# Sitting with unknowns when working with chronicity:

# A hermeneutic literature review

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A dissertation submitted to Auckland University of Technology

in partial fulfilment of the requirements

for the degree of

Master of Psychotherapy

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2021

## Abstract

This dissertation employed a hermeneutic literature review to seek to understand how Bion's interpretation of negative capability could support an understanding of the complexity of chronicity when working with the whole person treatment approach (WPTA).

What emerged was a roadmap identifying three major obstacles to comprehending how the capacity for not knowing, or negative capability, can support understandings of the complexity of chronicity when working with WPTA. The roadblocks encountered on the roadway are: firstly, the culture of biomedicine, and its inherent mind/body problem, along with our expectation that physicians provide expertise and diagnosis. Secondly, our human tendency to split and treat the resultant dualities and dichotomies as either/or choices. When mind/body becomes an either/or choice, it excludes the richness of the health information available at each pole, and excludes the use of WPTA. The defences of minus knowledge (-K) and dispersal formed the final roadblock.

Four vital bridge building materials were identified, for bridging the roadblocks. Firstly, the foundation of any bridge was formed by developing an internal container, essential for sitting with uncertainties and doubt, and enabling the translation of our own beta-elements into digestible alpha-elements. Secondly, curiosity created an openness to self-knowledge and new understandings of the complexity of chronicity. Thirdly, the ability to doubt proved essential in questioning all three roadblocks, and in integrating chronicity in a new way, opening the door to new learning. Finally, patient waiting, an active process at the heart of negative capability, provided a space from which original thought could develop.

Importantly, while each patient uses the same building material to bridge the roadblocks encountered, each bridge is painstakingly constructed by each patient, brick by brick. Each bridge is unique, as no two patients will construct exactly the same bridge. Moreover, once a bridge is built, it represents a skill set that remains for life, enabling patients to more quickly bridge future roadblocks. Broader implications of this study include its potential application to other uncertain situations, such as to the current global COVID-19 pandemic.

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**Attestation of Authorship**

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Bridget Lampard

22 November 2021

**Acknowledgements**

I wish to acknowledge those to whom I owe a debt of gratitude.

My family, the bedrock upon which my life is built; none of this would have been possible without your love and support.

My mother and father, for your love and my mother for identifying my suffering as migraine.

My friends, for listening, and for the laughter especially, when I lost faith that this project would ever end.

My course mates, from whom I have learnt so much, it wouldn't have been nearly as much fun without you.

To those who travelled this dissertation road with me, particularly, Steffi, Rodger, Charri, and Shivana - thank you.

To Cony, for generously sharing your talent and illustrating my roadmap.

To Joanne and Kerry, my supervisors, thank you for your contribution and input.

## Chapter 1. Introduction

The intention of this hermeneutic literature review was to explore the capacity for not knowing (or negative capability) to understand the complexity of chronic illness[1] when working psychotherapeutically with the whole person treatment approach (WPTA). I outline my interest in this topic before introducing core concepts used in this study: WPTA, negative capability, and chronic illness.

### My interest in this topic

My interest in the WPTA and negative capability stemmed from my lifelong, lived experience of migraines. I cannot recall a time before migraines. My mother, a fellow migraineur, reported identifying my migraine attacks when I was two years old. My lived experience of chronic pain led to an innate understanding of the complexities of living with chronic illness. Migraines disrupt many physical systems in the body. Intense pain sits alongside the inability to digest, nausea, vomiting, diarrhoea, vertigo, visual disturbance, photophobia, phonophobia, osmophobia, and allodynia. Some sufferers have reported temporary paralysis, often localised to one side of the body, and temporary loss of sight.

Migraineurs can suffer any combination of these symptoms, which can start almost without warning, and necessitate withdrawal to a dark room. Activities often associated with bed rest, such as reading a book, watching television, or surfing the web, are simply not possible. The migraineur is left to be with their symptoms. Attacks can finish as quickly as they can start, can last anywhere from a few hours to days, and for an unlucky few, one attack can roll into the next, leaving the migraineur with no respite.

Due perhaps to the depth of suffering amid an attack, combined with near-normal function once an attack passes, non-migraineurs may be left struggling to understand the attacks. In addition, the outside world is often shielded from the worst of these attacks, as migraineurs seek refuge in a cool, dark, quiet bedroom or bathroom, which can lead to the commonly held view, outside the migraine community, that migraineurs somehow exaggerate their illness and use it as an excuse. As a result, sufferers may feel misunderstood and disbelieved, leading to a reluctance to discuss symptoms.

[1] The terms “chronicity” and “chronic illness” are used interchangeably in this dissertation, as are “chronic pain,” “chronic disease,” and “chronic condition.”

Migraineurs, particularly those suffering chronic migraines, describe living in fear of the next attack. Migraine sufferers fear making plans such as meeting friends, for fear of cancelling and letting people down; this can result in feelings of loneliness and isolation.

My lived experience of chronic illness is intertwined with my essence of self in such a way as to be inseparable. There is a duality to my pain experience; it is all-encompassing and overwhelming during an attack. While in a recovered state, I return to my pain-free existence and carry on, often not mentioning my suffering to anyone outside of my household. Other times, one attack runs into the next, without respite, and I almost forget what it is like to live without pain.

As I discovered, seeking treatment becomes a fact of life for those suffering chronic illness. In Aotearoa New Zealand, our medical system relies predominantly on medications and surgeries. In many cases, these interventions provide relief, the patient[2] recovers, and life continues. However, difficulties can arise for both patients and physicians when our current medical interventions fail to relieve symptoms. Physicians may feel that they have nothing further to offer a patient. Patients may feel that their suffering is disbelieved, or that they did not try hard enough or adhere strictly enough to advised protocols. They can be left questioning their diets, water intake, exercise, sleep, work, social connections, family dynamics, belief systems, and mental health (this list is not exhaustive).

My experience has resulted in a deep respect for those suffering chronic illnesses. My familiarity drew me to study psychotherapy and embrace my placement at the Immunology Department at Auckland Hospital. I was struck by the bravery shown by many clients, and their capacity, at times, to hope for a better future. My first-hand understanding of the isolation associated with chronic illness, and my clients' struggle to find appropriate support in a medical system that silos mind, body, spirit, whānau, and community, struck a chord and left me grappling with meaningful ways to connect with my clients, to build a therapeutic bridge between us. In my placement, we utilised the whole person treatment approach (WPTA). The WPTA has proved helpful in treating chronicity (Broom, 1997, 2007; Broom & Joyce, 2013). This led me to want to deepen my understanding of the WPTA, as I continued working with those suffering from chronicity.

[2] The terms “patient” and “client” are used interchangeably in this dissertation.

**Whole person treatment approach**

Broom (Broom, 1997, 2007; Broom & Joyce, 2013) coined the term "whole person treatment approach" in Aotearoa New Zealand, to describe an "wholistic"[3] approach to healthcare, comprising, but not limited to, physicality or body elements, alongside subjective elements such as mind, spirituality, relationships, family history, community, culture, and environment (Broom, 2016a). In the WPTA, all aspects of personhood are welcomed and focused on (Broom, 2016b). The WPTA considers no single aspect of the whole person any more important than any other aspect, and all aspects are seen as co-emergent (Broom et al., 2012). That is, these aspects cannot be separated. They have been coemerging since the beginning of life, each impacting the other to create a whole person.

People may use *story* along with metaphor and symbolism, to attribute meaningfulness to their chronic illness. These meanings will be different for each client, and the client may not see the relationship between their story and their illness. Clinical examples of WPTA suggest that the combination of shifting focus between biomedical treatments and the story elements of personhood have yielded unanticipated improvements in people suffering from chronic conditions (Broom, 2016b; Broom et al., 2012; Lindsay et al., 2015).

**Defining chronicity or chronic illness**

It has proved problematic to find a consistent definition of "chronic disease," "chronic illness," "chronic condition," and "chronicity." Definitions differ widely in the diseases, illnesses, or conditions included (Bernell & Howard, 2016). In the literature, the length of time an illness must be present before it is considered chronic varies between three and twelve months (Bernell & Howard, 2016). I acknowledge the differing time frames and illness included. In this dissertation, I include any illness, condition, or disease that has caused suffering for a period over three months. In my experience working with chronicity, patients had regularly suffered for years or decades rather than months.

