



## “Atmosphere”, a Precursor of “Cognitive Schemas”: Tracing Tacit Phenomenological Influences on Cognitive Behaviour Therapy

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*Whilst individuals deal with divergent sorts of stimuli from the environment, they also tend to display some regularity in the way they respond to related patterns. These consistent responses can be conceptualised as cognitive schemas. A paramount component of Cognitive Behaviour Therapy (CBT) is the notion of cognitive schemas as they are a favoured point of therapeutic intervention. CBT as articulated by Beck in the 1960s owes intellectual acknowledgment to Merleau-Ponty and Heidegger and their notions of “atmosphere” and “clearing” respectively. This essay explores the notion of cognitive schema and atmosphere as applied to emotional pathology. It suggests that the well-known influence that phenomenology had on existential psychology could be extended to empirical clinical psychology, like CBT. The strategy adopted in this paper is to use Dreyfus’ ontological and epistemological distinction in psychopathology and then make a similar distinction, albeit using different terminology, in the CBT tradition. Some empirical findings from the literature are examined which render support to the existence of cognitive schemas and their crucial contributory role in the aetiology and maintenance of emotional disorders. It is noted that some of the features of these cognitive schemas were espoused well before Beck by Merleau-Ponty and the phenomenological-existential tradition.*

### 1. Introduction

This essay deals with psychopathology and philosophy in general and with Cognitive Behavioural Therapy (CBT) and Phenomenology in particular. Themes like psychopathology, phenomenology, and cognitive and behavioural psychology have at times been labelled movements rather than specific doctrines, and this makes the task of allocating strict definitions rather intricate especially when dealing with these broad areas as there is a wide-range of pertinent authors and eras. However, if there are umbrella concepts encapsulating them, it means that they share some conceptualisations, and I intend to capitalise on this to search for some commonalities.

When early phenomenology looked at psychopathology, it arrived at various ideas that could have been used in the genesis of some crucial concepts in cognitive-behaviour therapy and yet this important conceptual harmony has not been explicitly established in the literature. On the contrary, Husserl and Merleau-Ponty’s justifiable discontent with the psychology of their time is a common legacy displayed by contemporary followers.

This essay’s favoured area of analysis will be the practical aspect of psychology, that is, one oriented toward psychopathology, and so I will endeavour to take some phenomenological

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precepts into the psychopathological arena. It is therefore the more applied aspect of phenomenology that will be used. I do not claim that philosophy has to generate practical commodities to be valid. I am simply playing with the phenomenologists' own offerings, that is, that their observations have an application in psychopathology. Merleau-Ponty in particular had very specific comments about this and postulated that his phenomenological analysis had concrete implications for the area of abnormal behaviour. Fortunately, many of the predictions are unambiguous which makes the task of corroborating them less impractical. Part of this job has already been done and I will use these analyses to avoid unnecessary repetitions. In this regard, the irresistible style of Hubert Dreyfus in his essay "Alternative philosophical conceptualisations of psychopathology" (Dreyfus, 1989) is fully noted, and, given the relevance of his work, I will briefly summarise his paper. The section following this is a review of Cognitive Behaviour Therapy, highlighting its historical development and crucial contributions to the field of human behaviour. A comparison between the two closes this essay. Thus, the aim of this paper is simply to establish an observation, namely that certain crucial concepts within the CBT approach were articulated by philosophers from the phenomenological tradition. To this end, the Dreyfus' reconceptualisation of psychopathology is summarised. Then, an overview of the CBT and the concept of cognitive schema are offered. Subsequently, a brief literature review of the concept of cognitive schemas and their fundamental role in psychopathology is presented. Finally, as a conclusion, the commonalities and differences between these two philosophical and psychological notions are summarised.

## 2. Dreyfus' use of phenomenology to reconceptualise psychopathology

Dreyfus chooses to describe this area using two global alternatives, namely the epistemological

and the ontological, with Freud and Merleau-Ponty being the main proponents respectively. The epistemological approach involves the notion that the mind contains ideas, which might (or might not) correspond with the outside world. Freud's proposition introduces the notion of unconscious. It is in the unconscious where representations of the outside world take place. These representations are buried but still have a causal role; thus psychopathology becomes *depth* psychology.

