THE PATH OF A THERAPIST: FROM EARLY NOT KNOWING TO MATURE NOT KNOWING

from The Psychotherapy Institute Journal, Vol III, 1986
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In this paper I will describe a developmental choice point for therapists working in an intensive, "depth"-oriented frame. I shall use my own growth as a therapist as a point of departure, assuming--I hope correctly--that my experience will address similar issues for other therapists.

On Early Not Knowing

It has been thirty-eight years since I saw the first person I was supposed to help as a graduate student-diagnostician/therapist. During my work toward a Master's degree in psychology, I was asked to work with an eight-year-old girl in the Berkeley Unified School District. As I packed a little suitcase with play materials and assembled test kits, my head pounded with repetitive thoughts. How am I going to approach her? What am I going to say to her? What if she won't come with me into the assigned room? What if she comes with me but just sits and won't talk? What if she bolts from the room? Another cluster of questions ran: Why do I want to be a psychologist anyway? How can I be of use to another when I don't know anything and I'm worried only about myself and how I'm going to do?

The night before the first session with young Betty, I slept fitfully and had dreams that reflected chaotic feelings and fears that I would be unable to function. Lying awake and trying to quiet my anxiety, I created obsessive scenarios of all the things that could happen and what I might do as I traversed that utterly unknown terrain. Some of the solutions--such as standing in front of the door and blocking Betty's exit if she tried to run away--produced new worries. Would that be okay to do or would it be considered too controlling? Would an act that saved me from the humiliation of running after her through school corridors be bad for <u>her</u>? It dawned on me that I was looking to protect myself, and perhaps the very fantasies of what Betty might do reflected my own wish to run away from an experience that seemed vague and undefined, that made me feel uncomfortable and stupid. Clearly my dreams and thoughts were attempts to deal with unacceptable feelings. The anxiety I felt about entering that room to be with this child overwhelmed me.

What I remember most about that first session was that I was relieved when it was over and that much of my effort went into quieting my inner anxiety and the flooding recognition of how little I knew. Since Betty too seemed scared, though willing to be in the room with me, I decided that I would just <u>play</u> with her. Toward the middle of the session, it came to me that I had played and talked with children in other contexts and that they had liked me because I listened attentively and played engagingly with them. But was my way of being with friends' and relatives' children appropriate for me as the therapist for <u>this</u> child? How much initiative could I take during the play? How much physical contact was all right? I had some Lifesavers in my pocket. Was it okay to offer her some, or would that be considered bribery? What was the policy of school authorities and of parents about offering sweets to a child I was seeing? The fact that I ended the session with such thoughts and questions actually made me feel less anxious, for those were concrete questions I could talk about to my

teacher/supervisor. I became aware of how soothing it can be to think about something, in contrast to feeling the uncomfortable emotions which can make one feel out of control. This paper will be about our propensity to think, and will try to show how very useful and necessary but also how ensnaring and counterproductive that can be.

On The Need for--and the Pitfalls of--Knowing

Beginning therapists find themselves in the difficult situation in which (1) they do not know much and yet have to function, (2) they report their work to a more experienced person, and (3) they learn from that person through identification, idealization, and eventual differentiation.

When I was a beginner, I needed practical case management help and a conceptual lens through which I could look at what was happening. In those years, for me, the lens was orthodox psychoanalytic as well as neo-Freudian theory. My early learning stages--some of them unique to me, some common to most beginning therapists--were the following: (1) in a new situation in which I did not know how to organize what I saw, heard, and experienced, I found it easier to describe my own reactions than those of the other; (2) I paid attention to what was happening while walking to the therapy room, what went on immediately after sitting down, who started the hour and how, the manner in which the patient talked, and how I responded, when silences occurred and what I thought of doing about them, who ended the hour, what I could do to end the hour, and so on; (3) I learned to perceive the patient's discernible patterns from his different substantive narratives and to see his patterned behavior in therapy as similar to events in his life: (4) I learned to find meaning in the observed repetitive patterns through a conceptual scheme and to see what was once useful and could remain so and what was not, as well as what was inappropriate to current interactions in and out of the therapy context. That of course also included the productive and counterproductive patterns of the therapist. I began to see how early survival patterns were excessively relied on.

But I also learned that just as patients needed to undo old ways of managing their inner and outer lives, so I as a therapist had to re-experience old conflicts, patterns, and deficits in my way of working and to give up the stereotyped ways of reacting and thinking about them. For me, that has meant re-experiencing anxiety, confusion, and repeated not knowing. It has meant giving up old and comfortable ways of being and thinking, and letting new ways emerge.