**The missing link**

I was fully committed to working with WPTA. Yet despite my lived experience of chronicity, study of psychotherapy, and my placement that facilitated my practice of WPTA, I still found that something got in the way. Understanding the WPTA theory and weekly clinical supervision had

[3] Broom (2007, 2016a) used the term *wholistic* to communicate that people are wholes that language has artificially divided. Wholistic also communicates an intention to consider all aspects of personhood.

not been enough to fully integrate WPTA into my work with clients. Understanding the model looked easy, but in practice I found it difficult, and I wanted to understand my difficulty. Living with chronic illness has been described as living with chronic uncertainty (Wiener, 1975). Moreover, the WPTA encourages sitting with each patient's unique symptoms and waiting for meaning to emerge. Consequently, I had an inkling that my struggle may have something to do with not knowing, or uncertainty. Therefore, I turned to the psychotherapeutic literature to investigate the concept of not knowing.

**Beginning of a research question**

While searching for literature about uncertainty, I rediscovered the work of Wilfred Bion [1897-1979], an influential British psychoanalyst and contributor to psychoanalytic theory. Bion was considered by Symington (1993) to be possibly "the greatest psychoanalytic thinker… after Freud" (p. 97). Bion's understandings of the analytic process continue to shape the practice of psychotherapy today. I was struck by Bion's (1984a) use of Keats' concept of negative capability to describe a desirable state of not knowing, an ability to sit with uncertainty and unknowns. I wondered how Bion's concept of negative capability could support me, a beginning psychotherapist, to understand the complexities of chronicity when utilising the WPTA.

**Bion's theories**

While it is beyond the scope of this dissertation to explore all of Bion's theories, I acknowledge that negative capability sits within Bion's theories and processes of container/contained, K and -K, and O. An understanding of these concepts support and enhance an understanding of negative capability and are briefly outlined next. First, I briefly outline the etymology of the word "capax."

***Capax***

Bion understood the capacity to contain uncertainty, and tolerate ambiguity and paradox as negative capability (French, 2001), suggesting a link between the concept of "container/contained" and Bion's use of "negative capability." The etymology of the word "capax" means "to hold much" ("Capax," n.d.). Bion has utilised words derived from capax in the language employed, to name his concept of "container/contained" and in his use of "negative capability." Negative capability utilises derivatives of "capable" and "capacity," while "container/contained" draws on the meaning "to hold much" ("Capax," n.d.), alongside the derivatives of "capacity" and "capacious." I believe Bion's choice of language provides a further link between the concepts of container/contained and negative capability.

***Container/Contained***

Bion's (1962a) notion of *container/contained* builds on Klein's (1946) idea of projective identification. Bion saw *projective identification* as a means of embodied communication between mother[4] and infant (Waddell, 2002). Klein (1952/1975) suggested infants, as a normal part of development, operate from the paranoid-schizoid position. Infants during this phase, project unassimilated, intolerable, or bad thoughts into the mother's breast. Bion (1984a) summed up Klein's concept thus: "during their sojourn in the good breast they are felt to have been modified in such a way that the object that is re-introjected has become tolerable to the infant's psyche" (p. 90). Bion's (1984a) concept of container/contained expands on Klein's understanding by explaining how projected elements are modified. Bion (1984a) described *container/contained* as a dynamic process describing the capacity of a person or object to act as a container into which the contained projects their unconscious or frightening thoughts. The container digests and makes sense of these unprocessed elements before returning them to the contained in a form they can understand or tolerate.

The mother offers containment through her emotionally attentive presence to her pre-oral infant through the functions of translation and reverie (Bion, 1984b). The mother *translates* her preverbal infant's unthinkable thoughts. Without language, the infant communicates through cries, body language, and projective identification, to introject a range of raw experiences such as hunger, cold, tiredness, distress, and pain into the mother. Bion named these undeciphered signals from the baby to the mother as “beta-elements” (β-elements) (Bion, 1984a). The infant, not yet able to conceptualise these internal processes, relies on the mother to accurately translate their cries, name them, attribute meaning to them, (“ahh you are hungry”), thus returning them to the infant as thinkable thoughts. According to Bion (1984a), the process of the mother accurately translating the infant's unthinkable thoughts involves the infant projecting β-elements into the mother. Bion saw containing as an active, rather than passive, process (Biran, 2015). Bion coined the term “alpha-function” (α-function) to describe the mother's ability to translate accurately, or give words to her infant’s raw β-elements; he considered α-function the most critical act of a container (Biran, 2015).

The mother's capacity for reverie is the second essential element in her ability to contain the infant (Bion, 1984a). According to Ogden (2004), Bion understood dreaming as the process of making an individual's experiences available to the unconscious for processing. Bion described

[4] In this dissertation I use the term “mother,” as it is commonly used in psychoanalytic literature to describe the primary caregiver.

*reverie* as a form of meditation, which utilises the mother's intuition, faith and creativity "…to day-dream forward into a better future" (Biran, 2015, p. 6), even in circumstances of anguish, pain, and difficulty. Reverie is the means used to transform the infant's β-elements into alpha-elements (α-elements). Alpha-elements are digested, translated, and named, thinkable thoughts that can be safely returned to the infant (Bion, 1984a). Over time and with repetition, this process enables the infant (the contained) to tolerate and process, or think about, its own affect[5]. To better understand container/contained it is helpful to understand Bion's concepts of Knowledge (K) and O, which are introduced next.

***Bion's concepts of K and O***

Bion proposed a model of emotional relationships comprising three elements: L (love) H (hate) and K (knowledge), which he saw as representing affective relationships; X loves Y, X hates Y and X knows Y (Bion, 1984a, p. 111). Fisher (2006) interpreted this as Bion construing K as an emotional experience. Bion saw the drive to curiosity as the emotional driver behind the K impulse (Fisher, 2006). He linked his elements of L, H, and K, to container/contained, suggesting that the container in K wants to know and viscerally understand the emotional experience of the contained while maintaining a K state of mind. Fisher (2006) contended that Bion viewed the key to containment as the mother's curiosity, or K impulse. Eventually, the contained develops the capacity to contain their own affect.

*Knowledge (K),* the process of coming to know and learn about ourselves, is seen as the central goal of psychotherapy; "that aspect of it which establishes that it is a psycho-analysis and could be nothing else" (Bion, 1963, as cited in Fisher, 2006, p. 1232). Bion argued that separation from the truth of one's emotional experience was equivalent to physical starvation (Bion, 1962b). Bion regarded thinking as a requisite to the development of K (Bell, 2010). Learning from past experience is essential in developing K. Yet, to remain with ourselves, our own thoughts, processes and feelings, is challenging. Bion considered the impulse to curiosity to be a key concept in the drive for K (Fisher, 2006).

Bion did not see knowledge as an end goal, but rather, as a stepping stone in the ongoing quest for self-knowledge. Thus, every understanding gained is viewed as a working hypothesis, leading

[5] Affect is a term commonly used in psychotherapy to describe both the subjective feeling state and the emotional physical aspect, affect indicates that both feeling and emotion seem to be part of the same experience.

to additional questions (Fisher, 2006). To fully understand the boundaries of K, it is important to mention Bion's concept of O.

### *O*

Bion used the term "O" to represent the ultimate, unknown, and unknowable truth, the thing in itself which is too great to be known or described in words (Akhtar, 2009). Examples of a fleeting experience of O might be the researcher's insight or the artist's brushstroke. Bion consigned what could be known to the domain of K. By developing negative capability, abstaining from "irritably reaching for fact or reason" (Keats, 2005, p. 60) alongside eschewing memory and desire, Bion believed transformation in knowledge could allow fleeting brushes with O.

As capax suggested a link between container/contained and negative capability, I now outline the concept of negative capability.

### *Negative Capability*

The poet John Keats, in a letter to his brothers in December 1817, first referred to negative capability when he wrote:

> …at once it struck me what quality went to form a Man of Achievement, especially in Literature, and which Shakespeare possessed so enormously—I mean Negative Capability, that is, when a man is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason—Coleridge, for instance, would let go by a fine isolated verisimilitude caught from the Penetralium of mystery, from being incapable of remaining content with half-knowledge. (Keats, 2005, p. 60).