The ontological alternative (breadth psychology), secured by thinkers like Husserl, Heidegger and Merleau-Ponty, de-emphasises the notion of mind (a reaction to Descartes) and focuses on the way the whole human being is related to the world (even the term "related" is misleading). The favoured description is the now well-known "being-in-the-world". Human beings do have mental states, which are directed towards objects, but these states presuppose a context in which objects have their place. This context provides an understanding of what counts as real, as objects, as human beings.

According to Heidegger it is this understanding of Being which creates what he calls a clearing (*Lichtung*) in which entities can then show up for us. The clearing is neither on the side of the subject nor the object -- it is not a belief system nor a set of facts -- rather it contains both and makes their relation possible (Dreyfus, 1989, p. 2).

Merleau-Ponty's (1963) lucid example to explain this concept is by comparing the "clearing" to the illumination in a room. This illumination makes directness towards objects possible, however it is not itself an object to which the eye can be directed.

Dreyfus' contention with the epistemological alternative is that it fails to explain the existence of "character problems", which are repeated patterns of self-defeating behaviours leading to

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an inability to recognise and solve the difficulty. In Merleau-Ponty's words, the person has developed a way of relating to the world which, in turn, becomes part of the context, also called "atmosphere". In this regard, Freud deals with symptoms (e.g., phobias, compulsive behaviours, etc.) but Merleau-Ponty deals with character problems. The ontological position is that "pathology occurs when some aspect of the epistemological relation of a subject to other persons or objects, which should take place *in* the clearing, becomes part of the clearing itself. Merleau-Ponty (1963) calls this shift, "generalization" (p. 3).

The French philosopher offers the example of "inferiority complex" to illustrate this point. Once the inferiority complex develops, the person is committed to inferiority; it becomes his "atmosphere", a dimension of the person's context, i.e., his background. In this example, changes in life may alter the content of experiences but not the structure. The fixation does not merge into memory. Thus, a person with a character disorder is not aware of the origin of the trauma that initiated this pattern. Dreyfus argues that Merleau-Ponty does not explain how a childhood trauma leads to the ontological generalisation, so he uses Heidegger to attempt an account. According to Heidegger, moods and emotions are forms of dispositions that can "colour" the whole world. For example, a child might have developed anger at his father after the father mistreated him. Subsequently, the child may develop anger at the way his father always treats him, then anger at the way everyone has always treated him. The emotional reaction of the child magnifies, intensifies and finally totalises the way of being so that it engulfs the person's entire world. The original emotion subsides but the meaning carries out to the limits of the world. Using Merleau-Ponty's terminology, the body remains frozen in a certain stance which then distorts everything that shows up in its clearing (e.g., every person shows up as domineering); hence the difficulties in removing this

"atmosphere" which is impervious to counter-arguments. There are other dimensions in the person's world, e.g., sexual attraction, which play a role in the generation or accentuation of the problem.

Intervention should be congruent with this conceptualisation of atmosphere, "If psychopathology is the result of generalizing an issue until it becomes a dimension of experience, and then focusing on this dimension so that it colours all the others, then the cure must begin by showing the patient that his way of being-in-the-world has acquired a pervasive colouring" (Dreyfus, 1989, p. 6).

The therapist will not be effective by just offering counter-examples to the patient's view of the "world". The person cannot see his/her clearing; everything is coloured. The therapist should then try to lead the person to experience life the way it was before it became one-dimensional. However, as memories are already coloured by the current clearing, the therapist needs to use techniques such as exploring dreams in which past events are experienced as they were originally lived. This involves undermining the person's current sense of reality. It also requires showing the person the link between his view of reality and his current pain. If Merleau-Ponty's emphasis on body is right, some body work might also be needed (e.g., dealing with the rigidity of the body). The success of this ontological "talking cure" will be translated in the person's ability to have independent dimensions free from the obsessions.

Dreyfus suggests that there are differences in the practice of therapy dictated by these two conceptualisations. The obvious difference is that from an ontological viewpoint, neurosis is a pattern of behaviour that has been generalised into a dimension of that person's world; therefore the focus should be on character pathology not on symptoms.