In summary, when we start out as therapists and for years beyond, we accumulate a lot of knowledge about how to conduct therapy, how to be as therapists, how to understand and react to our patients while paying attention to our own reactions and feelings. It is easy to get stuck in that knowledge, to become doctrinaire, and to limit our focus and vision about the complexity of the therapeutic endeavor. Knowledge and the thinking mode, like all other ways of knowing and experiencing, can hamper us by becoming a defense against other modes more difficult to describe.

I am concerned that theories about the clinical process may lead to an intensification of the therapist's intellectual defenses as well as to an insistence that certain notions of what happens in the patient are more "true" than others. The problem with most of the metapsychologies and theories about clinical processes is that they emulate the theory building of the natural sciences, taking on their rules of objectivity, measura-

bility, replicability, and cause and effect paradigms, reflecting an excessive admiration for the nineteenth century logical positivists and their requirements of a respectable theory.

Contemporary social science models relying on hermeneutics seem much more relevant for the description of processes that are subjective, taking place within and between persons. The theoreticians who apply the more circular hermeneutic style of the social sciences--the perspectivist, interpersonal theories of Edgar Levenson (1983), a neo-Sullivanian, and the intersubjective context theory of Atwood and Stolorow (1984)--emphasize the complexity of the mutually influencing process and the multiplicity of meaning of its content and structure. Notions of absolute truth are irrelevant to their conceptualizations. The interpersonal situation--the dyad--develops its own coherence and meaning.

The many ground rules elaborated for the exploration of the patient's transferences and resistances and the accurate interpretations that confront them with truths about themselves may lead to stereotyped responses by the therapist. The unique heuristic nature of therapy cannot come into full play if too many aspects are experienced and dealt with in predetermined, rule-bound ways. The truly novel combination of the therapist and patient and the complexity of their intersubjective context get lost or are minimized. I refer you to Peterfreund (1983), who in the first two chapters of The Process of Psychoanalytic Therapy gives many excellent examples of stereotyped approaches from both his own cases and those of famous psychoanalysts. What such approaches provide is certainty about symptoms and meaning. What they overlook is the uniqueness of the patient and the manifold meanings of his or her interactions, dreams, and transferences as well as those of the therapist who brings along yet another set of meanings. In contrast, this complexity is fully acknowledged by the interpersonal, perspectivistic, and intersubjectivistic viewpoint and theories I have mentioned.

The point I wish to make is that adherence to rigid theories and their rules about the conduct of therapy can get one stuck so that one too readily labels and therefore limits the meaning of one's own and one's patient's inner experiences. One is then in danger of overusing intellectualization and, focusing excessively on interpretations that may one-sidedly blame the patient's resistances and defenses. As the therapist grows by looking critically at herself and all that she has learned formally and informally, all that she has assimilated and accommodated, she goes through periods of feeling confident and good about her work. These are followed by times of feeling uncertainty and incompetence, periods during which she subjects herself to self-examination and reappraisal of how her knowledge helps or hinders; it is then that she can slowly let go of some stereotyped ways with her patients. The discouragement and confusion that combine to stop her and bring her up short are the very states she needs to jolt herself out of complacency. These alternating states are akin to what our patients tell us they go through. This teetering back and forth between certainty and doubt tells us something vital, if only we do not try to close it off or to blame it on resistant, difficult patients, or on our own inadequacies of insight.

At those uncomfortable and disconcerting places in therapy, we often make an interpretation about resistance or transference in order to dispel our discomfort rather than to benefit the patient. We soothe ourselves with theories. Yet the therapeutic endeavor asks the patient to tolerate pain,

confusion, not having closure, not to act out but to feel and experience within. While therapists try empathically to understand patients' feelings, they must also accept those states in themselves, because such states can lead to surprises and new knowledge.

On Mature Not Knowing

I am now aware that what is so helpful in the early stages of becoming a therapist needs to become a backdrop against which a different development can take place--a new and different not knowing slowly begins to inform the work. As a therapist reaches a level of competence that is comfortable, she can let herself experience more consciously the many uncertain and confused periods that are part of the therapeutic situation. In what I would call a middle phase, an ongoing struggle is experienced between powerful needs to understand and to know on the one hand and feelings of uncertainty, confusion and unease on the other. Gradually the more secure therapist can let herself experience, rather than fight, these uncomfortable states. In fact, even if she cannot actually welcome them, she learns at least to hold still for them. Then a new phase begins in which immersion in the therapeutic process becomes possible. The therapeutic container holds both patient and therapist as they experience together the often turbid journey of two intermingling psyches.

