approach (see Davanloo 1980) can seem confronting to the point of provocation. For Malan (1976a and 1976b) the focus represents the therapist's choice of a psychodynamic theme. Such themes may represent a nuclear conflict of deep significance, or a less central issue. The therapist maintains the patient's involvement with this theme by selectively attending to, and interpreting, only those issues related to it. Malan reports that the patient's willingness to work with this kind of interpretation, the therapist's ability to maintain a focal approach in this way, and the linking of feelings about parents with the transference in relation to these focal themes were the three factors associated with successful outcomes in the cases treated with brief psychoanalytic therapy by him and his colleagues. It should be noted, I think, that these themes are clearly the ones with which they would have been most comfortable in view of their theoretical predilections.

The process of agreeing explicit goals, described in this chapter (and in Ryle, 1979a and Ryle, 1980) is similar to the cognitive/behavioural approach in so far as goals are spelt out very clearly. However, target problems, dilemmas, traps, and snags represent a more complex description of mental and behavioural processes and assumptions than do the target symptoms and behaviours of cognitive/behavioural therapists. In the emphasis on cognitive issues — assumptions, beliefs, and processes — these goals are referring to "dynamic" issues of the sort described in different terms by psychoanalytic therapists. They represent, in effect, hypotheses about the sources of difficulty, described in terms of "current procedures" although often informed by historical material. They may include, but are not exclusively concerned with, aims and beliefs and procedures of which the patient is not, or has not been, aware. Their accuracy and relevance will be tested out in subsequent therapy and the application of the ideas in the patient's life. The explicit sharing of these concepts at this stage distinguishes the approach I propose from psychoanalytic methods, the patient being given an idea of the therapist's model and of its application to his problems. He is in this way invited to be his own problem-solver, and the use of any particular procedures will be understood by him in the context of this general picture. The inclusion in these hypotheses of descriptions of procedures that are inflexible and no longer relevant, but are not necessarily the result of dynamically repressed issues, is another point of differentiation from the focus as described by Malan. Where the limitations of time or the extent of the patient's difficulties are such that only some issues can be dealt with, a decision as to which to attend to will be made in terms of the overall understanding and of the accessibility to change of the different problems. These strategic decisions will be more fully discussed in Chapter 10, after other therapeutic methods have been considered.

8

Active Methods in Therapy

As we have seen, the diagnostic and exploratory focus of the assessment phase of therapy does not rule out the introduction of comments and procedures designed to initiate change. In the same way, the emphasis upon change during the active process of therapy does not imply that the explanatory concepts formulated in the early stages may not be modified and extended. In time-limited therapy, however, it is important to identify the main goals early and to proceed primarily along the lines determined by those goals. In every case there will be continued discussion of the central issues, namely the adequacy of the patient's grasp of the reality of his experience, his maladaptive beliefs and assumptions, the nature and possible restrictiveness of his self-identity and strategic scripts, and the blocks on his changing—described in terms of traps, dilemmas, and snags. The understandings encapsulated in these ways can be applied to the patient's history, to his current life situation, and to his relation to the therapist. For many patients, this process of grasping and using new ways of looking at their problems is all that is required, and the therapist's role is to hold him to this task, to be alert to the ways in which older patterns of thinking continue to be manifest, and to help him form realistic evaluations of his progress. Beyond this, however, patients may be helped by two rather different methods: on the one hand by various active specific procedures, and on the other through the experience of the developing relationship with the therapist. In this chapter, we shall consider the use of active techniques, leaving the question of the relationship with the therapist to be discussed fully in the next chapter.