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### 3. Cognitive behaviour therapy (CBT)

CBT is the amalgamation of behaviour therapy and cognitive therapy. The new hybrid is exactly that, not a new set of views about the human nature calling for a new set of interventional tools. CBT is the utilisation of techniques generated in the behavioural and the cognitive tradition. There appears to be a greater emphasis on the cognitive aspect but the incorporation of pure behavioural techniques cannot make this approach purely cognitivist. For clarity and historical purposes, I will explain CBT using depression as an illustration. Cognitive therapy, as we now know it, starts its development with figures like Albert Ellis and Aaron Beck in the 1960s. Beck, in particular, seems to be a key intellectual in the formalisation of the cognitive school that he derived mainly from his work on depression. A therapist trained in psychoanalysis, Beck grew dissatisfied with the analytical formulation of depression and embarked on his own (1). He noted "Freud's conceptualisation of depression in terms of the attack of the sadistic part of the ego on the incorporated loved-object within the ego is so remote from any observable in clinical data that it defies systematic validation (Beck, 1967, p. 253). Other schools' etiological explanations of depression equally displeased Beck for their lack of specificity, that is, they were broad accounts that attempted to explain psychiatric problems in general without dealing with depression's specific presentation and details. He observed that the symptoms of depression are *affective* (patients' own descriptions of their feelings like sadness, emptiness, etc.); *motivational* (wishes for help, desire to commit suicide, loss of motivation, etc.); *cognitive* (negative self-concept, negative interpretations of experience, etc.) and physical (retardation, fatigability, loss of appetite, sleep disturbance, etc.). His paradigm, he argued, was able to link the symptoms, something that other models failed to do.

There are three critical concepts at the basis of his model of depression: the cognitive triad, the

cognitive schemas and the cognitive distortions (Beck & Weishaar, 1989). The cognitive triad includes the way the individual views him/herself, the *world* and the *future*. In depression, these three dimensions are seen by the individual in a negative way. The interaction of these components with the symptoms is well explained in the applied literature (see for example Hawton, Salkovskis, Kirk & Clark, 1989).

Cognitive schemas are of particular interest to this essay as they parallel some aspects of Dreyfus' observations.

A cognitive schema is a complex pattern, inferred as having been imprinted in the organismic structure by experience, that combines with the properties of the presented stimulus object or of the presented idea to determine how the object or idea is to be perceived and conceptualised (English & English, 1958, in Beck, 1967, p. 282).

Individuals face numerous and divergent sorts of stimuli from the environment but they tend to show a consistency in the way they respond to similar patterns. These consistent responses can be conceptualised as cognitive organisations or structures. The cognitive structures or schemas are enduring patterns in the cognitive organisation, which contrast with cognitive processes which possess a more transient nature. These cognitive structures have been examined prior to Beck's time; for example, Piaget suggested the existence of schemas, which are general ways of thinking about the environment. In Piaget's (1952) terms, this applies not only to thought content but also tendencies manifested in early development, for example an infant has a *sucking* schema; an adult might have schemas such as *human life is more valuable than material things* and so on. Different terminology has been employed to signify this phenomenon, e.g., conceptual modules, concepts, conceptual tools, coding systems, modules, and personal constructs, to mention but a few. A prominent

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resemblance to memory paradigms can be noted when inspecting cognitive schemas. Bower (1981), for example, extended previous memory accounts and suggested that information is kept as nodes in memory nets which are accessed by activating the corresponding node beyond a threshold. He extended this understanding of memory and postulated that emotional states are represented as nodes in the memory system and are activated whenever the emotional state is experienced.

Beck suggests that schemas get activated when a particular environmental stimulus, relevant to that schema, impinges on the individual. The process of the mental activity yields a cognition, which could be an idea, judgement, self-criticism, or verbally articulated wishes. When facing a very discrete configuration (e.g., a table) a simple linguistic category is activated. However, when dealing with more abstract conceptualisations, e.g., an individual's perception of other people's attitudes toward him/herself, more complex schemas are activated. For example, an individual who believes everyone hates him is likely to interpret other people's reactions or comments on the basis of this premise. These sorts of schemas are involved in the consistent misinterpretation associated with different psychopathologies. In the case of depression, Beck postulates that the individual's interpretation of his/her experiences, the explanation for its occurrences and his/her views about the future show a clear schema containing personal deficiency, self-blame and negative expectations. Reality is selectively attended and counter-arguments are distorted to fit the schema. The depressive schema assumes a dominant role in shaping the individual's thought processes. Note that cognitive schemas alone are not sufficient factors for the development of depression. The model emphasises the cognitive component as a good intervention point. For example a child might experience constant criticism from a hard disciplinarian father (you are weak, you didn't try hard enough, it's your

fault, etc.). His schema might be developing along the lines "I'm an inferior person. I'm a weak person. My worth depends on what other people think of me. If I don't please others, they will reject me, therefore I have to please everyone". Later in his life his marriage breaks down (critical incident) which activates his particular schema (It's my fault. I can't handle things; no one wants to be with me, etc.).

