THE CHALLENGE OF UNCERTAINTY IN PSYCHOTHERAPY: DEPTH PSYCHOLOGICAL VOICES FROM THE FIELD

by
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Abstract

THE CHALLENGE OF UNCERTAINTY IN PSYCHOTHERAPY:
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By Amanda E. Norcross

This study explores analytically-trained psychotherapists' experiences of uncertainty in their work with patients. Three experienced analysts were interviewed for the study: one Jungian analyst, one Freudian psychoanalyst, and one relational psychoanalyst originally trained as an ego psychologist. The analysts were asked a series of questions that explored the experiences, feelings, thoughts, sensations, changes, and images that they associate with uncertainty in their clinical work. Through phenomenological data analysis of the interviews, uncertainty was revealed to be an important and inevitable experience for the analysts that is both challenging and enriching and that impacts them inside and outside their consulting rooms. The implications of the findings are considered for both psychotherapists and laymen, and the study applies the findings to the research process itself. The study also includes an extensive review of the existing literature on clinical uncertainty. The electronic copy of this thesis is on a single disc containing a single PDF file which can be opened with Adobe Acrobat Reader.

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CHAPTER I
INTRODUCTION

One of the few certain statements that I believe can be made about uncertainty is that the experience of it is familiar to psychotherapists, regardless of theoretical orientation or experience in the field. As a neophyte therapist, I rapidly became acquainted with showing clients an outwardly helpful, earnest appearance, while inwardly churning with anxiety about how to help and how much I did not know. Though this experience is particularly acute for new therapists, the findings of this study indicate that some feelings of uncertainty, whether terrifying or benign, occur regularly in all therapists' consulting rooms.

I was struck and frustrated by this reality. Therapists go through many years of education and training, learning the skills and rules of the trade, and yet they repeatedly face situations of uncertainty in which they cannot rely solely on what they have previously learned. This meant that, no matter how many years I might practice as a therapist, I would always face uncertainty. This situation is, actually, not unusual for any profession but is particularly unsettling when the person sitting across from you is struggling with varying degrees of anguish and emotional pain and is paying you, *expecting* you to know how to help. Given my own struggles with uncertainty in working with clients, I was intrigued to find not only that therapists experience uncertainty regularly but also that they are, by virtue of their profession, actively choosing to spend a lifetime engaged in it.

Statement of Thesis and Purpose of Study

In the research for this thesis, I spoke with three analytically-trained psychotherapists (referred to in this thesis as "analysts") about their experiences of uncertainty in working with clients. The narrowness of scope of the study in terms both of number and of a theoretical orientation in depth psychology has been by necessity rather than choice, but I believe the focused attention has allowed for richer, deeper searching and prepares fertile soil for further exploration. With the research question—how do seasoned analysts experience and respond to times of uncertainty in their clinical work?—I was interested in gaining a deeper understanding of the phenomenon itself. What experiences, feelings, thoughts, sensations, changes, and images did the analysts associate with uncertainty in working with patients? (For a list of the specific questions posed to the analysts, see Appendix E.)

Certainly, I had some ideas about what I might discover in the interviews. In my personal experiences of uncertainty in working with clients, I felt something more than simple agony was at work. As I was learning to let go of my ego and be more comfortable with not knowing, I was increasingly intrigued by what seemed to me a deceptively simple paradox: patiently not knowing makes way for unexpected knowing. This grounded, Buddhist-like mindset, however, slipped away all too easily in moments of uncertainty with clients. I often wondered what the experience of uncertainty was like for other therapists, but the encapsulated, private nature of psychotherapy inherently limits one's ability to see other therapists at work.

Given my curiosity about the phenomenon of uncertainty, I was compelled to explore. By talking to experienced analysts, perhaps I was looking for validation of my

own experience. Perhaps I was looking for certainty or, more likely, reassurance in the midst of my own uncertainty and hoping to see a future as a therapist in which uncertainty was not so . . . uncertain. Beyond this quest, though, I was looking for different perspectives on clinical uncertainty, hoping to broaden my views of what it means to be in uncertainty and to expand my capacity for sitting with and learning from such experiences. This is also what I wish this study might provide for the reader.

I am not aware of any existing work that focuses solely on this topic in the manner of this thesis: a phenomenological exploration of the experience of uncertainty for seasoned analysts. This research, therefore, adds a rich texture to the existing literature by providing all therapists, no matter their level of experience or theoretical approach, with a set of personal, in-depth, and engaged views of this challenging and pervasive clinical experience. I hope that these views might not only mirror and validate therapists' own experiences of uncertainty but also possibly transform them.

The Experience of Uncertainty in the Research

More times than I can count while conducting research, I pondered (and railed against) the meta-uncertainty of what I had undertaken—I often thought of my struggle as experiencing uncertainties about uncertainty. I begin to realize that I had inadvertently plunged into darkness to force myself, it seemed, to work on my personal issues with uncertainty. I found my experiences in doing the research increasingly mirroring the research itself. You have to watch what you ask for, as the saying goes.

As my explorations progressed, the topic of uncertainty, the existing literature, and the interview material I gathered all coalesced to become much like a client with whom I was doing psychotherapy—a client about whom I had many uncertainties and

questions. To cope with the uncertainties, I found myself calling upon the therapist skills I had learned, turning to the ideas in the literature I was reading for my study, and recalling various things said by the analysts I had interviewed. In short, I attempted to approach my uncertainties and anxieties about the research and writing process the same way I would approach uncertainty with a client. When I felt lost and overwhelmed, for example, I would remind myself to return to the basic therapist skill of reflecting the current experience of my "client." Forget conclusions and clarity—most simply, what was this particular author saying in this particular passage of text? What was this particular analyst saying? I kept telling myself that faithful if gradual reflection over time would allow whatever wanted to emerge to do so.

Like an overly anxious therapist sitting in uncertainty with a client, I repeatedly had the sense of trying to get out of my own way. I tried to look more closely at and be aware of what I was experiencing so that my anxiety would not subvert what needed to happen for my client. I tried not to let my desire for some clarity, any clarity, lead me to premature conclusions or to force meaning on the data. Exactly like a therapist waiting for knowing to emerge out of not knowing in work with clients (as discussed throughout this paper), I reminded myself to have faith that the huge amounts of literature and interview material would eventually evolve into a coherent piece of work, even if I could not foresee it exactly and felt considerable anxiety about the outcome. Ultimately, as is the case with clinical uncertainty, I learned as much about myself as I did about my "client," and I found that researching and writing a thesis, a process shot through with uncertainty, was as much as, if not more than, about managing myself than about managing the thesis.

By managing myself—keeping my own anxieties from interfering with what wanted to emerge from my research while plodding ever forward in the dark—I found that the results of my research seemed to unfold and come into relief on their own. Having been immersed in the writing of the British psychoanalyst Wilfred Bion (1992) as part of my research, I knew that any other approach would prevent the truth from emerging, just as when trying to force answers and escape uncertainty with clients. Depth psychology scholar Robert Romanyshyn (2007) wrote about this approach in conducting research.

> The researcher who would keep soul in mind cannot drag the work into the upper world of his or her ego-projections. He or she has to learn to differentiate his or her projections onto the work from the soul of the work itself, which is not his or her possession. The researcher who would keep soul in mind has to learn to see the work through eyes that have let go of it. (p. 53)

The research presented here is an attempt to reveal the soul of the work. Having made an effort to do the research with soul in mind, I am aware, however, that in the process of revealing, I have also inadvertently concealed, an inevitability pointed out by Romanyshyn (2007). What I hope for in this research, therefore, is what Romanyshyn called an "approximation of soul" (p. 25), which can emerge when "one . . . stands in that gap between the fullness of experience and the 'failure' of language to command it . . . bear[ing] the tension between knowing and not knowing" (p. 10). That gap, I have discovered, is a place of uncertainty. Having done my best to tolerate the gap and hold my place in it (an effort also revealed by the analysts' in their interviews documented in Chapter III), I put forth this work with an awareness that, to paraphrase Romanyshyn, this particular body of research has manifested through me (someone who has struggled with uncertainty) in a particular way to further itself (p. 83). My intention has been, as in

work with clients and as Romanyshyn described, to be a catalyst for and servant to that larger process.

Terminology

Before proceeding, some points of terminology must be addressed. As might already be evident, a variety of words are used in this discussion of uncertainty. Even though the term *uncertainty* alone can convey the general experience researched here, the term does not, by itself, capture the many qualities of uncertainty. *Not knowing*, *unknowing*, *unpredictability*, *confusion*, *questioning* are among the many terms employed here to describe the experience according to the particular meaning intended at a given moment. This use of a variety of terms is intentional, in an attempt to best represent the essence of uncertainty as I comprehend it, as described in the literature, and as communicated by the analysts.

Regarding the use of *therapist* versus *analyst*, it should first be mentioned that I believe all the information presented here is relevant for all varieties of psychotherapists, analytically trained or otherwise. For this reason, I use the inclusive term *therapist* as much as possible, especially early in Chapter II. Further into the literature review and into Chapter III (the interview material), as the material becomes more oriented toward depth psychology and refers primarily to analysts, the term *analyst* is usually used because it creates less dissonance in the reading. I firmly believe, however, that the material in these sections is no less meaningful or useful for all therapists, and the term *therapist* is still employed as feels appropriate, especially in Chapter IV where, in conclusion, the thesis returns to a broader perspective. Beyond these personal choices, if a text or one of the analysts specifically used one term versus the other, the discussion reflects their usage.

When referring to the client, a similar pattern is followed. Early on in the thesis, the term *client* is used, and as the material becomes more oriented toward depth psychology, the term *patient* appears because it is commonly used in the depth psychology literature, and two of the three analysts interviewed consistently said "patient" in referring to their clients. As noted previously, these considerations are made in order to create the least dissonance in reading; the discussion is, however, true to the use of the term *client* when quoting material from others.

Overview of Chapters

Having previously alluded to the structure of the paper, only a brief overview of the chapters is in order. Chapter II presents a review of literature that currently exists on the experience of uncertainty for therapists. Though a review of all the writings about uncertainty is beyond the scope of this thesis, the selected sources and the material discussed represent several different views within depth psychology. Chapter III presents the findings from the interviews I conducted with the analysts, grouped by the major themes that emerged in the phenomenological analysis of the material. Chapter IV briefly reviews my findings and considers their implications for the field of counseling psychology and beyond.

CHAPTER II
REVIEW OF LITERATURE

Therapists' uncertainty is a broad topic with numerous possible points of focus. This review of literature is, therefore, necessarily narrowed, based on the depth psychology theoretical orientation of the interview subjects and the concepts and theories that emerged in the course of the interviews conducted for this study. The scope and details are also influenced by the inescapable subjectivity of the author. Similar to the inevitable impact of a therapist's subjectivity in clinical work (a central argument of intersubjective systems theory, which is discussed in the third section of this chapter), the material reviewed here has been gathered and highlighted by a particular hand. The shape of the material (as well as what has been omitted) is, therefore, not absolute or a priori but a shadow cast by a particular profile. This chapter is grouped into the following major sections, reflecting different facets of clinical uncertainty: desire for certainty, capacity for tolerating uncertainty, relational aspects of uncertainty, and disintegration of ego.

The Desire for Certainty

One cannot long ponder the phenomenon of clinical uncertainty and not knowing without also weighing the complementary experiences of certainty and knowing. A review of the existing literature on clinical uncertainty, then, would be incomplete without a brief review of some of the writings about clinical certainty. As two sides of the same coin, each experience influences and gives rise to the other. As psychologist Kristen Felch (2007) explained, however, the delicate and challenging task of balancing the two

is a “trick of combining science and art, technique and feeling, [that] often eludes us” (p. 6). Psychoanalyst Doris Brothers (2008) captured the difficulty in the following snapshot:

> Nowhere do I experience what I shall call *existential uncertainty* more starkly than in my own consulting room. It is there, as waves of this nightmarish dread wash over me and my patients, that I feel most tempted to dig my heels into the dry shore of analytic certitude. Any thoughts I might have entertained about heeding Bion's . . . advice to be without memory and desire vanish. I find myself “reaching after fact and reason” as if for a life preserver—at times, I am ashamed to admit, by trying to squeeze a patient into some preconceived theoretical pigeonhole so that the very things that make him or her (and our relationship) unique are smoothed over. (p. 13)

This digging in of heels, the desperate grasping for certainty, can be seen more broadly in today's largely empirical- and solution-based mental health care system in which “the desire for a scientific magic bullet is intense” (Felch, 2007, p. 15) and the focus is on “controlling symptoms as quickly and effectively as possible” (p. 15).

The desire for certainty is by no means, however, solely a product of the field's current climate. Extending back to the birth of psychotherapy, Sigmund Freud was and still is criticized by many different theorists and practitioners—most famously, Carl G. Jung—for the narrowness of his theories and his stubborn adherence to them. Toward the end of his life, Jung (1961/1989) wrote, for example, the following about Freud's insistence that sexuality plays a singular, dominant role in the psyche:

> There was nothing to be done about this one-sidedness of Freud's. Perhaps some inner experience of his own might have opened his eyes; but then his intellect would have reduced any such experience to “mere sexuality”or “psychosexuality.” He remained the victim of the one aspect he could recognize, and for that reason I see him as a tragic figure; for he was a great man, and what is more, a man in the grip of his daimon. (p. 153)

Perhaps Freud's thinking stemmed from his devotion to making psychoanalysis a science in an era that saw the peak of scientism, “the belief that accumulating scientific

knowledge will tell us all we need to know about human experience, meanings, and values" (Mitchell, 1998, "The Nature of Knowledge," para. 2). Jung's use of "tragic" and "daimon" in describing Freud, however, suggests something larger at work, something more than just a man's insistence on a particular theory. Although the purpose of this study is not to ascertain the underlying dynamics of Freud's thinking, his intense devotion to his theory—like any clinician's—seems to parallel the broader, existential ideas and warnings that authors have put forth about clinical certainty.

Clinging to Certainty

Much of the literature on clinical certainty echoes psychoanalyst Stephen Mitchell's (1998) assertion that "the greatest danger is not the wrong ideas but rigidly held ideas" ("Knowledge Claims," para. 2). The presence of rigidly held ideas in psychoanalysis was examined by philosopher and psychoanalyst Carlo Strenger (1997), who characterized purist clinical thinkers, those with "a unitary vision that guided their interpretation of every phenomenon they met" ("Hedgehogs and Foxes," para. 5), as "hedgehogs" (para. 5). Strenger heralded the value of hedgehogs in psychoanalysis as "major magnets that shape the field of possible voices. . . . [who] are valuable precisely because they show us the implications of certain ideas by pushing them to their logical extremes" ("The Charms of Purism," para. 1). Here, Strenger was intimating what he later described explicitly: "the greatness and misery of purism in psychoanalysis. . . . [that] can land a man as imaginative as Bion in unwitting dogmatisms that can end up disregarding the patient's subjective experiences" (para. 24).

As an oft-cited psychoanalyst on the topic of clinical uncertainty, Strenger's mention of British psychoanalyst Wilfred Bion as a hedgehog is ironic. Bion (1992) is

known for his ideas about being open to the unknown in clinical work and for his famous admonition that clinicians work without memory and desire; however, Strenger convincingly presented Bion as a hedgehog and cited examples of his "selective blindness. . . . [points] at which Bion himself was not capable of maintaining the state of nonsaturation" ("The Charms of Purism," para. 20). (The idea of *nonsaturation* is Bion's own concept, which Strenger summarized as being in a state of not knowing.)

Bion's "selective blindness" (Strenger, "The Charms of Purism," para. 20) then, suggests that even Bion sometimes succumbed to a need for certainty, a concept he defined as *-K* (Bion, 1962). The experience of -K is, according to Felch (2007), "fending off experience that might lead to the unknown . . . [and] clinging to what is known and refusal to let this knowledge be disrupted by new experience" (p. 61). Like Bion, other authors have also identified such existential fear as an aspect of clinical uncertainty. Philosopher Richard Bernstein's (1993) idea of "Cartesian anxiety" (p. 17) is cited by both Brothers (2008) and psychologist Peter Carnochan (1995) in describing clinicians' fear of uncertainty. Bernstein described Cartesian anxiety as "a dread of radical epistemological skepticism in which 'nothing is fixed' and uncertainty threatens to 'envelope us with madness, with intellectual and moral chaos'" (as cited in Brothers, 2008, p. 12).

The Client's Expectations

Jungian analyst Edward Edinger (1997) referred to Jung's description of psychotherapy as a reversal of the dialogue that takes place in empirical scientific experiments:

> Instead of putting questions to nature, like the scientist does, nature puts questions to us. A patient comes to us with a problem—a set of symptoms, dreams, fantasies—and these are nature's questions. It is our task to answer them. (p. 15)

In the face of such pressing questions and often intense suffering, a therapist sometimes feels a dire need to respond, to provide answers, and the client often plays no small role in exerting this pressure.

Clients come to psychotherapy with the expectation that the therapist will treat what is ailing them. As Edinger (1997) explained, the client pays the therapist money and assumes an essentially passive stance with "the idea . . . that the physician has healing knowledge and will apply it appropriately" (p. 17). This expectation, however, is not as simplistic as it appears. In describing the client's unconscious and conscious reactions to the therapist (called *transference* by Freud), Jungian analyst Murray Stein (1998) referred to Jung's "idea of the archetypal transference [in which] the figure of the doctor may be embellished . . . by a larger-than-life and much more powerful figure like the hero lover, the sage magician, or even God" (p. 82).

Similarly high expectations are placed upon the therapist as a priest-like figure. Priests are mediators with the gods, whom people rely upon to help pacify angry gods (Edinger, 1997). Commenting on this role in the context of psychotherapy, Edinger said, "Acknowledging an inability to 'communicate directly with the gods,' the patient seeks a mediator in an attempt to gain protection from the misfortune arising from their anger" (p. 15). The therapist is, thus, "forced into a role of omniscience . . . and it is expected that we know more about ultimate matters than does the common mortal" (Guggenbühl-Craig, 1971, pp. 22-23). Even though the client might not explicitly state these tremendous expectations, he or she holds them nonetheless: "Unconsciously, at least in

part, the patient often hopes to find a redeemer who will free him of all his problems and perhaps even awaken superhuman capacities in him" (p. 32).

A therapist's desire to be a savior figure, to offer wise and transformative responses, nevertheless cloaks something potentially darker—the therapist must "be vigilant not to exploit the authority and power that . . . [these client] projections lodge in us" (Edinger, 1997, p. 19). Brothers (2008) referred to the ever-present danger of therapists becoming "false gods" (p. 162) and Edinger (1997) warned of inflation due to identifying with the client's projection. Adolf Guggenbühl-Craig (1971) wrote convincingly and at length about the therapist splitting the physician-patient archetype such that the therapist is only a healer and loses awareness of his or her own wounds. In all these cases, the therapist pushes his or her own shortcomings into the shadow.

The Dangers of Certitude

One would think that, surely, therapists would quickly become aware of such clear imbalances in their work, that their ethical radar would immediately alert and propel them to take corrective action, yet a therapist's need for sure footing (potentially as insistent as the client's) is insidious. Brothers (2008) cited cult-like psychotherapy training programs in which well-meaning members came to realize they were harming themselves and others yet were reluctant to leave the group. She hypothesized that people in such programs "cannot disengage from one another without risking return to the disorganized chaos against which their connection affords some relief" (p. 161). Similarly, she described psychoanalytic institutes that, in response to uncertainties about coexisting theories, have been accused of developing rigid practices. In discussing this, Brothers cited Kenneth Eisold:

> In a sense, though psychoanalysis is all about facing the unknown, collectively analysts themselves are often reluctant to confess to ignorance. Indeed different analytic communities often organize around assertions of theoretical certainty and battle over claims to truth. As has been pointed out, analytic training often comes to resemble initiations of indoctrination. (as cited in Brothers, 2008, pp. 168-169)

Guggenbühl-Craig (1971) warned of the creeping danger of such certitude: "There is a great danger that the more the . . . [therapist] pretends to himself that he is operating only from selfless motives, the more influential his power shadow will become until it betrays him into making some very questionable decisions" (p. 9). Here enters the dark side of the physician, whom Guggenbühl-Craig called the charlatan, who assures hesitant clients that increased sessions are necessary and convinces everyone of their mental illness. Here also is the dark aspect of the priest, whom Guggenbühl-Craig called the false prophet, who feels pressured to "be the hypocrite now and again, to hide his own doubts, . . . to mask a momentary inner emptiness with high flown words . . . [and to] present himself to the world (and to himself) as better than he really is" (pp. 19-20).

Not only does the therapist risk personal inflation by professing certain or disproportional knowledge, but he or she also risks something potentially greater: a tragic loss of deeper sources of knowing. The therapist risks being unmoored from himself or herself—being without a sense of rootedness and knowing deeply who he or she is a therapist. Psychotherapist Robert Shapiro (1998) called this an internal consistency, which affords the analyst flexibility and a capacity to help far beyond mere certainty or certitude. The therapist also sacrifices knowledge that comes when one has a receptive mindset. In writing about analysts' need for objectivism, Carnochan (1995) said, "This need to be beyond doubt . . . acts to limit our ability to explore difficult ground in the

transference-countertransference matrix, and so represents a limiting distortion in the process of knowing" (p. 361).

