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# SEEKING A BALANCE BETWEEN KNOWING AND NOT KNOWING IN THE CONSULTING ROOM

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***Abstract***: Psychoanalysis has been based upon a theory that suggests that those properly trained become able to know some of what is in the unconscious minds of their patients, which the patients themselves cannot know. But the power differential in this can lead to problems. It is all too easy for the link between theory and interpretation to become circular and self-proving. I therefore maintain that it is sometimes important to stay with not knowing for longer than in some analyses, in order to remain open to meanings that could be more relevant to the individual patient, rather than treating similar patients as if they were more nearly the same. It then becomes important that we also learn to differentiate between those times when not knowing is appropriate from others when it is a firmer sense of knowing that is necessary. I try to indicate something of the balance between knowing and not knowing that I believe to be a skill that all analysts need to develop.

***Key words***: Certainty, Non-certainty, Psychoanalysis.

## INTRODUCTION

From the beginning of psychoanalysis there has been a problem about different kinds of knowing. We know what we have learned in the course of our psychoanalytic training: for instance, learning to read the minds of our patients by drawing upon what we claim to be derivatives from their unconscious. From this data, interpretations are given with regard to what is believed to be in the patient's unconscious mind. But, because of this interpretative work, a power differential is set up in the analyst/patient relationship – the analyst claiming to know what the patient cannot know except when attention is drawn to this through interpretation.

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In my opinion there are some therapists[1] who do not remain sufficiently aware of the fact that much of our assumed understanding of the unconscious of our patients needs to be regarded as tentative, and for a while provisional. We can easily become too sure in what we believe we know about our patients. Our knowing, or what we think we know, can then begin to take over our thinking as a dogmatic certainty, which we can always support from whatever we draw upon to guide us in our clinical work.

### *Some dynamics of certainty in relation to psychoanalysis and psychotherapy*

When we are training it is natural that we aim to acquire reliable knowledge and skills, in order that we may feel competent and able to meet the expectations of those who pay for our expertise. We also have expectations of ourselves – that we should not seem to be lacking in these respects. In most other professions, not knowing is often seen as ignorance or as a sign of incompetence, so we aim to know what we are doing and why. It is also natural that, as we become more experienced, we become more sure of how we see things. Then, when others disagree or see things differently, we can think of them as being less knowledgeable, or less skilled than we want to believe that we are. Or we see them as being wrong. As a consequence, anything that might be amiss in how *we* see things can be disowned onto others, projection coming back into the service of our defenses just as it had before we had analysis. Even though we may have completed our training, we can still slip back into denial and projection without realizing this – as if our training had protected us from being in error. And I have noticed this tendency in senior analysts too, especially training analysts, as they more readily assume – when there is a difference of opinion – that it is the other person who is in error rather than themselves (see also Casement, 2005).

Freud's theory of the unconscious, when applied dogmatically, lends itself for circularity in thinking. When a patient rejects our formulations about the working of their minds we can fall back upon the notion of resistance. This way of seeing a patient's rejection of our interpretations does of course sometimes apply, but not necessarily as often as we might wish to think. Then, within this circular thinking, our interpreting to patients can become self-proving, thinking that we see in the clinical material what our theory predisposes us to expect. Let us therefore remember that any preconception is likely to get in the way of more careful listening and

1. I shall be using 'analyst' and 'therapist', and equally 'analysis' and 'therapy', as equivalents here, not wishing to make any special distinction for the purpose of this paper.

re-thinking, both of which are essential in any fruitful analysis. For, without this careful self-monitoring, analysis can become a kind of brain washing, shaping a patient's mind to fit in with the analyst's views – based upon theory.

Analysts and therapists naturally look to each other for support alongside the isolated work they engage with in their separate consulting rooms. Here too it can happen that the theoretical framework, with which an analytic group is most aligned, will influence how the group members listen to clinical material and how they interpret – feeling supported in this by a consensus within the group's theoretical alignment. This shared view amongst analysts can also add to a sense of certainty, each seeing their patients with increasing confidence in terms of a theory that so often seems to be illustrated in how they and their colleagues are reading their patients.