In using active methods, the therapist is attempting to modify, by instruction, encouragement and guided experience, the self-monitoring, self-judging, and self-control exercised by the patient (PSM Stages 4 and 6) and to extend his skills (PSM Stage 3), so that he can learn to recognize and name his feelings more accurately, to understand and control his symptoms, to alter his unwanted patterns of behaviour, and to modify unhelpful ways of thinking (PSM Stages 7, 1, and 2). Behavioural and

cognitive therapists operate exclusively in these ways, but in the integrated approach suggested here, these methods would always be applied in the context of a more general understanding, based upon the PSM, and would usually be combined with interpretation of the transference and the use of non-directive exploratory methods.

SELF-MONITORING

The most useful active intervention consists of instructing patients in forms of self-monitoring, a method which owes much to the work of Beck (1976). Its application in the cases of Anne and David have been reported in the last chapter. The essence of this methods, and its purpose, can be conveyed by written instructions (see Chapter 14).

The rationale for self-monitoring is that many symptoms, mood changes, or unwanted acts are provoked or accompanied by mental images or thoughts which, while accessible to awareness, are not attended to. Subjects can be taught to attend deliberately to their thoughts and to record them in writing; in doing this, they come to understand better the reasons for their altered states and are usually able to achieve some distance from their irrational, exaggerated, or catastrophic thinking. This, in turn, leads to early recognition of and, in time, control of, subsequent episodes of such thinking. In terms of the PSM, monitoring enables one to discard distortions during Stages 2 and 4. The following case provides an example of this.

Michael

Michael, a male student, aged 20, had been an obese adolescent and was now slightly underweight, with a marked preoccupation with thinness. He spent much effort in controlling his food intake, and he felt guilty after eating, at times resorting to the use of laxatives. He was also aware that he frequently became quite cut off from his feelings, something which I observed during sessions, and he smiled compulsively, especially when discussing painful events. In order to understand the feelings and meanings which, at the time, he was not able to stay in touch with, he was asked to monitor the occasions on which he became preoccupied with questions of food or thinness. After one week of monitoring his food preoccupations he reported that the associated thoughts seemed to be confined to worrying about fatness, promising himself not to eat, or feeling guilty for having eaten. During the second week, he saw more clearly that there was also a self-depriving aspect to his eating habits. At the next session, which followed a month's gap, he reported much less food preoccupation, but he had had some sharp recurrences, and he had been able to see that these had been associated with the planning or carrying out of assertive acts. Assertiveness was something which he had always found difficult and which tended to make him feel guilty. At this stage, he was able to accept a more general construction about how his attitude to food had acquired inappropriate "moral" meaning. Not eating implied being in control, not being stuffed (by his greedy self, historically by his mother); it was also a punishment for the fact that he did want to eat and, as he now saw, for assertiveness.

Charlotte

A second example of the use of self-monitoring in a patient with a more fully developed eating syndrome (bulimia) is that of Charlotte, a young woman who was much preoccupied with control of her food intake, and who went through phases of binging and vomiting. She was invited to monitor these urges and occasions to see if she could understand better the situations and feelings associated with them. She produced the following in diary form.

Wednesday: Got a letter from Judith [her sister] today. It made me feel jealous, confused and a bit ashamed. Jealous because she sounded really happy and somehow it felt she had more of a genuine capacity to love than me. Confused because I kept looking for motives in my own feelings, like why did I feel unhappy for her happiness? Do I only thrive on others' misfortunes? But at the same time I really did feel happy for her and so I felt ashamed for crying and feeling sad. Anyway, the garbled confusion led to anxiety, ? hunger, stomach pains, and I sort of knew I might be going to binge. Well I ate more than usual for breakfast but did not carry on and vomit. Conversation with myself: What do you really want to do now, in this frenzy of emotions? Answer: Talk to Judith, so write her a letter. And that's what I did.

Tonight at a party: I usually binge and vomit at parties because of the excess of food and drink available and because it is a convenient way of not talking to people, and also of feeling distinctly unattractive. I ate a lot again but I did not throw it up, and I made a conscious effort to examine my motives. Conversation with myself: why are you just standing here eating? Answer: Because it is a very pretentious party and I have had enough of trivial smalltalk. If you're not enjoying it any more why don't you go home? Because I'm scared I'll just go back and carry on binging. What do you want to do? I'd like to polish my shoes and read my book. So, do that, walk home, it'll sober you up and you'll feel better in the morning. So I walked home, polished my shoes and read my book. Very nice.