Bion expanded on Keats' notion of negative capability. For Bion, *negative capability* referred to an openness he considered essential in both life and psychotherapy, and saw negative capability as the capacity to bear being in a state of not knowing, to stay with the mystery, without foreclosing on uncertainty and inflicting certainties on uncertain situations or uncertain affects (Lopez-Corvo, 2003).

Bion's work (1970) encourages therapists to listen without memory or desire, to clear mental space for the client's thoughts, feelings, and dreams, enabling the clients to tell their stories without focusing on outcome or theory. Bion's process of liberating the mind from memory and desire, at its inception, draws on Freud's[6] recommendation that the analyst employ evenly suspended attention. Describing *evenly suspended attention*, Freud (1912) wrote, "he should simply listen, and not bother about whether he is keeping anything in mind" (p. 119). The genesis

[6] Freud [1856 – 1939] is widely considered to be the founding father of psychoanalysis.

of Bion's understanding of negative capability combines his concept of no memory, no desire, alongside an expansion of Keats's notion of negative capability. Keats described to his brothers an aspect of creative genius found in high achieving people (Simpson et al., 2002). His description seems to have met with or provoked Bion's thinking, and negative capability became a central theme in Bion's work (Mitrani, 2011, p. 237).

*Negative capability* connotes the reflective mindset essential to containing the discomfort of uncertainty, rather than defending against uncertainty by dispersing from its disquieting effects. According to French (2001), *negative capability* suggests the ability to tolerate ambiguity and paradox, or in the words of Keats (2005, p. 60), "remain content with half knowledge." Implicit in negative capability is the notion of meeting change with a non-defensive stance; "what is deepest in human mystery gives way only before a *Negative Capability*" (Scott, 1969, pp. xii-xiii).

Listening without an agenda may prompt the therapist's reverie and intuition. Moreover, maintaining a mindset of not knowing or negative capability, can be seen as part of the containing function, allowing a space for the client to abide the frustrations of not knowing long enough to enable the creation of new knowing, and for the new knowing to be contained (Cartwright, 2010).

## Aim and scope

### *Aim and research question*

The purpose of this research was to understand how the capacity for not knowing (negative capability) may support a deeper understanding of the complexity of chronicity when working with the WPTA. I hope to support psychotherapists, who, like myself, may be grappling with the difficulties of keeping the whole person in mind when faced with chronicity. Searching the current literature, I was unable to find a research article that applies negative capability to the WPTA or chronicity, but located a number of articles in which negative capability was applied in other disciplines, such as business, social work, and psychotherapy (Decou & Kao, 2011; Saggurthi & Thakur, 2016; Simpson & French, 2006). By exploring the literature about Bion's understanding of negative capability, I hoped to understand better how to hold the complexities of chronic illness when working psychotherapeutically with the whole person. My research question was:

> How can Bion's interpretation of negative capability support understanding the complexity of chronicity when working with the whole person treatment approach?

**Structure of the dissertation**

Chapter two outlines predominant medical models and concepts before further exploring the core ideas embedded in this study. Chapter three describes my chosen methodology and method, a hermeneutic literature review. Chapters four and five outline the research findings, introducing the roadmap comprising obstacles (Chapter four) and bridges (Chapter five) uncovered on my journey to answering my research question. Chapter six summarises and discusses my research findings before outlining the potential implications of the research for psychotherapy. Finally, the limitations of my research and some of the challenges encountered throughout the research process are discussed.

**Chapter summary**

In this chapter, I explained both my special interest and my personal history with the topic. Next, I defined the key terms central to this research, including the WPTA and chronic illness. I introduced Bion's theories of container/contained, K, and O, which I consider necessary to appreciate Bion's understanding of negative capability. Finally, I introduced my research question: "How can Bion's interpretation of negative capability support understanding the complexity of chronicity when working with the whole person treatment approach?"

## Chapter 2. Setting the scene

*Be still and wait without hope,*
*For hope would be hope for the wrong thing: wait without love*
*For love would be love of the wrong thing: there is yet faith*
*But the faith and the love and the hope are all in the waiting.*
*Wait without thought, for you are not yet ready for thought (Eliot, 2014, p. 31).*

### Introduction

Initially, in this chapter, I briefly outline the biomedical models' reliance on evidence-based practice. Then, I introduce the prevalent models and concepts currently employed in Aotearoa to treat physical illness, which I believe provide essential background to understanding the current study. An initial overview was provided in Chapter one. In this chapter, I delve further into the whole person treatment approach (WPTA) before providing a brief discussion of the challenge of chronicity. Finally, negative capability is explored in more depth.

### Evidence-based practice (EBP)

The biomedical model relies heavily on evidence based practice (EBP), which impacts how Western medicine is delivered. Developed in the mid-19$^{th}$ century, the most commonly used definition of *evidence based practice* is "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients" (Sackett et al., 1996, p. 71). Greenhalgh (2019) emphasised the mathematical foundation of EBP, alongside noting that as healthcare operates within budget limitations, treatment costs must always be considered.

Evidence based practice sits within the biomedical model and looks for patterns and trends of symptoms in populations. These patterns are then applied to individuals to make a diagnosis. Within this model, there is no space for attending to individual differences or subjectivity in disease experience. As an example, doctors advised that my migraines could not last longer than three days, the inference being that I was exaggerating, lying, or was not suffering from migraines, when they lasted longer. The diagnostic criteria have since been updated, and it has been acknowledged that migraines can be classed as intractable.

### Introduction to the predominant medical models and concepts

The biomedical model dominates healthcare in the Western world (Borrell-Carrió et al., 2004). Mind and body are considered separate, and the body is privileged over the mind. However, many physicians have observed that not all illnesses or diseases can be adequately understood through the singular biomedical lens of physical dysfunction. Many physicians, for example,

acknowledge the contribution of stress to physical illness, and recognise the need for a discussion of holistic medicine. Several alternative models have emerged. I briefly outline the most prevalent models and key concepts used in the current study.

***Psychosomatic***

Traditionally, disease has either been classified as physical or psychosomatic. When disease falls into the *physical* classification, biomedical practitioners believe there is no need to consider factors other than the physical. When a disease is classified as *psychosomatic*, it involves mind factors, and there is no need to consider physicality. When viewed through the Western patients' biomedical lens, a physical disease often equates to a real disease (Gobert, 2013). *Real* disease is considered worthy of a physician's time, and the deployment of medications or surgeries is justified to cure the disease. There is a sense that in a psychosomatic illness, the mind has done something to the body to create a dysfunction.

***Somatisation***

The *Diagnostic and statistical manual and of mental disorders V (DSM V)* classification of somatic symptom and related disorders is used in cases of medically unexplained symptoms. The DSM recognises that the focus on medically unexplained symptoms makes this diagnosis "pejorative and demeaning, implying that their physical symptoms are not real" (American Psychiatric Association, 2013, p. 309). While making strides to lessen the prejudice implicit in this diagnosis, the DSM V acknowledges that diagnosing a person with a mental disorder simply because current medical knowledge cannot explain their symptoms, is inappropriate, dualistic and reinforces the mind-body split (American Psychiatric Association, 2013).

A psychosomatic or somatic symptom illness is regarded as less respectable, and not as real as is a physical illness (Borrell-Carrió et al., 2004), leading patients to think their physicians or therapists infer that their condition is not real, or is all in their head, or could be fixed by thinking themselves well. The split between mind and body is biomedical in outlook and illustrates the mind/body problem (Broom, 2007).

***The mind-body problem***

The mind-body problem arose from a desire to comprehend the relationship between mind and body. At the crux of this problem is the contention that mental processes such as consciousness, can be considered entirely separate from physical phenomena. Descartes considered mind and body as separate. His philosophy, instrumental in today's biomedical model, resulted in the

binary aspect of Cartesian dualism (Gobert, 2013). The mind-body problem has not been resolved, and many consider it unsolvable (McGinn, 1991).

***Biopsychosocial model (BPSM)***

Engel designed the biopsychosocial model (BPSM) in 1977 to challenge the biomedical model, by recognising that patients were more than bodies and that psychological and social factors need to be considered (Engel, 2012). Critique of the BPSM has suggested it is as dualistic as the biomedical model in its contention that the mind can cause dysfunction in the body (Broom, 2007). Although the BPSM highlights the mind's impact on the body, which is a step forward, it still considers the mind and body as separate entities, albeit able to influence each other.