## CERTAINTY AND NON-CERTAINTY

I learned something very valuable about certainty from a patient whom I quote in my book *Learning from Our Mistakes* (Casement, 2002). She once said to me: «It is very interesting to find that, in Sanskrit, the word for *certainty* is the same as the word for *imprisonment*. And the word for *non-certainty* is the same as the word for *freedom*» (Casement, 2002, p. 16).

This throws important light upon a problem that runs through much of psychoanalysis and psychotherapy. Certainties in clinical work, sometimes expressed in a dogmatic style of interpreting, often indicate the extent to which a practitioner's mind has become imprisoned by the dogma that has been accepted in the course of training, or in subsequent study. The patient's mind may similarly come to be imprisoned by the certainties of the analyst.

I return to this in my most recent book, *Learning from Life* (Casement, 2006), in which I clarify how I think of "non-certainty".

> I see this as very different from *uncertainty*. Non-certainty is not about indecision, nor is it about ignorance. Rather, we can make a positive choice to remain, for the time being, *non*-certain. This can help to keep us open to meaning that we have not yet arrived at (Casement, 2006, p. 195).

Our own sureness will often get in the way of fresh understanding, as we may already be convinced of the understanding we think we already have. We can then come to be caught in the net of our preconceptions, and the minds of our patients

can similarly come to be entangled by our interpretations. What can we do about this so that we may be better able to preserve a mind-set of non-certainty? I have come to believe that much depends upon the nature of supervision. The way we approach our clinical work, whether we become able to preserve an open mind or whether we develop a mind that tends to be closed, will often reflect the kind of supervision we have had or may still be having.

The nature of supervision often reflects the way in which a supervisor views the process of therapy and analysis. In one kind of supervision we may find that the supervisor is also shaping a view of the patient, to fit in with theory, so that a patient's communications are frequently interpreted in terms of preconception. Some supervisors may also be influencing the supervisee's work to fit in with their own ways of working. It thus happens that a lot of interpretative work comes to be led by theory. This is how the analytic process becomes circular and self-proving, and it is this circularity that feeds into the confidence of dogmatic certainty with which some practitioners seem to work.

In my own clinical work I try to protect the analytic process from whatever might influence or distort it. I am therefore careful not to bring a patient's mind into line with any theory or preconception. Instead, I see the process as a dynamic that unfolds between the patient and me, having a life and direction of its own that develops within the analytic space, but only when this is kept free from interference. So, one of the principal tasks of supervision – as I see it – is to help the supervisee to preserve the analytic space, and the analytic process, from anything that might impinge upon it or adversely affect it.

## INTERNAL SUPERVISION

To help me to remain true to this aim of preserving the analytic space from interference I rely on a process I call *internal supervision.* In parallel with that, when I am supervising, I try to help those I supervise to develop their own process of internal supervision. I therefore practice with clinical moments, selected from what is presented to me, in order to help supervisees to widen their awareness of the different options we can find in relation to such moments. The aim then is to be able to choose between these different options and to have reasons for the choices we make, rather than interpreting simply because we think we can see something to interpret.

We sometimes hear of interpretations that seem to have been made almost directly from theory – linking this to what the patient has been saying. I regard that

kind of interpreting as two-dimensional. It is like drawing a line between two points just because that is one way of seeing these as connected. Some interpretations can be like that, as if we were saying to ourselves: "I can see something triangular here so I could interpret this in terms of something Oedipal." But it may go no further than naming a connection we think we can see.

Instead, I prefer to wait until I find more than a single example of what I might eventually interpret: for instance, noticing that there has been a recurring theme in the clinical material. It is this repetition, which has a shape of its own, that I try to understand. This is quite different from giving interpretations that impose a shape upon what is heard, fitting this in with what may be anticipated by theory.

### *The analytic space*

Psychoanalysis and psychoanalytic therapy can truly be a way of understanding a patient's mind and ways of being. I therefore believe it is of utmost importance that we allow the patient to be the one who brings into the analytic space what needs to be attended to. This is not just a matter of letting the patient start each session. It is from moment to moment that I am trying to monitor any clinical sequence, asking myself: "Who is putting what into the analytic space?" This question helps me to recognize more readily those times when it is the therapist who is putting something into a session that does not truly follow from what has been brought by the patient.

