Kaplan (1974) combines behavioural and interpretive methods, and Skynner (1976) presents a humane eclectic account based in particular on psychoanalytic and systems theory concepts.