Thursday: Rebecca (a flat-mate, also a food-obsessed woman), came in tonight and said she felt bad. I asked her what was the matter, and she said he had been compulsively stuffing this week. We explored the reasons together and shared ashamed food experiences of this past week. It was very nice because it helped to dispel the myth I have of her being such an incredible purist with whom I feel I must compete.

Friday: Woke up feeling ill. Rebecca's over-concern, sympathy, and continuous "well you must just make sure you eat well and you'll get rid of it" made me so tense that after lying in bed until the afternoon I just went down and stuffed myself. I kept it down though. Went on feeling rather ill and tense. In the evening my best friend, Emily, came and I felt much more relaxed. Here was part of the real me that didn't care if people approved of it or didn't. She came to see me, and that's what mattered. I noticed immediately the contrast in the way Rebecca and I related and the way I felt with Emily. Rebecca always asks, "How are you? How did the day go? What have you done? What are you going to do? Did you enjoy it?", especially when there are symptoms to ask about and concentrate on. "You must eat well dear, lots of red sage tea". Later, after Rebecca had been in and talked again, Emily said, "It's not that I'm not sympathetic about your sore throat or that I don't care, it's just that I don't feel it necessary to keep asking about it." I suppose I feel good with Emily because it's just

that I don't see her as a threat because she doesn't make me feel like it's my accomplishments that are important, rather just my personality.

I am still finding difficulty generally in listening to people and taking things in. I seem to drift off into thoughts about trivial things, food, planning times, activities, and lose track of what they're saying, so I feel guilty and stupid because I'm not capable of processing meaningful or important information, so I lose confidence and then I find it hard to express any feelings. When I realize how far I have drifted off from the conversation I feel even less able to attend to the other, and feel even more nothing myself.

Sunday: I just threw up. I knew I was going to. After Emily left I felt really lost and unhappy. I know how much more real I feel around her than among other people. I felt restless, full-up, but hungry. I started to plan times not to eat like not cooking lunch tomorrow, etc., etc., and getting anxious. I sort of knew I was going to binge and in a way I wanted to, and then to throw it all up seemed like it would be a quick and effective way of getting rid of all the chaos I was feeling inside. Before I went down to the kitchen I wanted to go and talk to the other people next door, but I felt they wouldn't want me and I would be an intruder. I knew when Rebecca came back tonight I would have to tell her all about the weekend and how my throat was, etc. etc., and I would have to ask her about her weekend and I wouldn't really be interested at all.

Later on in the day: One binge and vomit has just started a whole succession. When I have emptied from the vomit I feel scared and anxious so I eat, vomit again, eat, vomit again, and so on.

Monday: I woke up this morning and felt slightly disgusted with myself, depressed and anxious. I couldn't tell whether I was hungry but I thought this could be, since I emptied myself out yesterday. It looked cold outside, snowing, and I still didn't feel very well, although I know I was getting behind on work and should go to the library. These thoughts made me feel more anxious and I started to get a nervous tension stomach-ache. This kind of stomach-ache always makes me panic and I think maybe if I eat something it will go away, but since I am never actually hungry, just tense and anxious, food never does any good. I just eat more and more, and then say, "What the hell" and throw it up. That's what I did this morning."

Charlotte is described further in the next chapter.

Another form of self-monitoring, also described by Beck, can be used by patients to help correct their blanket judgements about how they are living their lives. One self-perpetuating aspect of depression is the negative retrospective evaluation of achievement. Sometimes the patient's evaluations of activity are borne out by monitoring, but even then it serves to provide a realistic basis for therapy by making self-judgements more accurate and discriminating.