Unfortunately, we can all become skilled in applying theory and in seeing this as apparently fitting what we are hearing from our patients. We therefore become used to thinking that we are interpreting the patient's unconscious when we may sometimes be putting our own ideas onto what a patient is bringing to us, not necessarily revealing what is already in the patient's mind.

When therapists become too sure about their understanding of patients, or about how they think the clinical process should go, their sureness will inevitably contaminate the analytic space. It, therefore, distorts what follows because the patient has to deal with whatever has been introduced by the therapist. The rest of the session may be hijacked by this.

### *Trial identification with the patient*

In supervision, as in my own clinical work, I try to foster a dialogue of internal supervision. It is within this dialogue that we can listen for more than a single way of understanding what we are hearing from a patient, listening between different ways of understanding until one begins to seem most appropriate to the particular moment.

An important part of this inner dialogue is that of *trial identification*. By this I do not mean simply putting ourselves in the shoes of the patient. If we do that too literally it can become more misleading than helpful, as we are not the patient and our own history and sensitivities will be different. Instead, I try to imagine being inside the skin of a patient – with his/her history and sensitivities – to consider from that quite different point of view what the patient might have felt or might feel.

Also, when I speak of trial identification with the patient, I am not only referring to the patient's life outside the consulting room. I find it especially useful to trial identify with the patient *in the session*, to consider how the patient might feel about what I have just been saying. This can help me to recognize those times when a patient could be hearing me, or could be experiencing me, in quite different ways than I had intended or had imagined.

It can also help me to look for different ways of putting what I have in mind to say, so that I do not disturb the analytic process because of how the patient could be led – or misled – by what I am about to say.

### *An example*

In supervision I heard of a patient who had a history of secret relationships. There was something between her and her father that she could not, or did not, tell her mother. There had also been a secret relationship during her marriage, about which she was still sometimes preoccupied, but she had never told her husband about this because she was afraid of how he might react.

In the therapy there was a similar sense of secrecy, or things not told, as the patient would start most sessions with long silences. She would also curl up towards the end of sessions, again not speaking. But, in a recent session, she said she was afraid that she might be boring her therapist.

In this supervision we wondered what could be concealed behind the patient's apparently "boring" selection of things she chose to speak about in her sessions. For instance, it is possible that (in the privacy of her mind) she could be having a secret relationship with her therapist, as with her secret lover. But there could be major problems in saying any of that to her as we don't *know* what is in her mind even though we can guess at it. So, if we were to interpret on the basis of this speculation, the one thing we could then know for sure is that the patient would be hearing something of what has been in her *therapist's* mind. If he imagines she is having sexual phantasies about him it could suggest that this might be an expression of his *own* thoughts. So, who might be having sexual thoughts about whom?

From this supervisory dialogue we concluded that the closest the therapist could

safely get to any of this might be in drawing the patient's attention to the fact that her silences might not be, as she had earlier suggested, because of having no thoughts. It could be that she is choosing to keep some of her thoughts hidden from her therapist, perhaps being anxious about how he might "react" to these if she did not keep them hidden. I would not immediately link this with either the father (the secret lover) or the husband. It would be better for any connection to these to emerge from the patient's expression of her own thoughts rather than from the therapist anticipating these. Here I am, again, monitoring for "who is putting what into the analytic space."

## SEEKING A BALANCE

One particular skill needed in psychoanalytic practice is that of discernment: becoming able to distinguish between those occasions when it is important to remain tentative with patients and other times when it is important to be sure and firm. As I have been saying, it is when we are trying to understand the unconscious mind of a patient that we most often need to regard the sense of our understanding as provisional, continuing to be exploratory rather than becoming too sure. We can only form an opinion; and, even if this understanding may eventually prove to have been correct, we cannot usually – at the time – be certain that it is. By contrast, there are other times when patients need us to be a lot more sure than tentative.

Several situations in particular come to mind when firmness can be all important. I will outline just a few.

