



Understanding the Ubiquity of the Intentionality of Consciousness in Commonsense and Psychotherapy

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Abstract

A formal and idealised understanding of intentionality as a mental process is a central topic within the classical Husserlian phenomenological analysis of consciousness. This paper does not define Husserl's stance, because that has been achieved elsewhere (Kern, 1977, 1986, 1988; Kern & Marbach, 2001; Marbach, 1988, 1993, 2005; Owen, 2006; Zahavi, 2003). This paper shows how intentionality informs therapy theory and practice. Husserl's ideas are taken to the psychotherapy relationship in order to explain what it means for consciousness to have intentionality in various ways. The role of intentionality in psychopathology and its treatment within cognitive behavioural therapy is explained as a way of showing how understanding intentionality creates a medium for the delivery of care.

From 1913, Edmund Husserl made it clear that phenomenology is about the intentionality of consciousness. As he put it: "Intentionality is the name of the problem encompassed by the whole of phenomenology" (Husserl, 1913/1982, p. 349). The precise way in which Husserl intended his phenomenology of the mental relation to being and non-being, belief and non-belief, is that theory should be promoted for practices of every kind. The specific ways in which Husserl claimed that phenomenology could help were: (1) in the creation of a theoretical or pure psychology for promoting the practice of any applied psychology (Husserl, 1928/1997), and (2) in creating a pure phenomenological philosophy that would justify and promote theory for the sciences and applied philosophy in academic disciplines.

The Husserlian definition of intentionality specifically infers the donation or interpretation of the meaning of an object onto the perceptual sensations that are present (Husserl, 1900/1970, p. 860). While this notion is central to the argument presented in this

paper, Husserl exegesis is beyond its intent. The aim of this paper is, rather, to show that the original domain of phenomenology is understanding the conscious objects of qualitative experience in relation to *how* they are conscious, the forms of being-aware, the modes of intentionality (Husserl, 1913/1982, pp. 220-221, 244-245, 251-252). Such understanding makes the nature of psychological situations, and hence their treatment, clearer. Why intentionality is useful is that it accounts for all forms of psychological existence, many of which are not current but temporal (actively remembered, automatic influence of the past, the immediate moment that is coming, the anticipation of the future, the imagination of something at any time). In essence, understanding intentionality is about a fundamental understanding of what it is to be in a conscious world with others and share meaning experientially.

The level that phenomenology originally addressed was not that of higher, derivative claims about the justification of natural psychological science and its

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differentiation into bona fide and pseudo-scientific forms (Rorer, 1991). For phenomenology, there is primarily a seamless whole of meaning. The ubiquity of intentionality is something readily understood by clients, and therapists of different schools will grasp that what is being discussed is how consciousness can turn to the same object and, depending on the intentional relation, find different senses of it - as intellectually-understood, as emotively-understood, as visually-perceived, as remembered. What is being called on, as proof of intentionality, is understanding one's own experience and what others tell of theirs. The view is pre-scientific. Intentionality exists as awareness, behaviour, relating and affect. Intentionality is a necessary explanation of the commonsense psychological world. In psychology and therapy, the understanding of it goes further in specifying the details that lay people cannot.

Clinical vignettes will be used to explain the role of intentionality in its ability to map changes in forms of attention and awareness. This paper does not propose new interventions or a new brand name for therapy, but argues for a greater awareness about what therapy is in the practice of psychosocial skills. What is proposed is a needs-led approach to understanding the experiential creation of psychological problems in terms of intentionality - in order to connect with interventions in the same terms.

Identifying Some Forms of Intentionality

This paper concerns the ubiquity of intentionality in ordinary living and the theory and practice of psychotherapy of any type. This opens the door for explanations of the notion as applicable to other areas of psychology also. As a concept, intentionality is capable of enabling therapists and clients, supervisors and researchers, to *speak the same language*. Because intentionality clearly maps first-person experiences of seeing, feeling, thinking and behaving, it easily performs a mediating role in enabling clients and therapists to understand collaboratively the nature of psychological problems, and hence to make some headway in working to reduce or alter those problems. Staying at the level of generality for a while longer, intentionality defines the many types of relation between consciousness and the meanings of beings of all kinds. Specifically, intentionality comprises both simple and compound (or composite) types and refers to conscious meanings. Its objects could be linguistic-conceptual ones or non-verbal composite wholes, *gestalts* of non-linguistic meaning (Merleau-Ponty, 1962). Some specific forms of intentionality can be listed as follows.

Perceiving concerns the conscious awareness of sensations in the five senses about real events in the here and now, including how one's own body feels (Marbach, 1993, pp. 51-52).