The Capacity for Tolerating Uncertainty

What determines an individual's ability to tolerate uncertainty and ambiguity? Early psychoanalytic theorists made many inroads into this question. Moving from Freud to Melanie Klein to Donald Winnicott, Felch (2007) summarized the progression of these early theorists' contributions to answering the fundamental psychoanalytic question of "how we make sense of what is happening inside and outside of us" (p. 6). This particular progression of theorists seems especially salient to a discussion of uncertainty in an individual's development and, therefore, this thesis follows the same progression.

Sigmund Freud: The Unknown

As the pioneer of modern psychotherapy, Freud's major contribution to the understanding of the human psyche, as attributed by Felch (2007) and as many practitioners would probably agree, was his discovery that an unknown, autonomous part of individuals, the *unconscious,* influences their thoughts and behaviors in profound ways that often elude their best efforts to grasp its workings. Because the strivings of the unconscious are often at odds with the conscious mind, "Freud regarded conflict as *the* central clinical problem underlying all psychopathology. . . . [and] symptoms . . . [as] a direct, although masked, consequence of this hidden, underlying struggle" (Mitchell & Black, 1995, p. 19). Though Freud's conceptualization of this struggle evolved over time, as psychoanalytic historians Stephen Mitchell and Margaret Black clearly traced, Freud always considered the heart of psychoanalytic work to be exploration of a person's

unconscious material and *defenses* against the material, including *projection* of the material onto another person (Felch, 2007; Mitchell & Black, 1995).

Melanie Klein: Tolerating Ambiguity in Relating to the Other

Melanie Klein (1882-1960) was an Austrian-born British psychoanalyst and pioneer object relations theorist. Building on Freud's ideas about the individual's struggle with drives and instinctual impulses, Klein introduced a paradigm shift in the understanding of human behavior. Mitchell and Black (1995) characterized Klein's thinking as having themes of postmodernism: "the decentering of the singular self, the dispersal of subjectivity, and the emphasis on the contextualization of experience" (p. 111). Indeed, Klein was one of the earliest psychoanalytic thinkers to place the individual psyche in the context of relationship. Three key concepts of Klein's are pertinent to an individual's capacity for tolerating uncertainty: the *paranoid-schizoid position*, the *depressive position*, and *projective identification*.

Klein believed an individual experiences instinctual impulses "not as discrete tensions, but as entire ways of experiencing oneself" (Mitchell & Black, 1995, p. 91). One of Klein's concepts that evolved from this thinking was the paranoid-schizoid position. The paranoid-schizoid position is typically characterized in terms of an infant's experience (though it is not limited to infants) and is usually described in terms of the *good breast* and the *bad breast*: In the infant's dependence on the mother, the infant experiences "a loving breast that feeds, and a persecutory breast that withholds gratification" (Felch, 2007, p. 9). Because infants believe their loving feelings toward the good breast and hateful feelings toward the bad breast have a real and powerful impact on these objects, "emotional equanimity in this earliest organization of experience depends

on the child's ability to keep these two worlds separate. . . . Any confusion between the bad object and the good object could result in an annihilation of the latter" (Mitchell & Black, 1995, p. 92). Using defenses, then, the infant separates the good and bad objects to prevent their integration, which would mean destruction of self.

The depressive position is a progression from the paranoid-schizoid position in that the infant integrates the idea of the good and bad objects into a whole object. As Felch (2007) described it, the depressive position, "represents the capacity for relating to whole objects with both loved and hated aspects, and toleration of a whole self with both loving and hating impulses" (p. 11). This progression, however, brings its own anxiety. Now the child must tolerate a whole object that is the source of both bad and good, realizing that any aggression directed toward the bad is also directed toward the good. "The frustrating whole object who has been destroyed [by the child's rage against the bad object] is also the loved object toward whom the child feels deep gratitude and concern" (Mitchell & Black, 1995, p. 95). In this process, as psychoanalyst Thomas Ogden (1989) stated, "the continuity of experience of self and other through loving and hating feeling states, is the context for the development of the capacity of ambivalence" (p. 12).

The third Kleinian concept, projective identification, evolved from Freud's idea of projection. In the process of projective identification, the individual projects

> not simply discrete impulses, but a part of the self—not just aggressive impulses, for example, but a bad self, now located in another. Since that which is projected is a segment of the self, a connection to the expelled part is maintained, through an unconscious identification. (Mitchell & Black, 1995, p. 101)

Today, projective identification is considered by many clinicians to be an invaluable tool in their experience of *countertransference* (which is the therapist's experience of and feelings toward the patient). As Mitchell and Black stated, "the Kleinians . . . have come

to regard the analyst's experience as the central site where the patient's dynamics are to be discovered and recognized" (p. 245).

Donald Winnicott: Potential Space

Donald Winnicott (1886-1971) was a British pediatrician, psychoanalyst, and leading object relations theorist. His emphasis on the parenting environment addressed, as Felch (2007) noted, a shortcoming often cited in Klein's theory: emphasis on intrapersonal processes over interpersonal processes in the individual's development. Within the parenting environment, "Winnicott focused his attention on the development of the infant's subjectivity and the capacity for spontaneity, play, and liveliness—that which makes an individual authentically himself" (Felch, 2007, p. 12). Winnicott characterized the space between mother and infant as *potential space*, a space in which the child can simply exist and play, a space "in which . . . [the child] is simultaneously created and discovered" (Ogden, 1989, p. 199), allowing the true self to develop naturally. This development is dependent on the mother initially being extremely attentive to the infant's needs, creating a *holding environment* in which her responsiveness allows the child to be in a state of *unintegration* (Mitchell & Black, 1995). In unintegration, as Mitchell and Black described, "discrete wishes and needs emerge spontaneously and, as they are met, melt back into the drift, which . . . [Winnicott] termed 'going-on being,'" an experience which is "comfortably disconnected without being fragmented, diffuse without being terrifying" (p. 125). The mother's responsiveness in the child's state of unintegration is "a crucial psychological function provided by the mother: the psychological process by which the mother attempts to respond to her infant in a way that 'correctly names' (or gives shape to) the infant's

internal state" (Ogden, 1989, p. 201). The *good-enough* (Winnicott, 1965, p. 18) mother's responsiveness allows the child to develop according to his or her own needs and sets the stage for the child's ability to cope with the mother's inevitable and gradual decline in her responsiveness as "she becomes increasingly interested in her own comforts, her own concerns, her own sense of personhood" (Ogden, 1989, p. 126). The mother who provides such an environment allows the child to learn gradually to manage his or her frustrations, to self-regulate.

In contrast, a mother who does not provide this environment, whose "ego support is absent, or weak, or patchy" (Winnicott, 1965, p. 17), results in a child without a strong, core sense of himself or herself.

> If mothering is not good enough then the infant becomes a collection of reactions to impingement, and the true self of the infant fails to form or becomes hidden behind a false self which complies with and generally wards off the world's knocks. (p. 17)

Psychoanalyst Arne Jemstedt (2000) referred to Winnicott's idea of *unthinkable anxiety*, which is what the child experiences when the mother seriously and repeatedly fails to provide a holding environment. "Against this unthinkable anxiety the infant instinctively develops a defence that immediately comes into action: a rigid and premature self-holding. A protective barrier is established " (p. 126).

Wilfred Bion: Between Knowing and Not Knowing

As a seminal thinker on clinical uncertainty, British psychoanalyst Wilfred Bion (1897-1979) has been described as "an important voice that renounces rational vs. intuitive dualism and embraces a dialectical tension between knowing and not knowing" (Felch, 2007, p. 16). Also, given his ideas on the phenomenon of learning how to think, Bion's work naturally follows the previous theorists in this discussion. Bion's work,

however, is entirely unique. As psychoanalysts Joan Symington and Neville Symington (1996) pointed out in their historical review of his thinking, “psychoanalysis seen through Bion's eyes is a radical departure from all conceptualizations which preceded him” (p. xii). Indeed, the nature of Bion's ideas requires devotion of considerable space here to reviewing his work, proceeding by first establishing some of the basic building blocks in his thought and gradually synthesizing these seemingly disparate concepts into more complete, digestible elements. (Incidentally, readers will find this process to be quite similar to the process of learning to think that Bion described and might find themselves during the initial explanations experiencing their own distinct uncertainties.) Before proceeding, then, the reader should heed Symington's and Symington's advice: to approach Bion's ideas, one must assume the very stance that Bion recommended in clinical work—to be without memory and desire, to let go of all existing psychoanalytic concepts and theories (p. 1). Symington and Symington made it clear that Bion departed entirely from preceding theories in several significant ways and that viewing Bion's ideas through any lens other than his own is to block understanding of his ideas.

Before describing the key concepts in Bion's work that are related to uncertainty, it is helpful to understand some of the central orientations in his thinking. Bion was concerned with the experience of the analytic situation itself, and his ideas, rather than being a theory, are an attempt to describe that situation (Symington & Symington, 1996, p. 2). In the analytic situation, Bion is concerned with “the process through which truth evolves and the process through which truth is blocked” (p. 3), which depend on the individual's ability to tolerate frustration rather than evading it. Crucial here is the ability to think, which Bion (1962) clearly distinguished from merely having thoughts: one

“cannot 'think' with his thoughts, that is to say that he has thoughts but lacks the apparatus of 'thinking' which enables him to use his thoughts, to think them as it were” (p. 84). Elsewhere, Bion (1984) stated this same idea more succinctly: “Thinking has to be called into existence to cope with thoughts” (p. 111). In the words of Symington and Symington (1996), “for Bion, thinking is a transformation” (p. 143).

The Ultimate Reality: O

To begin reviewing Bion's ideas, it seems appropriate to start with what is essentially Bion's starting point, something he called *O,* which he thought was transformed in the process of thinking. Bion (1983) described O as

> the ultimate reality represented by terms such as ultimate reality, absolute truth, the godhead, the infinite, the thing-in-itself. O does not fall in the domain of knowledge or learning save incidentally; it can be “become,” but it cannot be “known”. It is darkness and formlessness. (p. 26)

Bion believed that O was illuminated through science, religion, and the arts, and that psychoanalysis was one way of being in contact with O (Symington & Symington, 1996, p. 181) in that “what transpires in the analytic session represents different transformations of the same emotional event, O” (p. 144). This starting point in Bion's ideas, noted Symington and Symington, gives his model of the individual a very different foundation that than of Freud or Klein, who were concerned with raw drives and impulses (p. 12).

Bion (1983) addressed the importance of the analyst *becoming* O:

> The analyst must focus his attention on O, the unknown and unknowable. The success of psycho-analysis depends on the maintenance of a psycho-analytic point of view; the point of view is the psycho-analytic vertex; the psycho-analytic vertex is O. With this the analyst cannot be identified; he must *be* it. . . . In so far as the analyst becomes O he is able to know the events that are *evolutions* of O. (p. 27)

Felch (2007) offered some helpful clarifications of this difficult concept and how one can become O. She suggested that “the willingness to enter into a state of receptivity and to tolerate the attendant emotional disruption without evacuating the mind or using knowledge defensively is the attempt to be at one with ultimately reality” (p. 38). Using the death of a loved one or a cancer diagnosis as examples of coming into contact with O, Felch described the fleeting but definite experience in such moments of having bumped up against a larger reality that one does not normally perceive:

> The fragility of human life, the inevitability of death, the hidden functioning of our bodies. . . . [The individual] cannot know and hold on to the full truth of that insight for any length of time, but for a moment an emotional awareness of ultimate reality dawns for the first time. (p. 39)

Psychoanalyst and artist Marilyn Charles (2003), commenting on engaging with an experience in the moment, referred to Bion's O and to Jacques Lacan's metaphor of a person finding a stone covered with hieroglyphics: “One need not know the meaning to know that meaning exists and is being depicted. In some ways, this is the analytic task: to mark and thereby affirm and reaffirm that we are in the presence of meaning” (para. 4).

Knowledge: K

Whereas O is an unmistakable but ephemeral truth, how is one to make any real meaning or use of it? Bion (1983) used the concept of *K* to represent knowledge and saw K as the only means of engaging with and transforming O. As an analogy for transforming O through K, Bion referred to the evolution and apprehension of an artist's O through his or her works of art (p. 35). This analogy, addressed by Felch (2007) and Symington and Symington (1996), indicates something other than absolute knowledge or possession of knowledge. Felch (2007) emphasized Bion's use of K as both the desire to know and the product of that desire: “K is the realm of creating meaning in order to share

it with others, to transform experience into something knowable. . . . Perhaps the capacity for K represents the development of an observing ego, the potential to feel and to know simultaneously" (pp. 40-41). Similarly, Symington and Symington (1996) emphasized K as a relationship with and attitude toward O:

> The K link is that linkage present when one is in the process of getting to know the other in an emotional sense, and this is to be clearly distinguished from the sort of knowing that means having a piece of knowledge about someone or something. (p. 28)

K, therefore, is the ability to tentatively hold, communicate, and symbolize experiences of O. The relationship between K and O shows, as Symington and Symington noted, how Bion replaced Freud's idea of the conscious-unconscious polarity with finite-infinite (p. 8). For Bion, "the struggle in an analysis is to prevent the finite smothering the infinite" (p. 9).

Some Building Blocks: Beta Elements, Reverie, Alpha Function, and Alpha Elements

Beta elements are "undigested facts" (Bion, 1962, p. 7), elements that "cannot be placed into a context that gives them meaning" (Felch, 2007, p. 22). Because they are "sense impressions devoid of meaning or nameless sensations which cause frustration . . . they are suitable only for evacuation because they cannot be thought about" (Symington & Symington, 1996, p. 62). This evacuation takes the form of projective identification into the body or external world, as Symington and Symington noted.

The only way to make use of beta elements is through the complementary abilities that Bion (1962) called *reverie* and *alpha function*. A concise description of these abilities was provided by Felch (2007): reverie is "[the] ability to consider disorganized experience" and alpha function is "aptitude for making sense of . . . [disorganized

experience]" (p. 26). Reverie and alpha function, as these descriptions indicate, work together in the processing of beta elements.

Reverie is the state of mind that allows an individual to be open to receiving beta elements. Reverie is similar to meditation or "a waking dream. . . . [a state in which] the mother is not actively trying to understand her baby, but she is semi-consciously attuned to the subtleties of their interaction and what it evokes in her" (Felch, 2007, p. 28). Refraining from trying to understand is an important feature of reverie. Ogden (1997) described reverie as "a state characterized by the absence of 'memory and desire'" (p. 133), a reference to Bion's (1992) admonition to be without memory and desire in clinical work. Ogden (1997) acknowledged the difficulty of maintaining this state of mind:

> [Reverie] involves a (partial) giving over of one's separate individuality to a third subject, a subject that is neither analyst nor analysand but a third subjectivity unconsciously generated by the analytic pair. To consistently offer oneself in this way is no small matter: it represents an emotionally draining undertaking in which analyst and analysand each to a degree "loses his mind" (his capacity to think and create experience as a distinctly separate individual). (p. 9)

When in a state of reverie, the individual's ability to process beta elements is alpha function, which Bion frequently described using the metaphor of digestion: alpha function allows an individual to digest and make use of beta elements by transforming them into alpha elements.

> Alpha function acts on the data from a person's total emotional experience. . . . It renders this emotional experience comprehensible and meaningful, by producing alpha elements consisting of visual, auditory and olfactory impressions, which are storable in memory, usable in dreaming and in unconscious waking thinking. (Symington & Symington, 1996, p. 61)

Felch (2007) provided an excellent example of reverie and alpha function working in tandem by recalling an analyst sitting with an adult patient who found herself silently

humming a lullaby that she sang to her own children. In becoming aware of this behavior (through reverie), and reflecting on it (using alpha function), “the analyst wondered if she wanted to soothe the patient, whom she unconsciously perceived to be in an especially vulnerable and childlike state” (p. 28).

In discussing the relationship between reverie and alpha function, Bion said that reverie is receptiveness of the mother to “the infant's projective identifications whether they are felt by the infant to be good or bad. In short, reverie is a factor of the mother's alpha-function” (1962, p. 36). In other words, a mother's ability to be receptive to unconscious communications from her infant (or, in the case of an analyst, from the patient) is a function of the mother's (or analyst's) ability to be receptive to his or her own inner experience. On this point, Ogden (1989) wrote, “When the mother can satisfactorily tolerate the recognition of her own desires and fears, she is less afraid of the states of tension generated by her infant that are in the process of becoming feelings” (p. 196).

The Prerequisite for Learning to Think: Containment

In Bion's terms, the mother's ability to tolerate and metabolize the infant's distress being projected into her, to use reverie and alpha function to receive beta elements and transform them into alpha elements, is her ability to provide *containment*. In this way, the mother becomes the *container* for the emotional experience that the infant cannot tolerate and is evacuating (which is then *contained*); and the mother uses her alpha function “ultimately . . . [to give the emotional experience] back to the infant in a modified form so that it is now tolerable for him” (Symington & Symington, 1996, p. 67).

The container-contained dynamic is central to Bion's theory of thinking not only because it is the vehicle through which beta elements are transformed into alpha elements

but also because the dynamic is "introjected by the infant so that the . . . [container-contained] apparatus becomes installed in the infant as part of the apparatus of alpha function" (Bion, 1962, p. 91). The infant learns to think through his or her experience of the mother's thinking. If the mother does not provide the containing function for her child, the child will not develop the ability for self-containment, thus limiting his or her ability to "psychically hold onto intense states without reacting to them or evading them" (p. 27). The infant's ability to think—like any individual's ability to think, including analysts'—depends on internalization of the containing function: "Alpha function and reverie, internalized from the mother, form the basis of the infant's ability to contain and make meaning of his own experience" (p. 31). The active and transferable nature of the container-contained dynamic is an important difference from Winnicott's holding environment (Symington & Symington, 1996, p. 58) and captures the organic, perpetual process of learning to think that Bion wanted to convey. Symington and Symington reported that for this reason, Bion chose to represent container-contained using the symbols for female and male, indicating the mating between different stages of thought, which begets new thinking, which again begets new thinking (p. 56).

Stages of Thought

According to Bion, an analyst's ability to contain and make meaning of his or her own experience is essential in times of clinical uncertainty—such self-containment affords an absence in which new meaning, new thoughts, can emerge. To understand this process, one needs at least a rudimentary understanding of Bion's ideas about the development of thought, which is conveyed in its full form in Bion's Grid (1962). Beta elements, alpha elements, and then myths and dream thoughts make up the first three

stages of thought, but it is the next stage, *preconception*, that is "the basic mechanism in the process of which mental growth occurs" (Symington & Symington, 1996, p. 40) and where the previously mentioned idea of mating manifests. Bion described a preconception as "a state of expectation" (Bion, 1962, p. 91), a state that Symington and Symington (1996) more fully described:

> The preconception is open to, and searching for, a particular experience with which it can match up and then be complete. This mating renders it emotionally real and is associated with the subjective experience of realizing something, that is, understanding its meaning. The analyst has this experience when he has looked and looked at his patient's apparently incomprehensible material and suddenly realizes what has been staring him in the face. The element which is searching can be thought of as having an unsaturated aspect which, when it meets the appropriate realization, becomes saturated. (p. 40)

Having become saturated, then, the preconception becomes a *conception*. A key point at this stage, in Symington's and Symington's (1996) tracing of the process, is that the thought can later become unsaturated again, forming a new preconception in search of a new realization, which again becomes saturated, although in a more complex form. Though this thesis will not explore the subsequent stages of thought, they also evolve in this way—"growth both in complexity and in degree of abstraction occurs in the movement through the next. . . [stages]" (p. 40). A danger worth noting, however, in moving into the next stages, is that excitement about a realization potentially blocks the truth. "When something is realized, for example when the analyst recognizes, in the patient's material, something previously unseen. . . . [the] feeling of excitement is not conducive to finding the truth and in fact may prevent it from emerging" (p. 41).

Responding to Frustration

One of Bion's (1984) primary concerns in the development of thinking, specifically in the stage of preconception, was how an individual responds when a

preconception is not saturated, as, for example, when the infant's preconception of a breast is mated only with a realization that there is no breast (p. 111). In such a moment, the individual's capacity for frustration comes to light, and Bion believed this to be the lynch pin in one's ability to grow—does the person tolerate the frustration and try to change it, or does he or she evade it?

If the individual evades the frustration, this is the realm of Bion's previously mentioned concept of -K. With K being the desire to know, -K is resistance to knowledge: "a hatred and fear of transformations in K because they may result in closer approximations to becoming O, or at-one-ment with O" (Symington & Symington, 1996, p. 119). Felch (2007) described -K as "saturating preconceptions with false knowing" (p. 61). As an example of movement into -K, Felch described an analyst who cannot tolerate the patient's projected affect or her own and "may move toward reactivity and management of the situation" (p. 59). An example of a patient moving into -K, cited by Symington and Symington (1996), is when a patient expresses appreciation for an analyst's interpretation and then immediately makes associations indicating he or she feels deliberately wounded or is suddenly overcome by hay fever (pp. 113-114). In its many forms, -K seems similar to Ogden's (1989) idea of *substitute formations*, which are

> utilized to create the illusion that the individual knows what he feels. Examples of such substitute formations include obsessional, authoritarian, as-if, False Self, and projective identificatory forms of control over one's internal and external objects. While these substitute formations help to ward off the feeling of not knowing, they also have the effect of filling the potential space in which feeling states (that are experienced as one's own) might arise. (p. 221)

If, however, the individual has internalized the ability to think, instead of evading the frustration, he or she can "bridge the gulf of frustration between the moment when a

want is felt and the moment when action appropriate to satisfying the want culminates in its satisfaction" (Bion, 1984, p. 112). In this state of unsaturation and not knowing,

> the infant is poised to encounter a previously unforeseen mode of satisfaction. The thumb, a blanket, or a toy in the mouth could all stand in for the breast and come to symbolically satisfy a child's need for soothing in the absence of the familiar desired object (Goldberg, 2005). These represent new thoughts. Crucially, it is the frustration inherent in the absence of the breast—a negative space—that motivates a child to discover a new symbolic solution that alleviates his distress. This appreciation of absence as necessary for the creation of something new is the foundation of Bion's respect for not knowing, or being unsaturated by what is already known. (Felch, 2007, p. 34)

Balancing Knowing and Not Knowing

Being "poised" in a state of waiting connotes the idea of balance, a holding of different possibilities, and indeed, Bion and numerous other authors have talked about the necessity, in clinical work, of balance "between knowing and not knowing, between making meaning and experiencing, between interpretation and receptivity" (Felch, 2007, p. 37). Bion's term for this balance is *binocular vision*, "which allows the simultaneous interweaving of conscious and unconscious elements, giving rise to depth and resonance in thinking and analytic intuition" (Symington & Symington, 1996, p. 130). (Felch pointed out that Bion [1983] later took a more adamant stand on the analyst relinquishing knowledge.)