***Psychoneuroendocrino-immunology (PNEI) model***

Ader and Cohen (1993) coined the term “psychoneuroendocrino-immunology” (PNEI) in 1975. Psychoneuroendocrino-immunology studies the interaction between mind processes and the nervous and immune systems of the human body, and is now the most accepted model for practitioners who acknowledge that human subjectivity impacts physical illness (Broom, 2007).

The BPSM and PNEI models have promoted recognition and consideration of both the mind and body in disease. However, both models are still primarily based on dualistic biomedical thinking. They view the mind and body as separate entities, leading to the question; are we a mind with a body or a body with a mind?

***Do we need another model?***

Suppose we accept the "vexing failures of medicine, its relentless positivism, its damaging reductionism, its appeal to the sciences and not to the humanities in the Academy and its wholesale refusal to take into account the human dimensions of illness and healing" (Charon, 2006, p. 193). If we accept the contention that people can express their story through a congruence of physicality and human subjectiveness, the answer must point to the need for another model. We have seen that our existing models present a mind-body dichotomy and cannot accommodate a unitary model of personhood. The WPTA presents a framework and method which enables clinicians to hold physicality and human subjectiveness together in the same clinical time and place. (Broom, 1997, 2000, 2002, 2007, 2010, 2011, 2016a, 2016b; Broom et al., 2012; Broom & Joyce, 2013; Lindsay et al., 2015).

***Whole person treatment approach (WPTA)***

The WPTA draws on both medical and psychotherapeutic principles to address physical (body) and subjective (mind) elements of illness in a non-dualistic way. The WPTA conceives life events, illnesses, and relationships as co-emergent. While not suggesting that we ignore physical symptoms, Broom (2000) urged the expansion of the medical lens to include human subjectivity. Utilising a traditional biomedical approach alongside personal meanings, he recommended that clinicians listen for a patient's personal meaning that could be at the core of disease aetiology. The WPTA is based on a unitary approach to health care that eschews the dualism of the biomedical model, rejecting the dichotomy of mind-body, along with the stance of either body primacy or mind primacy at the heart of biomedicine. The WPTA enables the clinician and the patient to explore the patient's story, their unique experience of physicality, and human subjectivity in disease, without separating them (Broom, 2000).

Broom (2002) contended that the patient's story encapsulates the concept of a somatic metaphor more accurately than does a theoretical definition of the term. He suggested that a somatic metaphor is present in any disease where the patients' story seems appropriate or remarkably consistent with their symptomology. Patients' background, behaviours, or language, seem to convey the same meaning as their illness (Broom, 2002; Broom et al., 2012), suggesting an underlying unity of body and mind expressing in personhood, and enabling us to discuss their confluence without separating them (Broom, 2000). Broom's articles and books are littered with examples of illness that corresponds with the notion of story.

One such example (Broom, 2000) is the case of a 70 year old woman presenting with a five year history of facial rash. The woman had no history of depression or any other medical or mental illness. She had difficulty expressing her feelings and noted that she kept a "brave face" (p. 168) in relation to her husband's depression. Broom (2000) reports that his patient improved with empathic listening and the understanding that her facial rash was a physical expression of her struggles to keep a "brave face" (p. 168) to the depression. There is no benefit in determining if the facial rash or the brave face language emerged first. Broom (2000) contended that his patient was expressing the same concern simultaneously with different elements of her personhood. Finding a symbol or meaning in illness is not a silver bullet to chronicity; instead, it is a gateway to the whole (Broom, 2016a). The WPTA seeks not to pathologise, but rather to normalise the meaning making inherent in personhood.

Clinicians trained in the WPTA attend to physicality and subjectivity simultaneously, irrespective of the biomedical categorisation of aetiology as physical, psychosomatic, functional, or organic

(Broom, 2000). Instead, WPTA clinicians consider all aspects of personhood, including and not limited to body and mind and relationships, love and friendship, family, family history, community, society, culture, spirituality, and ecology. Personhood comprises all these aspects of self; one part cannot be siloed from the other parts. Any illness or disfunction experienced cannot be compartmentalised and separated but must be treated as a function of the whole being, thus "freeing us from all the difficulties of dualistic medicine" (Broom, 2000, p. 173).

**The challenge of chronicity**

*Chronicity* is not a one-time event or illness but rather, an ongoing condition that requires the juggling of the demands of everyday life alongside the needs of the illness (van Houtum et al., 2015). Patients often manage debilitating physical and affect symptoms, and family, social, community, and work commitments. Western culture places a high value on independence and personal achievement, meaning the chronically ill strive to continue contributing at work and home, often to the detriment of their health (Royer, 1998). This striving eventually proves uncertain and exhausting for many, necessitating a step back from these spheres of life, impacting finances, connection, and sense of self-worth. Living with chronic illness has been described as living with chronic uncertainty (Wiener, 1975). When patients feel vulnerable and require increased medical attention, doctors can become disengaged, as they may become frustrated when a chronically ill patient fails to recover.

Physicians working within the Western, dualistic, biomedical model that values efficiency, may begin to view patients as difficult or a nuisance, leading to derogatory slang, such as *GOMER* (Get Out of My Emergency Room); *frequent fliers*, referring to patients who repeatedly present at accident and emergency (A&E) department; and *turfing*, which refers to transferring a patient to another service or department (Goldman, 2014). Turfing may result in a sense of relief for a doctor who does not know how to treat the patient (Goldman, 2014). I want to state that I have not personally heard any of these terms being used. However, patients have reported feeling like a nuisance, difficult, overlooked, and unwelcome. When illness is considered medically unexplained, physicians tend to classify the disease as psychosomatic or somatisation (Kirmayer et al., 2004). I wonder if, in some instances, this is a form of turfing.

In making these observations, I do not wish to imply that physicians intend to treat patients with disrespect. On the contrary, the physicians I have observed are hardworking with a genuine desire to help, doing everything in their power to help their patients. Nevertheless, there is a tension inherent in a system that views illness through a biomedical lens which privileges the physical.

**Negative capability: Providing a language of uncertainty**

Bion's legacy attached to the notion of negative capability has been to provide a language of uncertainty:

> Perhaps Bion's most pervasive influence was to create an intelligent language of uncertainty. The injunction to dispense with memory and desire... contributed to London analysts being able to be less bloody certain of everything and made it more possible for people to discuss doubts about their thinking. As such, in that way at least, he has had a profound effect on the way most analysts now discuss their work (Bollas, 1993, p. 419).

Negative capability facilitates continued thinking in circumstances that cultivate closing down the thinking. However, the very language used in the term “negative capability” can be puzzling.

Combining the terms “negative” and “capability” seems paradoxical. Capability, set against a Western culture that values performativity, is considered a high status word. On the other hand, the word “negative” is loaded with less desirable connotations. Together, “negative capability” may be misunderstood to mean lacking in ability rather than as "capability in negative situations" (Decou & Kao, 2011, p. 352). *Negative capability* is associated with what might be considered lower status activities such as patience, waiting, listening, observing, withdrawing, and passivity (Simpson et al., 2002). Thus, the term may be associated with lack or loss, and denotes the ability not to act, but to stay in reflective inaction. Negative capability may be most needed in circumstances considered negative. For example, there may be a lack of resources, perhaps physical or knowledge (Simpson et al., 2002). Another way of considering the word “negative” is its use in photography, in which a “negative” is an image barely visible against a backdrop of light, yet all the elements for the fully developed image are contained within the negative. Much like photography, the “negative” within “negative capability” also contains a developing positive. In a similar vein, Decou and Kao (2011) contended that the meaning of “negative capability” becomes more apparent if we consider negative in the context of a magnet’s negative pole, or the negative in electricity. Voller (2011) suggested that negative capability is challenging to describe, and therefore, often not discussed. She postulated that it is perhaps noticed by its absence rather than by its presence, in the same way that we tend not to notice our breathing or good health until they are compromised. Further, she suggested that the role of uncertainty in psychotherapy has become prominent with the growth of certainty in EBP (Voller, 2011).