Imagining concerns envisaging something that might or might not happen or exist, at an unspecified time (past, present or future), without believing that it is, was, or will be, real (Marbach, 1993, p. 75).

Behaviour is most often purposeful action towards a desired outcome. The English language sense of the word "intentionality" as "purposeful" is not what intentionality means in phenomenology. Behaviour can vary in its degree of skilfulness and in being either fully cognisant, automatic, or a mixture of the two.

Affect can be about values but most often represents how a self is relating, or has related, to others, and how others are relating or have related to self.

Empathy is the socially learned appreciation of the perspective of others (Husserl, 1931/1977, pp. 111-120; Marbach, 1993, p. 91; Owen, 2006, p. 162). In that empathy is a complex intentionality involving many parameters, a thorough theoretical account of it is beyond the scope of this paper.

Conceptual intentionality is the use of language in internal dialogue, discussion with others, reading and writing (Marbach, 1993, p. 3). Concepts have a general manner of referentiality: they can point either to first-hand experiences or to the second-hand, empathised experiences of others. Concepts employ an abstract manner of giving their meaning: they make meanings known often without the object itself coming into consciousness. Similarly, believing that something is the case can also be expressed in explicit speech or internal dialogue.

Nested types of intentionality also occur in conjunction with *temporality*, the many facets of the experience of time. These are important perspectives for understanding the orientation that clients have towards their psychological worlds - for instance, remembering what a visual perceiving of a scene was; remembering what was said by another and felt and thought by oneself (Marbach, 1993, p. 79); anticipating what will be seen; anticipating what will be said; anticipating how one will feel in relation to an anticipatory empathising with how another might act.

Finally, there are a host of possibilities for psychological experience concerning how others will react to self and how self will react because of the

reaction of others, plus ever more complex forms of these *intersubjective situations* - for instance, the empathic imagining of what someone might think or feel at some unspecified point in time. Empathy can be connected to imaginatively visualising what self and others could do, in the sense of creating an imaginary world and feeling emotion in relation to the scenes envisaged.

The Role of Theory

The role of theory in psychology and therapy is to point to what counts, so that psychological processes can be identified, discussed and interpreted in a variety of contexts - for instance, between clients and therapists; for clients and their lives outside of sessions; and for trainers and trainees. However, what appear are mixed, complex wholes of sense, *gestalts*, which exist in relation to complex composites of intentionality.

There are areas of hermeneutics and theory of mind that are relevant, but they cannot be fully explained within this paper. It must thus suffice, in passing, to point to the notion of the self-reflexive appreciation of what it is to understand intentionality itself. Because intentionality is closely tied to the conscious, it might be easy to forget the social dimension of life, but clearly this would be non-phenomenological (as well as non-psychological, non-empathic and non-inter-subjective). In brief, what is broached here is: (1) the intentionality of a person in relation to psychological experiences and other people generally, and (2) the reminder that intentionality is interpreted from complex wholes of what appears.

This paper argues for understanding the ubiquity of intentionality in psychopathology and therapy practice. The purpose of this paper is to elucidate the limits of therapy theory and practice: that what is being dealt with are conscious skills, directed towards conscious aims and encouraging free will to alter the use of intentionalities and their associated meanings. Having a better understanding sharpens practice by enabling a clearer grasp of what change is, in terms of the progression from problems to answers. It is claimed that intentionality is the key for unlocking the abilities of clients to self-help, whilst helping therapists know what their role is in helping clients.

Intentionality, as the interpretation of conscious experience, makes it clear how to position oneself in order to help clients act and interpret in specific ways. Some of the outcomes for sessions are to motivate and inform clients and help them to advise themselves - for instance, by helping them act on their own

behalf to reduce binge-eating because they know that binge-eating has no overall benefit for them.

The force of intentionality is illustrated by the following example. A traumatised and agoraphobic client reports his experience that, whilst walking down the street in the middle of the day, he saw two men running across the road towards him. He immediately concluded that they were about to mug him, for the third time that year. It was not until he realised that they were both wearing tracksuits, and had just come out of a sports club, that he understood that their intention was jogging and not theft. The point is that the forms of intentionality that phenomenology claims are interpretations of the way in which *experiences get superimposed on each other in different ways*. As Husserl put it: "while I perceive my material environment, a flash of memory comes to me and I devote myself entirely to it, this world of perception does not then disappear; no matter how much this world may lose its 'actuality', may 'withdraw from me', perceptually it is always there" (1939/1973, pp. 175-176). Through mis-empathising, this client mis-identified the joggers as muggers on the basis of the other attacks he had recently suffered. The retained meaning from his previous attacks was thus donated to or superimposed on the current situation.