CBT intervention is congruent with this conceptualisation. The strategy adopted is referred to as "guided discovery" because the patient is directed toward discovering the cognitive schemas, which filter his/her cognitive processes. Patient and therapist collaboratively and explicitly explore the events, cognitive formations and the course of the schemas. "The immediate goal is to shift the information processing apparatus to a more neutral condition so that events will be evaluated in a more balanced way" (Beck & Weishaar, 1989, p. 286). This is accomplished by a detailed programme, which incorporates cognitive techniques (checking with the patient the logic behind the assumptions, discussing alternatives, cognitive disputing, etc.) and behavioural techniques (behavioural exercises, exposure, etc.). Note that an assumption of Beck's work is that the cognitive intervention is similar to the psychoanalytical tradition, which fosters the uncovering of unhelpful material. The difference, as understood by Beck, is that the cognitive material which CBT focuses on is available to the individual and does not necessarily lie deep in unconscious memories which might take years to bring to the conscious level. However, this notion requires some re-thinking as recent developments within the cognitive tradition suggest that although depressed patients hold explicit beliefs about their inadequacies, a great deal of information processing is taking place at implicit levels. For example, MacLeod's work (MacLeod, Mathews & Tata, 1986; MacLeod *et al*, 2002) has focused on implicit selective information processing of depressive (and anxious patients)

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and has extensively investigated the idiosyncratic selective cognition of this population. MacLeod focuses on the cognitive biases of individuals suffering from affective disorders and suggests that these cognitive processes are outside the realm of the individual's awareness. Thus, the thought content that this population engage in is systematically distorted by cognitive biases that take place "automatically".

The support that CBT has received is dramatic. If the curriculum at university psychology programmes in Western countries serves as an indication of the widespread acceptance of a movement, then CBT is definitely a victor.

#### 4. Current status of cognitive schemas

The phenomenological proposition thus far outlined is amenable to experimentation in that the individual's "atmosphere" (Merleau-Ponty) or "clearing" (Heidegger) and his or her psychopathological "coloured" dimension could be tested using cognitive technology. There are two predictions, first that *there are* certain ways, colourings or schemas in some individuals that make their psychological difficulties ontological rather than epistemological. These schemas maintain the pathological character in the individual. The second prediction is that these schemas have probably been formed during the early stages of the individual's development. This section will focus on a brief literature review of cognitive schemas and psychopathology.

An assumption behind both phenomenological philosophy and CBT is that early experiences, parenting in particular, influence or shape some cognitive schemas. Harris and Curtin (2002) studied the relationship between retrospective reports of parenting, Early Maladaptive Schemas (EMSs) and symptoms of depression in a sample of undergraduate students ( $n = 194$ ). The EMSs of defectiveness / shame, insufficient self-control, vulnerability, and incompetence / inferiority were found to be correlated with

perceptions of parenting and depressive symptomatology. The authors postulate that these four EMSs mediate (partially) the relationship between depression and parental perceptions. A somewhat similar study was conducted by Bendo (2001) who explored the claim that core cognitive schemas are believed to originate in early family experiences. This research investigated perceptions of dyadic family processes associated with maladaptive cognitive schemas as reported by two self-report instruments: the Young Schema Questionnaire (YSQ), a measure of 16 maladaptive schemas; and the California Inventory for Family Assessment (CIFA), a measure of dyadic family relationships. Results revealed that higher endorsements of maladaptive schemas were negatively associated with perceptions of parental caregiving but positively associated with perceptions of parental intrusiveness. Multiple regression analyses showed a negative correlation between five schema domains (disconnection / rejection; impaired autonomy / performance; other directedness; over vigilance / inhibition; and impaired limits) and parental caregiving described as nurturance, time together, and warmth. Conversely, higher scores for the five domains were positively associated with perceptions of parental intrusiveness represented by emotional reactivity, projective assumptions, anger, and authority.

Taylor and Ingram (1999) examined the claim that children of depressed mothers are at increased risk for psychological disorders. They pointed out that the specific mechanisms of this elevated risk have not been clearly established. They investigated the information processing of children of depressed mothers and compared them with controls (children of non-depressed mothers). The results suggested that when primed, at-risk children showed a less positive self-concept schema and more negative information processing than did the control children.