### *With some borderline patients*

Some borderline patients react so immediately to what they are experiencing that we need to have confidence in our reading of those situations that are especially distressing to them. For instance, one such patient was repeatedly getting into a paranoid state at work–often assuming that people were talking about her. And sometimes they probably were. I therefore felt it necessary to grasp, as firmly as I could, the dynamic that she was engendering around her. A strange image then came to my mind which, upon reflection, I chose to share with her. I said: "I have an idea of what is happening. I believe that you are shouting at bus queues". She immediately looked very puzzled, which was not surprising, but she also seemed curious.

I continued: "I need to explain what I mean. If I walk past a queue of people waiting for a bus, and if I assume they are talking about me, I am likely to feel upset

by that. And I might shout at them that they should stop talking about me. Then, if I return a few minutes later, I may well find that some of the people in the queue really are now talking about me. The point of this is to try and help you to see that you can bring about the very thing that you are upset about. I think that you are so sure that people are talking about you at work that sometimes you find that they are. But they may not have been talking about you at all if you had not assumed that they were. "

The patient thought about this and agreed that perhaps she does do this. Subsequently, she would catch herself doing this but she would then check herself from letting it escalate into a major problem. This helped her to see the people around her in a different way and her work relationships improved greatly. Interestingly, some years after she had stopped coming to me, this patient telephoned me to say that she had begun to "shout at bus queues" again. The strange image that I had used, feeling that it applied to her in her relationships, had stayed with her ever since. She then said she just needed to hear my voice to help her to stop getting into this again.

### *A patient's need for confrontation*

It is through confrontation, engaged with by a surviving parent, that children can eventually become adults. However, as Winnicott (1971) points out, there are serious dangers here. When parents capitulate to a demanding child, in the child's mind they become collapsed parents. Consequently, the child may become "adult" *by a false process*. Instead of becoming truly adult they may instead become tyrants, dominating the world around them, as they had with the parents. But they inwardly experience themselves as seeming to be too much for anyone, no-one seeming able to challenge them. This is always a hollow triumph. Inwardly it is a disaster. (Winnicott, 1971, chapter 11).

Similarly, in analysis there will be times when confrontation is looked for by patients, and it is also important that the therapist can engage with this and survive–without collapse or retaliation. For example, there are times when a therapist has to stand up to a patient's manipulation of the boundaries, perhaps ringing up or emailing between sessions as an extension of the analytic hour. So long as a therapist goes along with this there is no challenge to a patient's assumption that he/she could not manage without these additional contacts. It is only when the boundaries are re-established that patients can find a safe enough containment within which they can then bring their frustration and rage, or whatever else, and an opportunity can be found for discovering that the assumed "monster" in them,

which no-one else seemed able to manage, can after all be managed by the analyst. Much depends upon this and much growth can follow from it.

### *When the analysis or therapy is in danger of breaking down*

There are occasions when we sense that a patient might be about to leave therapy. At such times the therapy is often in a state of crisis and this needs to be attended to as firmly as may seem necessary. It is not a time for being unsure.

When someone has fallen into deep water and seems unable to swim, we do not wonder about what degree of crisis there might be. We act promptly on the possibility that the person could drown. We do not wait to see if they do. Likewise in therapy we need to take very seriously those times when a patient may be communicating distress about the state of the therapy, that it seems not be working for them. They could be prompting us to see that something in the therapy may need to be handled differently, if it is not to fail them, and their threat of leaving is often a way of trying to get this across to the therapist.

For example, in my book *Learning from Life* (Casement, 2006, chapter 8), I give an example of a case brought to a clinical seminar. The patient had already been in a therapy that had failed and was showing many signs that she was afraid that the present therapy might also be failing her. In particular the therapist seemed to be unaware of the trauma it had been for the patient when he had not been there for her at the time of her session, his absence being experienced by her as a re-play of the abandonments of her early childhood – something that the therapist had not been picking up.

The patient had then dreamed of going to Anna Freud when she had stopped her therapy with this therapist and she had woken up feeling very anxious. I felt that there was an important opportunity here for the therapist to have picked up the degree of this patient's anxiety, even that this therapy too might be failing her so that she was dreaming of going to see an analyst who might understand her child experiences better than this therapist seemed to. I felt that he needed to have said something like: "I think you are anxious that I might not understand how disturbed you have been by what has happened recently with me, so anxious that you seem to be wondering about whether this therapy too might be failing you. And you dream of going to see someone else when you have finished seeing me."