Because his previous traumatic experiences led the client to be generally paranoid, he empathised a great deal of his social experience as people being against him and that others have bad intentions. Not only was there thus the current perception of the runners, but there was a re-connection to the previous intentions of his attackers that were added to the current moment. However, when he focused more on the actuality of the current moment, he realised that he had mistakenly empathised the men's intentions towards him. Because the same client frequently avoided leaving home altogether, there was also a future-orientation in his anticipation of what might happen. This client's affect was such that he preferred to stay inside rather than to go out, because he anticipated that open spaces, streets, and dark or crowded places would have muggers in them. His orientation in time, place and person is that he is both future- and past-oriented at the same time. His orientation in person is fearful in any current environment because of his past attacks. In person, he continued to experience himself as vulnerable to attack and he empathised that others have bad intentions towards him and his property. The anxiety he felt was intense with respect to what he anticipated might happen, so he often chose to stay inside rather than to go out. The more he stayed in, the worse his

fears became.

What follows is a note on the different kinds of psychological disorder that appear when intentionality is taken seriously. This focus gives way to understanding how therapy can respond in suggesting forms of self-help or making interventions in sessions. The claims made have been gained through clinical work. Of course, further work needs to be done in identifying the precise intentional components of any psychological disorder. The remainder of the paper is divided into two sections dealing with the explanatory power of intentionality in psychodynamics and cognitive behavioural therapy respectively. Firstly, the psychodynamics of the intersubjective relationship in a talking therapy are explained via intentionality, in order to show what Freud's basic terms of resistance and transference mean. Secondly, the cognitive behavioural therapy approach is re-interpreted in terms of intentionality, making it clear what is being assumed to be the problem and what the nature of therapy should be. For the sake of brevity, the paper does not attempt a full explanation of Husserl's view of the communalisation of intentionality between people in relation to cultural objects (Husserl, 1936/ 1970, 1931/1977), although his adherence to this latter, co-empathic and intersubjective view is noted.

How Intentionality Helps Explain Psychodynamics

Freud's practice revolved around the psychodynamics of intersubjectivity in a two-person relationship, but was reported through his terminology of unconscious communication, resistance, transference and counter-transference. This brief overview looks at resistance and transference in an intentional way. The aim is to show how Freud's practice still has worth today and how it can be clarified through understanding intentionality. Freud partially showed the phenomena of resistance and transference, but he got them caught up in forms of explanation that did not permit the phenomena to be grasped properly. Ellenberger (1970, p. 542) is one who has noted the influence on Freud in his youth of Brentano's earlier version of intentionality as "consciousness-of".

In outline, resistance does not apply only to the form of self-disclosure within psychoanalysis, but to self-disclosure of any type. Self-disclosure is essential to all types of therapy and can be best understood as a complex interconnection between different types of intentionality. Resistance is the sum total of a series of anticipated comparisons, that also hold a connection to the past. It exists in relation to any potential object of speech, in relation to anticipated

objects of the empathised response of the therapist, and in relation to anticipated emotional states of client and therapist. Freud's technique was to monitor the amount of resistance occurring and reduce it to enable clients to self-disclose sufficiently to get help (1914/1958, p. 155, 1940/1964, p. 179). Resistance occurs also in relation to clients who want to self-disclose and get help, through giving of an object of their private attention to the public domain in speech. Let us deal with resistance first.

Resistance can be seen most clearly in those cases where clients have difficulty in attending assessments for therapy. Clients who have resistance may wish to exert some control of the process of being assessed by including third parties to help them with the 'ordeal' that they anticipate will occur in asking for help. Once clients with this type of fearfulness finally get to meet the therapist, they may further experience anticipatory fear that inhibits self-disclosure of their story. Resistance can be understood intentionally as a composite of a number of intentionalities that together explain the gross negative anticipation of what will happen. Therefore, resistance supports the need to control assessment and therapy, possibly giving rise to an ambivalence or a complete inhibition in asking for help altogether. Resistance is also apparent in those clients who say that they would like to have therapy after assessment, but who do not come to the first session, or who may drop out after attending a small number of sessions. Resistance is also what happens when relevant topics for discussion are mentioned briefly by clients in passing and then are avoided thereafter. The phenomenon of resistance is also at play when relevant topics are completely omitted by clients.