**Chapter summary**

In this current chapter, I considered the place of EBP in biomedicine before outlining the other prevalent models and concepts currently utilised in Aotearoa. It transpired that these models all view mind and body as separate entities. The WPTA was further explored, alongside the challenge it presents to our Western sensibilities. Next, I briefly looked at the challenge presented by chronicity, and finally, negative capability was investigated in greater depth. In the following chapter, I outline my chosen methodology and method, a hermeneutic literature review.

## Chapter 3. Methodology and Method

*It's not what you look at that matters, it's what you see.*
*Henry David Thoreau*

### Introduction

In this chapter, I briefly outline my chosen methodology and method. I conducted a hermeneutic literature review. Initially, I explain the philosophical and epistemological underpinnings of hermeneutics, before outlining hermeneutics' suitability to both psychotherapy and my research question. Next, I explore my historical consciousness and the historical consciousness of biomedicine before outlining my chosen method, which comprised of two hermeneutic circles. Finally, I outline my inclusion and exclusion criteria.

### Methodology

I chose to undertake a hermeneutic literature review. Hermeneutics sits within the qualitative and interpretive paradigms. Developed in the mid-20$^{th}$ century, hermeneutics countered the reductionist thinking generated by the positivist paradigm (Grant & Giddings, 2002). The social sciences were gathering traction during this period, creating a cultural environment conducive to the acceptance of a new paradigm.

Interpretive approaches have become connected with qualitative research (Grant & Giddings, 2002). Husserl [1859-1938], the German philosopher who established the school of phenomenology, wrote of his wish to return to "the things themselves" (Husserl, as cited in Farber, 2006, p. 568). In other words, research situated within the qualitative, interpretive paradigm seeks to understand "what it is to be human and the meanings people attach to the events of their lives" (Grant & Giddings, 2002, p. 16). My research question asks how Bion's interpretation of negative capability can support understanding the complexity of chronicity when working with the whole person treatment approach (WPTA). An interpretive approach seemed a good fit, as the WPTA, and the complexity of chronicity, both require an intersubjective understanding of the potential meanings people attach to their illnesses. Research methodologies situated in the interpretive paradigm place the researcher alongside the participant in an intersubjective relationship (Grant & Giddings, 2002).For the purposes of the current research project, the literature being reviewed takes the role of the participant.

The origins of the term "hermeneutics" are found in the Greek word *hermeneuein,* which means to interpret (Moules, 2002, p. 2). In Greek mythology, Hermes was the messenger trusted to

carry the messages to the people from the gods. The power of interpretation enabled Hermes to solve puzzles through novel observations. Greek mythologists characterise Hermes as mischievous, inventive, playful, and creative (Moules, 2002). The ability to interpret, translate, uncover, and bring new insight, are paramount when utilising a hermeneutic methodology. This seemed a good fit with the WPTA, which seeks to uncover any meaning carried in chronicity.

*Epistemology* refers to "the way in which people gain knowledge about the world and come to regard some beliefs as true and others as false" (McLeod, 2011, p. 30). The epistemology of hermeneutics examines the philosophical foundations of the formation of knowledge, utilising the interpretative paradigm and acknowledging the benefits and limitations of the paradigm on hermeneutic research. One example of a key element of epistemological hermeneutics is the hermeneutic circle (McLeod, 2011). I applied Boell and Cecez-Kecmanovic (2014) model comprising two hermeneutic circles, to my research. McLeod (2011) explained that the hermeneutic circle acknowledges that making sense of the whole relies on understanding each of the parts. Equally, to comprehend the parts, it is essential to understand the whole. Working within the hermeneutic circle is to participate in circling between an alternating emphasis on the parts before focusing on the whole, and then circling around again (Boell & Cecez-Kecmanovic, 2010). The alternating focus between the parts and the whole seemed particularly appropriate for my research question, which draws together three different parts; negative capability, the complexity of chronicity, and the WPTA, yet seeks to make sense not only of these parts, but of the whole body of literature.

At the beginning of my research, I sought a research methodology that would allow my research question to evolve as my research evolved. Underlying this was a desire to remain open to the discoveries I anticipated in my research project. In line with my placement in a hospital setting, I contemplated undertaking a systematic literature review. The strength of a systematic literature review is that it undertakes to review a complete body of research, utilising search criteria that are unbiased and reproducible (Kitchenham & Charters, 2007 as cited in Boell & Cecez-Kecmanovic, 2010). However, Boell and Cecez-Kecmanovic (2010) explained that research questions in the social sciences and humanities usually emerge once the research is underway, rendering a systematic literature review unsuitable. Further, they question if any selection of literature can be considered comprehensive, unbiased, and reproducible. I was aware that positivism is ingrained in bio-medical thinking and research (Grant & Giddings, 2002, p. 13). Consequently, a hermeneutic methodology was likely to hold less weight with medical professionals. Positivists position qualitative research as "soft research" (Grant & Giddings, 2002, p. 16), preferring instead evidence-based approaches. In contrast, Downing and Mills

(2017) stated that "evidence based has come to be associated with cognitive behavioural perspectives" (p. xiv). They asserted that:

> The evidence-based platform is a political hegemony invented by empirical academics, their professional associations, and institutionalised forms of research. It is abetted by the insurance industry that underwrites treatments that are typically of briefer duration and have very little to do with real life, individuals' lived experiences, the actual vicissitudes of treatments undertaken…and what patients disclose to the clinician in professional practice. (p. xv)

In selecting my methodology I held these comments in mind alongside Grant and Giddings (2002) perspective that researchers utilising interpretative methodologies in health research "still report having difficulty getting ethical approval, funding, and/or their work published in prestigious journals" (p. 16). I also gave careful consideration to my research question, which suggested a need to explore different bodies of literature. I recognised the need for a methodology able to contain both the potential dualities and potential convergences that may be uncovered. Considering all of these factors, a hermeneutic approach felt more appropriate. The freedom to draw from other media such as fiction and poetry also appealed.

Hermeneutics positions the researcher and the literature as partners together in the research (Smythe & Spence, 2012). A *hermeneutic methodology* anticipates the considered listening to the way the texts speak to the researcher, and the inclusion of both the researchers' understanding of the texts, as well as their felt responses to the literature (Smythe et al., 2008). The allowing of myself and my subjectivity alongside the texts was appealing. Smythe (2012) suggested that each researcher will be drawn to one research type more than others; I felt drawn to hermeneutics. Both the WPTA and hermeneutics advocate the iterative process of circling around in ever increasing proximity, to *the thing itself*, not arriving at a definitive answer, but searching for greater meaning alongside new lines of questioning. Hermeneutics sparked my interest and appeared to provide the structure I needed, alongside the freedom I craved, to explore the intricacies of negative capability, the complexity of chronicity, and the WPTA.

**Good fit with psychotherapy and research question**

Understanding, interpretation, and reflexivity, are widely considered as core skills of psychotherapy. Historically, Freud (Thurschwell, 2009) highlighted the importance of interpretation, particularly in his work on the unconscious. According to Orange (2011), this implies that psychotherapy and hermeneutics are well suited. Hermeneutics is regarded as the theory and practice of understanding (Orange, 2011). The emphasis placed on interpretation and reflexivity in hermeneutics suggests a natural alignment between psychotherapy and

hermeneutics. Hermeneutics demands that the researcher moves outside sensory observations and listens to the content disclosed by participants, interpreting the importance of participants' understandings in a way that they have perhaps not seen before (Grant & Giddings, 2002, p. 16). According to Orange (2011), psychotherapy and hermeneutics are both regarded as intersubjective. Neither hermeneutics nor psychotherapy seeks a definitive understanding or interpretation. Instead, the objective is to explore new insights or understandings and present them in a way that does not foreclose on the thinking and interpretation of the reader, but enables the reader to think along with the researcher (Smythe, 2012). This objective further highlighted the alignment between hermeneutics, my research question and Bion's understanding of negative capability, which is to remain present in uncertainties and to resist jumping to premature conclusions.

Broom (2007) examined the need in the WPTA for the therapist to sit together with clients, exploring the underlying meaning in their symptoms, words, or stories. Akin to the hermeneutic circle, both the WPTA and psychotherapy seek to engage with the parts to make sense of the whole, and the whole to make sense of the parts. Crowther et al. (2017) argued that the role of hermeneutic research is to "illuminate essential, yet often forgotten, dimensions of human experience in ways that compel attention and provoke further thinking" (p. 827). I believe this expresses the need to focus attention and elicit further thinking on the suffering inherent in chronic pain/illness.