As therapists, because of our education and training, we tend to use rational ways to deal with whatever comes up in therapy. The paradox of dealing in that way with the irrational can and often does lead to an overemphasis on understanding, interpretation, historical reconstruction, in short, on finding explanations that make sense. But many of us have experienced early pre-reflective, pre-verbal states in our own intensive therapies or analyses. In some cases we know about feeling and somatic states that are indicative of early infancy, and are part of the developing infant experience. Sometimes if the mothering persons have not been able to provide good-enough mothering, the genuine neglect and disregard of the baby's physical and emotional needs start a process that in part accounts for the many problems in living we see in our consulting rooms. In other instances, they are the ordinary lapses, the necessary frustrations that lead to further development. These pre-verbal states--so difficult to put into words--can make patient and therapist feel uncomfortably frightened. Where will their partial re-experience and concomitant exploration lead? Patients worry that they are going to be engulfed and that their adult coping mechanisms will not hold up in the face of such primitive, somatically felt experiences. Therapists often unconsciously cut off the emergence of these early states by reacting to them cognitively. If experiencing and integrating periods of discomfort and deintegration are essential for human development from infancy through adulthood, then therapists need to find out how to avoid aborting such experiences.

Case Material

A case may provide an illustration. A woman in her forties had been in therapy with me for about three years. She had come because she was having problems with one of her children and because she wanted to figure out what to do with her life now that her children were all past junior high school. In time, her difficulties in parenting improved enormously. She resumed her interest in music, became a member of a small local performing group,

and began attending a local conservatory to develop performing and teaching skills. Clearly, the symptoms she came with were largely resolved. Yet she wanted to continue therapy. Months went by. We met twice a week, much of the time spent reviewing the work we had already done. Little new material emerged. Since she became frightened by long silences, I tried to facilitate by asking her to explore her feelings about the fear. She had little to say. I became more puzzled as her inability to uncover any substantive material continued. We talked about how our process might be contributing to the stalemate. I sensed that trust was an issue because of an intrusive, controlling mother who could not and would not validate her daughter's separate needs. The patient protested that I was not like her mother. She loved coming to therapy with me.

After several months of trying to make sense of our predicament, I saw that I was struggling too hard, that my mind was always active, and that I was going after a specific problem. Therapy, I seemed to be saying, has to be about something. What if I acknowledged openly that I didn't know? What if I proposed to myself that I sit with the anxiety and fear, that I not scramble to find meaning, that I suspend my thinking and just try to be present? It didn't come easily. The patient often panicked and insisted that I do something. She begged me to tell her why she felt so frightened while not being able to ascribe any content to the fear. I reflected how frightened she was. I began to focus on her physical sensations, while she in turn let me know how difficult it was for her to connect with them. I discussed with her what it was like to be with me when she experienced me as confused and unhelpful.

Gradually over several months, during which there was little talk, she began to describe sensations in her arms and her right side, sensations of prickling and itching. She wanted to scratch herself but was unable to. To questions about what prevented her from scratching, two themes emerged: (1) in her family she had been taught never to exhibit to other people anything connected with her body that would be considered out of control; severe scratching, for example, would be a crude sign of preoccupation with bodily needs; (2) her mother, under the guise of attending to her well-being, had attempted to control everything about her bodily functions.

Ever so gradually, the patient elaborated two seminal images that embodied those themes. The first was of having her hands tied to the crib to prevent scratching, the second was of being given enemas as a prophylactic whenever a cold or minor physical ailment started. These memories of physical restriction on the one hand and of invasion with attendant feelings of loss of control on the other flooded her with terror, anger, and helpless rage. There were moments when I wondered if it was necessary for her to go through these violent eruptions of feeling. There was little for me to do but contain them and to reflect her upset empathically, and furthermore--perhaps most important--I could choose, by <u>not</u> invading her with probing questions, to <u>not</u> repeat her experience with her mother.

I would nevertheless inadvertently make small mistakes in ways that were not immediately visible to me. She was able to react with disappointment and anger. Her need to keep me protected and idealized lessened. As she claimed those feelings of dissatisfaction with me, she took an enormous leap in creativity. She began to compose and write songs and to develop a flexibility and freedom in music that was rewarding. We understood that the severe physical restrictions and unnecessary intrusions into her body had cramped her creativity. Becoming comfortable with my own doubting and

not knowing, my not intruding and restricting her with questions, made it possible for her (1) to experience a helpless, contentless, restricting terror and fragmentation; (2) to get fully into the earlier experiences; and (3) gradually to understand these and to reclaim greater mobility. (Occasionally during our work together, she would take a cup of tea into the room and nearly always spilled a bit walking up the stairs. That clumsiness stopped--a metaphor for her new-found gracefulness.)