Similar to binocular vision is Felch's (2007) suggestion that moving comfortably between knowing and not knowing requires the analyst to weave two complementary abilities: positive capability and negative capability. The idea of negative capability comes from poet John Keats letter to his brothers in 1817: "When man is capable of being in uncertainties, Mysteries, doubts, without any irritable reaching after fact & reason" (1979, p. 863). In this vein, competence as a therapist "includes a capacity to

tolerate feeling ignorant or incompetent, and a willingness to wait (and to carry on waiting) until something genuinely relevant and meaningful begins to emerge" (Casement, 1991, p. 9).

Positive capability, on the other hand, was described by Robert French as "the ability to use rational intellect, skills, and discrete knowledge" (as cited in Felch, 2007, p. 43). For analysts, positive capability largely stems from their education and clinical experience, which acts as a holding environment similar to that in a mother-child relationship (Belger, 2002). Over time, as psychologist A. W. Belger indicated, just as with the mother-child relationship, the therapist internalizes knowledge and experience from theory, teachers, colleagues, supervisors, and other figures, gradually developing his or her own therapeutic ego. Internalized knowledge and abilities increasingly become the resource to which the analyst turns for aid. One of the most concretized descriptions of this phenomenon is psychoanalyst and training supervisor Patrick Casement's (1991) idea of the internal supervisor, which allows the therapist to observe himself or herself from both within and without (that is, from the therapist's perspective and the client's). Similarly, psychiatrist Robert Caper (1997) argued that analysts' toleration for ambiguity and pressure from patients depends on their relationship to their own internal objects, especially their passion for psychoanalysis.

Inherent to the idea of balance between knowing and not knowing is that knowledge should always be tentative and supplementary. Knowledge should be "servant to the work of therapy and not its master" (Casement, 1991, p. 9). This tentative stance highlights an important nuance of the balance of knowing and not knowing: repeatedly allowing what is known to break down and restructure. In this sense, Bion modified

Klein's idea of progression from the paranoid-schizoid position (which Bion labeled *Ps*) to the depressive position (*D*). Whereas the Kleinians, generally speaking, viewed D as the ultimate, ideal goal, Bion seemed to feel "the association of Ps with bad and D with good prematurely stunts a full investigation of what Ps may have to offer" (Eigen, 1985, "Bion Vs. Klein," para. 5). For Bion, oscillation between Ps and D, which he represented as Ps↔D, was crucial because it represented the basic mechanism in thinking (Symington & Symington, 1996, p. 80). Recalling the previous examination of the progression of Bion's stages of thinking, one can see the parallel between the ever-evolving patterns in learning to think and the Ps↔D movement: "[Ps] . . . with its attendant splitting . . . [and D] the bringing together of splits" (Bion, 1984, p. 26). In describing this movement, psychoanalyst Michael Eigen (1985) emphasized that Ps and D are in natural relationship with each other.

> One tears apart or discriminates and [then] builds anew. . . . Bion tries to tap into a dimension in which it is an innate part of the self's rhythm to fall apart and come together. For this to happen, it is unnecessary to hold on to anything or to make anything part of oneself. The tendency of the self to seek a container often forecloses the incessant fall apart-come together rhythm. This may happen in so far as one tries to hold on to the container rather than be true to basic movements. ("Bion Vs. Klein," para. 3-5)

Lest this fall-apart, come-together rhythm sound too idealistic and easy, Charles (2003) described the painful experience of being open to one's truth in the moment, as Bion advocated, which inevitably results in a breaking down in order to make way for that which is new:

> In opening ourselves to the truth of the moment, we invite catastrophe—the fragmentation of whatever ostensible truth had contained the sense of impending disaster. . . . This is a dilemma in growth of any sort, in that growth by its very nature entails the destruction of whatever had become the status quo in order to make way for a new ordering of reality. (para. 53)

How do therapists, particularly those who feel under pressure, remain open to repeated destruction of what they have believed to be truths in their clinical work? Bion makes it clear that the therapist must work *without memory and desire* and must have what he called *faith*.

Working Without Memory and Desire

A simple analogy from Symington and Symington (1996) describes working without memory and desire. They said it is

> very closely allied to what Buddhists referred to as *Nirodha*. *Nirodha* means the cessation of thirst for all that is transient. . . . *Dukkha* means attachment to the transient aspects of this world that brings about suffering. (p. 169)

For Bion, memory and desire are attachments to the transient and, as such, they bring about suffering because they act as obstructions in the search for ultimate truth by distorting the analyst's perception.

> Memory is always misleading as a record of fact since it is distorted by the influence of unconscious forces. Desires interfere, by absence of mind when observation is essential, with the operation of judgment. Desires distort judgment by selection and repression of material to be judged. [Memory and desire] deal, respectively, with sense impressions of what is supposed to have happened and sense impressions of what has not happened. Psychoanalytic 'observation' is concerned neither with what has happened nor with what is going to happen, but with what is happening. (1992, p. 380)

For an analyst to be open to what is happening in the patient's reality, to allow the patient's reality to seep into and become the analyst's *psychic reality* (Symington & Symington, 1996), the analyst must be willing to continually relinquish all preconceived notions and pet theories and face the unknown. In fact, Bion (1992) thought the unknown was the only point of importance in an analytic session (p. 381). This clinical stance, said Bion, requires negative capability (Symington & Symington, 1996, p. 169) and is a terrifying endeavor. “In every consulting room there ought to be two rather frightened

people: the patient and the psycho-analyst. If they are not, one wonders why they are bothering to find out what everyone knows" (Bion as cited in Casement, 1993, p. 8).

The ways in which an analyst can succumb to memory and desire are myriad. Bion offered tentative ideas about the exact mechanics of memory and desire and concluded that the two concepts "represent one phenomenon that is a suffusion of both." (1992, p. 384). He explained, "I have tried to express this by saying 'memory' is the past tense of 'desire', 'anticipation' being its future tense" (p. 384). Ultimately, however, he refrained, in typical Bionian fashion, from concretizing these concepts for others. "I suggest that every psychoanalyst should make up his mind for himself by simple experimentation as to what these terms represent. . . . make up his mind about what he would call 'Memory' and 'Desire'" (p. 384). Casement (1993) offered some specific examples of how an analyst might fall into the trap of memory and desire: relying too much on what is remembered from previous sessions or the patient's history, looking for evidence to support a particular idea about the patient, trying to make the patient better in a particular way, and attempting to understand the patient of today in a way that is not found in the session of today (p. 195). Even these few examples make it clear that clinging to memory and desire "fill[s] the mind's potential space with sensible phenomena" (Symington & Symington, 1996, p. 122) and ultimately shortchanges both the analyst and the patient. As behavioral psychologist Baird Brightman wrote,

> the driving need to know may deprive the [therapist's] patients of the chance to do their own thinking and understanding, and may prevent both parties from experiencing the frustrating but often fruitful periods of confusion and ambiguity that precede a truly new and fresh perspective on their work together. (As cited in Felch, 2007, p. 72)

Faith (F)

> It may be wondered what state of mind is welcome if desires and memories are not. A term that would express approximately what I need to express is "faith"—faith that there is an ultimate reality and truth—the unknown, unknowable, "formless infinite". This must be believed of every object of which the personality can be aware: the evolution of ultimate reality (signified by O) has issued in objects of which the individual can be aware. (Bion, 1983, p. 31)

In *acts of faith*, the analyst "cannot depend on rules for O, or O→K , but only on his ability to be at one with O" (Bion, 1983, p. 32) and, in these acts, "[faith] has a relationship to thought analogous to the relationship of *a priori* knowledge to knowledge" (p. 35). Faith (F) in Bion's sense of the word, then, is F in O and is characterized by "an attitude of pure receptiveness. . . . an alert readiness, an alive waiting" (Eigen, 1985, "Faith in O," para. 4). In this state of receptivity and unsaturation, the analyst allows what is known to fall away and has faith that the emotional reality of the moment (that is, O) will emerge. Over time, Bion came to see faith as "the proper primordial and developed response to catastrophe" (para. 1), and Eigen summarized the role of faith in this way: "Through F in O, we tolerate the work of Ps↔D" ("Faith and the Precocious Container," para. 6).

In examining the role of faith, Charles (2003) made an important distinction between two types of faith. She cautioned against faith that creates imaginary fulfillment in the gap between what is and what might be, precluding the possibility for the real and for growth. In this context, Charles referred to, among other theorists, Lacan's concept of the Imaginary and Winnicott's idea of the false self—in both cases, the gap between desire and satisfaction is filled "in a way that assuages our discomfort without resolving our dilemma, thereby further attenuating the possibility of greater resolution" (para. 3). Charles speculated that, "When Bion (1970) enjoins us to refrain from memory and

desire, it is this obfuscating aspect of faith or hope that he seems to be alluding to" (para. 8). Standing in distinct contrast to this limiting, preconceived faith, Charles said, is faith in actual possibilities, faith in our capacity to bridge the gap between what is and what might be. This is faith in "what might *become* possible if we can find sufficient faith to remain open to it" (para. 7). In this way, "faith that we can come to know what might be known, and that we can come to know it in a way that might invite growth, is what creates possibility in [psychoanalytic] work" (para. 35).

The Relational Aspects of Uncertainty

Having explored now some of the theories and writings about the individual's capacity for uncertainty and, in particular, the importance of internalizing that capacity from caretaking figures, relationship begins to emerge as a critical factor in one's experience of and response to uncertainty. Building on and deepening this theme, a diverse group of psychoanalytic theorists have established the field of relational psychology. These theorists, some of whom are cited in this section, consider relationship to be more than merely a developmental factor in early life, more than an external entity from which the individual simply internalizes what he or she needs and then moves forward as a self-contained person. In their view, the classical developmental conceptualizations of relationship are oversimplified and absolute.

> [In developmental theories] the image of an isolated, individual mind is retained in the form of an ideal endpoint of optimal development. . . . The autonomous ego of the healthy older child or adult . . . is presumed to have achieved immunity from the "slings and arrows" encountered in experiences of the surround. (Stolorow & Atwood, 1992, pp. 12-13)

Relational theorists have, in turn, moved "from a view of mind as monadic, prestructured, and 'inside' the individual to a view of mind as emergent within relationships" (Brothers,

2008, p. 6). For a critique of the relational perspective that is beyond the purposes of this study, the reader is referred to the American psychoanalyst Michael Bader (1998) who praised the contributions of the theory but felt it stopped short of providing "a practical guide to clinical technique" ("The Possibility of Accurate Understanding," para. 11).

Before reviewing some of the specific ideas in relational psychology, an observation made by Brothers (2008) serves to convey the flavor weaving through all relational perspectives that is especially salient to this thesis. Inherent to the relational perspective, Brothers observed, is the experience of uncertainty because, in relationship with another, one is directly and continually confronted with otherness, or alterity (p. 7). In describing the experience of relating to the Other, Brothers cited the philosopher Emmanuel Levinas:

> The relationship with the other is not an idyllic and harmonious relationship of communion or a sympathy through which we put ourselves in the other's place; we recognize the other as resembling us, but exterior to us—the relationship with the other is a relationship to a Mystery. (As cited in Brothers, 2008, p. 7)

Brothers summarized philosophers' views that, in response to the mysterious Other, individuals tend to either reduce the Other to sameness or dismiss the otherness as being of no importance. Instead, as Bernstein suggested, "there is a reciprocity between the I and 'the Other' . . . that is compatible with their radical alterity. For *both* stand under the reciprocal obligation to transcend their narcissistic egoism in understanding the alterity of the Other" (as cited in Brothers, 2008, p. 8). To frame this experience in terms of psychotherapy, "every therapist has to learn to be open to the 'otherness' of the other . . . however different that person is from themselves" (Casement, 1991, p. 82). Being open to the Other, as described by the relational theorists in this section, requires one to engage, challenges one's knowledge, and presents an opportunity for personal growth.

Stephen Mitchell: The Analyst's Knowledge and Authority

Generally regarded as the founding father of relational psychology, American psychoanalyst Stephen Mitchell (1946-2000) reflected at length on the knowledge and authority of the analyst—he termed this *metatheory*, that is, theory about theory (1993, p. 42). What exactly does the analyst know, and what does this knowledge afford him or her in the inherently uncertain endeavor of analysis? In considering these questions, he contrasted analysts' claims to knowledge in Freud's time with the premises under which analysts practice today. In Freud's time, stated Mitchell, analysts operated under

> the premise that the analyst knows better, sees more maturely and deeply into the patient's difficulties and into the very nature of life—the premise that the analyst's vision is a rational antidote to the chaotic, infantile, illusion-bound hopes and dreads of the patient's emotional inner world. (p. 17)

In this classical view of analysis, "the analyst delivers these truths to the patient, and the latter, if he is able to consider them openly and unresistantly, is transformed by them" (p. 41). As previously cited, Mitchell pointed out that this positivistic perspective was a natural outgrowth of the scientism of Freud's time.

Today, however, the idea of absolute scientific knowledge and control of nature through science has withered, having become unsustainable in the face of new realities. Faced with numerous adverse consequences of scientific and technological advances, such as global warming, humanity sees the "possibly fatal hubris" (Mitchell, 1993, p. 19) of its aspirations. Scientific discoveries, like those of quantum physics, have even, ironically, revealed to humans the limits of their knowledge and ability to know (pp. 19-20). The result is a "postmodern" mindset in which

> human knowledge is no longer regarded as an incremental march toward a singular, complete understanding. . . . All knowledge, including scientific knowledge, is regarded as perspectival, not incremental; constructed, not

> discovered; inevitably rooted in a particular historical and cultural setting, not singular and additive; thoroughly contextual, not universal and absolute. (p. 20)

Regarding analysis, then, where does this relativization of knowledge leave the analyst? Mitchell examined the strategies typically adopted in psychoanalysis to cope with the crisis of metatheory, and the strategy that Mitchell seemed to consider most appropriate to the relativization of knowledge, "has been designated differently by different authors: hermeneutics, constructivism, constructionism, perspectivism" (1993, p. 56). Though there are many differences in these positions, Mitchell asserted that at the heart of all these ideas is belief in "the inadequacy of the traditional premise that psychoanalytic ideas correspond, in a direct and immediate fashion, to the structure of the mind" (p. 56). Instead, whatever the analyst knows

> is not simply discovered or revealed. . . . [but] is organized, constructed, fitted together by the analyst herself or, collectively, by the analytic community in its repertoire of theoretical concepts. The analytic method is not archaeological and reconstructive; it does not simply expose what is there. Rather, it is constructive and synthetic; it organizes whatever is there into patterns it itself supplies. (p. 56)

In this sense, for Mitchell, analysis is a highly collaborative and co-creative endeavor, in which there is no singular truth and "experience is created on a moment-to-moment basis" (p. 60). Analysis is not uncovering pre-existing structures of the mind, like lifting a rock to expose insects underneath, to borrow Mitchell's analogy—it is using language in a way that "creates new experience, something that was not there before" (1998, "Minds: Uncovered or Constructed?" para. 5). The analyst and analysand are mutually influential partners and co-creators in this act of creation, in which the analyst's theory, perspective, and personal responses inevitably shape what emerges (Mitchell, 1993, pp. 60-62).

In considering this view of analytic work, Mitchell (1998) asserted that the analyst's knowledge is not objective, empirical knowledge about a patient's pre-existing

mind but, rather, a different type of knowledge that Mitchell considered Freud's most important contribution to psychoanalytic theory: “an enriched method of explanation and meaning-making itself” (“Knowledge Claims: Excessive and Legitimate,” para. 11). Mitchell felt this basic but valuable knowledge is often overlooked in the claims to special knowledge and authority.

> What is often missed in these battles between anachronistic positivism and total relativism is that the convictions developed by both analytic clinicians and their patients rest on an intuitive, pragmatic credibility, a kind of enriched common sense. Ironically, by claiming a special, esoteric knowledge and privileged expertise, and by trying to protect the Truth through institutional control, psychoanalysts have traditionally deprived themselves of the strongest, most compelling basis for the most important thing they have to offer—a method of self-reflection and participation that is, generally, extraordinarily useful, immediately graspable, and enriching. (para. 4)

Illustrating this self-reflective and meaning-making slant in his own analytic work, Mitchell explained his approach in working with patients' dreams. Instead of trying to find the right meaning of a dream, Mitchell said, “what is important is engaging . . . [the patient] about the dream in a way that sparks and quickens his own analytic interest in himself” (“Robert and His Inner World,” para. 7).

Mitchell (1998) therefore concluded that the analyst does, indeed, offer knowledge and authority of a very valuable and specific nature. The analyst is an expert in systems of meaning and how they evolve (“Knowledge Claims: Excessive and Legitimate,” para. 15). The analyst is also an expert in “his or her understanding of a process—what happens when one person begins to express and reflect on his or experience in the presence of a trained listener” (“Minds: Uncovered or Constructed?” para. 19). Considering collectively all facets of the analyst's expertise, Mitchell asserted

that the analyst "can justifiably claim: an expertise in meaning-making, self-reflection, and the organization and reorganization of experience" (1998, para. 3).

Robert Stolorow: The Unbearable Embeddedness of Being

One of the most well-known theorists in relational psychology is American psychoanalyst Robert Stolorow. For the past three decades, he has been instrumental in developing *intersubjective systems theory*, working closely with other psychologists, including George Atwood and Donna Orange. In intersubjective systems theory, one of the ideas implicit to relational psychology (and, indeed, modern scientific study in general as mentioned in the preceding section on Stephen Mitchell) comes into distinct relief: "There is no escape from the mutual influence of observer and observed" (Orange, Stolorow, & Atwood, 1998, para. 2).

In understanding the nature of this mutual influence, some clarity arises from first reviewing the ideas that intersubjective systems theory strives to transcend. Foremost here are the efforts by Stolorow and his colleagues to debunk "the myth of the isolated mind" (Stolorow & Atwood, 1992, p. 7). Humans cling to this myth in a multitude of ways because the myth "serves to disavow a set of specific vulnerabilities that. . . otherwise may lead to an unbearable sense of anxiety and anguish" (p. 8). Stolorow and Atwood suggested that individuals defend against these vulnerabilities by alienating themselves in a variety of ways, counteracting what the authors termed, in a paraphasing of the words of novelist Milan Kundera, "the unbearable embeddedness of being" (p. 22). Among the types of alienation, two are particularly important to this thesis. First, individuals alienate themselves from the implications of relationship by harboring "reassuring illusions of self-sufficiency and autonomy . . . [that] serve to disavow the

intolerable vulnerability of the very structure of psychological life to interpersonal events over which the individual has only limited control" (pp. 10-11). Second, individuals alienate themselves from subjectivity itself, wanting to believe that their minds look out on an external, absolute world, rather than "the permanence and substantiality of the world . . . [being] constituted and maintained by intersubjective fields" (p. 11).

Stolorow and Atwood (1992) pointed out psychological theories that further the myth of an isolated mind, purporting the possibility of individuals ultimately reaching, as cited earlier, "an ideal endpoint of optimal development" (p. 12). They pointed to Freud as setting the stage with his idea that

> the developing organization of experience is shaped by the mind's successes, failures, and compromises in the processing of drive energies emerging from *within* [italics added]. . . . Accordingly, the organization of experience is ultimately the product of internal forces, and the mind's insularity is symbolically reified in the image of an impersonal machine. This image has insinuated itself into all the variants of Freudian psychoanalytic theory. (p. 12)

Of particular interest are Stolorow's and Atwood's (1992) commentary on the theories of Heinz Kohut, the founder of self psychology, and Mitchell (whose theory was previously discussed). Stolorow and Atwood criticized the ideal of an isolated mind in Kohut's early idea of transmuting internalization, a phenomenon in which the individual forms internal self-structures by gradually internalizing "regulatory functions heretofore performed by others" (p. 13). They, however, lauded Kohut's later work and his overall contributions to diminishing the myth of the isolated mind, citing his primary contribution as "the recognition that *self-experience* is always organized within a constructive intersubjective context" (p. 17).

Regarding Mitchell's theories, Stolorow and Atwood (1992) complemented his ideas but ultimately relegated them to the many theories infiltrated with the myth of the

isolated mind. Their criticism focused on Mitchell's overemphasis on the *patient's* subjectivities in the therapeutic relationship and Mitchell's commensurate neglect of the influence of the *analyst's* subjectivities, the latter of which Stolorow and Atwood (1979) began to explore very early in their work together. They found that in Mitchell's work, "insufficient attention is given to the patient's becoming a coactor in the *analyst's* drama, to the reciprocal impact on the patient's experience of the *analyst's* predesigned categories" (1992, p. 22).