**Historical consciousness**

The nature of being and becoming is innate to human beings; the subset of philosophy which examines these phenomena, is ontology (McLeod, 2011). In hermeneutics, *ontology* denotes the process by which we understand a person's context through his or her individual historical, cultural, and social situation (McLeod, 2011). Gadamer [1900-2002], a German philosopher, introduced the notion of "historically-effected consciousness" (Gadamer, 1993, p. 264), meaning each individual is embedded in the time and place in history, and the culture and family system in which they were raised. Gadamer (1993) also referred to this as "prejudice" (p. 241), referring simply to the preunderstanding that our personal histories imbue us with. As a researcher, it is vital to recognise the preunderstanding or prejudice I bring to my research topic.

Hermeneutics demands that researchers bring awareness to their own prejudices, and exercise reflexivity, to both acknowledge and utilise preunderstandings as an integral part of the research process (Gadamer, 1993). Just as we make sense of our own preunderstandings, hermeneutics requires that researchers also examine the unique historical, social, and cultural contexts of our

participants, as we enter into discourse (McLeod, 2011). Hermeneutics is ontologically positioned within critical realism due to its importance placed on context (Braun & Clarke, 2013).

Gadamer's notion of historical consciousness (Gadamer, 1993, p. 264) suggests that one must understand the historical environment of the object of study to comprehend the object fully. According to this premise, it is not possible to fully understand anything, be it language, text or art, without understanding the historical context, the place and time, in which the object is situated. Schleiermacher, a German philosopher who is considered the father of hermeneutics, illustrated this when he wrote:

> Hence the work of art, too is really rooted in its own soil, its own environment. It loses its meaning when it is wrenched from the environment and enters into general circulation; it is like something that has been saved from the fire but still bears the burn marks upon it. (Schleiermacher, as cited in Gadamer, 1993, p. 166)

The researcher must exercise reflexivity to explore their own historical context, or relationship, to the researched phenomenon (Grant & Giddings, 2002; McLeod, 2015).

***My historical consciousness***

Consistent with a hermeneutic methodology, I entered my research using my own lens, historical consciousness (Gadamer, 1993) or set of prejudices (McLeod, 2011). My first-hand lived experience of a chronic pain/illness, described in Chapter one, was so ingrained in my psyche, as to be inseparable from my sense of self. I was raised in a household that placed a high value on medical science, the biomedical model, and a low value on the identification or expression of feelings. I am a middle-aged Pākehā woman with a background in business, and was drawn to articles applying negative capability to disciplines outside psychotherapy. As a student of psychotherapy, I have learnt to cherish affect as a valuable source of knowing. At my placement, I was privileged to train with a team committed to the health of the whole person, and who rejected the Cartesian/dualistic split of mind/body. The team sought explanations for suffering in the meaning each individual attributed to their illness, named “somatic metaphors,” and described as "the highly specific and personal meanings in bodily disease, at times with extraordinarily obvious symbolic features" (Broom, 2007, p. 1). Broom (2007) asserted that meaning-full disease is ubiquitous and not restricted to conditions commonly related to psychosomatic presentations. The combination of these elements comprised the personal historical consciousness I brought to this research.

***Cultural historical consciousness***

Aotearoa New Zealand predominantly follows the Western dualistic biomedical model of healthcare. The biomedical model describes "health" as freedom from pain or disease, and focuses on the physical causes of pain and disease. Rene Descartes [1596 – 1650] is attributed with proposing the separation of the concepts of mind and body in medicine (Gobert, 2013). Descartes viewed the body as mechanical and separate from the mind. His theory of mind-body dualism suggests that the body was more real than the mind (Gobert, 2013). Today, Cartesian dualism still forms the foundation of the predominant Western biomedical model, resulting in the view that physical pain and chronic illness reflect mechanical issues in the body. This has led to the privileging of objective physical symptomology. Perhaps unintentionally, it has been proposed that mind-body dualism has led to teaching the physical and mental aspects of healthcare separately, and privileging the physical over the mental (Johnson, 2013). The biomedical model offers limited consideration to individual subjectivity, meaning-making, social, spiritual, or cultural factors, and their relationship to illness (Annandale, 2014). Broom (2016a) cautioned that psychotherapy may be as dualistic as the biomedical model, but sits on the other side of the Cartesian split by privileging the mind over the body. While it is beyond the scope of this research to explore the cultural aspects of hospital care or psychotherapy thoroughly, it seems essential to acknowledge the cultural dynamics at play.

In Aotearoa New Zealand, while psychotherapy predominately follows Western literature, originating in Europe, indigenous Māori have traditionally employed a more holistic attitude to healthcare. Broom (2007) contends that Pākehā acceptance of spirituality in Māori concepts of health and wellbeing may create an openness to including such aspects in Pākehā concepts of psychotherapy.

The hospital, where I had my placement, utilised the biomedical model and focused on the body, specifically how to fix illness/pain/dysfunction. Conversely, the team I worked with focused on the WPTA. While a focus on the body was important, other areas of personhood were considered equally important. I sensed a cultural uneasiness alive in the hospital, in my clients, and in myself. We grappled with the differing perspectives of the hospital as an organisation, the department, and the discipline of psychotherapy.

With time and immersion in the hermeneutic research literature, I came to identify positivist leanings in my historical consciousness. The disciplines of science and medicine value positivism for its emphasis on objectivity and quantifiable data (Grant & Giddings, 2002). Sitting within the *realist* ontological position, "realism assumes a knowable world" (Braun & Clarke, 2013, p. 27).

Practitioners of positivism regard the researcher as the expert and value the separation between subject and researcher. In my family of origin, doctors and the biomedical model were respected and not questioned. My clients were predominantly raised in a Western context, either partially or entirely, and had faith in the biomedical model. I found a desire alive in both my clients and myself, to find the answer, to know the reason for their suffering. I noticed a time pressure for this knowing, alongside an understanding that an expert would provide the answer, therefore absolving the client from any need, beyond describing symptoms, to grapple with this knowing. As a fellow chronic illness sufferer, I recognised and identified with my clients' desire for an expert to provide a quick answer.

***Global consciousness***

My research area, and the inclusion of negative capability, was selected before COVID-19 fully impacted Aotearoa New Zealand. Nevertheless, I find it curious that I am writing a dissertation in 2020-21, against a backdrop of the COVID-19 pandemic and intermittent lockdowns, increasingly impacting Auckland in particular, where I live and study. While the city, country, and the world grappled with uncertainty, uncertainty became the key focus of my work.

**Method**

I applied Boell and Cecez-Kecmanovic's (2014) hermeneutic framework, comprising two hermeneutic circles. The search and acquisition circle is concerned with the locating, reading, and selecting of texts (Boell & Cecez-Kecmanovic, 2014). I utilised a structured approach to searching for literature, searching OVID, PsycInfo, PEP and Google Scholar for relevant articles. Applying the search terms "bion" or "negative capability*" or "uncertain*" or “knowing” or “not knowing” or “-K” and "wholeperson*" or "whole person" or “whole person treatment approach" or "WPTA" or "mindbody" or "mind-body" or "mind body" and “chronicity” or “chronic illness” or “chronic pain” or “chronic disease” or “chronic condition”. I discovered that there was no research combining my topics of interest. I changed tack, and searched for the disparate bodies of research separately.

Initially I searched for literature about the WPTA in the Auckland University of Technology library databases. As I was specifically interested in Broom's concept of the WPTA (Broom, 1997, 2007; Broom & Joyce, 2013), I narrowed the search to include all literature concerning the WPTA, either authored or co-authored by Broom. To ensure I had all the relevant texts, I employed reference tracking. Next, I began to search OVID, PsycInfo, PEP, and Google Scholar for Bion and negative capability. Here, I found an abundance of information including explanations of Bion's

understanding of negative capability and Bion's core theories (briefly outlined in Chapter one) within which negative capability sits. I was particularly interested in the application of these texts to understanding the complexity of chronicity. As the researcher using a hermeneutic methodology, I become the interpreter of any possible connections between these collections of literature.

