Cognitive Psychopathology

Bruno G. Bara (bruno.bara@psych.unito.it)
Center for Cognitive Science
University and Polytechnic of Torino
via Po, 14 - 10123 Torino, Italy

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Can Cognitive Science do without cognitive psychotherapy?

Cognitive Science has dominated in the last 30 years the landscape of the human sciences. In such a long period it has reabsorbed alternative paradigms like connectionism, and it survived explosive openings of new domains like neuroscience. It is surprising that such a triumphant enterprise has left unexplored the area of the greatest collective interest, viz. psychopathology. While Education entered into the so-called *cognitive hexagon* in the nineties, psychopathology still remains alien to it.

Cognitive Science studies minds in good health, only and always in good health. If neuroscientists appreciate brain damage as a possible event of life, cognitive scientists pretend that mental suffering is so occasional as not to be worthy of investigation. However, outside laboratories all of us are deeply involved with the mental rolling between happiness and pain.

We experience it in the first person, and we observe it in the life of everybody around us. Psychopathology is immersed in our common world: it may help Cognitive Science toward a program of naturalization, where human beings are studied in their natural context of interaction. We may begin by defining cognitive psychoterapy as the achievement of integration between emotions and cognitions, aiming at maintaining a conscious dynamic equilibrium, and obtained thanks to the client-therapist relation. The goal of therapy is not that of modifying the person's external behaviour -the symptoms- but the subjective causes of behaviour, and these depend on internal structuring: perception, cognition, emotions, and above all the image of the self.

Cognitive therapy investigates two fundamental dimensions:

1. Analysis of the past. Attention centers principally on moments of crisis, seen as the breaking of equilibrium, a painful but necessary process in development. Besides re-elaborating infantile and adolescent experiences, events that may induce loss of equilibrium -love, marriage, children, bereavement- and thus require reflection on the self, are scrutinised. The primary objective of this phase is the construction on the part of the clients of a theory about themselves. Such a theory helps to understand both one's own personal history and one's particular mode of emotional and cognitive organisation that led to the current state of malaise.
2. Analysis of the present. Starting from the onset of the disorder, it proceeds to the here and now of the therapeutic situation. The objective aimed at is not so much definitive stability as much as acceptance of possible future crisis, in the name of continuing individual development.

The method by which the therapy is realised is through the therapist-client relationship. This is a cognitive-emotional relationship whose objective is the client's well-being.

The idea is that through the relationship with the therapist, which becomes increasingly clearer and deeper, the clients learn not only to understand themselves, but also to re-establish a channel of communication between his cognitive part and their emotional part.

Cognitive psychotherapists daily face situations which are incommensurably more complex than the most complicated experimental designs. They do it constantly, drawing their inspiration from theories proposed by Cognitive Science.

The participants at the symposium will start to walk along the continuum which connects normal, quasi-normal and pathological aspects of the mind.

Participants

Simon Baron-Cohen (sb205@cus.cam.ac.uk)
Autism Research Centre, Cambridge University, Cambridge, UK.

Is autism an extreme form of the male brain?

Autism affects boys much more often than girls. One possibility is that autism simply represents an extreme of the male cognitive style. Sex differences research suggests that on average, females have a stronger drive to empathize, and males have a stronger drive to systemize.

Studies are reported that test if people with autism show a profile of empathy deficits alongside hyper-systemizing.

Such results are also discussed in terms of their neural basis, and the role of fetal testosterone in particular.

Baron-Cohen S. (2003). *The Essential Difference*. Basic Books.

Antonio Semerari (terzocentro@iol.it)
III Centro di Psicoterapia Cognitiva, Roma

One or More Metarepresentation Disorders?

During psychotherapeutic sessions the patient is constantly encouraged to monitor and reflect upon his/her own mental states. Therefore analysis of the session represents a privilege point of view in the study of metarepresentation disorders and their course in time.

Several studies on transcribed sessions of patients with personality disorders give us the following suggestions.

Patients with personality disorders present typical impairments in metarepresentation.

Since only the specific disorder affects some specific subfunctions while others have good functioning, it may emerge different metarepresentation pathologic profiles.

This is the reason why different patients have different disorder profiles according to different specific impaired subfunctions. In personality disorders the impairment has not a fix and stable course in time but it is influenced by the life events and patient's relationships. Specific damages in single subfunctions involve each specific clinical consequences and difficulties in the adjustment.

Discussant

James McClelland (jlm@cnbc.cmu.edu)
Center for the Neural Basis of Cognition Carnegie Mellon University. Pittsburgh, PA