The reciprocal impact of analyst and patient subjectivities is the foundation of intersubjective systems theory. The theorists clarified, however, that intersubjectivity does not claim, like most forms of postmodernism, "that there is no truth, that there exist only narratives, fictions, and co-creations" (Orange et al., 1998, para. 6). Rather, Orange et al. asserted that "*meanings* are co-created" in the interplay between the subjectivities of the analyst and analysand (para. 6) and that "intersubjectivity theory contains a commitment to examining and analytically reflecting upon the impact of the analyst *and his theories*, as well as that of the patient's organizing principles, on the analytic process" (para. 6). In this sense, intersubjectivity is "a field theory or systems theory in that it seeks to comprehend psychological phenomena not as products of isolated intrapsychic mechanisms, but as forming at the interface of reciprocally interacting subjectivities" (Stolorow & Atwood, 1992, p. 1).

In distinguishing their theory from others, Stolorow and his colleagues have primarily emphasized, it seems, the pervasive influence and broad scope of intersubjective fields.

> Our use of the term intersubjective has never presupposed the attainment of symbolic thought, of a concept of oneself as a subject, of intersubjective

> relatedness in Stern's (1985) sense, or of mutual recognition as described by Benjamin (1995). Nor have we confined our usage to the realm of unconscious nonverbal affective communication, as Ogden (1994) seemed to do. We use intersubjective very broadly, to refer to any psychological field formed by interacting worlds of experience, at whatever developmental level those worlds may be organized. For us, intersubjective denotes neither a mode of experiencing nor a sharing of experience, but the contextual precondition for having any experience at all. In our vision, intersubjective fields and experiential worlds are equiprimordial, mutually constituting one another in circular fashion. (Stolorow, 2004, "Footnotes," para. 4)

Though Stolorow & Atwood (1992) acknowledged the influence of self psychology on their work, they pointed out major differences between intersubjectivity theory and self psychology. Unlike a self-selfobject relationship, an intersubjective field is "a system of reciprocal mutual influence" in which both individuals turn to each other for selfobject experiences (p. 3). Also, the subjective world is broader than that of the self: "An intersubjective field exists at a higher level of generality and thus can encompass dimensions of experience—such as trauma, conflict, defense, and resistance—other than the selfobject dimension" (p. 4).

In these descriptions of their work, one can sense that Stolorow's and his colleagues' ideas about relationship and intersubjective fields have evolved and continually broadened over time. Always, though, their thinking has urged fundamental shifts in psychoanalytic concepts and a willingness to acknowledge both the power to shape and the uncertainty that is inherent to relationship. In one of the most important of their reorganizations of psychoanalytic thinking and an idea they repeatedly emphasize in their writings, Stolorow and his colleagues proposed a

> shift from the motivational primacy of drive to the motivational primacy of affectivity. . . . Unlike drives, which originate deep within an isolated mental apparatus, affect—that is, subjective emotional experience—is something that from birth onward is regulated, or misregulated, within ongoing relational systems. (Stolorow, 2004, para. 20)

In describing the direction and intent of their work, Stolorow said, “We have attempted to move psychoanalysis toward a post-Cartesian contextualism that recognizes the constitutive role of relatedness in the making of *all* [italics added] experience” (para. 24). The constitutive role of relatedness extended for Stolorow and his colleagues to even the evolution of intersubjectivity theory itself. Paraphrasing his colleague, George Atwood, Stolorow said,

> The process by which our intersubjective perspective is being created is a metalogue of its basic principle—the claim that all human psychological products crystallize within systems constituted by interacting, differently organized worlds of experience. It has been a belief shared by the collaborators of intersubjectivity theory that, when it comes to psychoanalytic theorizing, many experiential worlds are better than one. (2004, “Concluding Remarks,” para. 1)

Doris Brothers: A Psychology of Uncertainty

Though Doris Brothers' (2008) name is not as readily recognizable as Mitchell or Stolorow, her recent book, *Toward a Psychology of Uncertainty*, offered a next-generation perspective on relational psychology in which she seemed to leapfrog over much of the quibbling about details of different theories and cut right to the heart of the experience of uncertainty in relationship. In doing so, she argued that the field is now poised on the edge of a psychology of uncertainty.

> Having turned away from the psychology of certainty that was rooted in the objectivism of Freud's positivist paradigm with its glorification of scientific certainty, I believe that we have, in a variety of ways, begun to cultivate a *psychology of uncertainty* in which the complexities of the human experience are thought to elude all attempts to find authoritative, irreducible, transcendent explanations, and the unique nature of each psychoanalytic relationship is celebrated. (p. 3)

In support of her argument, Brothers (2008) cited many theorists whose ideas rest on the inevitability of uncertainty in psychoanalytic work and the importance of

preserving alterity in the relationship. She lauded Kohut as the first to truly embrace uncertainty, noting that his ideas about loosely holding theories and concepts, as well as the composition of self psychology itself, reflected his understandings of relativity theory and quantum physics.

> In keeping with these implications, self psychology is based on a belief in the nonverifiability of human understanding, the indivisibility of observer and observed, and a rejection of mechanistic, casual modes of description, all of which are indispensable to a psychology of uncertainty. (p. 4)

Also noted by Brothers was the intersubjective theory of Stolorow, Atwood, and Orange as well as psychoanalyst Irwin Hoffman's dialectical constructionist model, which viewed the analyst's subjectivity as a source of uncertainty: “the reality that . . . [the analyst] creates with the patient is selected at the expense of other possibilities that are unrecognized or that are inaccessible to the analyst and the patient for various reasons” (as cited in Brothers, 2008, p. 5). Also supporting a psychology of uncertainty, Brothers suggested, are the theorists whose ideas embrace that which is known but not necessarily conscious, “the implicit dimension of human experiencing” (2008, p. 5).

> Bollas's (1987) “unthought known,” Eugene Gendlin's (1962) “felt sense,” and what Lyons-Ruth (2000) refers to as “implicit relational knowing” are all loosely related conceptualizations that indicate a willingness to seriously consider experiences that, by virtue of the fact that they cannot be named, elude certain understanding. (p. 6)

Lest theorists believe that uncertainty has been fully embraced in psychoanalytic theory, Brothers (2008) enumerated many examples of the residuals of certainty, including developmental models, such as the Oedipus complex, which represent structures of certainty. “Any psychological configuration that is believed to occur, without exception, at a predictable moment in development, especially if that belief flies in the face of mounting evidence to the contrary, must surely be regarded as an anchor to

certainty" (p. 9). Among other anchors to certainty that Brothers cited are psychoanalytic terminology (pp. 9-10) and claims to objective analytic authority (p. 10). Even critiques of other's theories and assertion of the superiority of one's own theories "may involve bids for a kind of certainty" (p. 11).

Having noted the various movements toward a psychology of uncertainty, what exactly does Brothers believe it means to advance a psychology of uncertainty? Fundamental to Brothers' idea is the concept of *existential uncertainty*, which she defined as "uncertainty about psychological survival" (2008, p. 22). In relationship, existential uncertainty is a given.

> These experiences [of existential uncertainty] involve the awareness (more or less conscious) that since we are utterly reliant on others (as they are on us), and we cannot dispel the alterity of others (or that which is alien and "other" in ourselves), psychological survival is never a sure thing. (p. 12)

In relationship, one never knows whether one's relational needs will be met, and yet Brothers proposed that it is precisely through relationship that experiences of uncertainty are changed. "Experiences of uncertainty (and certainty) as to the availability of a self-sustaining relational exchange are continually transformed within living systems" (p. 21). (An important clarification is Brothers' assertion that it is the *experience* of uncertainty, not the uncertainty itself, that is transformed [p. 25].)

The transformation of the experience of uncertainty, Brothers (2008) suggested, occurs through various regulatory processes in which patterns of relating emerge naturally from the initial chaos of the relationship. As an example, the interactions between a caretaker and infant demonstrate the coordination of expectations and actions over time that gradually results in reassurance for both individuals that their needs will be met (pp. 22-23). In this way, "virtually any regulatory process within a relational system

may transform experiences of uncertainty; that is, it may change expectations with respect to the orderliness and predictability of a relational exchange" (p. 25).

The beliefs that emerge from this self-organization of a relationship Brothers (2008) termed *systematically emergent certainties* (SECs), that is, beliefs that arise out of relationship and are experienced as unquestionably true (p. 37). Brothers defined trauma as the destruction of SECs, "when the certainties that emerge from and stabilize our relational worlds are destroyed by some experience that powerfully reveals their falsity" (p. 46). The meaning of trauma seems to be broad for Brothers and not limited to, for example, more obviously traumatic experiences such as physical endangerment or harm. She described trauma variously as "betrayal of self-trust" (p. 67), loss of "ability for self-reflection" (p. 47), and "exile from certainty" (p. 82).

Brothers (2008) also extended the idea of trauma to include not only the destruction of certainties, but also the resulting "rigid, restrictive relational patterns that come into play within a traumatized system" (p. 96). Brothers characterized these rigid patterns as attempts at self-restoration after trauma; these restorative behaviors can include reduction of complexity, unshakable certitude, denial of difference, denial of sameness, creation of dualities (either-or thinking), and aggression (pp. 54-59). Brothers made it clear that analysts are just as subject to these behaviors in the face of trauma as patients. As previously mentioned in this thesis, Brothers cited the allure of cult-like psychotherapy training programs, noting that therapists who join such programs are often experiencing personal crises (p. 162) and find comfort in the uniformity of the group and its rules, especially the god-like, omniscient authority of the leader (pp. 160-166).

Brothers (2008) seems to view a mutually supportive, loving relationship, in this case, the psychoanalytic relationship, as a container in which trauma (the devastating loss of certainty) can be both reignited and healed for both analyst and patient. In this container, experiences of uncertainty are continually being transformed for both individuals in what Brothers called "bilateral healing" (p. 80). The patient comes in with his or her trauma, the experience of which can loom for the analyst as "the horror of meaningless chaos" (p. 65), making the analyst equally susceptible to re-emergence of his or her own rigid, trauma-generated patterns and certitudes.

> As this sense of sameness is shared in innumerable ways in the course of treatment, the unspeakable loneliness of exile [from certainty] is ended. Together, the analytic partners learn to speak in new ways until the experience of uncertainty no longer poses a threat to survival but signals the opportunity for greater mutuality, creativity, and joyful vitality. (p. 82)

Faith is the term Brothers (2008) used for this letting go of what was once deemed necessary for psychological survival (pp. 147-148). "This sort of faith involves the acknowledgment and acceptance of the ineluctable uncertainty of life and, at the same time, a profound sense of certainty that one's self (or soul or spirit) is not in jeopardy" (p. 148). Relieved of the threat of psychological survival, other ways of being in relationship can emerge. Brothers revealed,

> During moments when I have felt at peace with my doubts and uncertainties, moments, perhaps, of faith, I have caught glimpses of a different kind of knowing that seems to involve a deeper, more intuitive way of experiencing myself and others. (p. 160)

The Disintegration of Ego

Moments of uncertainty for a therapist, born of and magnified by being in relationship with a client (as explored in the previous sections), call upon the therapist to be open to the Other (the client) in new and sometimes uncomfortable ways. As

previously noted, both the therapist and the client "stand under the reciprocal obligation to transcend their narcissistic egoism in understanding the alterity of the Other" (Bernstein as cited in Brothers, 2008, p. 8). When the therapist maintains this stance, the therapist's ego inevitably undergoes some degree of dissolution or breaking down, as Bernstein's statement suggests. Jungian analyst Robert Moore (2001) directly stated the importance of ego disintegration:

> A "heroic" ego tries to work out every crisis or transition from the ego position with no consideration of the periodic need for the ritual death of the ego. In fact, however, a successful transition requires a deconstruction of the ego followed by its reconstitution in a post-transition ego structure. (p. 30)

The rhythm of this regenerative process that is necessary for new life is at the heart of what another Jungian analyst, Barbara Stevens Sullivan (1989), characterized as the Feminine principle. When operating from the Feminine principle, "there is an unconflicted acceptance of the value and necessity of death as an integral part of life" (p. 17). She described Feminine time as "periodic and rhythmic, . . . the time of the Book of Ecclesiastes reminding us that there is a time to be born and a time to die, a time to plant and a time to reap, a time of joy and a time of woe" (p. 26).

The process of the disintegration of ego is fully represented in depth psychological literature, and its archetypal nature marks a departure in this literature review from what has thus far been explanation of theory and a move into the realm of the symbolic. Jung would likely approve of this movement into the symbolic because the experience of uncertainty, for all the talk of theory and specifics, is ultimately an experience that evokes something beyond the narrow confines of mere words. For a richer understanding, one must therefore turn to the symbolic, where the known and unknown can come together. As Jung (1964) described the symbolic, "it implies

something more than its obvious and immediate meaning. It has a wider 'unconscious' aspect that is never precisely defined or fully explained" (pp. 20-21). This section explores the symbolism of ego disintegration in three different images: the woodcuts in the alchemical text, the *Rosarium Philosophorum*, as examined by Jung; the concept of liminal space; and the physician-patient archetype, specifically Guggenbühl-Craig's ideas about the importance of the therapist embodying the patient pole.

The Rosarium Philosophorum

The woodcuts in the alchemical text, *Rosarium Philosophorum*, provided Jung with a series of images that captured his growing understanding of the complex dynamics between the psyches of analyst and patient. Jung had begun to grasp that "perhaps the doctor was in analysis, too; and perhaps this was more of a two-way business than at first had been realized" (Stein, 1998, p. 82). Not only was the patient's transference "goal-seeking" (Perry, 1997, p. 147), moving toward individuation, but the analyst was also equally immersed in the process with his or her own transferences, which was not only inevitable but necessary. Stein (1998) said about Jung's idea of the analyst's intimate involvement, "[Jung] came to regard transformation in analysis as dependent upon psychic interaction rather than upon detached interpretation" (p. 76).

The psychic interaction between analyst and patient happens along many different pathways that traverse the conscious and the unconscious of both individuals in the analytic pair. Jung called these "counter-crossing transference relationships" (as cited in Perry, 1997, p. 147) and illustrated them in his diagram of the marriage quaternio (Perry, 1997, p. 147). The relationship between the unconscious of the analyst and the unconscious of the patient is reflected in the 10 alchemical woodcuts of *Rosarium*

Philosophorum. The woodcuts describe the process of mutual but subtle transformation that occurs in the darkness of the unconscious as the analytic pair interacts consistently over a long period of time (Stein, 1998, p. 85). Because Jung's explorations of the woodcuts were in-depth and complex, this thesis does not attempt to portray them in detail; rather, the explanation here is a simple overview based on authors' condensed summaries of Jung's insights.

As Jungian analyst Christopher Perry (1997) emphasized, the tightly-sealed container, the *vas*, is of central importance throughout the woodcuts (as it is in alchemical work). The vas appears in the woodcuts mainly as a bath and represents the immersion of analyst and patient together in the analytic work.

> The container refers to the analytic setting and to the analyst's interventions which are required to keep the heat at a level of anxiety optimal to the patient's self-discovery and the analyst's development both as an analyst and a human being. (p. 148)

The first image (Stein, 1998, p. 87) in the woodcuts is that of the fountain, "a sacred space. . . . that will contain and nourish the psychic process with its ever-vivifying waters" (p. 85). Though this space is one of potential, what happens in the space is "beyond the ego's control" (p. 85) and one should take heed of the deadly potential for sickness as well as wholeness to emerge (Perry, 1997, p. 149).

In the second image (Stein, 1998, p. 88), a king and queen meet, grasping each other's left hands. This meeting of the opposites through the shaking of left hands (left usually being associated with the unconscious) represents the beginning of the "unfolding of the dialectic between the unconscious of the analyst and that of the patient" (Perry, 1997, p. 147). Coming into contact with each other, "this signals a pregnant moment of

irrational recognition. . . . a moment of massive but hidden projection, suffused with archetypal fantasies and a profound longing for union" (Stein, 1998, p. 86).

The third image (Stein, 1998, p. 89) shows the king and queen naked, "which symbolizes analyst and patient denuded of their personae. . . . [as] shadow elements from both parties creep in" (Perry, 1997, p. 150). Then the pair immerse themselves in a bath, which is image four (Stein, 1998, p. 90), and have sex, which is image five (p. 91), the latter not being "an invitation to sexual enactment. . . . [but rather an image of] the frustration of longing to be connected" (Perry, 1997, pp. 151-152).

Images six and seven capture the darkest and most uncertain phases of the relationship, although there appears to be some disagreement between authors as to which image marks the onset of darkness. Image six (Stein, 1998, p. 92) shows the union of king and queen in one body, which Stein labeled a "profound merger of unconscious psyches" (p. 86). Perry (1997), however, observed that image six is called Death, which

> suggests conception through rotting—putrefaction. This is the darkest time, the time of despair, disillusionment, envious attacks; the time when Eros and Superego are at daggers drawn, and there seems no way forward. This, in alchemical treatises, is called the *nigredo*, the blackening. One has to have faith in the regenerative capacities of compost through long periods of apparent inertia, inactivity, and most importantly, despair. Faith in the process, faith in the relationship, the analyst's faith in method/technique have to be counterbalanced . . . by an absorption into total doubt. (p. 153)

Image seven (Stein, 1998, p. 93) shows the king and queen still united in one body and a tiny human being in the clouds. Both Stein and Perry (1997) characterized this image as a pivotal point at which there is a loss of soul (represented by the figure in the clouds), not "ego-lessness but a loss of the experience of I-Thou, Ego-Self, conscious-unconscious relatedness" (p. 153). The loss for Stein (1998) signaled:

> the darkest moment of pupation. . . . a crisis of faith. . . . Is this relationship going to end in loss of soul rather than transformation? Or is this loss of soul a prerequisite for the coming transformation? . . . [After the] birth of new being . . .all is quiet. . . . What gives? Is it over? Did we make it all up? Or is there something that endures but is quiescent for a time, catching its breath? (pp. 86-88)

In this desperate time, the analyst must remain vigilant, open, and patient, resisting urges to make something happen.

> One may see desperate attempts to jump-start the relationship again. . . . The pupa becomes worried; in the darkness of the cocoon, it fears that it is buried there for keeps. . . . [This phase] is most productive—and tolerable—when its presence and reality can be jointly acknowledged. . . . Of course, the analyst risks some "authority"—the illusion of possessing constant and sure knowledge of what is going on, how long it will take, what will come of it—if he or she admits mutuality in this darkness. . . . The only approach is patience, mindfulness, and *wu wei* (the Taoist term for nonjudgment and neutral but keen attentiveness to what is happening). Fordham, following the thought of Bion, says that this involves faith. (pp. 89-92)

In image eight (Stein, 1998, p. 94), it is raining, finally a "sign of hope" (p. 92). "The *nigredo* of despair and loss of soul are now followed by the falling of the heavenly dew, which prepare the soil of the analytic relationship for the return of soul, transformed" (Perry, 1997, p. 153). This return of soul is shown in image nine (Stein, 1998, p. 95), leading to, Stein said, "a resurrection or rebirth" (p. 93).

Image ten (Stein, 1998, p. 96) portrays the newly emerged image of unity (Perry, 1997; Stein, 1998), the king and queen still united in a single naked body but now out of the bath and upright, bearing once again their royal trappings. Stein called this hermaphroditic image the Rebis, which "symbolizes a realized union of the opposite masculine and feminine" (p. 97). Jung stated, "What the alchemist tried to express with his Rebis . . . is wholeness—a wholeness that resolves all opposition and puts an end to conflict, or at least draws its sting" (as cited in Stein, 1998, pp. 96-97). The deep nature of the relationship from which the Rebis emerges leaves both individuals permanently

changed, leaving both analyst and patient with "the memory of an enduring archetypal image of union—of the self—that was constellated in the depths of mutual unconsciousness during [the] analysis" (Stein, 1998, p. 99). Stein noted that this constellation of self causes deep transformations in the individuals, a pointed echoed by Perry (1997):

> Both [patient and analyst] have been transformed by the work. The patient hopefully has introjected the analyst as a helpful figure, and has internalized the analytic relationship. . . . The analyst likewise has enlarged or deepened his/her clinical experience and expertise, and has changed primarily as a result of his/her mistakes and failings. (p. 155)

Liminal Space

A space in which ego dissolution can occur safely is *liminal space* (Moore, 2001). Embodied in the idea of the *vas* in alchemy, said Moore, liminal space is any tightly sealed space with clearly defined boundaries that are tended by persons, *ritual elders*, who have the experience and ability to maintain the impermeable sanctity of the space. Because the boundaries are tightly sealed and honored, noted Moore, the *vas* can heat up sufficiently for real transformation to occur. Specific manifestations of liminal space vary, from more obvious examples such as formalized rite-of-passage ceremonies (Markstrom & Iborra, 2003) to the less formal setting of an analytic consulting room (Moore, 2001).

A vivid metaphor for liminal space is that of a butterfly's cocoon (Plotkin, 2003, Stein, 1998). In the cocoon, the creature is no longer a caterpillar but not yet a butterfly—it is "betwixt and between" (Markstrom & Iborra, 2003, p. 403; Plotkin, 2003, p. 72, Stein, 1998, p. 20). Reflecting back upon the process represented in the *Rosarium Philosophorum* woodcuts, one can easily imagine an uncertain therapist, immersed in relationship with his or her client, to be like the amorphous pupa in the cocoon. This

image echoes in Stein's (1998) characterizations of a person in a state of liminality: “a person feels at a loss for steady points of reference. . . . everything seems to be in flux. . . . angst is the mood of liminality” (p. 20). This phase of transformation is characterized by “anxiety and fear, and agony . . . composed of helplessness, depression, and inner crisis” (Markstrom & Iborra, 2003, p. 403).

