

Disavowal in cognitive therapy: the view from self psychology

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It is argued that standard, or 'classical' cognitive therapy will encounter a specific difficulty in the treatment of patients whose central pathology involves disavowal (Freud, 1938; Basch, 1983) and the so-called 'vertical split' in the self (Kohut, 1971; Goldberg, 1999). It is argued that certain central aspects of the cognitive model may, if adhered to clinically, fail to heal or, at worst, enhance such pathology, with or without the amelioration of observable symptoms, not because of any specific intersubjective circumstance, or therapeutic technique, but because of essential (indispensable) tenets of the cognitive theory itself—the theory itself contains the problem. This paper is a comment on theory, and should not be mistaken for a global evaluation of any kind of therapy or therapists

No therapy promises to cure every kind of psychopathology. Accordingly, it is hoped that most psychotherapists will neither claim, nor expect to be able to cure every patient. Some therapists believe that certain therapies are better suited to particular kinds of psychopathology, but whatever form of psychotherapy we choose to practice, we must become blinded to certain aspects of our patients' clinical presentation. Just as every theory gives us fresh eyes to see otherwise invisible phenomena, so too does every theory imply what is unimportant, and what is to be ignored.

As the contest for the most effective outcomes between different approaches to psychotherapy is fading in the minds of many, it behooves us to not take a competitive attitude to approaches to psychotherapy that are foreign to us. Rather, we need to take an inquisitive approach in order to learn something of the blind spots of our preferred theory (*cf.* Popper, 1994). It is from this perspective that

the present paper seeks to make a contribution. A specific consideration is the use of cognitive therapy in the treatment of patients who display a specific intrapsychic defence, namely that of *disavowal*, as seen in patients suffering from what self psychologists call '*structural disorders of the self*.' It is argued that aspects of the *theory* that informs cognitive therapy prevent the therapy from alleviating the patient's use of the defence of disavowal. This shortcoming exists not as a function of any specific intersubjective circumstance, or of therapeutic technique, but rather that it must be so, in principle, *i.e.*, *a priori*.

The defence of disavowal and the vertical split

A number of analysts have turned their attention to disavowal from a self-psychological viewpoint, beginning, of course, with Heinz Kohut (1971, 1979), whose point of departure was Freud's work on the subject (1938, 1927). While there is no scope here for a comprehensive discussion of disavowal¹, three aspects of our

present understanding of disavowal are emphasised:

1) To be effective as a defence, disavowal does not require an abandonment of, or any deficit in, the capacity for logical thought. Whereas repression precludes the opportunity to apply logical thought processes to unwanted mental contents (because they are unavailable to conscious awareness), the defence of disavowal allows one to talk about defended-against mental contents *ad infinitum*.

2) As Basch (1988) summarised succinctly: '*Repression disrupts the bond between affective memory and words; disavowal blocks the formation of a bond between perception and affect*' (p. 124). For the disavowing patient, by definition, the usual continuity between the mental registration of something and its affective consequences is not to be expected.

3) If repression can be seen as a horizontal split (*i.e.*, content below the threshold of conscious awareness), then disavowal can be seen to lead to a *vertical split* (*i.e.*, material defended

against by being ‘held to the side’, and still available to consciousness). This vertical split shows itself phenomenologically as two parallel experiences of perceptions (Freud, 1938)—both a knowing and a not-knowing of the disavowed content. Clear-cut cases of the vertical split show an oscillation between two simultaneous, side-by-side (and often contradictory) sets of views or perceptions, motives, pleasure aims, or goals², for example, the morally upright patient who periodically frequents massage parlours, or the affluent university professor who steals books he never reads (cf. Goldberg, 2001c). The most benign clinical instance of disavowal might show itself in the grieving patient who knows that he has lost the loved one to death, and yet at times finds himself behaving and thinking as though the loved one were still alive (such as maintaining the deceased’s bedroom, expecting the deceased momentarily when the telephone rings). A perception is not fully integrated, and so leads to two contradictory modes of functioning.

