Tel +44 (0)20 7794 2313
12 Maresfield Gardens, London, NW3 5SU
www.annafreud.org

Caring
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minds

Anna Freud Centre

Not-knowing stance

This is a patient has had multiple hospital admissions and presents at the session saying that he is 'about to blow'. He indicates that he thinks the answer is to go into hospital again. The clinician's task is to stimulate the patient to consider this more widely and be less fixed in his view that the answer to the problems is to be admitted, which has been his preferred solution for a number of years.

The not-knowing stance is focused on the content that the patient brings and the process that is generated. The aim is to increase reflection by the patient on the content without early closure of the topic. In non-mentalizing mode closure usually occurs by the patient or clinician making assumptions or coming to premature conclusions. It is important to differentiate a not-knowing stance, aiming to generate a reflective process about internal states, from a stance gathering more factual information, the method of socratic questioning, and interrogation.

Initially the patient is agitated and anxious and says 'it' is all coming back'. In the not-knowing stance, generic statements such as 'it is all coming back' are questioned. It is important not to assume what 'it' is. Asking the patient to expand on 'it' requires more reflection and less assumption on part of both patient and clinician who may have different 'its' in their minds.

As the patient talks he becomes more agitated and anxious so the task of the clinician at this point is to reduce his arousal. Arousal reduces mentalizing so if there is to be any chance of getting the patient to have better mentalizing in the current context, it is imperative that his arousal decreases. The clinician engages the patient in a brief relaxation exercise before returning to the topic.

The clinician asks the patient to reflect on his current state and to consider what is working him up. The focus on current processing is important in MBT. This encourages the patient to develop a reflexive capacity and to be alert to changes in his mental states.

The patient and clinician clarify the process that they are discussing at a number of points. What unfolds is a sense that the therapy does not leave the patient feeling resilient to manage a week between sessions. But the main trigger to his mental collapse and distress is a painful experience of being alone. He finds this intolerable perhaps because it leads to a collapse in his sense of self. He does not know what to do and seeks hospital admission. Yet hospital admission is exposed as not meeting his needs even though it feels like a solution to the acute crisis.

The patient asks what he can do? Rather than immediately giving suggestions the clinician agrees that this is a good question and one that they need to focus on to find an answer.

The clinician then makes a misjudgement and tries to change the tone of the session by using a 'joke' as a challenge to try to get the patient to start thinking from a different perspective. The patient does not recognise this humourous approach. So the clinician retreats and accepts that it was not in good taste and takes up the seriousness of what they were trying to deal with. At this point the patient realises that there was a certain level of humour and returns to the theme with a joke of his own. Importantly the jokes point towards

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an interpersonal/attachment solution to his problem of feeling alone – ‘phone a friend’. What a good idea! The patient and clinician are now on track to consider relationships as a way of learning to manage experiences in a constructive and developmental way.