As Stein (1998) observed about the caterpillar, faith is at the heart of the ability to submit to and endure this process, “faith that a butterfly will emerge from the cocoon where liminality reigns” (p. 20). The result of this faith, of enduring the discomfort, is the emergence of a new form. This progression is not only illustrated in the butterfly stage of metamorphosis but also by the many images and concepts that capture and mirror the same process. The *Rosarium Philosophorum* woodcuts reflect the progression from darkness to the ultimate emergence of a new, whole form. Rites of passage and initiation ceremonies include later phases in which anxiety gradually gives way to a “new awareness of the spiritual significance of the change;” numinosity begins to outweigh the anxiety (Markstrom & Iborra, 2003, p. 416); and the person's new identity is affirmed (p. 417). The hero's dangerous journey into the Underworld culminates with his or her return to the normal world in a transformed state (Campbell, 1949). Also Jung's (1957/1960) idea of the transcendent function holds that in tolerating the agony of opposites, “[confronting] the two positions generates a tension charged with energy and creates a living, third thing. . . . a living birth that leads to a new level of being, a new situation” (p. 90).

The Wounded Healer

As mentioned in "The Desire for Certainty" section at the beginning of this literature review, Guggenbühl-Craig (1971) wrote at length about the physician-patient archetype and its impact on any relationship between someone in a helping profession (such as an analyst) and the individual seeking help. In describing the nature of archetypes with two poles, Guggenbühl-Craig said, "Both poles are contained within the same individual. . . . Psychologically, this means not only that the patient has a physician with himself but also that there is a patient in the doctor" (pp. 83-84).

Of primary concern to Guggenbühl-Craig (1971) was what happened when the physician-patient archetype is split within the individual so that one pole is repressed and projected onto the outer world. "The patient, for instance, can project his inner healer on the doctor treating him, and the physician can project his own wounds onto the patient" (p. 84). When this happens, "a polarity takes shape with the regressed, childish, fearful patient at one end, and, at the other, the superior, proud physician, aloof though perhaps still somewhat coolly courteous" (p. 77). Guggenbühl-Craig made it clear that "this projection . . . may bring momentary satisfaction. But in the long run, it means that the psychic process is blocked" (p. 84).

The "psychic process" to which Guggenbühl-Craig (1971) referred can be understood through the fundamentally reciprocal behavior of two-poled archetypes: "If one pole of an archetype is constellated in the outside world, the inner and opposite pole is constellated as well" (p. 83). In other words, if the physician constellates only the physician pole, the patient will respond by constellating only the patient pole. If the physician, however, can maintain awareness of his or her own wounds, the patient's inner

physician will be constellated in response. This latter dynamic is the "psychic process" of greatest importance in the physician-patient relationship.

> Despite all his knowledge and technique, in the final analysis, . . . [the physician] must always strive to constellate the healing factor in the patient. Without this he can accomplish nothing. And he can only activate this healing factor if he bears sickness as an existential possibility within himself. (p. 92)

Analysts are therefore of greatest service to their patients when they allow themselves, to be a "wounded healer" (Perry, 1997, p. 157), a concept from Greek mythology furthered by Jung. "Such an analyst recognizes how the patient's difficulties constellate his own problems, and vice versa, and he therefore works openly not only on the patient but on himself. He remains forever a patient as well as a healer" (p. 120). This thesis asserts that uncertainty and not knowing are among the many "wounds" or shortcomings that the analyst must allow to exist within himself or herself—similar to Guggenbühl-Craig's (1971) example of the mother who strives to be a perfect mother, without weaknesses, thereby creating a helpless daughter with no ability to mother or care for herself (p. 88).

The necessity of the analyst consciously practicing as a wounded healer cannot be overstated, it seems, according to Guggenbühl-Craig (1971). "The self—the meaningful and purposive center of the psyche according to Jung—can in general only appear if the ego is not brushed aside and killed off as insignificant, but runs aground in tragic involvement" (p. 28). Later, he stated, "It is precisely in this tragic breakdown of . . . ego that the self, the divine spark in man, begins to shine through" (p. 29). Ultimately, Guggenbühl-Craig concluded that the analyst must be open to "renewed contact with his [or her] own shadow" (p. 138) through involvement in his or her close, personal relationships beyond the consulting room. The analyst

> must actively, painfully, and joyfully come into direct contact in his dealings with humanity. He must somehow find a way to once more expose himself to the most difficult challenges. He must be shaken. The senile, “I know, I know,” must become the Socratic, “I don't know.” (p. 140)

Summary

As this literature review has shown, uncertainty is a complex clinical phenomenon that raises difficult questions, touches analysts' deepest selves, and presses upon analysts not to simply retreat into the comfort of certainty but to open up to that which is other in their patients as well as themselves. In this process, analysts must call upon their capacity for holding intense emotions, both theirs and the patients', and for tolerating often prolonged periods of not knowing. The journey into the darkness with their patients thus becomes a mutual process of transformation in which analysts, as much as patients, are subjected to difficulty and doubt and the unknown and are ultimately transformed. The findings from analysts' actual clinical experiences of uncertainty documented in the next chapter bring the previous discussion of this process to life.

CHAPTER III
FINDINGS

> Instead of trying to bring a brilliant, intelligible, knowledgeable light to bear on obscure problems, I suggest we bring to bear a diminution of the light—a penetrating beam of darkness; a reciprocal of the searchlight. . . . The darkness would be so absolute that it would achieve a luminous, absolute vacuum. So that, if any object existed, however faint, it would show up very clearly. Thus, a very faint light would become visible in maximum conditions of darkness.
>
> Bion as cited in Casement, 1993, p. 358

This chapter presents the nature of the experience of uncertainty for analysts in their clinical work as revealed through interviews with three analysts. As real-life experiences are wont to do, the analysts' descriptions and sharings revealed a much richer and more full-bodied phenomenon than any text, including those reviewed in Chapter II, can convey. This chapter endeavors then to bring the analysts' experience of uncertainty, in all its complexity and allure, to the reader—making this chapter itself, in some ways, an effort to grasp the ungraspable. In the findings presented here, the analysts reveal that not only do they experience uncertainty in their clinical work, even after many years of clinical experience, but they also ultimately value the experience of uncertainty and the growth it makes possible for them and for their patients.

Method

The phenomenological research method described by Amedeo Giorgi (1985) was used in this study. Phenomenological research follows the guiding theme of phenomenology, which is to go “back to the 'things themselves'” (p. 8). Giorgi explained that “one interpretation of that expression means to go to the everyday world where

people are living through various phenomena in actual situations" (p. 8). Exploring the experience of uncertainty for analysts in their clinical work is then a return to "the things themselves" in order to derive an understanding of the essence of this phenomenon.

The interviews conducted for this study were approximately two hours in length, occurred over a two-week period, and consisted primarily of the questions listed in Appendix E. Three experienced analysts were interviewed: one Jungian analyst, one Freudian psychoanalyst, and one relational psychoanalyst originally trained as an ego psychologist. All the analysts were Caucasian Americans and ranged in age from 58 to 73. Two analysts were female, and one analyst was male. The analysts were located through recommendations from colleagues and friends and were chosen based on their theoretical orientation in depth psychology as well as their interest in discussing the topic of clinical uncertainty. Every effort has been made in this chapter to preserve the analysts' confidentiality, and the quotes cited from their interviews are referenced as anonymous personal communications.

Emergent Themes

The themes listed below emerged from the interview data. A theme is common to all analysts interviewed unless the theme indicates "some analysts" have the experience, in which case the experience was significant for two of the analysts.

1. Analysts are generally wary of certainty in clinical work and strive for a mindset of uncertainty, flexibility, and exploration.
2. Maintaining an uncertain mindset in clinical work is challenging and rewarding for the analysts.
3. Analysts strive to normalize uncertainty with their patients.

4. Analysts experience times of unknowing about patients.
5. Some analysts experience discomfort and doubt in moments of unknowing about patients.
6. Clinical and life experience makes it easier for analysts to tolerate uncertainty in clinical work.
7. Analysts believe that uncertainty is an inevitable and significant part of the human experience.

Wariness of Certainty in Clinical Work and Striving for a Mindset of Uncertainty, Flexibility, and Exploration

The topic of certainty wove through the interviews, which, as mentioned in Chapter II, seems inevitable when discussing uncertainty in clinical work. Certainty seemed to function, at times, as a contrasting factor in understanding uncertainty, like discussing the characteristics of daytime to more fully understand the concept of night. More often, though, in the conversations with the analysts, the ideas of certainty and uncertainty seemed to be not in contrast to each other as much as in a slippery dance with each other, shifting on a continuum.

Even though all the analysts interviewed for this study referred to moments of inspiration, sudden clarity, or instinctive certainty, they all expressed the belief that certainty can undermine their work with patients. One analyst recounted an early lesson in being cautious regarding feelings of certainty:

> Very early in my practice—this shot through me like electricity. Very early in my practice, I saw someone who told me an event, and I was just about to say something about it, which was my perception of what had happened and how she should feel, based on how I would feel if I had had it happen. Thank goodness this client told me, before I said anything, how she felt and what happened and the revelation that came to her, that was different than I might have said. I think if I had said that, it would have colored what she felt, or colored her experience of the

> reality of what she felt. And I have never forgotten that because I was so relieved that I didn't get a chance to say what I was about to say. . . . Certainty is very comfortable, I mean it's a very comfortable feeling, very comfortable feeling. And a dangerous one. (Anonymous, personal communication, November, 2008)

The general sense among the analysts interviewed is that possibilities are lost when certainty is not kept in check and when clarity and concreteness are sought too quickly in the analytic work. "Prematurely trying to escape uncertainty forecloses so much," said one analyst (Anonymous, personal communication, November, 2008).

The loss of possibilities resulting from searching for certainty in the clinical setting relates to many of the ideas explored in Chapter II. Because certainty can act to prematurely saturate a preconception, certainty can, from Bion's perspective, be an obstacle to truth. Bion (1983) said, "There can be no genuine outcome that is based on falsity" (p. 28). Carnochan (1995) observed that "the need for certainty . . . leads us to an impoverished position. It insists we . . . habitate a shrunken, though seemingly secure realm" (p. 364). Most distinctly though, the potentially limiting nature of certainty described by the analysts interviewed evokes Mitchell's (1998) previously cited assertion that "the greatest danger is not the wrong ideas but rigidly held ideas" ("Knowledge Claims," para. 2). Implied in Mitchell's statement is the importance *of play* as conveyed in the German and French meanings of the word (Miller, 2005, p. ix). In referring to a conversation about this particular meaning of play, David Miller described the other person's analogy of a bicycle wheel.

> He remarked that I probably knew that it was important not to tighten the nuts too tightly, else the wheel would not turn. "It has to have some *play* in it!" he announced in a teacherly fashion. . . . And then he added, ". . . and not too much play, or the wheel will fall off. You know," he said, "*Spielraum*, 'play-room,' some room for play. It needs space." (pp. ix-x)

The *Spielraum* sense of play is the spirit with which all the analysts in this study approach their clinical work: an awareness that they possess and provide the patient with a basic foundation of knowledge, but they must not be rigid or too certain in wielding that knowledge because it will suffocate the work. As Egendorf (1995) described, therapists must be "capable of hearing *with* such knowings, rather than imposing them" (p. 12). Like the bicycle wheel, space must be allowed in clinical work for movement, for what is unknown or not yet understood. One of the interviewed analysts described this approach:

> I think an analyst has to stay with a foot in two worlds all the time. One is always knowing, learning, exploring, reading, studying, watching, developing the understanding of how the psyche works because it works—the psyche works in a very definite way. This is not guess work, it's not "Ehh, maybe it does this, maybe it does that." No, the psyche works in a definite way, and we absolutely need to know that, and know it backwards and forwards well, and why it works that way, and all the tiny machinations that make it work that way. And everybody's psyche works that way, everybody's. But at the same time, to remember that while everybody's psyche works that way, every psyche works that way in a slightly different way. So you have to stay with one foot in knowing and the other foot in not knowing. Or one foot in a certain amount of certainty and another foot in absolute uncertainty. (Anonymous, personal communication, November, 2008)

All the analysts in this study repeatedly described the importance of keeping things loose and open to change. One analyst referred to the importance of both her and her patients having "a willingness to play" in the analytic process:

> I always see my interpretations and suggestions as tentative. They're like throwing a ball into the air and kind of waiting to see how the other person is going to throw it back to me. So it's not like I won't say: "This is what I think is going on." But in my mind, it's like throwing somebody a ball and now it's their play. Very often, patients will just catch the ball and hold it, and they think, *Now I've got it*. And when that happens, I know we've got problems. . . . And it's very hard to loosen them up from that wish to take your words, and to then think, *Okay, now I've got it!* (Anonymous, personal communication, November, 2008)

This analyst associated uncertainty with, among other ideas, Winnicott's concept of play, which has a similar feeling to *Spielraum*. Play, according to Winnicott, happens in the potential space, the overlap of realities, between analyst and patient.

> In the potential space the question of what comes from inside and what comes from outside is kept suspended, inner and outer touch each other in a movement that resembles dancing. In this movement resides the possibility to discover something new and to let oneself be surprised by oneself. (Jemstedt, 2000, p. 125)

An attitude of discovery and curiosity was clear in all the interviewed analysts' descriptions of their efforts to be receptive in their work. One analyst talked about analysis as "a process of exploration of seeking to know" (Anonymous, personal communication, November, 2008), and the other analysts interviewed made statements such as "If you're curious, you're uncertain," (Anonymous, personal communication, November, 2008) and "I try to stay with wondering, wondering all the time. And wondering by definition means: I am not certain" (Anonymous, personal communication, November, 2008). One analyst in the study used the highly illustrative analogy of looking through a kaleidoscope: seeing a particular pattern and then, upon turning the scope, suddenly seeing a new pattern (Anonymous, personal communication, November, 2008). Allowing that shift and reorganization to occur is akin to Bion's (1984) emphasis on Ps↔D, that is, not only striving to bring things together but also allowing them to fall apart so that something new can emerge. Based on their interviews, the other two analysts in the study would seem to share the belief expressed by the third analyst who spoke of the kaleidoscope, that discovery happens in psychoanalytic work because "we could be in those places of not knowing, of being willing to turn that kaleidoscope. Because if you can't turn the kaleidoscope, you are really stuck" (Anonymous, personal communication, November, 2008).

For one of the analysts in this study, being in relationship with the patient directly correlates to a need for *Spielraum*. This analyst believes "that the task of the therapist involves establishing an intimate relationship . . . that's the way we do good therapy. It's not like being a distant observer" (Anonymous, personal communication, November, 2008). Intimate involvement with his patients reminds this analyst of the Heisenberg uncertainty principle and the observer effect: the phenomenon of an observer changing a system, the analyst said in his interview, is "sure going to make you appropriately uncertain" (Anonymous, personal communication, November, 2008). Expressed another way, "There is no escape from the mutual influence of observer and observed" (Orange, et al., 1998, para. 2). For this reason, the interviewed analyst approaches his work with patients as a collaborative effort.

> I see the conversation as a collaboration. . . . I see an analytic conversation as a co-constructed conversation. I think there are three subjectivities involved: mine, the patient's, and the shared view of what's going on—and the conversation has to be collaborative. So you know, how could I be certain of—you know, I'm certain of that. I'm certain that it should be collaborative. And then there's . . . [the idea of] . . . an analytic third, shared subjectivity. So, you know, of course I'm not certain. (Anonymous, personal communication, November, 2008)

This approach seems to be the essence of the relational perspective. As described in Chapter II, the relational theory holds that analysis is a collaborative conversation constructed by analyst and patient in which "the understandings about the patient that emerge within the analyst's mind are embedded in the fluid, interpenetrating tapestry of their encounter, with their perpetual impact on each other" (Mitchell, 1998, "Minds: Uncovered or Constructed?" para. 17). This overlapping of subjectivities gives rise, as the interviewed analyst described, to what Ogden (1997) called the analytic third: "a third subjectivity unconsciously generated by the analytic pair" (p. 9).

For the analysts in this study, feelings of certainty, then, have the potential to constrict their work with patients. Certainty functions like an internal alarm bell in some cases. One analyst said, "When I'm not uncertain, I worry about what's going on. . . . It makes me think I'm not listening or open to the person I'm talking to" (Anonymous, personal communication, November, 2008). Another analyst, describing her feeling of "rightness" in hearing patients' opinions that conflict with her own, said,

> I have to check myself—check what I'm thinking and feeling, and where these are coming from. My thoughts, feelings, and imaginings affect what goes on in the room between my client and me, whether it is obvious or not, whether I say anything or not. If my silent attitude is, *You're wrong*, I'm fairly certain this has a subtle affect, so I try to listen to myself and rearrange things. The rearranging I do inside myself goes something like this: *How could I possibly know what's right for the country; apparently nobody knows for sure. I can only guess*. . . . So my attitude of rightness is an inflation on my part. . . . And what I need to do is put that monster to rest and hear something that's completely different, and value this as another opinion, another idea, another set of feelings, another set of concepts of a completely different way of viewing the world. (Anonymous, personal communication, November, 2008)

Assumptions about the patient are another warning sign for the analysts interviewed, encouraging them to examine and question themselves. Recalling the influence of a colleague, one analyst remembered the person's encouragement to "always . . . be aware that . . . the way I happened to be thinking about things and seeing things was not necessarily the same as the way my patient was seeing things" (Anonymous, personal communication, November, 2008). Another analyst described her efforts with a patient, saying that she tried

> not to be certain that I know who she is. Because indeed in being certain, I cannot be open to new things that are coming up out of her that don't fit into that framework. And if I am not, I don't think she can be. (Anonymous, personal communication, November, 2008)

Such efforts by the analysts in this study are attempts, as Bion (1992) urged, to work without memory and desire, but also it seems to preserve the alterity of the patient, rather than "facilely assimilating the alterity of 'the Other' to what is 'the same' . . . or simply dismissing (or repressing) the alterity of 'the Other' as being of no significance—merely contingent" (Bernstein as cited in Brothers, 2008, pp. 7-8).

A sense of continual questioning and pushing boundaries was evident in the perspectives of the analysts. One analyst strives to hold the field of psychoanalytic psychology itself in uncertainty: "It's a very young field. It's in its infancy and so much we don't know. Certainty is an inhibition on the development of the field" (Anonymous, personal communication, November, 2008). Another of the analysts described in detail her imaginings about an act committed by a patient, putting herself in the patient's shoes and walking through the act step-by-step to determine whether she could commit the same act. She said that she came to "the understanding that there isn't anything that any human being can do—*anything,* that I as a human being am not capable of doing under the same circumstances" (Anonymous, personal communication, November, 2008). She agreed that such exercises challenged her to be "without the certainty that I could or would do something, or wouldn't or couldn't do something" (Anonymous, personal communication, November, 2008).

Though all of these statements about cautiousness regarding certainty vary in the details of their subject matter, they capture the intent of allowing for play, *Spielraum*, in clinical work, as communicated by all of the analysts interviewed—in these specific examples mentioned, the play is within the analysts' own minds and thinking, trying to make room for something else, room to be surprised, and, one could say, room for the

Other. For the analysts in this study, the Other to whom they strive to be receptive takes many different forms: the uniqueness of their patients, the perspective of their patients, the possibilities of what they do not know or understand about the human mind, the possibilities of what do they not know about themselves. They strive to repeatedly challenge their thinking on multiple levels. Referring again to Bernstein, the analysts are working to "transcend their narcissistic egoism in understanding the alterity of the Other" (as cited in Brothers, 2008, p. 8).

By allowing for *Spielraum*, the analysts interviewed for this thesis are allowing Bion's (1983) process of Ps↔D, turning their internal kaleidoscopes so that they are always open to the the breakdown of old thinking and emergence of new understanding. Put another way, in Bion's terms, the analysts are working to be at one with O, the ultimate reality that is present in the moment with the patient, and their attitude toward O is one of K rather than -K. The analysts realize that, in Bion's words, "the transformation O→K depends on ridding K of memory and desire" (p. 30).

The analysts in this study all agree that if they were not willing to challenge themselves and remain open to uncertainty, something would be lost. What exactly? The analysts' statements make it clear that one of the losses would be a personal loss.

The Challenge and Reward of Maintaining an Uncertain Mindset in Clinical Work

The two analysts interviewed for this thesis who have the most clinical experience spoke at length of being comfortable with uncertainty. One analyst experiences uncertainty as "just a part of who I am" (Anonymous, personal communication, November, 2008) and referred to being able to "listen analytically," with curiosity and uncertainty, as a "luxury" that is not possible outside clinical work (Anonymous, personal

communication, November, 2008). Interestingly, though, all the analysts interviewed expressed how challenging it is to maintain a mindset of uncertainty and receptivity, echoing Ogden's (1997) description of the effort required to be in a state of reverie: “To consistently offer oneself in this way is no small matter: it represents an emotionally draining undertaking” (p. 9). The effort is that of balancing of negative and positive capability (Felch, 2007), constantly trying to suspend assumptions, judgment, and the trappings of analytic theory while utilizing and applying knowledge.