On gentle inquiry, what appears is that clients fear that there will be disapproval from therapists and hence a negative change for clients in their feelings about themselves. Resistance has consequences for some, in that to admit a 'fault' or 'mistake' would make them feel uncomfortable about themselves because of some taboo behaviour or some socially unacceptable thoughts, impulses, emotions or other indiscretion to which they would be admitting. Thus, one aspect of the whole of resistance is an anticipated empathising that there will be disapproval from others.

The point of intentionality, for client and therapist, is that it opens up all the parts that comprise the whole in intersubjectivity. Any two persons are intertwined in such a way that, even in the anticipation of self-disclosure, anxiety, shame and fear can arise sufficiently to inhibit the speaking of the object of

consciousness. When the future-orientation of resistance is understood, remarks can be made to clients to help them self-disclose in a respectful manner, at their own pace and in their own way. Although not every aspect of conscious communication is continuously conscious, all potentially conscious aspects can come to consciousness from time to time.

Similarly, the nature of what is called transference, according to Freud, is disputed when therapists pay close attention to whom the inaccurate empathy is directed. For it is often the case that no mis-empathising occurs with respect to the therapist, and that the mis-empathising is entirely directed to the notional possibility of an anticipated future relationship that has not yet begun. Yet, such a possible relationship is anticipated as being fear-inducing or otherwise neglectful, for instance, in an indirect relation to the influence of the past, from the personal history of the client. Most generally, what is called transference is an incorrect donation of empathic sense to anyone, leading to repetitive psychological and intersubjective problems. Let us consider its component parts via the concept of intentionality.

Transference is mis-empathy, heavy with the influence of anticipation that the future will be like the past. The fear is that actual, or potentially actual, people will arise, who will be similar to traumatic or problematic people from the past. The phenomenon is clearly recognisable in the survivors of sexual and physical abuse. It is temporally founded and, when attended to as a conscious phenomenon, such anticipations may not appear at all in relation to the therapist. This is particularly the case when the therapeutic relationship is set up in such a way that a focus on clear aims is maintained, and when the roles of therapist and client are clearly defined. If therapists do not encourage clients to make guesses about them and do not permit lengthy silences in sessions, then a difficult job is not made into a harder one. On the contrary, it is quite possible to enable grossly abused clients to take part in co-operative and secure therapeutic relationships.

What is called “transference” is an anticipatory mis-empathising about specific or non-specific others. It is imprecisely and cumulatively related to the past. Sometimes, it may not be at all related to any specific occurrence between the client and any specific other. It may have a tenuous link to a non-specific situation such as generally growing up in a family and neighbourhood. It is thus no wonder that clients cannot relate their feelings or mode of relating to any

one specific incident: There is none. The lack of specificity with respect to any single past situation highlights the anticipatory and defensive anxiety in relation to a creatively anticipated problematic that is not actual and only ‘hypothetical’ in relation to current and future relationships that clients may have. The psychological function of this defence is creating a problem and then trying to avoid it or solve it in different ways.

Consequently, what is referred to as transference is better identified as a complex total of conscious emotions, retained influence and anticipation, loosely related to past actuality and loosely related towards the non-actuality of the future. When it interferes with current relationships, it can be interpreted from the safety-seeking that does appear in the here and now. These emotions, beliefs and automatic influences are conscious and capable of description. Such emotions are only descriptively unconscious when they are not current. The inaccuracy is a socially learned experience related to prolonged experiences such as prior attacks, betrayals, bullying or relationship breakdown. What happens is that layer upon layer of empathic experiences build up across the lifespan. As such, the types of experience called attachment, internal working models, object relations, schema and suchlike refer to the same type of experience: that of the ability to understand others and their intentions in relatively accurate or inaccurate ways.

How Intentionality Helps Explain Obsessive-Compulsive Disorder and its Treatment

Rather than veer off into the abstract or the fine detail of what Edmund Husserl really meant, let us now go straight to how intentionality has worth in identifying forms of psychological problems. Let us take the case of obsessive-compulsive disorder (OCD). Usually, OCD is classified according to the type of compulsive behaviour that follows the obsessional worry about and excessive focusing on specific objects. The outcome of this way of thinking about OCD is seeing it as counting, checking, orderliness, cleaning or hoarding, for instance. However, this says nothing about the forms of intentionality involved. My practice with people with OCD leads me to conclude that there are at least three sorts of this problem when the types of intentionality involved are taken into account. This information is gained by directly asking clients about the order of experiences they have, rather than assuming that all forms of OCD are the same. In brief, there are at least three different types of OCD, distinguished in terms of the intentionalities involved, as described below:

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1. Visual imagination predominates in causing anxiety that leads to repetitive behaviour. This may include visual imaginings contrary to perception, plus visualisation of the catastrophic consequences of the imagining (see *Figure 1*).
2. Explicit beliefs in language are repeated in internal dialogue as worry that causes anxiety that leads to the repetitive behaviour. This may also include the production of future imaginings of personal catastrophe and responsibility that are driven by worry (see *Figure 2*).
3. A habitual form of conditioned anxiety exists with repetitive behaviour but without internal dialogue and without visual imagination of problems and catastrophes. Even on reflection, clients report no other intentional experiences and have no rationale or explanation for the compulsive behaviour (see *Figure 3*).