Cora

Cora was a young woman who spent a great deal of time "arranging" not to do the things she needed and wanted to do. She was helped to recognize this by keeping an hour-by-hour chart of activity, which she then coded as either "coping" (which meant working or getting on with the ordinary businesses of life) or "enjoying", and also a third category that we called "limbo", which was a suspended state exemplified, for example, by lying in bed, drinking endless cups of coffee, or making needless forays to the shops. She was able to learn from the use of this diary both

how often she had under-reported those things that she had done effectively, but also how much of each day she did in fact make null and void. (This tendency was linked in her case to an extensive underlying snag, and with the common dilemma summarized as "if I feel I must, then I can't or won't").

Some workers add to these forms of self-monitoring, which serve to make patients aware of how their self-evaluations are unrealistic and negative, an explicit training in more adaptive and realistic self-instructions. In my experience, most patients develop their own self-instructions on the basis of their own more adequate introspection, and from the discussions of the results of monitoring which take place with the therapist.

BEHAVIOURAL METHODS

Monitoring techniques play an important part in the planning of behavioural forms of treatment.

Sally

Sally suffered from panic attacks in many situations. Monitoring these situations for a week enabled her to list the hierarchy of difficulties, from the most to the least, as follows:

(a) Public situations when seated away from the exit.
(b) In company in any kind of formal situation where she felt observed and could not get away.
(c) Out of doors, in crowds.
(d) Alone in her room for long periods.
(e) Being with a close friend.

Under this last condition she very seldom felt any anxiety. Her symptom was an expression of a pervasive over-dependency upon the judgements and validations offered by other people of her existence. Related to this, she was controllingly dependent upon her boyfriend, and acted in ways which neither he nor she liked. Sally was advised, on the basis of this, to try two different ways of controlling her panic. The first was the behavioural approach of rehearsal in imagination, and graded exposure. She was told to enter the easier situations first, and to rehearse before going there. To do this she was told to get herself as relaxed as possible, and then to imagine in as much detail as possible how she would feel in the situation, while maintaining her relaxation. However, when she tried to do this, she suffered unacceptable levels of anxiety. Supervised sessions of relaxation and rehearsal might have been effective, but in fact she obtained rapid control of her panics by the technique of paradoxical intention.

In paradoxical intention, the patient is instructed to try to produce the symptoms. The rationale in the case of panic attacks would seem to be that the essence of the symptom is one of loss of control, and that by attempting to produce it deliberately one is inevitably asserting control. More generally, paradoxical intention may help

to control any symptom which is maintained by performance anxiety. By instructing the patient not to attempt to control the symptom, the anxiety about not being able to stay in control is dissipated. Sally obtained rapid relief of her panics by this means and treatment was discontinued after five sessions. Most of the treatment time had been devoted to discussing her controlling dependency on her boyfriend, that is to say with the hypothesized underlying self-identity and strategic scripts. At follow-up, 5 months later, she reported no further panic symptoms, and said that her tendency to be controlling, both of her boyfriend and of her other friends, was much diminished. At a casual encounter 2 years later she reported that she was "fine".

For patients with variable, situation-dependent symptoms, paradoxical intention can be tried out in combination with instructions in self-monitoring. The patient is told to enter the situations where symptoms occur and to try to experience the symptoms as fully as possible, with the aim of recording an accurate account of what has happened. There are three possible responses to this instruction: the patient may discover that he cannot produce the symptoms, and he can then be told to use the instructions as a means of control in the future; he may carry out the instruction but still suffer the symptoms, in which case the monitoring aim is still being fulfilled; finally, he may fail or refuse to carry out the instructions, in which case one is left with the need to explore further the reasons for his refusal or failure, a situation which occurs not uncommonly when behavioural methods are used.