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Thus, there appears to be some evidence for the claim that certain maladaptive cognitive schemas have been developed during early stages of development and that family styles might be causally related. However, cognitive schemas may change or develop in later stages. Exposure to traumatic events seems to have an impact not only on the person's general psychological and social functioning but also on his/her cognitive schemas. Slaton and Lyddon (2000), for example, postulated that women who have been raped, often experience profound psychological and emotional changes in addition to dramatic changes in their entire worldview. Moreover, they may develop cognitive schemas that are maladaptive and dysfunctional. Their therapeutic strategy involves assisting women in constructing more adaptive schemas via accessing and re-processing trauma-related beliefs. Similar findings were reported by O'Shields (1999) who examined the relationship between the age of sexual assault and post traumatic stress symptoms upon the cognitive schemas of female assault victims. The author used forty-three subjects who were assessed using the Impact of Event Scale to measure post traumatic stress (PTSD) symptoms, the Beck Depression Inventory (BDI) to measure depressive symptoms, and the Traumatic Stress Institute Belief Scale - Revision L (TSI) to measure disruption in cognitive schemas. The results regarding cognitive schemas suggested a relationship between PTSD symptoms and cognitive schema disruption: the higher the level of PTSD symptoms, the higher the cognitive schema disruption. A similar phenomenon has been observed in the area of vicarious traumatization, that is, people who do not experience the trauma themselves but work or deal with directly traumatised individuals. For example, changes after vicarious trauma exposure on specific cognitive schemas has been observed on paramedics (Galloucis *et al*, 2000) and therapists (Cunningham, 1997; Pinsley, 2000; Simonds, 1997; Weaks, 2000).

Glaser and colleagues (2002) noted the primacy of cognitive schemas among theories of psychotherapy. They attempted to provide construct validity for specific cognitive schemas, measured by the Early Maladaptive Schema Questionnaire-Short Form (EMSQ-SF), by examining their relationships with common clinical symptoms. The results suggest that scores of the EMSQ-SF possess a degree of construct validity comparable (and in some respects greater) to those of the EMSQ (205-item version). When exploring gender differences in the development of Post Traumatic Stress Disorder (PTSD), Tolin and Foa (2002) observed that females appear to be more likely than males to develop PTSD. They examined the cognitive factors that influence gender differences in vulnerability and postulated that the study of cognitive schemas, in particular, appears useful in elucidating the potential mediators of gender differences in the prevalence of PTSD. Males and females tend to be exposed to different forms of trauma; this creates differences in trauma memory records that may partly explain the difference. A significant difference in terms of schemas is that females appear more likely than males to engage in self-blame regarding the trauma, to hold more negative views of themselves, and to view the world as more dangerous.

Petrocelli and colleagues (2001b) examined the cognitive schemas of five distinct clusters that emerged from a cluster analysis of the personality disorder scales of the Millon Clinical Multiaxial Inventory-II. They were interested in the degree to which early maladaptive schemas (as measured by the Cognitive Schema Questionnaire-Short Form) could correctly identify empirically-derived patterns of personality disorders. Discriminant analyses revealed two significant functions composed of cognitive schemas which correctly identified 61.2% of the entire sample ( $n = 129$ ; aged 18-50 yrs) in terms of cluster group membership. A little earlier, Petrocelli and colleagues (2001a)

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also studied the role of cognitive schemas in mediating the relationship between the self-defeating personality and depression. They used 82 mildly to severely depressed adult outpatients and found that that 57% of the variance within depression was accounted for by the self-defeating personality and 5 maladaptive cognitive schemas: abandonment / instability; defectiveness / shame; failure; subjugation; and vulnerability to harm. The schemas abandonment / instability and defectiveness / shame statistically were more prominent in mediating the relationship between the self-defeating personality and depression.

Markley (2000) investigated Beck's predictions by using forty-five depressed women and a group of 45 non-depressed controls. They were exposed to positive, negative, and neutral videotaped scenes of social interactions. Their attention during the scene and subsequent memory were assessed and they were also asked to evaluate the scenes and rate how often they had experienced - or expected to experience - similar interactions. Results indicated non-significant differences between depressed and non-depressed groups in terms of attention during the scenes. However, the depressed group tended to perceive neutral scenes more negatively than did non-depressed controls. Finally, the depressed group was more likely than the non-depressed group to report experiencing situations resembling the negative scenarios both in the past, and in the future.