The opening phases of treatment

The vertical split, as described above, often leads to a strong ambivalence around the motive to engage in treatment (Goldberg, 1999). In these instances, the initial contact with the therapist is often more of an invitation to the therapist to bolster the disavowal by siding with one side of the patient’s split experiences. For example, the adulterer who comes to therapy to try to save his marriage, typically asks the therapist ‘to help me stop committing adultery’. He will often plead his case that he wants to stay married, that he loves his wife, and that he hates himself for cheating—all of which is perfectly true. Nevertheless, the therapist is being asked to help the disavowal rather than to heal it; the therapist is asked to help the patient do away with a part of himself that the patient is perfectly ambivalent about: the pathological behaviour is abhorred, but kept to the side, in case it might be required to serve its function at a later date. Let us now examine what happens to such a split patient when she enters cognitive therapy.

Cognitive therapy and the theory of cure

Cognitive therapy claims to effect its cures by altering dysfunctional mental patterning. Mental patterning is believed to be responsible for pathology

the path to cure through cognitive therapy usually begins with the verbalisation by patient and therapist of these organising patterns (i.e., schemata, core beliefs). Inevitably, any pathology can be reduced to

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insofar as it both constructs subjective experience and organises behaviour, by processing inner and outer sensory perception in an idiosyncratic way (Beck, 1976). We can summarise that

irrationality in either the content of the cognitions, or in the thinking and reasoning processes, even where the cognitive distortions deal merely with misperception or misinterpretation of



Illustration: Savina Hopkins

'reality' (Beck, 1976). As we read in Hamlet, "*nothing is right or wrong, but thinking makes it so*"; one is depressed not about the world, but because of one's perception and interpretation of it. As such, we might assume a

to bring the irrational schemata into conscious awareness through a process of rational verbalisation and reorganisation. The rational aspect of the patient is buttressed by its resonance with the (rational) therapist

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reduction in psychopathology once the patient's thought processes are more reasonable, and his perceptions of reality are more realistic. Reality is usually enough, if not to make one perfectly happy, at least to make one non-pathological and no longer depressed.

While this brief summary omits many details of treatment found to promote positive therapeutic outcomes, (e.g., adherence to 'homework' tasks in therapy), it captures the essence of what would identify a treatment as 'cognitive'—a focus on the elucidation and alternation of irrational thoughts, beliefs and schemata that govern behavioural patterns and subjective experience.

The alliance of the rational

Like psychoanalysis—and perhaps all forms of therapeutic activity—cognitive therapy makes certain demands of the patient if therapy is to be possible. While these requirements might not be obvious immediately, and are not outlined explicitly in classical texts on the subject (e.g., Beck, 1976; Beck et al., 1979), the first requirement is that the patient must have the ability to think more or less rationally and logically. Simultaneously, he or she must have organising principles (schemata) characterised by an internal inconsistency from a rational, logical, 'empirical' point of view. Without the simultaneous presence of these two aspects of mental functioning, cognitive therapy cannot proceed—without the irrational aspect there is nothing to treat, and without the rational aspect there is no hope of changing the problem.

Further, the patient is required

through collaborative empiricism and the therapeutic alliance (Beck et al., 1979). Once established, the irrational must be brought under the observation of the rational faculty. Therefore, it can be said of cognitive therapy that the dialectic aspect of the therapeutic alliance—the observing part versus the observed part—becomes layered onto the rational dialectic. As a necessary consequence of the theory of psychopathology in cognitive therapy, the therapeutic alliance becomes an alliance against irrationality.