Behavioural techniques depend essentially upon the careful analysis of symptoms or difficulties as behavioural sequences in relation to situations. In terms of the PSM, the emphasis is on Stages 4–6 of low-level, tactical scripts. When strategic issues are being treated, such as marital difficulties or problems like shyness, behaviourists will focus upon the sequence of small-scale acts and situations through which the larger problems are manifest, seeking to generate a change in detail, and then to generalize from this. The specific and commonsense nature of this approach is appealing and offers the possibility of accurately evaluating the changes produced. One can accept the effectiveness of the methods used, without accepting the adequacy of the underlying theory. In terms of the PSM, it is clear that extending control at tactical levels can lead to a revision of negative self-efficacy assumptions, but not clear that this is always the full extent of change needed. To this neglect of the wider meanings which are commonly, although not always, attached to symptoms must be added the tedium involved for patient and therapist in carrying out behavioural treatments. Moreover, though it is commonly believed that behavioural techniques are quicker than interpretive ones, this is not necessarily so, as the following case illustrates.

Bridget

Bridget consulted at the age of 22 because of depression and a phobia. Her phobia had started when she was it school, and had been present, with variable intensity, for 10 years. It consisted of a panicky dread of being sick or seeing someone else be

sick, and it had led to avoidance of situations where there were many people present. If such situations were entered, she had to sit by the exit. Bridget chose to combine interpretative therapy with a behavioural approach to this phobic symptom. She prepared a hierarchy of difficult situations and enlisted a friend's co-operation with the aim of getting the friend to talk about, and later to mimic, vomiting. However, before she embarked upon this programme, she realized, as a result of her reflections following her first three assessment sessions, that the phobia of throwing up was linked with a forbidden *wish* to "throw it all up". The symptom expressed symbolically a major problem in her relationship to others. In terms of the PSM, self-acceptance was conditional upon her evaluation of herself as being clever, good, under control, and not angry. She could give herself no permission to do other than work hard and compliantly, and her symptom had served as a means of evading this strict requirement but also of punishing her. Once that was understood, symptom relief was rapid, and the extensive and personally important issues were dealt with in the course of, and after, her subsequent therapy.

Simple cognitive and behavioural approaches can often be incorporated in treatment with minimal supervision, and written instructions can cut down the time needed to apply them (see Chapter 14). Self-monitoring is easily learned and patients are quick to see its the value. Most people can understand the concepts of rehearsal, graded exposure, step-by-step change, reinforcement and extinction, and if control of symptoms can be achieved by these means, confidence is restored, and time and energy are left to attend to other matters. Long-established and severe phobias, and elaborate and pervasive obsessive–compulsive disorders, are best treated by specialist behaviour therapists in the first instance: the former by graded exposure to the feared situation, under the control of the patient; the latter by exposure combined with some form of response prevention. However, it is my firm opinion that active methods should always be applied in the context of a treatment approach which gives consideration to the full range of meanings of the patient's difficulties, and to the implications of his change.

DISCUSSION

Recent years have witnessed the evolution of a spectrum of behavioural and cognitive/behavioural therapies. The purest, or most extreme, form, is based upon the principles of operant conditioning and specifically excludes or forbids attention to cognitive processes which are seen to have no initiating or causal role in the determination of behaviour. The main therapeutic methods used by this school are the application of reinforcement or punishment to influence carefully analysed small units of behaviour. The main application is to subjects under the control of others, that is to say adults or children in institutions, or children in families and schools.

Many behaviourists applying classical stimulus–response (S–R) ideas to the treatment of neurotic problems allow complex mediational processes to perch upon the hyphen between the "S" and the "R", but even though rehearsal in

imagination is one of the common techniques employed, the use of the word "cognition" is not encouraged, and the attempt is always made to refer treatment to principles based upon laboratory experiments with animals, a position quixotically identified by the protagonists as being scientific.