The influential role of cognitive schemas has been studied in eating disorders. For example, Henry (1997) postulated that the role of stress and avoidant coping factors has been extensively explored in the study of binge-eating but the contribution of cognitive expectancies and self-schema in the domain of dieting has been neglected. She studied college students ( $n = 445$ ) whose dieting schema was assessed prior to the first experiment session. Using regression analyses, the experimenter reported that increased levels of dieting schema were

significantly related to increased binge severity and increased likelihood of a binge episode. Furthermore, greater negative eating expectancies were significantly associated with more severe and frequent binge-eating and increased likelihood of a binge episode.

There are numerous studies examining the role of cognitive schemas in the development or maintenance of a range of psychological disorders. For instance, Beebe (1997) studied the role of cognitive schemas in Generalised Anxiety Disorder; Zucker, *et al* (1995) examined the role of early childhood knowledge and attributions about alcohol as indicators of emerging cognitive schemas regarding alcoholic beverages; and Segraves (1978) investigated the contribution of cognitive schemas in the perception of the opposite sex as a common therapeutic mechanism in the dissimilar models of marital therapy.

##### 5. Summary and conclusions

The differences between CBT and phenomenology in relation to psychopathology are evident and have been historically highlighted by the literature. The similarities, which are the focus of this paper, tend to be de-emphasised. A few of these similarities can be brought forth when one compares some phenomenological propositions related to psychopathology and some propositions put forward by CBT. One of the crucial concepts in this similarity is Dreyfus' criticism of the epistemological alternative in favour of ontological explanations. This distinction gives rise to the notion of "character problems". Recall that character problems are repeated patterns of self-defeating behaviours which do not allow the person to recognise the problems. CBT's notion of schema resembles the notion of "character problems" in that they both refer to a sort of mental filter that tints incoming information. For the schema to be a schema with the features that Beck describes (and Piaget before him) it needs to be part of the context or as Merleau-Ponty calls it, part of the atmosphere.

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This would suggest that for a CBT practitioner not to recognise the existence of the schema it would involve treating the problems epistemologically (as put by Dreyfus) but once the recognition of the cognitive schema takes place a more ontological view is adopted. There is an admission that incidents take place in the *clearing*.

Perhaps the most striking resemblance is in the area of therapeutic intervention. Merleau-Ponty's example of the inferiority complex fits almost perfectly with the CBT's conceptualisation of depression. Both the phenomenological and the CBT approaches acknowledge that counter-examples are not enough because the "way" of seeing is part of the clearing, and thus the basic tenet of the intervention is to challenge the schema and help the patient to "see" this. That is, to challenge the maladaptive cognitive schemas, to help the patient to see that his/her way of being in the world is shaped by pervasive colouring. Although the techniques proposed by the phenomenological school, as promoted by Dreyfus, would emphasise the utilisation of dreams as a less contaminated account of past events, today's research does not support this putative neutrality. However, the specific tools are secondary since both the phenomenological and the CBT goals are to show the patient the connection between his/her schemas/atmosphere and the pain being experienced.

There are a few obvious objections to a comparison of this nature. Beck favours a definition of schemas that appears to violate basic phenomenological precepts. As pointed out earlier, Beck suggests that schemas get activated when a particular environmental stimulus impinges on the individual. This manifest division between the environment and the subject does not go well with Heidegger's "being in the world" principle. However, another CBT principle seems to override (in a way) Beck's ambitious epistemological claim. That is, the exact origin of the cognitive schemas - although

an intellectual challenge to decipher - is not a necessary factor for good therapy. That is, if outcome-research shows that challenging cognitive schemas is therapeutically effective in diminishing or extinguishing depressive symptomatology, one could forgive Beck's dualistic etiological explanation. The notion that practical and effective intervention doesn't guarantee knowledge of causality acquires significance here.