I believe that the patient needed her therapist to be recognizing the degree of her alarm, and that she might really stop seeing him. Instead he stayed with the dream text, staying with the impossibility of going to Anna Freud because she is dead. Putting it that way was not, in my opinion, acknowledging that the patient could in reality leave him and go to someone else–perhaps an analyst who might

understand her better. But, to feel better held at this moment, the patient would need to have a sense that her therapist could be addressing his own part in the crisis and the degree of upset that this had been causing her.

### *When a patient may be suicidal*

Similarly, there are times when we may get an impression that a patient is feeling suicidal. I do not think that is a time for asking questions such as: "Are you feeling suicidal?" A patient is quite likely to say "No" in response to such a question, offering the therapist the reassurance he may be looking for – that the patient may not actually be feeling suicidal. Also, a patient might not feel inclined to share such an inner truth with a therapist who seems not to know (unless he is told) that the patient is feeling that desperate.

Instead, I prefer to be more direct. I might say, for instance: "I am sensing something suicidal in how you are at the moment," or something like that. I am trying to give the patient a chance to be more open about this possibility on the basis that I am already aware of it. Often this has led patients to become more open about how they are feeling, now that there is someone who is prepared to be in touch with this. They are then not so alone with it which can make an important difference.

I have always made a point of being alert to the possibility of suicide, and sometimes patients have expressed their relief that someone was at least in touch with how close to giving up they had been feeling. I have never felt that I might be putting a suicidal idea into the mind of a patient. If I am wrong a patient can tell me. But more often I have actually picked up something that could have remained much more dangerous, if not acknowledged, than in having it brought into the open.

### *When there are boundary issues*

I have noticed in supervision, as in my own practice, how easy it is for clinical boundaries to become blurred, and for this blurring to spread into other aspects of the analytic work.

This is one of the few occasions when I am inclined to say "always" rather than "sometimes." I think that the analytic boundaries are always important and, when a boundary is relaxed, there will always be repercussions that can be observed in the clinical work–if we are prepared to recognize this. Unfortunately, practitioners can become blind to the repercussions that emanate from a boundary having been altered, or allowed to be unclear, often because they want to believe that it is in the interests of the therapy that they have allowed things to become more relaxed.

For example, when we give extra time because a patient is distressed at the end of a session, it quite often happens that the same patient will again get extra time by being distressed near the end of other sessions. The therapist, having extended a session before may give more time again–and so on. This can become a pattern in an analysis, some sessions being extended. Or there may be an extra session offered, or an extended telephone call, letters, e-mails, or text messages on a mobile, etc. (With present-day technology there are multiple ways of communicating with a therapist outside of a session.) But I don't think that patients are necessarily better contained by such means. Instead, it may seem to a patient that we are confirming their sense of being uncontainable; seeming to be too much for the therapist to be able to manage within the normal boundaries of clinical availability.

Why is this so important? In my own work, and in supervision, I have often noticed that one result from analytic boundaries being extended is that patients often read into this, and maybe correctly, that the therapist is protecting himself from their upset or rage – if they were to be deprived of whatever boundary extension has begun to be allowed.

Let us take, for example, the ending of a session. I have very rarely let a session run over time and I have sometimes regretted it when I have. Instead, I end firmly on time – however upset a patient might be – saying something like: "I know that this is a difficult time to end but we have more time tomorrow" (or next week or whatever), or some other similar statement. I don't recall a time when I came to regret having held the boundary this firmly. A patient might rage at me later for "not having cared enough" to have allowed more time, or whatever, but I am there for the patient's anger for "someone" who is being experienced as not caring enough.[2] Also, I have not deflected this anger by being nice or by giving extra time, for instance. Paradoxically, as parents know, it often requires a much greater caring for the other person when we continue to be there for strong feelings, like the rages in a tantrum, rather than capitulating to these in order to be protected from that rage, etc.