Social learning methods of therapy, as described by Bandura (1977a), incorporate the full range of behavioural techniques, and edge into the consideration of cognition. Behaviour, including symptomatic behaviour, is seen to result either from a response to an environmental stimulus or as an instrumental act shaped by the consequences of the act, or as being determined by central "mediational processes" where such learning is stored as hypotheses, rules, strategies, etc. The self is frequently referred to, but is defined rather seldom; in particular, much attention has been paid recently to the question of self-efficacy and its relation to performance (Bandura, 1977b). In this model, therapy is made up of a number of discrete, highly-specified acts. *Modelling*, which is the most specifically social aspect of the theory, represents the modification of the existing response patterns through the observation of another's performance of the act, in which the other performs differently, with different consequences. Modifications of behaviour based upon modelling need to be reinforced for the individual by direct positive outcomes provided either by self or other. Such modelling is seen to occur in any interpersonal and social relationship, not always helpfully. Bandura argues that therapists should take care to provide the patient with a model of self-exposure and personal accountability. Unwanted behaviours are altered by controlling reinforcement so that desired behaviours are rewarded (*conditioning*) and undesired behaviours are either not rewarded (*extinction*) or are met by *aversive conditioning* in which punishing outcomes are provided. In *counter-conditioning*, anxiety or other unwanted effects are replaced by incompatible responses during a process of controlled graded exposure, either to the actual feared situation or symbols of it. In some cases, this must be supplemented with training in appropriate coping skills. In aversive counter-conditioning, used especially in the treatment of alcoholism and sexual deviation, control over deviant acts is developed by associating the acts, or the stimuli leading to the acts, with punishing outcomes.

In this model, consciousness, or awareness, is seen to enhance, but not to be essential to, the process of learning, although "individuals eventually infer, from observation of their behaviour and its differential outcome, the correct reinforcement rules which partly control subsequent responding". The main feature of Bandura's model can be incorporated in the PSM but the emphasis on cognition in the PSM is not accepted by social learning theorists. The strength of social learning theory lies in its specificity and its basis in reasonably well-controlled and observed experiment. Its main deficiency is in its neglect of self-evaluation and self-judgment; these issues receive only one out of more than 600 pages in Bandura's book (1977a). One can only agree with the following observation, while wondering why it has not been given more consideration in practice:

> Since the person's own self-demands and self-respect serve as his main guides and determinants, behaviour that is under the latter form of self-control is apt to be less affected by variations in specific situational contingencies.

As Bower (1978) argues, the distinction between social learning theory and a basically cognitive psychology seems difficult to maintain. This convergence is also exemplified in Mischel's (1973) social learning theory of personality, which emphasizes person/situation interaction, and sees the relevant variables in the individual as being his competence in constructing schema, his mode of categorizing, his outcome expectancies, the subjective values he attaches to possible outcomes, and his self-regulatory systems.

In terms of the PSM, operant and S–R based treatments aim to intervene at the tactical level: they influence the individual's retrospective evaluation of his acts by manipulating the consequences in ways that serve to alter subsequent predictive evaluations, so that different acts can be selected. It is inevitable, however, that higher level self-identity and self-efficacy assumptions should be influenced by the non-specific factors operating in any treatment situation and by observation of the changes produced.

Accounts of paradoxical intention are to be found in Haley (1963) and Cade (1979). These authors emphasize the use of the technique to outwit the patient who is using his symptom controllingly, an approach I feel to be somewhat manipulative, although Cade defends himself against the charge. Ascher and Turner (1980) report that a straightforward account of the rationale behind the procedure is as satisfactory a method as one in which the description is adjusted to match the patient's beliefs. Paradoxical intention operates at the stage of predictive evaluation of performance, by circumventing the cycle of negative prediction followed by confirmation by failure: once control is established, self-efficacy assumptions will also be revised.