Before going into the details of the above, a brief note needs to be made about the behaviour therapy interpretation of this same situation. The behavioural interpretations of classical conditioning and operant conditioning (Walker, 1984, 1987) concur overall with the phenomenological interpretation of the intentionalities involved. The difference, however, is that the phenomenological interpretation goes a great deal further in specifying the order and detail of what happens for clients. Indeed, close questioning of clients supports the one-person interpretations that classical and operant conditioning are genuine phenomena. But the explanatory framework becomes explicitly more cognitive and affective when the fine detail of the intentional events is uncovered by inquiring into the specific elements of the experiences for each client.

One major difference between behaviourism and phenomenology is that, when intentionality is taken seriously, it is clear that there are differences about what actually constitutes the repetitive experience of OCD for a single client, and in how hermeneutic ideas are taken to the experiences of a client to make sense of them. For phenomenology, it is clear that a hermeneutic and explanatory process is at stake, in so far as certain portions of the experiences of clients are highlighted as being relevant while others are discounted.

What appears for explanation is what clients mention and what emerges through discussion in sessions. This is not the same as knowing with absolute certainty what is causing the OCD, for there may be genetic factors that precipitate this type of anxiety

disorder. Accordingly, the obsessive objects that 'demand' compulsive behaviour may have been adopted in an arbitrary fashion. It might be the case that there are other sources of anxiety or unbearable feeling in a client's life. OCD could act as a means of controlling these negative feelings. Let us look at the three types of OCD and their treatment in a way that shows the detail of intentionality as a kind of go-between for understanding the problems and preparing for a self-help therapy.

Firstly, there is the situation where a client has a number of OCD behaviours that have the specific intentional form shown in *Figure 1*. Let us take a concrete example of someone who checks taps to make sure that they are off, despite the taps actually being off already. The situation is one where there are clear perceptions that there is no water coming out of the tap and that, visibly, the tap is not dripping and the plug is out. Yet the client visualises water gushing out of the tap and anticipates that there will be a flood, with water throughout her house leading to electrical fires and her home burnt down, leaving her homeless. Before therapy, she checks both her bathroom and kitchen taps up to twenty or more times a day, for up to 15 minutes at a time. Whilst checking, she manages to break the washers inside the tap and that makes the water-sealing capability of the tap poor, so that the taps begin to leak rather than maintain their integrity when closed. Consequently, a plumber has to be called several times a year to stop the taps leaking, because the metal assemblies have become damaged.

Behaviourally, only two composite intentionalities are occurring. There is classical conditioning between the tap and anxiety. The anxiety is diminished by the checking behaviour that brings relief from the anxiety. Regarding the behavioural interpretation, the operant conditioning supports classical conditioning. The behavioural answer to this problem is to reduce checking and endure the anxiety produced, until the anxiety diminishes. The learning is to discover that it is possible to bear the anxiety itself and that the anxiety cannot remain at high levels.

Therapists can ask open questions around the experiences of clients and so capture what happens for each client. On closer inspection, what happens for this client is that her visual imagination plays a role in producing a number of images of flooding and fire in her home. These are contrary to the clear perception that the plug is out of the washbasin and the kitchen sink. Yet the images that come involuntarily, non-egoically, are those concerning water pouring out of the taps full blast, the sink

overflowing and flooding throughout her home that will lead to fires in her household electrical equipment. As a consequence, she prefers to use only one tap in the house and to fill numerous large pans with water in order to touch the taps as infrequently as possible.