The two phenomenological predictions, as articulated by Dreyfus, are first that *there are* certain ways, colouring or schemas in pervasive conditions, and second that these schemas have probably been formed during the early stages of the individual's development. It should be noted that these predictions are supported by empirical findings. An association between cognitive schemas and psychological disorders has been consistently established; in studies, for example, investigating depression (Markley, 2000), eating disorders (Henry, 1997), generalised anxiety disorders (Beebe, 1997), alcohol abuse (Zucker, *et al* 1995) and marital dysfunction (Segraves, 1978). In relation to the development of cognitive schemas, it has been established that early maladaptive schemas partially mediate the relationship between depression and parental perceptions (Bendo, 2001; Harris & Curtin, 2002; Ingram, 1999). It has also been recognized that cognitive schemas might change or develop in later stages. This has been established in women who have experienced sexual abuse (O'Shields, 1999; Slaton & Lyddon, 2000) and in the area of vicarious traumatising (Cunningham, 1997; Galloucis, *et al*, 2000; Pinsley, 2000; Simonds, 1997; Weeks, 2000).

Heidegger and Merleau-Ponty's influence on psychotherapy has been well documented but it is not as common in the empirical approaches to emotional pathology, as is CBT (2). Heidegger was very interested in psychotherapy and through his friend Medard Boss, the founder of the approach known as *Daseinanalysis* (together

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with Ludwig Binswanger), regularly lectured to a group of Swiss psychotherapists who are reported to be the first group of psychoanalysts to incorporate existentialism into therapy. Notes of these seminars known as the *Zollikon Seminars* remained untranslated into English for a long time. However, there is now a full English translation available edited by Boss (Heidegger & Boss 2001). Additionally, a good account of these developments is given by Cohn (2002) in his *Heidegger and the roots of existential therapy*. Cohn states that existential phenomenology is, in his view, the creation of Heidegger, rooted in the insights of Edmund Husserl. Phenomenological influence on psychology in general is well examined by Spinelli (1989) although Spinelli and Cohn's accounts still leave largely unexamined the possible influence of phenomenology on the more empirical approaches to psychopathology.

In summary, Beck's work and subsequent research, suggests that some phenomenologists, as espoused by Dreyfus, anticipated various elements in the CBT tradition. Specifically, the importance of cognitive schemas that was articulated by Merleau-Ponty and Heidegger has found empirical validation in a variety of investigations examining the role of the cognitive schemas on emotional pathology. It is also interesting that the notions of atmosphere and clearing have not been acknowledged by the empirical approaches as unambiguous precursors of the notion of cognitive schemas: The resemblance is far too evident to circumvent, and the immediate question is whether Beck and his predecessors in the empirical psychopathology domain were unaware of this philosophical proposition or whether they did not find the similarity striking. It is also interesting that most attempts to de-value empirical approaches to emotional pathology do not consider this sort of link. The use of different terminology (e.g., schema versus atmosphere) might mask similar conceptualisations and thus encourage the current trend of explaining in a parallel fashion without

connection. Unfortunately, this perpetuates the gulf between psychopathology and philosophy. Finally, there is a myriad of concepts that, if appropriate terminological obstacles are overcome, might reveal an interesting association between empirical propositions and phenomenology within the psychopathology domain, thus opening up future theoretical and clinical explorations.

#### Endnotes:

(1) *Beck set out to validate Freud's explanation of depression, which incorporated as its main concept "anger turned on the self". Using psychoanalytical methodology he observed negative cognitive biases rather than retroflected anger (Beck & Weishaar, 1989).*

(2) *An interesting early exception is the work edited by T.W. Wann in 1965: "Behaviorism and phenomenology".*

#### About the Author

Rodrigo Becerra studied four years of Philosophy in Chile before emigrating to Western Australia in 1987 where he completed a Bachelor of Psychology degree in 1991 and has worked in the profession ever since. He later completed a Master of Clinical Psychology degree, studying cognitive rehabilitation of attentional difficulties after brain damage. He has conducted studies in emotional processing and has published on Alexithymia in the "Brain Injury" journal and presented his findings in the Netherlands, Australia and Chile. He is currently conducting research with Murdoch University and Sir Charles Gairdner Hospital where he has worked for the last six years. The focus of this research is emotional blindness in normal and clinical samples. Rodrigo is currently taking up an invitation to write a chapter for a forthcoming book on Psychology of moods. In the Philosophy arena, he is completing a PhD in Philosophy under the supervision of Dr Paul MacDonald [a IPJP review panel member – Editor's note] which examines

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"Neuropsychological syndromes and emotional pathology; non-phenomenal events affecting

phenomenal consciousness". He has published a few articles on issues of Consciousness.

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