One of the analysts in the study compared sustaining the mental posture of uncertainty to an enjoyable but rigorous physical exercise that he practices, saying, “Usually at the end . . . I’m glad it’s over, because, you know, I’ve pushed myself. It’s hard work, you know, and I do it. . . . You know, isn't that a good feeling? But it's hard work” (Anonymous, personal communication, November, 2008). For this analyst, the stance of uncertainty also brings up the image of Rodin's sculpture, *The Thinker*, (Anonymous, personal communication, November, 2008), suggesting focused, alert mental activity that is productive and gratifying but also intense and demanding. Joseph Coppin and Elizabeth Nelson (2005) spoke about this stance as the yin posture of inquiry and compared it to a zoologist waiting, still but alert, in the wilderness to study an animal. Such a person is directing his or her full energy and entire being toward closely observing and understanding the animal's natural behaviors while refraining from interfering with or manipulating the behaviors.

Another of the analysts interviewed, describing holding an uncertain mindset in her clinical work, used the word “tension” over and over. “It's always a tension. It's never a comfortable place to be. . . . . It's this constant, constant tension in our work, I think,

between those two poles [of being in uncertainty and providing answers]" (Anonymous, personal communication, November, 2008). Jung (1957/1960) acknowledged both the discomfort and the possibilities in holding such a tension of opposites—this is his idea of the transcendent function (discussed in Chapter II), a holding of tension that gives birth to "a new level of being, a new situation" (p. 90). The interviewed analyst who talked about tension captured the dynamic of the transcendent function in her characterization of uncertainty as "this moment of anxiety but a moment of creative potential" (Anonymous, personal communication, November, 2008).

Every analyst in the study, indeed, described being transformed through the process of sitting with uncertainty and the alterity of their patients. By opening themselves to uncertainty, the analysts willingly undergo a disintegration of their egos, dissolving without knowing what will emerge, as with the hero's journey into the Underworld and the process represented in the *Rosarium Philosophorum* woodcuts (Perry, 1997; Stein, 1998). One interviewed analyst described this sense of openness: "When I start working with someone, I don't know whatever either one of us is going to be at the end. And I don't know what we're going to discover, and I don't know what we're going to uncover" (Anonymous, personal communication, November, 2008). Though the analysts acknowledge that their personal growth is not the primary goal of psychoanalytic work, they speak of the work they do as a "mutual growth experience" (Anonymous, personal communication, November, 2008) and a "continuous growth experience" (Anonymous, personal communication, November, 2008). The analyst who talked about putting aside her feelings of rightness in order to open up to her patient's opinions emphasized the impact that this has on her:

> That grows me. You know, that really grows me. Now, I am not getting paid to be grown; however, it does happen. And that's one of the reasons I love this work so much because it keeps—it makes me stretch, really makes me stretch. Social issues, political issues, every kind of issue finally comes up. And I have lots of opinions that I would love to think are not opinions, but facts. Truth. . . . So the work stretches me. (Anonymous, personal communication, November, 2008)

The language the analysts used in the interviews to express their experiences of growth conveyed deep appreciation, humility, and possibly even awe for this amazing process that happens repeatedly with patient after patient but is never quite the same. Expressing what it means to him to have shared uncertainty with the people in his life, one of the analysts said,

> I actually think [sharing uncertainty is] a gift that human beings bring to each other, not just something that I bring to . . . [my patients]. I mean, you know, I got here by sharing uncertainty with the people I've worked with. . . . And they—it's not just my teachers . . . and my colleagues. I mean, I've learned from my teachers, my colleagues. I've learned an enormous amount from the people I've analyzed. (Anonymous, personal communication, November, 2008)

Speaking to the fluidity of an analyst's ego in psychoanalytic work and the uncertainty of being suspended in that liminal space, one of the analysts interviewed provided a striking description of how she is transformed in her work with patients.

> I think when you enter in with a patient into a process, and it's a deep process, you really do hand over a piece of yourself to be molded by the patient, and then you observe who that "you" is now. I don't mean that the patient just molds you. Obviously the patient finds something in you for their purposes. But you are kind of letting yourself be used as an instrument by the patient, I think. . . . When it's really going well, you kind of let the patient find the keys in you to kind of play, and you resonate. And that's a different identity than you may be 45 minutes later with the next patient. It's not false. It's not pretend. It's just a different piece. And there's an uncertainty there, too. . . . And so it is very much about liminality. And analytic space is a liminal space. (Anonymous, personal communication, November, 2008)

This description, along with all the analysts' descriptions of the challenging but rewarding experience of being open and uncertain in their work, is a movement toward the symbolic

to capture an experience that is compelling yet mysterious. This movement hearkens back yet again to the transformative process reflected in the *Rosarium Philosophorum* woodcuts (Perry, 1997; Stein, 1998)—a process that calls upon analysts to surrender a part of themselves to each patient. The impressions these experiences have left on all the analysts in the study seem to move them to encourage their patients likewise to be open and embrace uncertainty in the analytic work.

Striving to Normalize Uncertainty With Patients

Acknowledging uncertainty in the consulting room and actively engaging their patients in uncertainty is important to all the analysts interviewed. Not only does this keep open possibilities, *Spielraum*, in the work and the space between analyst and patient, but it also encourages the kaleidoscopic rhythm in patients' thinking, allowing for new possibilities and, ultimately, it seems, empowering them to heal themselves.

The analyst who spoke about her mental efforts not to be too certain about knowing her patient also expressed the importance of holding uncertainty for both her and the patient: “Because . . . in being certain, I cannot be open to new things that are coming up out of her that don’t fit into that framework. And if I am not, I don’t think she can be” (Anonymous, personal communication, November, 2008). This analyst felt that holding a position of uncertainty was a instrumental part of her role as the analyst. “What I have to do is, you know, really just hold that space, be steady in that space, trust the psyche, which is critical, and trust the uncertainty” (Anonymous, personal communication, November, 2008).

In this same spirit, all the analysts in the study set the stage for their patients, framing uncertainty as an inevitable and important part of analytic work. In clinical

parlance, all the analysts model acceptance of uncertainty for their patients, which serves to normalize uncertainty as part of the process—uncertainty becomes something to be taken up with awareness rather than fended off with dread. Bringing a sense of adventure to the experience, one analyst described how he frames uncertainty with his patients:

> What I convey to my patients is that we're going to share uncertainty . . . and that we're going to learn together. That we're going to discover things and then some of those things that we discovered, we're going to discover were wrong, that we're going to modify our view. That . . . over time, what we talk about is going to change, that they're going to change. What was true at the beginning isn't going to be true at the end, and I won't be the same analyst at the end of the analysis as I was when they started. (Anonymous, personal communication, November, 2008)

The analysts' descriptions of this particular aspect of their role evoke Winnicott's (Mitchell & Black, 1995) idea of a holding environment, and one analyst in the study directly associated holding uncertainty with creating a holding environment:

> I think being able to hold the place of uncertainty and make it okay to be there is part of holding the frame for a patient, part of creating a holding environment so that uncertainty can be tolerated by both parties. (Anonymous, personal communication, November, 2008)

The importance of an analyst's ability to tolerate the uncertainty as a prerequisite for the patient's toleration (just as with mother and child) is clear in one interviewed analyst's description:

> I have to know that I can tolerate the unknowing. And if I can tolerate it . . . and not just barely tolerate it, but really be comfortable with it, really allow it to be in the room—that makes it much easier for the client to trust it. Now at first, sometimes they just have to trust my trusting it before they can trust their own. But I mean, that's just part of it. (Anonymous, personal communication, November, 2008)

The patient learning to engage with uncertainty in this way, learning to play, is an important implication of Winnicott's theory of play.

> Psychotherapy has to do with two people playing together. The corollary of this is that where playing is not possible then the work done by the therapist is directed towards bringing the patient from a state of not being able to play into a state of being able to play. It is in playing and only in playing that the individual child or adult is able to be creative and to use the whole personality, and it is only in being creative that the individual discovers the self. (Palmer-Daley, 2007, p. 4)

Also emerging in these descriptions is Bion's (1962) idea of learning to think, a theoretical movement beyond Winnicott's holding environment. In Bion's terms, an analyst provides containment for the patient's experience of uncertainty by using reverie and alpha function to metabolize the beta elements (the uncertainty) into alpha elements that the patient can tolerate; that is, the analyst acknowledges uncertainty, normalizes it, and makes it less terrifying so that the patient gradually internalizes the ability to tolerate uncertainty and to allow "the destruction of whatever had become the status quo in order to make way for a new ordering of reality" (Charles, 2003, para. 53). This gradual internalization of alpha function, that is, the patient learning to think from experiencing the analyst's ability to think, is the key difference in Winnicott's holding environment and Bion's containment (as described in Chapter II). A mother-child situation described by one of the analysts interviewed conveys how an analyst's normalization of uncertainty provides containment for the patient, not only helping the patient tolerate the uncertainty but also legitimizing the patient's experience and strengthening his sense of self.

> It's like a child who is terrified of the dark because they think there is a monster under the bed, or they're not quite sure what they're afraid of, but they are afraid. If the mother comes in and says: There's nothing to be afraid of, or you're not scared—something that is completely foreign to the child—the child knows this isn't right. But because the mother is somewhat of an authority, the child thinks that must be true, or I must be thinking that, or I should think that. And it sets up a very chaotic sort of feeling in the child. *I think I feel this, but I'm not supposed to feel it*, or *I think I feel this, but, no, mother says I don't feel it*, or, *There is something very frightening in this room, but mother says there's not anything frightening in this room*. So it isolates the child from the mother who may be attempting or probably is attempting to comfort the child. But the child simply

> feels more alone, and, therefore, more frightened. On the other hand, if a mother says, "Oh, you're really frightened in here. This is such a big room to be in all by yourself, isn't it? And it's so dark. I can see why you would be frightened," then the child can accept the feelings as legitimate, and thus, accept herself as legitimate and have herself and her feelings, that thing that comes up from the deep. The core of the self is legitimate. And [the child can] know that this real thing can be shared with the world, and also can trust the mother because the mother can understand so she can say more things. And the mother feels like a stronger figure, one that can also hold the fears. So, you know, there's some similarities there between . . . a parent-child relationship—some similarities, not total similarities, but some similarities—between a parent-child relationship and a patient relationship, especially early on. (Anonymous, personal communication, November, 2008)

Some of the analysts in the study talked about normalizing uncertainty, specifically when patients expect them to have answers. Patient expectations can be tremendous, as discussed in Chapter II, so that the analyst is considered "the great helper . . . the source of all hope" (Guggenbühl-Craig, 1971, p. 77). One of the analysts interviewed described how she handled this scenario.

> Patients come in, and they want me the therapist, the analyst, to tell them the way. . . . Initially, they see my role as providing answers. They have questions, and I have answers, and I'm going to give them the answers. And what I often say to them is: "I don't have the answers. Only you have the answers. What I have is, I know how to get . . . to help us get into a process of trying to find the answers." (Anonymous, personal communication, November, 2008)

This approach normalizes uncertainty as well as empowering patients to take an active role in helping themselves. Even seemingly simple clinical situations offer opportunities to normalize uncertainty (and empower the patient), as illustrated by another analyst interviewed who said he frequently shares his uncertainties with patients.

> At one point, the patient says, "I want to change the subject. Is that okay?". . . . My response to this patient was, "Well, of course, you can bring it up. You know, you basically set the agenda," which is true. But, beyond that, I said, "You know, I don't know if continuing the discussion we're having and not changing the discussion is the right way to go. If you feel you want to take this in a different direction now, go ahead. Let's do it." And so I'm trying to be collaborative, and I'm also acknowledging that it's not like I know. I don't know for sure whether

> we should change the subject or not, but I certainly don't know for sure that we shouldn't. So if the person wants to change the subject, we change the subject. (Anonymous, personal communication, November, 2008)

The idea of empowering the patient in this fashion is particularly interesting when viewed in the light of Guggenbühl-Craig's (1971) idea of the physician-patient archetype, explored in Chapter II. By admitting that he or she does not have the answers, an analyst is effectively embodying the patient pole of the archetype, which, as Guggenbühl-Craig explained about dual-pole archetypes, activates the physician pole of the archetype in the patient. The patient is thus empowered to be active in healing himself or herself. This, it seems, is one of the aforementioned losses if analysts fail to welcome uncertainty in clinical work: patients are ultimately deprived of the realization that they have the capacity to heal themselves.

Looking more closely at analysts' embodiment of the patient pole of the archetype, the analysts' statements from the interviews seem to say that, ironically, they are ultimately strengthened by embodying this pole. Their ability to hold uncertainty in their clinical work is strengthened, their relationship with the patient is strengthened, and their inner relationship to themselves is strengthened. The previous section about the rewards analysts find in embracing uncertainty supports this idea. Recall also the analyst who, telling the story about the mother and the child in the dark room, said that the child can "trust the mother because the mother can understand, so she can say more things. And the mother feels like a stronger figure, one that can also hold the fears" (Anonymous, personal communication, November, 2008). Another analyst said, "I help myself with my uncertainty, I think, through trying to help them with their own uncertainty" (Anonymous, personal communication, November, 2008).

Paradoxically, then, it seems that analysts do more to help both their patients and themselves by acknowledging and normalizing uncertainties (both the analysts' and the patients') than by attempting to reassure the patient or professing certain knowledge. Through acknowledging and sharing uncertainty in the contained, safe environment of the consulting room, the individuals in the analytic dyad seem to experience what Brothers (2008) called "bilateral healing" (p. 80), in which the experience of uncertainty is transformed for both people so that "the experience . . . no longer poses a threat to survival but signals the opportunity for greater mutuality, creativity, and joyful vitality" (p. 82).

Times of Unknowing About Patients

The uncertainty described thus far has largely had a particular flavor, which might be called *voluntary* uncertainty. This uncertainty is a mindset that the analysts in the study strive to maintain and bring into work with patients, seeking to loosen rigidity and to allow for flexibility and breathing space so that possibilities can arise. Another type of uncertainty, seemingly different than the intentionally-adopted uncertain mindset, came up in the interviews with the analysts. This uncertainty seems to emerge unbidden in clinical work as what might be called an *involuntary* or *profound* uncertainty. In moments of this involuntary uncertainty, the analysts experience unknowing about the patient—truly not knowing something about the patient or the patient's experience. Two subthemes were evident in the interviews: (a) uncertainty about the patient's ego strength and response to the work and (b) uncertainty, maybe even more accurately, confusion, about the situation with the patient at a given moment.

Regarding the patient's response to the work, one analyst interviewed felt uncertain about how he was addressing an issue of personal motivation with a patient. Specifically, the analyst wondered about how the patient would respond to the analyst's approach. “I’m not sure when I approach him if all it’s gonna do is discourage him and undercut him so that he can’t organize himself and get motivated; or whether what I’m doing is going to help him organize and get motivated. And how do I feel? I feel uncertain” (Anonymous, personal communication, November, 2008).

Similarly, the analysts expressed uncertainties about patients' ego strengths and how that affects the patients' ability to participate in and benefit from psychoanalytic work. In one case, the analyst weighed ego strength as one of many possible reasons for inertness in her work with a client.

> I feel uncertainty about whether or not her ego is actually strong enough—it seems to be—but is it actually strong enough to incorporate and hold this information? Or are the defenses so strong that she’s continually pushing this down. Well, I know that’s true. But why? Because sometimes that comes because the ego is not strong enough to hold—it can’t deal with it. I do not see any overt signs of that. But when this keeps happening over so many years, I wonder. (Anonymous, personal communication, November, 2008)

The question of ego strength was of particular concern for an analyst with a patient who had experienced a psychotic break in the past. The analyst described her feeling that there was “a lot at stake” with this past psychotic break as a key to potentially unlocking the patient's current issues and, yet, the analyst felt tremendous uncertainty about the patient's ability to discuss the psychotic break.

> My uncertainty with the patient was: How far can I go with her in terms of her ability to recognize this vulnerability, and what had happened to her, and what role it played? . . . And at what point would I push her back into it? Or alternately if I didn’t push her back into it, would she just shut down and not talk to me anymore if I were pushing up against the defenses that were just too solidly in place? (Anonymous, personal communication, November, 2008)

In the two cases above, the analysts mentioned the patients' defenses as a factor, and one of the analysts described the difficulty in engaging patients in certain cases:

> I think I really get what's going on with this person, but I just don't know how to help them work with it. You know, the defenses are just so brittle or they're so concrete, that I can't figure out how to get them to enter into a kind of analytic process with me. (Anonymous, personal communication, November, 2008)

In question here are the patients' abilities to tolerate difficulty and emotional strain associated with particular issues. Can the patients think? Bion would say. How well have they internalized the ability to think, and, when that ability is absent or lacking, how does the analyst work with the old defenses that rise up? The analysts in the study recognize that, even though the defenses might seem to be obstacles, they are also to be respected, and so the analysts' uncertainties seem to center around exploring but not violating the defenses.

The other experience of involuntary uncertainty described by all the analysts was a more profound uncertainty that one analyst summarized as "What in the world is going on here. I don't know what is going on here" (Anonymous, personal communication, November, 2008). The analysts all described experiencing points at which they truly do not understand some aspect of their work with a patient. One analyst talked about the work with a patient being "pretty much stuck" (Anonymous, personal communication, November, 2008). Another analyst expounded a bit more on the experience:

> I don't know what in the hell is going on here. I just don't know. I don't know what this is about. I don't know what's going on in the room between us. I don't know why this person is even here to see me. I know she wants something from me. But I can't figure out what it is. (Anonymous, personal communication, November, 2008)

While this “what is going on here” uncertainty was experienced by all the analysts at times, the feelings and thoughts they described were not consistent; that is, not all the analysts responded in the same way. Two of the analysts, however, described similar responses, which are discussed in the next section.

Whether it be a question of ego strength or a moment of sheer confusion, the analysts in this study are, undoubtedly, faced with the stark otherness of the Other in these times of unknowing about the patient. As noted in Chapter II, “the relationship with the other is a relationship to a Mystery” (Levinas as cited in Brothers, 2008, p. 7). In all the situations described by the analysts in this section, they come up against something about a patient that is not familiar or that they do not understand and, in some cases, might never fully know or understand. Just as the patient's ability to think in the face of uncertainty and difficulty is being tested, so is the analyst's. A mirroring or echoing of uncertainty seems to take place between the two people, then, in which the analyst functions as a lynch pin. Crucial to the therapy is whether the analyst evades the frustration of unknowing or, instead, acknowledges and attempts to modify it.

Discomfort and Doubt in Moments of Unknowing About Patients

As has been shown so far, the analysts interviewed strive to hold and imbue their clinical work with a perspective of curiosity and wondering, yet they all encounter moments when a deeper uncertainty, an involuntary unknowing about their patients, presents itself. For one of the analysts, such times of unknowing are not uncomfortable. He described the times when he does not know “what is going on” with a patient as being no different than the other ways he listens to his patients: “It’s just all part of what goes on in my mind” (Anonymous, personal communication, November, 2008). Being able to

maintain his curiosity even in states of unknowing seems to be due to a variety of factors, including his belief that he was “inclined” to be comfortable with uncertainty (Anonymous, personal communication, November, 2008) and his numerous years of clinical experience. The latter factor, the impact of clinical experience on the experience of uncertainty, is discussed more fully for all the analysts in the next section.

For two of the analysts interviewed, however, times of unknowing give rise to questions about their abilities and to different degrees of emotion. In Bion's (1984) terms, these times of unknowing are unsaturated preconceptions—moments when the “expectation of a breast is mated with a realization of no breast available for satisfaction. This . . . is experienced as a no-breast, or 'absent' breast inside” (p. 111). In such cases, the analyst's expectation of having the abilities to help the patient comes up against the experience of unknowing, in what Bion called “the mating of a preconception with a frustration” (p. 111). The frustration seems to result in questions about the analyst's ability to help. One of the analysts interviewed described this occurrence:

> A number of very unhelpful issues about my own superego kick in. If I don’t know what’s going on here, does that mean I’m a lousy analyst? Do I know enough? . . . What's wrong with me? Why don’t I know what’s going on here? (Anonymous, personal communication, November, 2008)

Another analyst described different questions that cross her mind in times of unknowing in her work with a patient.

> Have I missed something? Is there something in her history that’s critical that I have somehow missed? Maybe one event that told her something and set up a whole series of concepts, that she’s going on that. . . . I also feel some—wondering about whether there’s something else going on. . . . A whole other piece of something else that needs to be added. I feel uncertainty whether I’m fully understanding this problem. . . . I also wonder, you know, if I have somewhere along the way done something wrong. (Anonymous, personal communication, November, 2008)

Both analysts mentioned wondering whether other analysts would be more capable in the situation they are experiencing. They said, "I've wondered if somebody else might be able to get to this [issue] with . . . [my patient]," (Anonymous, personal communication, November, 2008) and "Somebody else who's had more experience than me, someone who has had many more years of experience than me, maybe they know what's going on here" (Anonymous, personal communication, November, 2008). One of the analysts fantasized:

> An analyst who was really, really good, and really—I mean, I think I'm good—but who was really—maybe they had been doing it for years and years and had tremendous confidence—. . . would sit with uncertainty . . . in real uncertainty, far, far longer than I feel that I can sometimes tolerate. (Anonymous, personal communication, November, 2008)

Also present for these two analysts in moments of involuntary unknowing were different emotions, which were, indeed, almost inseparable from the thoughts and doubts. At the core of these emotions seemed to be what one of the analysts called a feeling of "oh my gosh" (Anonymous, personal communication, November, 2008). To assume, however, that anxiety is the basic emotion for both analysts is an oversimplification. For one of the analysts, varying degrees of anxiety were indeed a part of the experience of unknowing. This analyst described her feeling of nervousness as she tentatively moved into new, risky territory with a patient.