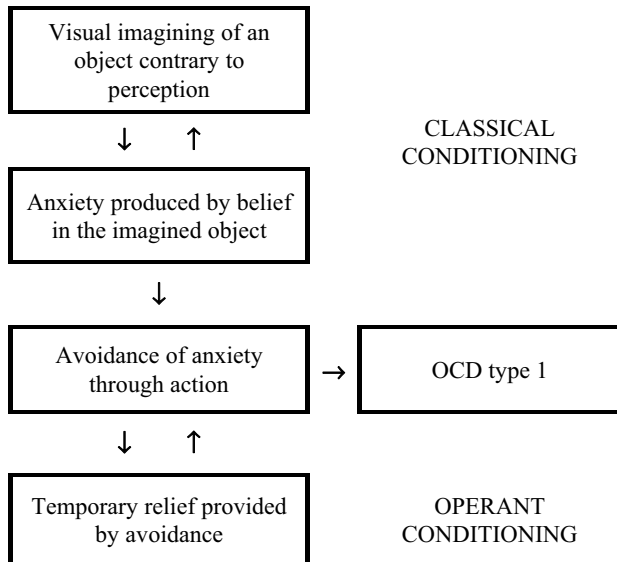


Figure 1

Given that the anxiety and avoidance are, in this case, mediated through her visual imagination, her therapist suggests that she could imagine a number of antidotes to compete with the imagining of taps pouring water, flooding and fire. She is encouraged to visually perceive what her taps look like when they are off. She is encouraged to experiment with what happens when she imagines calming and enjoyable visual scenes. She is requested to reduce the amount of time that she spends checking her taps from 15 minutes, in successive steps. In the intentional formulation, the awareness of what intentionality is and does is more detailed than the standard cognitive behavioural way of providing the self-help treatment of breaking the conditioning involved.

Figure 2 shows an intentional formulation of what happens in another discrete form of OCD. In this type, the driving force is internal dialogue in the form of questions that a male client asks himself. He answers his own questions with catastrophic answers. In this case, the problem concerns the fear that, whilst driving his car, he may inadvertently have knocked somebody over and killed or injured a pedestrian. The anxiety produced by this thought leads to him driving back to re-inspect the piece of road that he had earlier crossed. He drives back across the piece of road as slowly as possible, looking all around to see if he has

killed anybody. When he gets home he is still agitated because of the possibility that he might have killed somebody. Secondary to the internal dialogue driven by the belief that he is liable to kill people are his intentional connections to the perceptual events of driving and then to the possible consequences of what would happen if he were to kill somebody. Because of this line of explicit internal dialogue, he imagines appearing in court and feels strong shame in relation to this.

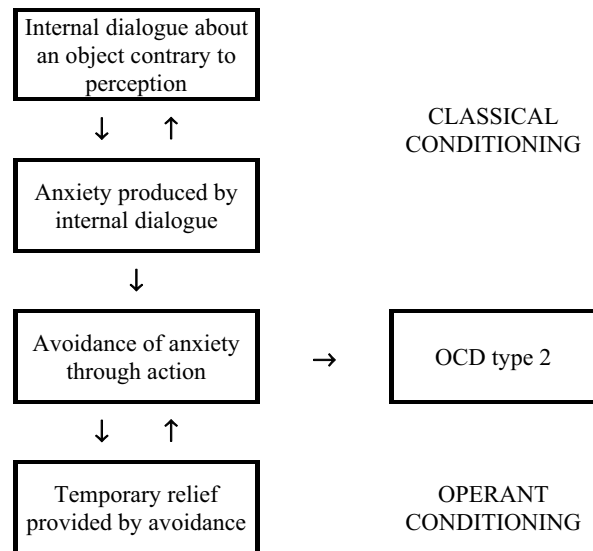


Figure 2

In response to questioning in therapy, the client becomes worried that he might have injured or killed somebody at specific places such as busy parts of his hometown, pedestrian crossings and speed bumps in the road. At a pedestrian crossing he has no audition or sight of having hit somebody with his car. But this absence of a large audible impact, the absence of seeing someone being near his car, and the lack of a physical impact on his car, are insufficient evidence for him. He tells himself that he has to drive back and inspect the pedestrian crossing that he has already navigated safely. Sometimes one inspection is not enough. He tells himself what would happen to him, his wife, his colleagues and his children, were he to appear on charges of manslaughter and leaving the scene of an accident, and what would befall him after being prosecuted on these charges. These situations he can anticipate vividly: they would bring financial ruin on his family and colleagues and he would be entirely to blame.

The problem is that this gentleman may well have conditioned himself into having this problem. Again, the simple behavioural view is that he should not drive back, no matter how he feels or what he thinks

in internal dialogue, or what he anticipates may happen. But the behavioural understanding in itself is a blunt instrument. The more nuanced understanding of the intentionalities present is that interpreted implicit beliefs and explicitly held beliefs drive the worry in his internal speech that produces the anxiety, and that the action of returning and checking only affords short-term relief in each instance. Clearly, there is a lack of connection between the evidence that he is a safe driver who has never knocked anybody down, and his linguistically-expressed worries that that he is a danger to the public and potentially irresponsible towards the people whom he cares about most. Treatment for him was to pay more attention to the evidence that he is a good driver and to set his worries aside and drive on without returning.