In summary, cognitive therapy requires a patient to evidence irrational mental structures and, at the same time, subject these structures to his own competent, rational faculties—to be both rational and irrational about the same psychic material. Similarly, the patient is required to form an alliance between her observing ego functions and the therapist. This alliance is required, more or less, to observe and to objectify the pathological aspects of the patient's functioning. The rationale of cognitive therapy requires the therapeutic alliance—the dichotomy of observing aspects versus observed aspects—to correspond with the dichotomy of rational versus irrational aspects: the rational observing functions must alter the irrational observed functions. From this position, we begin to see the fate of the 'self' in cognitive therapy.

Being of two minds In cognitive therapy

Two basic problems arise when the theory of cognitive therapy is applied to the treatment of patients whose central pathology involves disavowal and the vertical split.

1. Two paths to solving the problem

The clinical literature on the problems of disavowal and vertical split notes two basic methods by which the problematic symptoms of the vertically-split patient can be reduced. (this needs to be referenced?). One method is to resolve the vertical split itself; the second method is the deliberate or unintentional bolstering of the defence of disavowal and, therefore, the vertical split—strengthen the split and the 'problem' will be less evident. This latter situation is more likely to develop in therapies that seek to control, reduce, avoid, or otherwise sequester the behaviour associated with the split-off sector (e.g., aberrant sexual behaviour; solipsistic arrogant behaviour; substance abuse; etc.), and in any therapy whose primary outcome measures are third-person-observable behaviours. The therapeutic intention of a simple reduction in problem behaviour can be regarded as consonant with, and therefore potentially supportive of, the function of defensive disavowal. In the example of the narcissistic behaviour of an adulterer, this is manifested as an increased ability to abstain from the act of adultery, at least for a period of time, rather than a reduction in the need to engage in the act.

The active ingredient of cognitive therapy, cognitive restructuring, also relies on the dialectic of the therapeutic alliance. Eventually, the patient must see, from the viewpoint of his rational faculties, the irrational aspects that lie elsewhere in his psychic household. If the self-observing faculty corresponds in cognitive therapy with the ability to apply logic and reason, it must also be so that when a vertically-split patient comes to cognitive therapy, and the disavowed pathology is activated in the treatment, the split-off sector most often will be the target of the therapeutic interventions.

Each side of the split is aligned with a different set of ideals and given the incompatibility, by definition, one will soon be identified as 'pathological' and the other as 'healthy'; one as basically rational, the other as basically irrational; one as delivering the patient's 'therapeutic' intentions, the other as the patient's 'problem'.

Typically, the patient will present

the symptoms of one side as 'the problem', and it will be easy and usually inviting for a therapist to form an alliance with the other 'presenting' side. In other words, the 'split' between the observing ego and the object of its observation, will correspond prototypically with the vertical split of the patient's disavowal, if cognitive therapy is ever to be carried out.

With logic and rational thinking as the tools, cognitive therapy serves to cleave-open the split caused by disavowal. The theory directs the therapist to occupy a position from which the split itself is taken for granted, i.e., the 'alliance' and the split are unified as determined by the theory, and therefore the very quality of the split itself—of parallel sets of experience, being both rational and irrational—is not examinable therapeutically.

This is not a situation that may arise in therapy if certain patient-therapist configurations are not handled properly, but rather, a description of the necessary conditions for a cognitive therapy to be conducted with patients that demonstrate a vertical split, according to the cognitive theory itself.³

Goldberg (1999) argues that therapies that aim to increase control over the split-off sector, often result in extensions of the period of abstinence, or in a more effective, permanent removal of the problematic behaviour at the price of a more permanent, pervasive, mild depression. In contrast, the primary aim for the psychoanalyst in such cases is dissolution of the split itself, while the amelioration of symptoms remains a secondary aim. More precisely, symptom amelioration is not desirable in psychoanalysis unless it is achieved via the dissolution of the vertical split.

2. The problem of disavowal for cognitive therapy

A second problem arises in the cognitive treatment of disavowal. Cognitive therapy takes certain synthetic mental functions for granted. Specifically, it relies on the natural, cause-and-effect link between cognition and affect. The theory takes for granted that a change in cognition will ensure a change in affect. However, for the disavowing

patient, it is precisely this otherwise automatic consequence that is severed in service of the self. As Freud (1938) noted, disavowal '*...seems so strange to us because we take for granted the synthetic nature of the processes of the ego*'.