I explored literature that applied Bion's understanding of negative capability to other disciplines such as business, education, and social work. Perhaps due to my business background, I found that articles applying Bion's concept of negative capability to business (Crossman & Doshi, 2015; Decou & Kao, 2011; Fournier & Grey, 2000; French, 2001; French & Simpson, 2000, 2005; Jameson, 2012; Saggurthi & Thakur, 2016; Simpson & French, 2006; Simpson & von Bulow, 2020; Simpson et al., 2002) were a natural way to begin to engage with and think about the real world application of negative capability. Boell and Cecez-Kecmanovic (2010) noted that texts gathered for a hermeneutic literature review do not claim nor attempt to review all potentially relevant literature. Rather, in selecting literature for inclusion, the hermeneutic circle comes into play. The researcher's subjectivity becomes a research tool, guiding the selection of a pertinent and meaningful subset of the available literature. Utilising the hermeneutic circle ensures researchers select the most relevant texts, thus, increasing the understanding of the phenomena being explored in the literature, thereby improving the quality of the literature review (Boell & Cecez-Kecmanovic, 2010). Applying the hermeneutic circle to my search, I reviewed each potential text, taking notes of key themes and my responses to these themes. I excluded any texts that did not further my understanding of negative capability. Again, I employed reference tracking, and followed up on readings suggested by my supervisors and colleagues.

Having selected literature that matched the search and acquisition phase of Boell and Cecez-Kecmanovic's (2014) framework, I began to draft my initial chapters. My introductory chapters outlined my topic, what drew me to it, and introduced the topics key elements. The current chapter explores the hermeneutic methodology, and methods applied. Following this, I moved to the analysis and interpretation, or second circle of the framework (Boell & Cecez-Kecmanovic, 2014). This needed a deeper dive into the literature.

The texts selected for a hermeneutic literature review question the researcher, requiring active participation (McLeod, 2011). Each person discovers different truths in the literature. Boell and Cecez-Kecmanovic (2010) maintained that once saturation is attained, the researcher exits the hermeneutic circle. *Saturation* is described as the time when further inquiry does not seem to add new understanding. I found the point of saturation difficult to identify, concerned I might

miss something, I repeatedly returned to the search and acquisition circle, almost becoming overwhelmed by the expanse of literature available. Eventually, I came to trust the hermeneutic framework and was able to exit the search and acquisition circle, put aside my positivist leanings, which I identified as the driver behind my desire for a complete set of texts, and remind myself that no body of literature was comprehensive. At this point, I was poised to engage more deeply with the process of data analysis. My note taking had become prolific. I employed Microsoft Word and OneNote in an attempt to bring order to my thoughts.

Perhaps due to the large set of texts, I was still struggling and felt I was dangling and spinning, rather than circling ever closer to the thing itself. The theoretical understanding I gained in reading about the hermeneutic circle, had not prepared me for the sense of confusion and overwhelm experienced. Here, I discovered Quirkos, a software package designed to help analyse qualitative data. Although time consuming, requiring a line-by-line analysis of my notes, Quirkos assisted in extrapolating and grouping themes embedded in my literature. Nevertheless, more analysis was required. My sense of dangling continued. At the point of almost giving up, I realised that I was having a lived experience of uncertainty, and that with each iteration, although it did not always feel like it, I was gaining insight. Once again, I immersed myself in the texts and engaged in a discussion with the literature. Eventually, the texts were in conversation with one another (Boell & Cecez-Kecmanovic, 2010).

I held in mind Smythe's (2012) contention that the purpose of the hermeneutic circle is to facilitate interpretation of the literature in a way that does not exclude the interpretation of others, but supports individual readers in their own interpretation and insights. Seven themes began to emerge from my literature, and in my mind, took the shape of a roadmap; these are explored in Chapters four and five. In line with the hermeneutic methodology and the concept of negative capability, I understood I would not arrive at an ultimate understanding or interpretation in writing my discussion chapter. Rather, by keeping the space open, alongside the constant analysis and interpretation inherent in the hermeneutic circle, I hoped to come closer to describing the lived experience of understanding whether the capacity of negative capability could support an understanding of the complexity of chronicity when working with the WPTA.

**Inclusion and exclusion criteria**

Bion's theories are prolific; reminiscent of the hermeneutic circle, each of Bion's theories fitted into the whole body of Bion's work. To understand the whole, I needed to understand each part or theory. Equally, the understanding of each theory facilitated the understanding the whole

jigsaw of Bion's work. Early in my research, I found myself lost in the exploration of Bion's work. Eventually, I realised that a study of Bion's work would be a lifetime's journey, and beyond the scope of this dissertation. In Chapter one, I provided a brief theoretical context of container/contained, K, -K and O, which I consider necessary for understanding the concept of negative capability. For the purposes of this dissertation, I have excluded Bion's other theories.

Negative capability is a core concept of exploration in my research. I searched databases about how others applied this concept to their varying disciplines. Initially, I read widely, seeking texts that would expand my understanding of the concept. Ultimately, I began to exclude texts that were not adding to my understanding, and settled on a core group of articles to explore more closely.

As discussed in Chapter one, the WPTA is a term coined by Broom (Broom, 1997, 2007; Broom & Joyce, 2013). I began this research by familiarising myself with all of Broom's writings on the topic, then focused on those texts I considered most applicable to my study.

For the size and scope of the current research, it would have been impractical to introduce a third body of literature. Therefore, the texts exploring chronicity were limited to defining and briefly explaining the complexities of chronicity. However, I was particularly interested in connections between negative capability and chronicity, and between the WPTA and chronicity. While the WPTA can be applied to any illness, it is regularly applied to chronicity.

**Chapter summary**

In this chapter, I initially focused on the philosophical and epistemological foundations of hermeneutic research. Then, I described why I believed my chosen hermeneutic literature review was a good fit with psychotherapy, my research question, and myself as the researcher. Next, I explored my historical consciousness, the cultural historical consciousness of Western biomedicine, and the current global context of COVID-19. Then I detailed the method used in my hermeneutic literature review, including specifying the processes of data searching, collection, and analysis. I also outlined difficulties encountered, potential limitations, and my inclusion and exclusion criteria.

In the following Chapters four and five, the findings chapters, I outline the seven themes that emerged. Chapter four explores the obstacles encountered, while Chapter five focuses on the themes that assist in bridging these obstacles.

## Chapter 4. Findings: Obstructions or roadblocks

### Introduction

Chapters four and five synthesise the literature explored. Seven themes emerged, which I grouped into two distinct categories to facilitate understanding. The current chapter explores the three roadblocks encountered on the roadway to utilising negative capability to support understanding chronicity when working with WPTA: the culture of biomedicine, dualities/dichotomies, and finally, -K and dispersal.

### Roadblock 1 - The culture of biomedicine

Patients seek the services of a professional, such as a doctor or psychotherapist, when they reach the end of their knowledge or understanding of their illness. Patients arrive seeking answers or solutions.

#### *The fantasy of the silver bullet*

As a psychotherapist working with chronicity, I have felt an urgent desire to know the cause of my clients' suffering and provide a solution. Uncertainty and not knowing feel unacceptable, even unbearable. Clients have expressed frustration that no-one has fixed their illness. The fantasy of the silver bullet is the belief that if we search hard enough, if the doctor or therapist is expert enough, and the appropriate medical intervention offered, the client will be cured of their suffering and the responsibility of thinking about their illness. In my lived experience of chronicity, I have frequently wished for the elusive silver bullet.

The desire for the silver bullet evokes Freud's (1922/2011) pleasure principle. Essentially, Freud attributes the *id* (Latin for "it") with seeking immediate gratification from anxieties and stresses. The id employs omnipotent and hallucinatory means to evacuate intruding reality anxieties (Israelstam, 2009). Physicians are trained to diagnose and cure, but I wonder if physicians and patients seek to discharge the discomfort of not knowing the cause of chronic illness with premature knowing or early diagnosis?

#### *The expectation of performance and expertise*

Performance, decisive action, and cost-efficiency, permeate Western culture (Simpson et al., 2002). Societal pressure is exerted "to subordinate knowledge and truth to the production of efficiency" (Fournier & Grey, 2000, p. 17). The biomedical model emerged from a Western

cultural perspective. Patients and the medical profession expect physicians to be experts, diagnose, and cure, all in a standard 15-minute doctor's visit, which seems unrealistic.