Figure 3, lastly, refers to a situation where OCD behaviours exist with little or no conscious awareness as to how the person feels and what he or she thinks, or what may be going on in his or her life in general. Perhaps because of many years of repetition and lack of reflection, such clients have neither rationale nor understanding of any sort concerning their compulsive behaviour. Perhaps the thoughts are as meagre as “I should be checking”, followed by hours of physically painful and mentally exhausting checking. In this latter case, the intentionalities are not available to the ability of clients to reflect on their own experiences. Accordingly, the intentional formulation of the obsessions and compulsions becomes anxiety and the repeated behaviour as one item, leading to temporary relief as the reward of operant conditioning. Part of treatment might be to explore the horizon of the client’s life to find out if there are other worries that might bring some understanding to the psychological function of the OCD: as a block against other worries and emotions, perhaps. Behavioural principles could be applied to reduce anxiety once the overall intentional balance in the client’s life is understood.

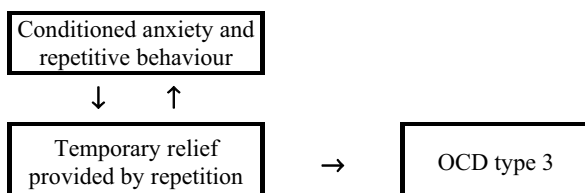


Figure 3

A Note on Cognitive Behavioural Formulation

This final section offers some critical comments on the theoretical stance of cognitive behavioural therapy from the intentional viewpoint. In cognitive behavioural therapy, there is an emphasis on formulation as a way to interpret and create a mutual understanding of psychological problems and hence provide therapy. There are many formulations extant for a number of problems and a whole literature on how to formulate and treat. Clearly, it is not possible to address the fine detail of the literature here. The problem with the cognitive behavioural approach is that it is not intellectually clear about what it is doing and how it is doing its work. Also, what happens is that monolithic assumptions are made about psychological causes in general, possibly without attention to the client at all. Such an attention could only promote theory ‘over’ the experience of clients and would be entirely non-phenomenological.

In passing, however, it is noted that the overall tendency in the cognitive behavioural literature is to sketch diagrams of cause and effect without any self-reflexive explanation of how the diagrams have been created. As there is no accompanying theory of mind, the explanations arise out of nowhere. A thumbnail sketch of some of the current cognitive behavioural ideas regarding the maintenance of psychological problems will now be provided.

Anorexia is dealt with in terms of egoic factors such as self worth and self-control, in relation to the emotional effects of mis-empathised others anticipated as a result of the failure of self-control due to ‘over-eating’ (Fairburn, Shafran & Cooper, 1998, pp. 5-6). In this model, however, the thoughts and feelings of others are downplayed. The model of bulimia provided by Clark and Fairburn (1997, p. 212) is more accurate, but does not make explicit the role of vomiting and laxative abuse as operant conditioning. Nor does it highlight the emotional changes before and after binge-eating and vomiting that would be central to a phenomenological understanding. Secondly, the anticipated empathy of others is omitted, providing an excessive focus on self with the senses of others implied rather than explicit.

Generalised anxiety disorder (GAD) or worry has been portrayed in two ways. The first, by Dugas et al. (1998, p. 216), refers to relevant factors but notes the role of belief as creating anxiety, when it is likely that anxiety could be a direct consequence of self-talk, visual imagining or anticipation. Wells (1997, p. 204) has created a much more complex account that

distinguishes between levels of self-reflection but has no relation to any hermeneutic factors or values in terms of what might make something an important factor for worry in the first place.

OCD and health anxiety are both similar to worry. OCD is given a fair account by Salkovskis (1985, p. 578), but the role of temporary relief is downplayed. The view of Wells (1997, p. 242) on OCD is that beliefs are explicit and the topic of hermeneutics is implicit, but the role of temporary relief is omitted altogether. Health anxiety is postulated as being due to the centrality of belief, but with no mention of what beliefs are or how they are re-evaluated through therapy (Clark & Fairburn, 1997, p. 320). Also, the role of temporary relief is omitted by Clark and Fairburn. The view of health anxiety by Wells takes a developmental or historical element into account in explaining classical conditioning, but does not make explicit the intentionalities present in the catastrophic thoughts that are at the heart of creating the anxiety actually felt (1997, p. 135). Again this model omits the role of operant conditioning.