If the defining characteristic of cognitive therapy is the assumption of

an automatic process of thoughts that lead to affective experiences, it can be argued that a cognitive therapy will not be able to treat a pathology organised around disavowal.

If the cognitive therapist retains the goal of helping the patient change irrational thinking, she will encounter the patient's frustrating response whereby cognitive insights will be understood, appreciated and discussed, but nevertheless will fail to effect a behavioural or affective change. From this clinical configuration we may hear a complaint of patients in cognitive therapy, "*I know what you are saying is true, but I don't really*

believe it". Are these patients trying to express the subjective experience of disavowal? In this instance, the rational perception of reality is prevented from forming a bond with an affective response, "*I think it, I think I know it, but I don't really feel it*". It is likely that such a patient will comply,



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and may even engage in treatment with enthusiasm, but the otherwise expectable consequences of the insights achieved (i.e. cognition causing a change in affect) may not be so easily forthcoming. Therapists must be alert to 'changes' that result from the insidious defence of compliance, rather than genuine therapeutic change.

The difference between a cognitive and a psychoanalytic approach

It has been argued that a cognitive therapy cannot resolve the pathology of patients who present with a vertical-split, once one aspect of the split is

declared 'better' or 'more correct' than another, and where there is overt or covert communication to the patient of an effort to support the dominance of one over the other. Because cognitive therapy deliberately avoids the unconscious psychogenesis of pathology, the pathological aspects are simply designated as such and, being irrational, they cannot, by definition, be understood. Psychoanalysis takes the irrational as its point of departure, the subject of its focus, and using knowledge of the patient's unconscious, hopes to allow what was irrational to be understood (Goldberg, 2004). Cognitive therapy takes the irrational as a problematic foreign body in the patient's psyche, which (whether removed or allowed to fall into disuse) must be abandoned in the process of cognitive restructuring, in favour of other, rational replacements or detours.

Psychoanalysis argues that the split cannot be healed through cognitive insight alone. Were this possible, the overwhelming majority of such patients would have healed themselves long ago. Rather, the existing evidence of how a split is healed with psychotherapeutic treatment points to its spontaneous, unforced dissolution via the interpretation of dual transferences mobilised from both sectors of the split psyche (Goldberg, 1999).

In other words, the patient typically shows a structural defect that invokes the split-off sector as a restorative (i.e., defensive) manoeuvre, and eventually must come to see that, despite an abhorrence for it, this other side of the picture is also he. Psychoanalysis has long addressed itself to the therapeutic rehabilitation of psychic structure and, as a consequence, analysis has seen the split heal through the structure-building action of the treatment.

How psychic structure is restored or developed in analytic therapies is too broad a topic to be covered here, but most relevant to the present argument is that the split itself is the condition of the patient's structure, and as such, the split, rather than the problematic behaviour, must be the focus of the treatment. The path to cure requires that the structural configuration be addressed.

Discussion: why only cognitive therapy?

The informed reader might ask why this theoretically-determined quandary would not be found in therapies other than cognitive therapy. Why doesn't the same impasse, whereby the therapy proceeds inadvertently to bolster the vertical split, appear in other approaches to therapy? This must be asked especially given the proclivity of all treatment to require self-observation of the patient, and therefore to run the risk of observation leading to mutual judgment. Even if the issue of the therapeutic assumption of a spontaneous link between thoughts and affects speaks of cognitive therapy in particular, are not all therapies prone to the layering of the self-observation dialectic onto the vertical split in our patients? The simplest answer is that such impasses can, and indeed do, occur in therapies other than cognitive ones, including psychoanalytic ones. The point is not to ask which therapies have difficulties with such patients, but rather, which therapies are guided by theories that are more likely to inform and to direct treatment in a way that is helpful or unhelpful with a specific mental configuration.