I think this is an area of clinical practice where we need to be much more knowing than tentative. We need to know that a boundary has been extended, or is being allowed to remain extended, and we need to know that this can have continuing implications. We also need to know that it is often counterproductive for the on-

2. I quite often speak of "someone" as a way of not getting into a premature focus, whether on me or on some other person This can potentiate the listening between a patient and myself, as the issue being explored (here "not having cared enough") can be discovered as having been an important experience in the patient's life – now being found also in relation to the therapist.

going work of analysis when we are seen by the patient as offering to be a "better parent" rather than remaining a therapist: and we will always fail in our attempts at re-parenting. We can never make up for what has been missing, and we will never approximate to being a replacement parent – unless we offer to foster a patient in our own homes, which is often why some patients increasingly push for exceptions, perhaps attempting to force us to live up to what we seem to have been offering. Instead, what we *can* offer is to be "there" for our patients while they are bringing into their relationship with us their own most difficult feelings, which others have often failed to engage with.

### *Trying to reassure*

I think it is also important that we know, again with a degree of certainty, that reassurance in the consulting room may never really work. Patients are quick to recognize, when a therapist is wishing to believe that things will turn out all right, that the therapist could be taking a distance from how the patient is actually feeling.

I had a very useful reminder of this with a patient who had been hospitalized during an earlier summer break. When we were approaching another long break I told her that I felt she was more able to cope this time away from therapy than she had been before, and I felt that I had reason to believe this to be true. However, when this patient came to her next and final session before that break, she told me she had felt fine during the week but had noticed that *on the way to the session* she had suddenly felt as if she was "beginning to go to pieces." I saw this as her bringing back to me her fragile state, for me to take better notice of this than I had when I had been trying to reassure her.

I acknowledged that I had let her down in the previous session when I said I believed she would manage this break from therapy better than before. She immediately agreed, saying that when I had tried to reassure her it had felt I didn't want to know how close to falling apart she was actually feeling. She then added: "It might spoil your holiday if you really knew that."

This patient had read me quite accurately, and many patients also read us in this perceptive way. This is why reassurance so rarely works, except superficially, and why I believe we need to know this. When we are prepared to notice the signs, in how our patients respond to our attempts at giving reassurance, we can often see that they have read us as being defensive – as taking a distance from how they really are. They may also see us, just as my patient did, as not wanting to be disturbed by how they are actually feeling.

### *The notion of providing patients with "better" experience*

It is tempting to believe that we may be able to provide patients with better experience than they have had previously; some therapists believe that this is how therapy becomes curative. Patients of course can benefit greatly from having some of the positive experiences they have been deprived of before, but there can also be problems with this approach to therapy.

I believe we should firmly know that when we present ourselves as a "good object" in an analysis or therapy, we are always in danger of fending off the negative experiences that some patients most need to work through in relationship to ourselves. It is not enough for us to remain a good person with whom a patient can discuss their bad experiences with others. It is only when a patient feels free to bring those bad experiences into the analytic relationship that more radical change can come about.

Many of the people who come to us for therapy have developed a sense of some "monster" in their minds, a self image formed through their experience of others who have not been able to bear what these patients feel to be the worst in themselves. Consequently they have a specific need to bring that "worst" in themselves into the analytic relationship, to work this through with the therapist.

However good a patient's experience of the therapist may seem to be, we need to know that there is a real danger that whatever most needs to be worked through with us may still be seen as apparently too much for us too – if this is not being directly experienced within the analytic relationship.

## CONCLUSION

I have been stressing the need for therapists to develop a clearer sense of those times when the analytic process can be distorted by too much sureness in how we interpret to our patients. Equally, we must recognize those other times when a patient needs us to be firm and sure. Finding a balance between those times for knowing, and those other times for remaining not (yet) knowing, is a "skill of discernment" that is essential for our clinical practice.

## REFERENCES

Casement, P. J. (2002). *Learning from our mistakes: Beyond dogma in psychoanalysis and psychotherapy.* London: Routledge.

Casement, P. J. (2005). The emperor's clothes: Some serious problems in psychoanalytic training. *International Journal of Psycho-Analysis, 86,* 1143-1160.

Casement, P. J. (2006). *Learning from life: Becoming a psychoanalyst.* London: Routledge.

Winnicott, D. W. (1971). *Playing and reality.* London: Tavistock.