Of the remaining noteworthy models, panic episodes are given fair treatment by Clark and Fairburn (1997, p. 138), but the precise forms of the intentionalities that might occur are not mentioned. The understanding of panic disorder offered by Wells (1997, p. 102) is one that mentions a complex intentional state of affairs that provides the anxiety (but omits relief). Classical conditioning mentions body sensation, but omits coverage of how the body is catastrophically interpreted. Post-traumatic stress disorder (PTSD) is represented in terms of the findings of cognitive psychology (Brewin, 2001, p. 382). The treatment given PTSD by Ehlers and Clark indicates that it is more complex and gives a place for the idiosyncratic thoughts and experiences of the meaning of the trauma for its survivors (2000, p. 321). A model of intimate relationships is provided by Tarrier, Wells and Haddock (1998, p. 406) in such a way as to omit any mention of attachment theory and research on intimate relationships between adults. Finally, social phobia is referred to without mention of the attachment literature, and yet it correctly understands that the apperception of self by self is the central event, although it does not state how the self comes to treat itself in any specific way (Clark & Fairburn, 1997, p. 141). The picture of social phobia in Wells (1997, p. 169) is that a number of intentional processes coincide, but the role of the relief provided by social avoidance is downplayed.

What the above all share is the assumption that they know how consciousness works. Yet none of the

papers include any mention of qualitative research on these experiences or make reference to a theory of intentionality. It is the clear assumption of cognitive behavioural theory that the intentionality of consciousness is central to the production and maintenance of psychological problems. Yet its interventions create changes in the amount and quality of attention to objects of various kinds. When the type of intentionality is changed, then the sense experienced also changes. Changing from one object to another also provides new experiential senses. Specifically, what the cognitive behavioural approach assumes (like any non-philosophical model of therapy or psychology) is that beliefs interpret ontologically. What is believed to exist does exist: hence the usefulness of the idea of intentionality in the first place. Felt emotions exist in relation to what is believed to be the case in the past, current moment or future. Without the conceptual ability to compare and contrast the different manners of intentionality towards different senses of the same object of attention, there can be no theory that gets close to human experience. The problems of clients and inaccurate theory are then remarkably similar. The over-fixation on belief and its use in regions where it is inapplicable produce: (1) inaccurate interpretations of the evidence of both the part and the whole, and (2) inaccurate interpretations of the proper regions of evidence. Both false understandings prevent accurate actions because the more accurate experiences cannot be attained.

Summary

A full account of intentionality in classical Husserlian phenomenology has not been provided in this paper. Husserl's search for ontological a priori concerned sorting less dependent superficialities or parts from more independent wholes (*The Third Logical Investigation*, 1901/1970). Applying phenomenology is taking the ideas and methods for concluding on a priori (such as the intentionality of consciousness) to a chosen area and working there constructively. What this means is that classical Husserlian phenomenology was a practice for theorising, but not as an end in itself. Husserl's view was of a meaningful whole of the self as meaningful and social. The self, for instance, is an experiential whole that runs across the traditional categories of what is intrapersonal and interpersonal, social, systemic, and so on. The raw data for Husserl's phenomenology is lived experience. Consequently, psychopathology and its treatment are both experientially influence-able. The concept of intentionality is a gateway to understanding psychological existence: something that natural psychological science cannot grasp. In

brief, a certain type of pragmatism exists between genuine understanding and effective action. Purposeful conscious actions of the ego can be

attained through explicit and implicit aims and beliefs that consistently bring about the wanted and anticipated outcomes.

About the Author



Ian Rory Owen was born with the Dutch family name van Loo in Wellington, New Zealand in 1960. He was awarded his Bachelor of Technology degree in Mechanical Engineering in 1982 and worked briefly as a technical journalist and in business during the 1980s before commencing his training in counselling, hypnotherapy and psychotherapy. He began his therapeutic career in 1987, gaining a Master's degree in counselling and psychotherapy from Regent's College, London, in 1991, and a PhD in 2005. He became a Graduate Member of the British Psychological Society in 1999 and a UKCP registered psychotherapist in 1995. As a Senior Lecturer in Counselling Psychology, he led the MA/MSc course in Counselling at the University of Wolverhampton until 2001. Since 2001 he has worked for Leeds Mental Health Trust, where he is currently a Principal Integrative Psychotherapist, providing individual brief therapy for adults. He is the author of more than 50 papers and three books in the area of phenomenology, theory of mind and psychotherapy.

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