A chief difference between cognitive therapy and psychoanalysis is that the preceding formulation of pathology, disavowal and the vertical split, cannot be contained within the cognitive theory alone. Further, the cognitive therapist has nothing in his theoretically-determined resources to identify and repair this peculiar configuration. Clearly, the explanation as presented above is dependent upon psychoanalytic constructs for its articulation. Further, in psychoanalysis, the therapeutic intent of valuing one kind of thinking over another (i.e., rational over irrational) typically is not within the analyst's system of ethics, and so the tendency to be aligned with the removal of certain mental functions is less. Psychoanalysis is usually conducted upon some variant of the Freudian principle of neutrality—another Pandora's box of psychoanalytic fervour, which for our purposes can be restricted to mean a neutrality of intent, if not of effect. That is, ideally the psychoanalyst is not trying to change anything in his

patient (Wolf, 2002a), but rather to maintain a certain set of conditions (i.e., the analytic ambience) via his single activity of interpretation. Under those conditions, the patient can change according to potentials and programmes of development inherent in the patient, not the therapist. Today the inevitability of interaction with our patients is acknowledged and while, at some level, we cannot help but introduce some value system to treatment, we are more likely to accept and to interpret (Wolf, 2002b), rather than to eschew and to help to remove.

Another subtle difference between the analytic approach and some other therapeutic approaches (including cognitive therapy), is in the understanding of the selfobject significance of the pathological sectors. Without a long explanation of this self-psychological construct, it will suffice to say that cases such as those under discussion reveal transferences of early developmental derailments. A foundational precept in psychoanalysis is that the transference is mobilised spontaneously from the sectors of the patient's psyche that have the structural weaknesses or defects—the transferences identify diagnostically the heart of the patient's pathology, and as such, show a revival of early developmental needs that are intertwined with the pathological behaviours and experiences. If the treatment serves merely to inhibit these behaviours, then the development of these aspects of the psyche remains foreclosed. It is for this reason that a psychoanalytic treatment calls us not to sequester the problematic behaviours, even those the patient might present as wishing to desist. Instead, the aim is to understand and explain them, lest the fruits of that particular line of (derailed) development be lost to the process of controlling and abstaining from problematic behaviour. In other words, the pathological behaviour that the patient pleads to be free from, must be analysed and understood, because it contains simultaneously the information needed to restore the structural defect—the psychoanalytic viewpoint tells us that to come to a deep understanding of the problem is to do the work of repairing the problem structurally. In contrast, to change

the cognitions around the problem without understanding its origins, is to leave the structural defect in constant and regular need of cognitive compensation. For example, a theory like self psychology would hypothesise that the seeds of the pathology in certain behaviour disorders such as substance abuse, sexual perversions and eating disorders are simultaneously the seeds of such symptoms of mental health (i.e., structural integrity) as empathy, humour, wisdom, and the capacity for enthusiasm (Kohut, 1966; 1971), if only the treatment is able to identify them, and permit their belated development.

Footnotes

1. For a general discussion of disavowal and its consequences from the self-psychological perspective, the unacquainted reader is directed to Basch (1983) and Goldberg (1995, 1999).

2. The incongruence of these two sides of the vertical split is the essence of the problem, and although disavowal need not produce such a problematic pair of incompatible and antagonistic experiences of self, it is those with just such opposing sets of experience that we are more likely to see in treatment.

3. A number of colleagues who read earlier drafts of this paper were upset by this assertion, having mistaken it to be a comment about therapists instead of a comment about theory. Any number of therapists who describe themselves as 'cognitive', might treat the disorders under discussion with clinical success, however, I submit that it is logically impossible for this to be achieved by a treatment that is informed, to the letter, by the cognitive theory. The interested reader is directed to 'The Concept of Structure in Psychoanalysis', Ed. T. Shapiro, 1991, CT: International Universities Press.

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