> I . . . felt that . . . I was stepping out on thin ice and kind of waiting to see if it was going to hold me. And if it seemed to hold, I'd go a little bit further; and if it looked like it wasn't, I'd come back. I was anxious. I was a little bit anxious. . . . I felt that I was kind of taking a risk and seeing if . . . [my patient] could go there. . . . There were a couple moments where I thought: *Gosh, if I go too far, will she fall apart?* But she didn't seem to. But I always felt a little anxious. . . . I felt like I was taking a risk, and I was anxious, but not overly so. But just feeling: I don't know how this is going to go. (Anonymous, personal communication, November, 2008)

More intense anxiety arises for this analyst when the work with a patient feels extremely murky. Bernstein (1993) called this "Cartesian anxiety" (p. 17), as discussed in Chapter II, and Bernstein cited a passage from René Descartes to capture the experience: "[It was] as if I had all of a sudden fallen into very deep water [and] I am so disconcerted that I can neither make certain of setting my feet on bottom, nor can I swim and so support myself on the surface" (as cited in Bernstein, 1993, p. 17). In these moments, the interviewed analyst talked about feeling pressure to produce something.

> And sometimes it's my own anxiety. That I can at moments, in spite of myself, particularly with certain patients, feel under intense pressure to come up with an answer or to come up with a formulation. "Answer" isn't always the word. But a formulation of something that says: Oh, here we are. This makes sense. . . . It's out of an anxiety to have to establish a map, you know, right then and there. (Anonymous, personal communication, November, 2008)

The other analyst also acknowledged the emotions and feeling of pressure that can churn inside an analyst in moments of unknowing.

> Sometimes it can be kind of terrifying to have someone sitting there in great pain, depending on the analyst or therapist to be of help, knowing what to do. And the analyst or the therapist feels an urgency to know and to do something. And sometimes I have no idea—I have no idea what to do. I am baffled about things as [I was] this morning. That is more terrifying, I think—frightening. And let's see, there's another word. Frightening and, well, more confidence-eroding to a younger therapist than an older one, or a more experienced one. (Anonymous, personal communication, November, 2008)

This last analyst has many years of clinical experience, making her less susceptible, it seems, to strong emotions in the face of unknowing; however, she seems to be still in touch with the alarm of not knowing what to do but desperately wanting to do something. Both of the interviewed analysts' descriptions echo Brothers' (2008) "existential uncertainty" (p. 13) cited in Chapter II: "As waves of this nightmarish dread wash over

me . . . I feel most tempted to dig my heels into the dry shore of analytic certitude. . . . 'reaching after fact and reason' as if for a life preserver" (p. 13).

These emotions are not, however, as straightforward as they might seem. Complicating the experience is the clinical phenomenon of Klein's idea of projective identification (Mitchell & Black, 1995) in which the patient unknowingly projects his or her intolerable, unconscious emotions into the analyst so that the analyst experiences the emotions as his or her own. Though it can be very difficult, especially for new clinicians, to be aware of this phenomenon in their work, both of the analysts discussed in this section cited projective identification as not only being a common source of their anxiety but also providing a window into the patient's unconscious anxiety and uncertainty. For one of the analysts interviewed, her awareness of projective identification emerges in a progression of first having various anxious thoughts (including thoughts that the patient is frustrated with her), then collecting and reorienting herself:

> Then I think I get focused on—I'm able to shift myself to the patient's anxiety and to try to speak to their anxiety. Because I think maybe when I'm feeling that—I think probably when that comes up—but I won't say invariably—but I think it's probably often a kind of countertransference reaction to a patient's anxiety. And they're feeling that they need something from me. They need something very concrete, and so a certain kind of pressure that I feel in the transference to produce something that I'm not ready to produce. And then I think I try to focus back on the patient's anxiety and their feeling that they need something from me right now. And how uncomfortable it is for them to sit with their own uncertainty. (Anonymous, personal communication, November, 2008)

The other analyst provided a similar description of this dynamic:

> If I have . . . [feelings of uncertainty] now, I have usually introjected . . . [the patient's] feelings. I mean, that's what very often happens. *She's* feeling uncertain. *She's* feeling scared. *She's* feeling hopeless—like she's never going to get it. Then that's in the room, and I take it. I take it, and I start carrying it. It's also important for me to be able to carry that. Hold it and not go berserk when I get it. . . . and not start to act on it, but to recognize that maybe I'm getting some of this from her. Maybe I've picked some of this up from her, maybe. Not that it's

> impossible for me to feel on my very own, you know, hopeless or confused—but put it out there in the room and not to have some hidden or secret thing that's going on. And sometimes if I say it, then she can say, "That's exactly what I'm feeling." . . . And sometimes when I . . . [ask], they don't know they're feeling it. So they may catch on right away. . . . Or they may say, "No, I don't feel that way." And then a week later, or two weeks, or three weeks later they will say, "You know, that time when you said I felt hopeless, well, I realized that I do feel hopeless—that I'm scared, that scares me," or something like that. (Anonymous, personal communication, November, 2008)

As these descriptions show, recognizing projective identification is important for the analysts, distinguishing whose emotions they are experiencing. Just as important, however, is then using that knowledge as a tool to bring patients' feelings to consciousness. This allows the analyst to normalize the uncertainty for the patient, as in the analyst's story, earlier in this chapter, about the child in the dark room. As that analyst described, normalizing the uncertainty allows the patient to begin to recognize, accept, and trust his or her feelings, strengthening the patient's sense of self as well as the analytic relationship and the analyst's sense of self as an analyst.

Moments of unknowing, of involuntary, profound uncertainty, are pivotal moments for the analysts interviewed. As Bion (1984) said, the step following a moment of unknowing "depends on the . . . [analyst's] capacity for frustration: in particular it depends on whether the decision is made to evade frustration or to modify it" (pp. 111-112). The analysts discussed in this section, in spite of pressing thoughts or feelings, strive to modify their frustration rather than "saturating preconceptions with false knowing" (Felch, 2007, p. 61). They understand Carnochan's (1995) point that their uncomfortable emotions are an invaluable resource: "While often less comfortable, the registering of affect is a further source of insight. When we allow things to affect us, when we tolerate emotion, we gain further perspectival positions that expand our range of

knowing" (p. 362). The analysts described here work to maintain a state of unsaturation and to be open to even very uncomfortable experiences of uncertainty, using their alpha function to provide containment for themselves. They variously try to maintain a mindset of wondering (as the more experienced analyst conveyed), be aware of projective identification, or look to a visual cue, like the other analyst does in her office to remind her in moments of unknowing that "it's okay. . . . This is where it needs to be" (Anonymous, personal communication, November, 2008) . The interviewed analysts seem to appreciate, as Felch described, the necessity of absence in their clinical work.

> Crucially, it is the frustration inherent in the absence of the breast—a negative space—that motivates a child to discover a new symbolic solution that alleviates his distress. This appreciation of absence as necessary for the creation of something new is the foundation of Bion's respect for not knowing, or being unsaturated by what is already known. (Felch, 2007, p. 34)

The ability to maintain such a state of unsaturation in clinical work is increased through both clinical and life experience, as the next section shows.

Clinical and Life Experience Easing Toleration of Uncertainty in Clinical Work

The interviews with the analysts revealed, interestingly, that not only their clinical experience but also their life experience has made them more comfortable with uncertainty. Though two of the analysts are slightly older than the third analyst and, thus, have more life experiences to draw on, all the analysts discussed their personal experiences with uncertainty increasing their comfort with uncertainty in their clinical work. One analyst said, "I'm a lot more comfortable with uncertainty now than I was when I was younger. And I think that age and experience, no matter *what* I had experience in, has made that happen" (Anonymous, personal communication, November, 2008). Another analyst, the oldest of the analysts in the study, reflected on the process of

growing more comfortable with uncertainty through the years and, ultimately, more comfortable with himself.

> It's been a life-long experience, you know, my development as a comfortably uncertain person. . . . It's . . . been a growth process. . . . I'm more comfortable [with uncertainty now] than I was . . . [10 years ago]. I was more comfortable [10 years ago] than . . . [20 years ago]. . . . As far as me as a human being. . . . I think I'm more comfortable with myself in every way, and that's what's—and Erickson taught us that—that's what's supposed to happen in life, if you are lucky and things go well. And, you know, I have been. (Anonymous, personal communication, November, 2008)

Recalling a specific time in her early years when she was experiencing uncertainties about important decisions in her personal life, one of the analysts recalled how she handled the uncertainties and how those experiences inform her work with patients.

> At some pretty critical points, I would throw myself into something, not knowing exactly where it was going to lead me, having all sorts of questions about whether it was the right choice, or in spite of fears I had or anxieties I had. And I used to—I had this image of myself. I used to say to myself, about myself, that I would throw myself over a cliff to see if I could fly yet. So throwing myself into moments of uncertainty and the unknown was kind of a way of seeing if I could find my wings. . . . It's that coming up against these moments and saying, "I don't know, but here I go." . . . I went this way, and then I went that way, and somehow, in the end, I think it all goes very much into who I am. But it's not a simple path. . . . It's just so much a part of me, I guess, that when I listen, I listen from that experience. I listen out of a sense of, *You know, who knows*? Patients want to know, "Should I do this or should I do that?" I think, *Well, you know at some point you have to take a risk*. I know what I do say to patients a lot of times who are kind of struggling with *Should I do this? Should I do that? What if this? What if that?* I will often say something to the effect of "In order to have anything, you have to give up something else. In order to move forward—the only way to move forward is to close another door. If you're going to take this path, then you can't go on that path. If you stand at that crossroads, uncertain about which path to take, you're not going anywhere." . . . And so I think it's both the ability to move into uncertainty and the ability to tolerate loss and limit and mourning what you have to leave behind. I think those two are all part of what makes it all possible to live a creative life, to live an open life. (Anonymous, personal communication, November, 2008)

The reciprocity between personal and clinical experience that this analyst expressed was described by all the analysts. This reciprocity suggests that experiences of uncertainty for analysts are ubiquitous and interwoven, continually feeding into and informing each other, a theme that is expanded in the next section.

Regarding the effect of specifically clinical experience on the analysts' tolerance of uncertainty in clinical work, previously difficult periods of work with patients provide touchstones for two of the analysts interviewed. One could say that their faith in possibilities, which Charles (2003) felt was Bion's meaning of faith, has increased over time as they have repeatedly experienced and worked through (*survived* might not even be too dramatic a term) difficult phases of analytic work with a variety of patients. The interviewed analysts can recall previous times of darkness in their work when, like Stein's (1998) interpretation of the pupa in image seven of the *Rosarium Philosophorum* woodcuts, they were in "the darkest moment of pupation. . . . a crisis of faith" (pp. 86-87) and, only later, when the dark time had passed, realized that something had been at work, even in the darkness: "something that endures but is quiescent for a time, catching its breath" (p. 88). These experiences act as an internal holding environment (Belger, 2002) for the analysts interviewed, becoming an internal object that holds them steady when they encounter the darkness anew. One of the analysts described this evolution over time:

> What happens after years of experience is that you can look back and you can see how maybe something that maybe you thought at the time, and maybe even months at a time, was going absolutely nowhere. And then you look back, and you realize that there was this very, very important period that was unfolding, and it was slow. But at the end of that period, and it may have been months later. . . . where you realize what was happening during that period. And it looked like nothing was happening, but an awful lot was happening. And so you have those experiences to draw on. And it helps you the next time you're in the middle of it. You can kind of go *Hmm, that's just the nature of this work.* You know, *Here we go*. (Anonymous, personal communication, November, 2008)

A sense of something else being at work in the psychoanalytic process—something that undoubtedly requires the analysts' expertise but is ultimately beyond their knowledge—pervaded their descriptions of faith. One analyst said,

> [It's] not so much necessarily at any particular moment a faith in my own knowledge or a faith in my own wisdom, but a faith in the process. . . . It's a very different ability than having all of this knowledge and being able to come up with brilliant interpretations, to apply your developmental knowledge to understand the relationship of early childhood problems to current problems. It's much more about how closely you listen to a patient and how attuned you stay with where they are, and that you have faith that in the exchange between the two of you, that you have the skills to track what's going on between the two of you most of the time. (Anonymous, personal communication, November, 2008)

Another analyst echoed this, having gained enough experience to know, as she expressed, that sticking with the psychoanalytic work through difficult phases will eventually open doors. "I have learned that the psyche has its own way of working through things, whether I know exactly what to do or not, whether I'm mistaken sometimes or not" (Anonymous, personal communication, November, 2008).

Having learned in their previous experiences of uncertainty that new life will emerge from sustained uncertainty, the analysts in the study have developed what seems to be faith in O. This faith allows the analysts to re-engage in the unknown with their patients over and over again; as Eigen wrote, "through F in O, we tolerate the work of Ps↔D" (1985, "Faith and the Precocious Container," para. 6). The analysts have developed "an appreciative sensibility for what remains out of reach. . . . [They have learned] the gesture of repeatedly starting from scratch, of living in a wall-less moment and sensing . . .[their] walls in a way that makes a difference" ("Faith in O," para. 3).

From a Jungian perspective, it seems the analysts interviewed have, through their clinical and personal experiences, developed a "relativization of the ego. . . . a partial

consciousness of the ego-Self axis" (Alschuler, 1997, p. 287) that "entails a realization that there is an autonomous inner directive power supraordinate to the ego, which is the Self" (Edinger as cited in Alschuler, 1997, p. 287). The Self, in one of Jung's many uses of the word, is "the tendency of the psyche to function in an ordered and patterned manner, leading to *intimations of purpose and order* [italics added]" (Samuels, 1997, p. 9).

In the experiences of uncertainty for the analysts in this study, there seems to be a recognition of and even deference to a greater order at work such as Bion and Jung both described. Though the analysts did not, for the most part, express their experiences of uncertainty in terms of a higher power, they all described uncertainty, as the next section shows, as an important part of being human, at once limiting their grasp of knowledge and truth and drawing them into that which they cannot grasp.

Belief in Uncertainty as an Inevitable and Significant Part of the Human Experience

Uncertainty is not merely an aspect of clinical work for the analysts interviewed, but a pervasive, meaningful phenomenon in the totality of their existence. All their encounters with and ideas about uncertainty, whether clinical or personal, seem to flow into and fold back into each other multiplicatively so that uncertainty in their lives has a rather seamless quality as a fundamental and important truth of human existence. "Uncertainty to me is an essential part of the human condition. . . ." said one of the analysts, "and curiosity . . . willful, motivated, focused curiosity is part of what makes us as good as we can possibly be as human beings" (Anonymous, personal communication, November, 2008).

The idea that uncertainty is an inevitable and important experience for all humans (not just analysts) seems particularly appropriate in the field of depth psychology, where the basic premise is that an unseen and independent entity, the unconscious, continually and covertly influences each person's thoughts and behaviors. The nature of the unconscious is such that there is always an unknown element, thus an element of uncertainty, in one's psyche. This idea, that there is so much the interviewed analysts do not know (and, more importantly, cannot fully know) about themselves and others, seems to somehow parallel a larger acknowledgement by the analysts, a world view, that there is so much they do not know (and cannot know) about life itself. Whether the analysts carried this perspective already, and they discovered analysis as resonating with this belief, or the profession of analysis planted the seeds of this belief in their world view, is not entirely clear. What does seem clear is that uncertainty is integral to the analysts' view of the world and humanity itself. One could say, alternatively, that the analysts believe there is always a mysterious Other—something that cannot be known, understood, predicted, controlled—always slipping beyond their grasp.

All the analysts in the study embody this world view in their personal development—they remain continually open to discovering themselves, believing that they are never a finished work and that who they are and what they know is ultimately uncertain. Recall the analyst who talked about continually pushing herself to be open to her patients' perspectives and who looked within herself to find that she had the capacity to carry out a particular act (Anonymous, personal communication, November, 2008). Another analyst sees himself as

> an evolving human being, and not as a static—oh, yeah, I'm 25 years old, and I'm wonderful, and I've arrived, and I know just who I am, and I'm going to be this

> way for the next 60 years—well, not me. (Anonymous, personal communication, November, 2008)

Echoing the sentiment of ceaseless horizons, one of the analysts said, “I think as you get older, you get . . . beyond the 'and they lived happily ever after.' And realize that it’s in that 'happily ever after,' after the book ends, that everything happens” (Anonymous, personal communication, November, 2008). Casement (1993) pointed out a similar idea in Bion's thinking: “Bion stressed that 'becoming' is a process which begins, continues, and is never completed. We should always be in a state of becoming” (p. 32).

The constant need to grow has been reinforced for one interviewed analyst by his interactions with family members who have encouraged him “to be curious and uncertain” (Anonymous, personal communication, November, 2008). He noted that his wife, in particular, has been influential:

> My wife pointed out to me very early in the relationship that there were things I thought I knew that I didn’t know, and that was good. And it was a very good experience, and it made me realize that there were things I didn’t know—there were a lot of things I didn’t know, things I had to learn, ways I had to grow and develop. (Anonymous, personal communication, November, 2008)

Of interest here is Guggenbühl-Craig's (1971) conclusion that analysts can individuate only by engaging with their loved ones—“in such relationships shadow contents are constellated, since these people challenge the analyst from completely different sides and angles than do his patients” (p. 137). Guggenbühl-Craig asserted that engagement with uncertainty, being thrown off balance, within the love of personal relationships is the only means for analysts to maintain contact with their shadows—a necessity if they are to embody the patient pole of the physician-patient archetype and, thus, activate the physician pole in their patients.

Capturing the impossibility of any person achieving absolute, final personal growth, one of the analysts interviewed described the process as a continual "movement" that she associated with Jacques Lacan's idea of desire:

> Lacan has this notion of desire, and . . . there's a difference between desire and demand. "Demand" has a content: *I want. I want to be a brilliant student. I want you to pay attention to me. I want my husband to love me.* I *want my parents to respect me.* Those are all demands. Those demands are efforts to. . . . capture something about desire, but desire in itself has no content as such. But it's this kind of continuum—wherever you are, it's always elsewhere. . . . [it's] always a movement, it's always beyond, it's always the excess of whatever you have. . . . Whatever you think you have or think you know is always elsewhere. (Anonymous, personal communication, November, 2008)

Expounding on this idea, the same analyst said,

> It's not like we go through an analysis or a therapy, and we get it all put together, all wrapped up, we're just fine, and out we go. There's no stopping point. . . . There's that uncertainty that's built into life itself. And it's being able to tolerate that and in a sense, being able to embrace it, that to me is kind of the goal of an analysis or a psychoanalytic therapy. That there's an embracing of this open-endedness to everything and to uncertainty. (Anonymous, personal communication, November, 2008)

Life itself as being imbued with uncertainty, as being "unknowable," (Anonymous, personal communication, November, 2008) in the words of one interviewed analyst, seems to be at the core of the analysts' experiences of uncertainty. Their knowledge, indeed the knowledge of humanity, exists for them in the much larger context of what they do not know. This gives the analysts pause—in their work with patients and in their personal lives. The analyst who referred to the Heisenberg uncertainty principle and the observer effect was expressing a fundamental uncertainty about what humans can know. Said another analyst, "The only thing I know is that nobody knows anything for sure" (Anonymous, personal communication, November, 2008).

Of great importance in understanding the interviewed analysts' perspectives is that, rather than adopting a cynical or cavalier or discouraged attitude in the face of so much that is unknown, the analysts have a spirit of curiosity and engagement and acute alertness. Their simultaneous awareness of both the limitations of their knowledge and the larger mysteries with which they are deeply engaged seems to me to be captured by Jung's (1989) statement: "Only consciousness of our narrow confinement in the self forms the link to the limitlessness of the unconscious. In such awareness, we experience ourselves concurrently as limited and eternal, as both the one and the other" (p. 325).

Standing between limited and eternal (or between finite and infinite, Bion might have said), holding both, in the ultimate tension of opposites, is where the analysts in this study seem to reside. The ubiquitous yet elusive nature of the eternal is seen by one analyst in the Egyptian goddess, Ma'at.

> There are laws here [in the universe]. There is order here, unquestionably. Thousands, millions of interlocking natural laws both of people and material objects, and of non-material objects. . . . And they're all working in perfect tandem with each other, each one, each adjusting to the other, moving in ways that I don't think the human mind—in ways that I don't think one single human mind —can comprehend. The Egyptians call that Ma'at, that's the woman with the feather in her hair. "Ma'at" . . . means truth in the Egyptian language. . . . These laws are a truth—a universal truth, and that truth completely interlocks with ultimate justice. That is, Ma'at's laws bring an order to the universe, and this order constitutes a truth beyond what human beings are able to grasp. . . . We might be able to grasp the fact that Ma'at's law and justice are in place, but not exactly what this all means. The connections of order, truth, and justice are bigger than the human brain can handle. . . . My image of uncertainty is kind of standing aside—standing on one side, and that ultimate order and truth and justice on the other. Not even being able to see it—I mean, there it is right before us. It's in that big tree. It's in the chair. It's in this relationship between the two of us. It's in my dog. It's everywhere, but it's too much. I can't grasp it. (Anonymous, personal communication, November, 2008)

Grappling with what they do not know seems to be, for the analysts, an important task both in clinical work and in life. As one analyst pointed out, using Bionian concepts, "the

creative work of the analysis is to turn those [beta elements] into alpha elements, to make them symbolizable, to put words to them" (Anonymous, personal communication, November, 2008). For this analyst, symbolizing and giving shape to the unknown is both difficult and essential.