Treatment based on cognitive or social learning approaches is consistent with the PSM, as we have discussed already. Different approaches under these headings show variations in the particular focus of concern. The rational-emotive therapy of Ellis (1962) seems to consist largely of bullying the patient into agreeing that many of his beliefs and assumptions are silly. In Beck (1976), self-monitoring and self-evaluation of thoughts not normally attended to serve to illustrate the irrationality and emotional significance of underlying thoughts and beliefs. Other writers (Meichenbaum, 1974; Mahoney, 1974; and Goldfried and Goldfried, 1975) pay more attention to teaching problem-solving strategies and, in particular, to the explicit teaching of more effective modes of self-instruction.

The best evidence for the efficacy of behavioural and cognitive treatments is found in methods involving direct exposure, notably to feared objects or situations in phobias or obsessions (Gelder, 1979; Emmelkamp and Wessels, 1975). The evaluation of narrowly focused treatments in terms of observable behaviours is, of course, much easier than the evaluation of treatment with more complex aims, and

it remains uncertain how often such treatments are adequate on their own. The behaviourist literature reports only rare examples of "symptom-substitution" following successful behavioural treatment, but the concept of symptom-substitution is a very narrow one, and ignores the many possible effects of behaviourally-induced change on other aspects of life. The narrow definition of neurotic difficulty employed by behaviourists inevitably determines the range of phenomena to which they attend and, hence, changes in patterns of relationship or in subjective experience are neglected or conceived of as unrelated to the "symptomatic behaviour". When a wider focus is employed, wider effects are noted. Hafner (1977 and 1979), for example, showed how the cure of agoraphobia in housebound housewives produced jealousy or morbidity in a proportion of their husbands. A more serious indication of the narrowed attention of some workers in this field is given by Bayer (1972), reporting the successful behavioural treatment of compulsive hair-pulling (trichotillomania) in a depressed young woman. To therapists interested in the self, this symptom is expressive of an angry attitude towards the self, and the comment that "treatment was interrupted by the patient's unfortunate death in an automobile accident" would have been less baldly presented. In terms of the PSM, it seems quite possible that the removal of the patient's self-attacking symptom might have led to an increase in guilt and, hence, to increased risk-taking or risk-seeking, so that the accidental nature of the death was not entirely beyond question. This is not to suggest that behavioural methods are not apropriate for symptoms of this sort; they are clearly effective, but their relation to more serious and extensive difficulties must be attended to. An example of "symptom substitution" is given in Chapter 12.

Wilson (1978) takes the evidence for the superiority of direct exposure over rehearsal in imagination and other cognitive approaches, as providing evidence for the redundancy of any cognitive concepts in therapy. However, the efficacy of direct exposure is as consistent with the PSM or other cognitive models as it is with the behavioural one, for clearly one most effective revision of negative predictive evaluations of performance is to observe the self performing satisfactorily. Wilson concludes his discussion of this issue as follows:

> Another advantage of social learning theory is that the concern with cognitive mediating processes is deliberately tied to overt action. This interdependency between cognitions and behaviour underscores the fact that, whereas cognitive mechanisms may underlie behaviour change, they are not the treatment targets per se.

This represents a statement of faith or, more critically, the self-imposition of tunnel vision. Changes in cognitions seem to me to be important and appropriate aims of therapy, and I have reported how one can define desirable cognitive changes at the start of therapy and demonstrate that they have been achieved at the end, using repertory grid techniques (Ryle, 1979a; 1980).

Even in the hands of humanly open and generous-minded therapists, the various behavioural and cognitive approaches described in this chapter fail to attend to a

number of issues which are comonplace and important in the work of any therapist who is less confined in his attention, notably those concerned with personality structure, and with the question of intrapsychic conflict and the pervasive importance of guilt and guilt-avoidance in maintaining neurotic difficulties. In the PSM, the crucial role of self-defining and self-judging scripts is acknowledged, and the defensive strategies (psychoanalytic defence mechanisms restated cognitively) are accommodated. Moreover, while the PSM explains the effects of therapeutic methods that act upon only part of the system, it also points to wider issues and to the implications of change achieved by such local interventions.