This patient had not been satisfied with symptom improvement alone. She had wanted to explore other realms of her psyche. She wanted to go forward at just the time many improved but mildly dissatisfied patients stop therapy. This is the point at which the therapist must willingly embrace states of puzzlement and not knowing in order to further the work of intensive therapy. Therapist and patient have to embark on an uncertain voyage, leaving behind compass and rudder, not knowing exactly where they are heading as they move into stormy and dangerous waters. It is difficult to contemplate doing that. Who would be brave enough to face the unpredictable elements in our psyches?

As a result of such experiences, I am advocating a flexible approach to theory and an acknowledgement of the uniqueness of every therapeutic relationship. Aware that we cannot know and codify everything about a relationship, we have to live with much uncertainty in our lives, as in therapy. We can get a large number of our patients to agree with our views if we insist, if we bully them into accepting our formulations about them. That can make us feel we know, but is usually at their expense.

On the Limitations of Knowing

There is another aspect of mature not knowing that does not go away so easily. It is existential and concerns the limits of our capacity to know, to understand and to change what we do not like in our lives. We may be able to change our internal landscape and still not get what we want in the outer world. To sit with a person who is changing in many ways, whose inner child is growing and maturing, yet who, for example, yearns to get pregnant and become the parent of a real baby, is painful and difficult. It is important to be with the infertile woman and not be optimistic or think that greater psychological probing and understanding will help solve the problem. Psychologically developed women who yearn for a life partner are another group whose helplessness must be endured as they grow and expand while yet remaining lonely and unfulfilled. The therapist has to be able to contain these patients' despair and helplessness and eventually stop putting forth psychological formulations. The reality of the ultimate frustration of the so-desired goal has to be endured, and when possible, a discussion of what it means ought not be avoided. At such times, one is tempted to find one more psychological explanation, to believe that if the issues embedded in the interpretation could be worked through, all would be well. That is when the need to know for sure, the unwillingness to tolerate the utter uncertainty and real limitations come into play.

When two people are immersed in understanding the experience they share, in order to inform one participant's life patterns and behaviors, they stub their toes on rocks in the path that cannot always be broken into pieces and analyzed. In systems predicated on cause and effect, linear paradigms, there is no room to acknowledge what may not be understandable or analyzable. The mysterious is anathema and is relegated to the irrational

and unscientific. Yet to insist on knowing can violate the patient.

Linear thinkers have problems with the notion that the relationship between the participants may be more important and helpful than correct conceptualizations about what the patient is saying, feeling, and experiencing. By its very nature, a relationship involves circular processes with highly individual characteristics not easily defined in terms of older frames of reference.

Within the therapy container, the relationship unfolds gradually. It requires openness on the part of both participants. The therapist thinks about what is going on and is able to change as necessary. She gives up ideas that do not apply to the case. Clinging defensively to ideas which the patient does not accept as germane to her situation may mean that the therapist is so committed to her own theories that she says, in effect, let the patient be damned. The patient either has to accept that the powerful therapist is right, often accommodating to her and re-enacting early instances of accommodating and becoming the self-object of a parent, submerging a part of the self, or she must leave therapy feeling misunderstood and wronged. "It takes two to tango," applies as much to therapy as to dancing. The <u>therapist</u> may need to think of changing, of pulling back and discovering with the patient the meaning of their joint experience. They may agree to disagree without the implication that either one is right or wrong.

One pursues knowledge not only for its own sake. Fear and confusion pull one into the safety of orthodox frameworks. The out-of-control therapist who after all is supposed to be <u>fully</u> in control, grabs for a doctrine. It is not altogether unlike the adolescent who joins a cult. Both involve moving from confusion to certainty, from isolation to community. If this comparison has any validity, the experienced therapist can afford to be more separate, more differentiated, less rigid, and less doctrinaire. That can be achieved only if one is willing to let uncertainty, not having to be sure, not needing to be right, re-emerge in a context of greater humility about the extrinsic and intrinsic limitations of our knowledge of life in general and the therapeutic situation in particular.

The not knowing that occurs later in the professional life and development of the therapist reflects the limits in knowledge, but more cogently reflects the increasing inner recognition of and connection to the quixotic, unpredictable aspects of the human condition, as well as the inherent limits in how completely one person can understand another.

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