> Levi-Strauss . . . a cultural anthropologist. . . . has this phrase: "Myths are to think with." I live with that phrase . . . because I think that about theory. Theory is to think with. I think that about almost anything. And to me what that captures is that life itself is unknowable. Our existence in some profound way is unknowable. We have various symbols and tools we grab to be able to try to think with, to kind of create something that—to give shape, shape to our lives, shape to existence, shape to experience. But it's always against this background of so much more that's unknowable and that we don't know; and all we can try to do is paint something at a particular moment that brings into relief some plausible shape. (Anonymous, personal communication, November, 2008)

One particular moment from the interviews brings to vivid life the feeling of trying to give shape to the unknown—an instant in which the experience of being both limited and eternal seemed to hang in the air, palpable. This moment, this quote from one of the analysts also captures and summarizes the larger theme described in this section: uncertainty, for the analysts, is both inevitable and essential to the human experience.

> I always knew people died—intellectually known. Now I really know. And I really know for sure that I'm going to be dead one day. . . . [Death] has become a reality to me now . . . a certainty. For some reason, that makes me more certain that the experience of uncertainty is okay—and inevitable. Here's another place where words are difficult—inadequate. I'll have to think about how to express what I just said—how the inevitability of uncertainty makes uncertainty more comfortable. What is the word that comes to me? More right—a truer way of being. I guess it's the fact that we do not know these things here—we just guess, we have opinions. We don't know very much. We don't know very much. We're getting more information: bags and boxes and vaults full of information. But still, we don't know very much. So we'd do well not to be too certain about anything. (Anonymous, personal communication, November, 2008)

Summary

Having considered and examined the major themes in the analysts' experiences of uncertainty, the essence of their experience can now be summarized. This expression of the essence is called, in Giorgi's (1985) phenomenological methodology, the general description of the situated structure of uncertainty. It captures "the psychological structure of the event. . . . [and] communicate[s] the most general meaning of the phenomenon" (pp. 19-20). Presented in this summary is the structural description of the experience of uncertainty for the analysts interviewed for this study.

Uncertainty is an integral part of the analyst's clinical work. The analyst strives to maintain a questioning mindset and transcend his or her ego in working with patients. Though embracing uncertainty is challenging for the analyst, clinical and life experiences increase his or her ability to be in sustained uncertainty, which is of pivotal importance in analytic work, allowing growth for both patient and analyst. All of the analyst's experiences of uncertainty—whether his or her own or the patient's, whether clinical or personal—inform the analyst's perspective, culminating in a world view that holds uncertainty as a fundamental human experience from which there is much to learn.

This structural description and the themes discussed reveal that uncertainty for the analyst is a complex yet provocative experience that consistently draws both analyst and patient into new possibilities. The structural description and themes are likely unique to this group of interviewees, in at least some ways, because this is a particular group of analysts who, by virtue of their theoretical orientation, hold a particular set of ideas about the human psyche. Furthermore, depth psychology, as mentioned previously, seems to have a framework that inherently accommodates the notion of uncertainty. The question

remains: how much of the experience revealed through this research is particular to these analysts? Although one cannot be sure without doing further research (such as that proposed in Chapter IV), the research established here casts the analyst's experience of clinical uncertainty in a compelling light made even more so by the finding that uncertainty for the analyst goes far beyond the consulting room.

CHAPTER IV
CONCLUSION

Having reached the far side of this long and intense journey into uncertainty, I continue to be stirred by what I experienced, what I heard, and what I discovered. I am privileged to have sat with the analysts, who engaged with me wholeheartedly, willing to ponder deeply with me and at length on a challenging and slippery topic. The spirit of our discussions has stayed with me, resonating in my approach to this work, inspiring me to take up uncertainty in new ways with clients, and expanding my budding views of uncertainty as an experience that has much to offer both clinically and personally.

The results of my work are, I believe, a starting point. The possibilities and new life that this study shows can emerge from mindful, receptive uncertainty have implications for all theoretical orientations in psychotherapy and for all people in general. I therefore hope that this work will contribute to a broader set of questions and self-reflections for therapists as well as non-therapists.

At a minimum, I believe that the findings I have presented will provide reassurance and stir possibilities in the minds of novice therapists who need a life raft to hold onto when uncertainty threatens to envelope them. Perhaps this research will increase their capacity for tolerating and working with uncertainty, given that real-life examples go far beyond theory in exemplifying an experience. For more seasoned therapists, I hope that my research will inspire them to reflect anew on their experiences with uncertainty, as our discussions seemed to inspire the analysts I interviewed.

Speaking more broadly to all therapists, this study contributes another set of voices to the question of what we can and cannot know, what we can and cannot offer to our clients. As the analysts in this study expressed, the answers to this question should be evolving always and be held with a degree of uncertainty. The findings of this study should give all therapists pause and encourage them, as one of the analysts expressed it, to always be curious: to continually examine how they are responding to their experiences of clinical uncertainty, to continually question what they believe to be true about their clients, to continually weigh what the field of counseling psychology is saying about how we can help out clients, and to always be on guard about the slippery slope of certainty.

Given these intentions, this study clearly calls for expanded research on the different theoretical orientations in psychotherapy. If future research increased the scope to include many different therapists with varying years of clinical experience and approaches in their clinical work, what would be discovered? Would there be a wealth of common ground on the experience of uncertainty, or would the question highlight significant differences between groups? My choice to study only analysts stemmed partially from time constraints and partially from my innate interest in depth psychology, but I have lamented the absence of other theoretical perspectives. In short, I realize that I have violated the very nature of uncertainty itself, as revealed in this study: uncertainty (in this case, an influx of many different ideas) is necessary to arrive at some approximation of the truth. Though I have attempted to be as true as possible to the nature of uncertainty for this group of analysts, I have undoubtedly remained in territory that is familiar to me, thus reinforcing to some degree my own beliefs (and those of depth

psychology) and missing out on vastly different perspectives that have the potential to fracture and thus reshape my own ideas (and those of depth psychology) about uncertainty. Knowing this, I sincerely hope that I or someone else will have an opportunity to broaden this body of research. Such an expansion potentially risks loss of reassuring certainty but also opens up unforeseen possibilities, as this study has shown.

To the larger point raised by the need for receptivity to other perspectives and possibilities, this study makes it clear that, contrary to how therapists might feel under pressure in the moment, they have much to gain and learn about themselves and their clients by being in uncertainty. By fleeing the discomfort of uncertainty or spinning anxiously and mindlessly within it, therapists lose the opportunity to see what might emerge for them and for their clients if they can acknowledge the uncertainty and allow it to be present.

Based on the results of this study, I assert that the statements it makes about therapists thus far are also true for all people: that is, uncertainty is an unavoidable and important experience that can generate possibilities and growth for anyone. I have found it incredibly synchronistic that, during the time I have spent researching and writing about this topic of uncertainty, the United States and global economies have been deeply shaken and threaten collapse. Meanwhile, humanity faces other large threats that seem to linger as constant uncertainties, including ongoing wars, global warming, and terrorist attacks. My intention is to not venture too far afield in this topic, yet I have a strong sense that we are living in a time when, globally, there are many Others—things we do not understand and cannot control. Through modern technology, we are personally and collectively faced with a constant pressing in of unknown people and seemingly

inexplicable events and opinions. Each one of us, by virtue of being confronted with this barrage, decides how to respond, and I cannot help but think of Bion's question about the individual's response to frustration: does the individual "make meaning in a flexible manner that deepens . . . [his or her] growth, or in a rigid manner that sacrifices true learning for the false security of omnipotence" (Felch, 2007, p. 21). Asked another way, paraphrasing an earlier quote from Bernstein, does the person dismiss the Other as the same or unimportant, try to defend against it in some way, or try to transcend ego in an effort to receive and understand the Other (as cited in Brothers, 2008, pp. 7-8)? I believe these are pivotal questions for our time, just as they are pivotal questions for therapists. As with therapy, we have something to learn from our dealings with the Other, an idea most clearly expressed by the social psychologist Edward E. Sampson (2008), who examined Western society's chronic repression of the Other. By being in dialogue with the Other, said Sampson,

> we learn how many possibilities there are, how open we must be to this diverse range, and how no one voice can be quieted without losing the greatest opportunity of all: to converse with otherness and to learn about our own otherness in and through those conversations. (p 187)

Given the scope of Sampson's explorations and the results of this study (and other research beyond my awareness), I feel that studies of uncertainty beyond the field of psychotherapy would be fascinating. Uncertainty could be examined across socioeconomic groups, professions, and cultures. As an inescapable reality of being human, uncertainty is an experience all humans share, and such studies could yield many interesting, cross-pollinating insights.

In closing, it is important to address what some could see as an idealization of uncertainty in this body of research. It must be noted that sustained uncertainty can be

harmful and even dangerous for some therapy clients, as one of the analysts pointed out. As all therapists are taught, some clients' ego strength or situation is such that they require more structure in doing the work of psychotherapy. This said, I address here, criticisms of what Bader (1998) terms the postmodern tendency to "to fetishize uncertainty, idealize ambiguity, and admire complexity" ("Postmodern Sensibilities and the Turn From Therapeutics," para. 1). In quoting Bader, I must clarify that he was speaking specifically about a shortcoming of relational psychology.

The idea of fetishizing uncertainty is important to this discussion in order to respond not only to Bader's very specific critique but also to a general (albeit assumed) criticism of overemphasizing uncertainty within a world view. Emphasizing uncertainty is, for me, a counterbalancing response to what feels like constant, desperate grasping for certainty in the field of psychotherapy and in the culture at large. This is not to say that uncertainty is more important than certainty. We, as therapists and as humans, do require some sense of structure and order in our daily existence. My point, similar to the analysts', is that, in overemphasizing certainty, we risk structuring ourselves right out of room to breathe and change and discover—*Spielraum*—and so we must allow for, maybe even slightly overemphasize, the inevitable experience of uncertainty and what it also has to offer in the midst of our mad, fearful, sometimes prideful dash to have definite answers, clear judgment, and full understanding right now.

In this sense, I believe that depth psychology has been an excellent starting point for this research because it provides a unique and valuable perspective for considering the experience of uncertainty. As I have already mentioned, depth psychology, with its idea of the unconscious, naturally accommodates uncertainty. Equally useful, I think, is depth

psychology's emphasis on the symbolic—symbols and myths that capture and pay homage to the unknown serve as a reminder that uncertainty has always been part of the human experience. The existence of a wide and ancient array of symbols and stories about this facet of human experience strongly suggests to me that uncertainty and the unknown are not a threat or cause for fear, but a profound fact for humans that, when we are at our best, simultaneously humbles us and compels us to explore.

Appendix A
Ethics Committee Application

ETHICS COMMITTEE APPLICATION FOR APPROVAL FOR THE USE OF HUMAN PARTICIPANTS

Researcher Amanda Norcross Today's Date 10/22/08

Full Address [omitted for publication]

Phone (Day) [omitted for publication] Phone (Eve) [omitted for publication]

Title of Activity The Experience of Uncertainty in Depth Psychotherapists: A Phenomenological Study

Sponsoring Organization N/A Contact Person N/A

Signature of representative of sponsoring organization N/A

Phone number N/A

II. Affix appropriate signatures

I will conduct the study identified in the attached application. If I decide to make any changes in the procedures, or if a participant is injured, or if any problems arise which involve risk or the possibility of risk to the participants or others, including any adverse reaction to the study, I will immediately report such occurrences or contemplated changes to the Ethics Committee.

Investigator Signature _____ Date_____

I have read and approve this protocol, and I believe that the investigator is competent to conduct the activity as described in this application.

Research Coordinator_____ Date_____

III. Notice of Approval

The signature of the representative of the Ethics Committee, when affixed below, indicates that the activity identified above and described in the attached pages has been approved with the conditions and restrictions noted here.

Restrictions and Conditions:_____

_____

Ethics Committee Representative _____ Date_____

ETHICS COMMITTEE APPLICATION (Cont'd)

Brief description: This study will explore the experience of uncertainty and not-knowing for depth psychology-oriented psychotherapists in their work with clients.

1. PARTICIPANTS: Describe the participant population and how it will be obtained. Who will participate and how will you find/select them?

   I will interview 3-4 psychotherapists in my geographical area who have a depth psychology orientation. I will identify potential co-researchers by contacting and networking with therapists I know. In this process of finding co-researchers, I will keep confidential the identity of every therapist I speak to. When I locate a co-researcher, I will explain the study, its procedures, and its confidentiality issues (see Appendix C).

2. PROCEDURES: From the participants point of view, describe how you will involve them in your study. How will you conduct your study?

   After initial phone contact, I will send to the co-researchers who want to participate in the study a packet that includes an informed consent form (see Appendix B) and an information form (see Appendix D). Co-researchers will participate in an audiotaped interview lasting 1-2 hours. The interviews will take place at a mutually agreed upon location and time. After the interviews have been transcribed, I will ask each co-researcher to review the transcribed interview and add to or change the information until the co-researcher feels the information is clear and accurate. If I feel a follow-up interview is necessary, I will schedule a second interview to meet again with the co-researcher. At all times, I will assure the co-researchers about the maintenance of confidentiality.

3. CONSENT: Describe procedures for how and when you will receive informed consent from your participants. Enclose in this application a copy of the informed consent form you will use.

   See Appendix C.

4. RISKS: Describe and assess any potential risks and the likelihood and seriousness of such risks. How might participants be harmed during or after their participation in the study?

   I do not anticipate substantial psychological risk for the co-researchers in recounting their experiences of uncertainty. A potential risk I do see is neglecting to be open to suggestions or ideas from the co-researchers about how they would prefer to structure our work, including anything from interview locations to the questions I ask them to the information in their interview transcription. In other words, I could inadvertently or unconsciously neglect to be open to the direction in which the co-researchers would

like to take the work, which would disrespect the co-researcher's needs as well as the natural direction of the research. A second potential risk is maintaining confidentiality.

5. SAFEGUARDS: Describe procedures for protecting and/or minimizing the potential risks (including breaches in confidentiality) and assess their likely effectiveness. Given the risks, how will you prevent them from occurring?

   To mitigate the first risk of neglecting the co-researcher's requests and desires (and thereby the natural direction of the research), I will strive at all times during the study to adhere to Robert Romanyshyn's admonitions for research in *The Wounded Researcher: Research with Soul in Mind* (2007). Romanyshyn said, "The researcher who would keep soul in mind cannot drag the work into the upper world of his or her ego-projections. He or she has to learn to differentiate his or her projections onto the work from the soul of the work itself, which is not his or her possession. The researcher who would keep soul in mind has to learn to see the work through eyes that have let go of it" (p. 53). I will continually strive to place the research in the hands of psyche and receive and honor all unexpected developments as psyche's efforts to manifest in the work.

   Regarding the second risk of confidentiality, I will be mindful at all times during the study of maintaining confidentiality. My efforts to maintain confidentiality will include the following:

   - As I network with therapists to locate co-researchers, I will not identify other therapists I have spoken with. If I feel I need to use a referring therapist's name in contacting a co-researcher, I will ask the referring therapist for permission to use their name in contacting the other therapist. I will not reveal to any therapist the identify of other therapists who are participating in the study.
   - Regarding the audiotaped interviews, I will strive to exclude identifying information from the interview content. Because I will use a transcription service to transcribe the interviews, I will make sure the transcription service signs a confidentiality form and I will not reveal the identity of the co-researchers to the transcription service. I will also inform the co-researchers about the use of the transcription service (see Appendix B – Informed Consent Form).
   - In the thesis content, I will use a pseudonym when referring to each co-researcher, and I will ensure that the content contains no identifying information about the co-researchers.

   Finally, I will make it clear to the co-researchers that their participation in the study is voluntary and they can withdraw from the study at any time.

6. BENEFITS: Describe the benefits to be gained by the individual participants and/or society as a result of the study you have planned. What good will come of this research?

The co-researchers could benefit from reflecting on their experiences of uncertainty just as a therapy client benefits from reflecting on their material. Focused exploration of the experience, time for reflection, and review of the interview material might lead the co-researchers to greater understanding and insight into their experiences of uncertainty and not-knowing in clinical situations.

At this time, I am not aware of any existing work that focuses solely on this topic in this manner—a phenomenological exploration of the not-knowing experiences of several depth psychotherapists. Therefore, this research will add a richness and texture to the existing literature by providing several personal, in-depth, and conversant views of the challenging and pervasive clinical experience of uncertainty. The resonance of these views could not only mirror and validate therapists' own experiences of uncertainty but possibly transform them as well.

7. POST EXPERIMENT INTERVIEW: Describe the contents of your conversation with people in the study after their participation is completed. How will you inform them of the study's purpose?

   I will mail each co-researcher's transcribed interview to that co-researcher and follow up with a phone contact. I will ask co-researchers to share their experience of the interview process and to add any additional comments following from their review of the transcript. The purpose of the study will be described during initial contact with prospective co-researchers (see Appendix C) and in my opening statement in each interview (see Appendix E).

8. ATTACHMENTS: Include in this application all of the following supplemental information: 1. Informed consent form, 2. Verbatim instructions to the participants regarding their participation, 3. All research instruments to be used in carrying out this study, including a list of questions to be asked, and 4. Other documentation pertaining to the study, which will be shown to participants.

   See Appendices B-E.

Appendix B
Informed Consent Form

Title of the study: The Experience of Uncertainty in Depth Psychotherapists: A Phenomenological Study

1. I agree to allow Amanda Norcross to ask me a series of questions on the topic of my experience with uncertainty and not-knowing in my clinical work.

2. Following the completion of a brief information form, I will participate in a 1 to 2 hour audiotaped interview at a mutually agreed upon location and time. After the interview is transcribed, I will receive a copy and complete a telephone interview for additional comment and reflection. If Amanda Norcross requests it, I will participate in a second face-to-face audiotaped interview that will last 1 to 1½ hours.

3. I understand that Amanda Norcross will use a transcription service to transcribe the interviews and that my confidentiality will be respected at all stages of the transcription process. The transcription service will sign a confidentiality form for content, and the transcription service will not know my name.

4. The purpose of this study is to investigate the nature of psychological experience relating to psychotherapists' uncertainty when working directly with clients. The study findings will be published in the form of a Master's thesis and possibly future publications.

5. I understand that a pseudonym will be provided to insure my confidentiality and that the thesis content will not include any information that reveals my identity.

6. I realize that this study is of a research nature and may offer no direct benefit to me. The interview material will be used to further the understanding of psychotherapists' uncertainty.

7. Information about this study, the time and location of the interviews, and my contribution to the study was discussed with me by Amanda Norcross. I am aware that I may contact her by calling [phone number omitted for publication].

8. Participation in this study is voluntary. I may decide not to enter the study or to refuse to answer any questions. I may also withdraw at any time without adverse consequence to myself. I also acknowledge that the researcher may drop me from the study at any point.

9. I am not receiving any monetary compensation for being a part of this study.

Signed_____ Date _____

Appendix C
Description of Study for Potential Co-Researchers

1. I am searching for depth psychotherapists to interview on the topic of uncertainty and not-knowing in their clinical work with clients. Specifically, I am interested in the times a therapist experiences uncertainty about how to proceed or help when working directly with a client. My research is designed to capture and communicate the essence of this experience, and I view participants as co-researchers who are partners in my exploration. My findings will be published in the form of a Master's thesis and possibly other forms such as professional journals or a book.

2. All interviews will take place in a mutually agreed upon location and at a mutually agreed upon time. The first interview will last 1 to 2 hours. A second, follow-up interview will be scheduled if necessary and will last 1 to 1½ hours.

3. In the interviews, I will ask you questions about your experiences of uncertainty in your clinical work, its associated difficulties, and other relevant experiences. Although I will initiate discussion with these questions, the dialogue will be open and you are free to comment on anything that seems significant to you.

4. The interviews will be audiotaped. The interviews will then be transcribed into a written format by a professional transcription service. Your confidentiality will be respected at all times. The transcription service will sign a confidentiality form for content, and the transcriber will not know your name.

5. If at any time and for any reason you want to take a break from or discontinue an interview or you want to discontinue your participation in the study, you are free to do so.

6. When the interviews have been transcribed, I will send you a copy of the transcript. After reviewing the transcript, I will contact you by phone and ask you to add any comments or clarifications you feel are necessary. Your changes will be included in the final draft of the thesis.

Appendix D
Co-Researcher Information Form

Name_____

Address_____

Phone: Work:_____ Mobile: _____ Home:_____

Degree(s) held and granting institution:_____

_____

_____

License(s) held:_____

_____

_____

Brief description of trainings and certifications you have received related to clinical practice:_____

_____

_____

_____

Number of years of clinical experience:_____

Appendix E
List of Interview Questions for Co-Researchers

1. Try to remember one of the last times you felt uncertainty in working with a client, and tell me about that situation, how you felt and acted, and what you said.

2. What feelings were generated by your experience of uncertainty?

3. What thoughts stood out for you?

4. What bodily changes or states were you aware of at the time?

5. What dimensions, incidents, and people stand out for you as intimately connected with the experience of uncertainty?

6. How did this experience of uncertainty affect you? What personal and professional changes do you associate with the experience?

7. Did you share this experience with your client?

8. Have you shared all that is significant with reference to your experiences of uncertainty?

9. Describe an image, dream, gesture, myth, folktale, literary figure, poem, or musical expression that is evoked for you in the experience of uncertainty.

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