An illustration of the biomedical imperative to be expert and economically efficient came at my hospital placement when my usual supervisors were away. A physician suggested that limiting psychotherapy to four or six sessions would help more patients. I found this thought provoking, as chronically ill patients referred for psychotherapy were engaged with the hospital system for years, not months. Patients were commonly referred from specialist to specialist, each looking at one part of the body. Furthermore, patients lamented that no-one looked at their whole body. Psychotherapy provides a space for chronically ill patients to reflect on their symptoms, their impact on their lives, and consider possible meaning in their chronicity. Several patients noted using fewer medical services, for example, A&E, while engaged in psychotherapy.

As discussed, biomedicine views body/physicality and mind/subjectivity as separate compartments. The body is viewed as a machine. Illness is understood as a biological breakdown caused by hereditary, degenerative or traumatic disruptions in the body machine (Borrell-Carrió et al., 2004). Therefore, the biomedical lens considers it appropriate to focus solely on physicality and exclude factors such as human subjectivity (Broom, 2000).

Biomedical physicians view their initial duty as the diagnosis of physical disease. Termed *essentialisation*, diagnosing physicians search for commonality or patterns in patients' symptoms and tend to disregard symptoms not fitting their diagnosis. Thus, the doctor is an observer, and the patient an object (Broom, 2000). Failure to diagnose a patient is construed as a failure by both the patient and physician. Broom (2000) argued that the worldwide explosion of medical costs is partially rooted in the need for physicians to identify the physical cause of a patient's suffering. Without a diagnosis, a further round of medical investigation ensues, but what if more than physicality is contributing to illness?

***A challenge to our cultural lens***

The whole person treatment approach, a unitary model of personhood that views physicality and human subjectivity as co-emergent, is considered a radical position when viewed through a Western cultural lens (Broom, 2000; Broom et al., 2012). Broom (2002) argued we need a paradigm shift, a new model that enables holding physicality and human subjectivity in the same time and space. Physicians' resistance to seeing somatic metaphors is perhaps explained by the challenge they pose to current medical thinking about disease genesis, diagnosis, and even the way reality is constructed in biomedicine (Broom, 2002).

Western biomedicine provides an enculturated lens or way of seeing (Broom et al., 2012). A perhaps unintended consequence of current biomedical training is that it conditions young doctors to see disease through the lens of body-as-machine, that is, physically based. Biomedicine cannot see meaning in disease, nor allow the possibility that human subjectivity and physicality could occupy the same clinical space (Broom, 2002). Initially trained as an immunologist, Broom (2007) described not seeing patient stories matching their physical illnesses, until he trained as a psychotherapist (p. 5). Once clinicians begin attending to the patient's story, examples of highly congruent stories and symptoms are common (Broom, 2000). Biomedicine contributes to disease continuation by limiting the lens to the purely physical dimension of illness (Broom, 2002, p. 26).

Psychotherapists may also fail to see meaning in disease. Situated within a background of Western enculturated dualism, therapists can encounter resistance to the WPTA in their clients and in themselves. Acquiescing with biomedicine, therapists focus on human subjectivity and abdicate physical responsibility to physicians rather than listening for congruent communication between physicality and human subjectivity.

Western culture is individualistic. There is an emphasis on "I," and "I am," yet much of who we are is made up not just of an "I am," but also a "we are." Interestingly, in cultures focusing on the collective, disease as an expression of the collective or *we are*, is considered usual. Durie (2001) designed Te Whare Tapa Whā, a Māori[7] model postulating health comprising four pillars: *taha tinana* (physical health), *taha wairua* (spiritual health), *taha whānau* (family health) and *taha hinengaro* (mental health). Unlike the biomedical model, all walls are considered equally important. Without attending to all four walls, a person, persons, or the collective, may become unwell (Durie, 2001).

In working with WPTA, Broom (2007, 2016a) observed many examples of the *we are*, where disease holds meaning imbued by our family systems, communities, spiritual beliefs, and cultures. For example, Broom (2007) drew on his experience of developing a lesion on his arm, where the skin appeared to have atrophied and remained unchanged for several years. Whilst engaging in personal psychotherapy, he reported a dream about his father, who had died of lung cancer aged 59, leaving Broom wondering if he might die of cancer in his 50s. His dream, set in a rest home, saw Broom sitting in a deck chair on a balcony. The wooden chair frame contained round cancerous growths, similar in size to the lesion on his arm. After the dream, Broom reflected on his relationship with his father, culminating in a visit to his grave. Over the next ten

[7] Māori are the indigenous people of Aotearoa New Zealand

days, the lesion disappeared along with his fear of succumbing to cancer in his 50s (Broom, 2007, pp. 198-200). Broom's example illustrates a physical and dream representation of the *we are*, a fear passed from father to son but through a biomedical lens, only the skin lesion would have been visible.

Recently, attention has focused on the damage caused by intergenerational trauma, either in family groups or larger populations subjected to the historical and ongoing trauma of colonisation or wartime atrocities such as the holocaust. Studies have found that adverse health outcomes of such trauma are not confined to the generation suffering the trauma (Cohn & Morrison, 2018; Moewaka Barnes & McCreanor, 2019; Mulligan, 2021; Yehuda et al., 2016). Therefore, meanings or symbols in disease may originate in a time or space outside the individual who carries the disease.

The mathematical foundation of EBP, the mind/body split, and essentialisation as the method of diagnosis, are woven into the historical consciousness of biomedicine, and form the foundation of the roadblock presented by biomedicine. The dualistic lens of biomedicine with its defined boundaries viewing illness as a breakdown in the body-as-machine, seems too narrow to allow for the complexity of chronicity. Moreover, the dualistic lens seems designed to impose certainties, rather than allow physicians time to sit with uncertainties. Conversely, the WPTA suggests we start with each individual's story and symptoms and listen for the echoes, that provide clues to disease genesis in each individual. We each carry our own unique cultural heritage, family patterns, attitudes, gestures, language idioms, and physicality, which make up our historical consciousness and implicitly impact how we interact and understand each other (Schermer, 2014). Western culture and biomedicine are individualistic and focus on the *I am,* excluding the potential *we are* in disease genesis. The ideas that disease may originate outside the individual and/or be expressed in story, are confronting, even frightening to Western sensibilities, yet can be contained and explored using the WPTA or indigenous models of health. Next, the second roadblock emerging from the literature, our cultural struggle with dichotomies, is explored.

**Roadblock 2 – Dualities/dichotomies/polarities**

> The truth is not in the middle, and not in one extreme, but in both extremes. (Charles Simeon 1892, cited by Simpson et al., 2002, p. 1219)

At the foundation of biomedical culture is the mind/body split, which presents a paradoxical dilemma for those suffering chronic illness. Behal (2014) contended that people have a reduced capacity to contain uncertainty when confronted with paradoxical dilemmas. Commonly, we

tend to split and view a duality/dichotomy as two separate or opposed concepts, an either/or choice. In the literature studied for this research, the words "dualism," "dichotomy," "reductionism," "polarity," and "paradox" were featured liberally and used interchangeably[8]. Our difficulty holding both poles of a paradox is worthy of further investigation, as we explore what obstructs negative capability, the ability to tolerate ambiguity and paradox (Bion, 1970; French, 2001; Keats, 2005).

In my reading, I encountered many dualities or dichotomies that illustrate our human tendency to split: mind/body, subjective/objective, knowing/not knowing, negative capability[9] (Voller, 2011), being/doing, affect/cognition, personal/professional and childhood/adulthood. Generally, one side of each duality carries more weight. For example, body and objectivity are given primacy in biomedicine within the mind/body and subjective/objective dualities. According to Derrida et al. (2002), all texts contain poles. He believed that in any duality, both poles are always present, even if one is prevalent.

Our human and cultural imperative to view dualities, polarities, and dichotomies as either/or choices evokes Klein's (1932) good breast/bad breast theory. Briefly, Klein (1932) contended that infants view the mother's breast as two separate objects, the good breast, providing food, warmth, and satisfaction, and the bad breast, withholding food, and experienced by the infant, as absent or cold. It is a developmental stage for the infant, with a good enough mother, to realise the good and bad breast is the same breast. The infants' positive and negative experiences are part of the whole experience of the breast. Without reaching this developmental stage, the defence of splitting is evident. According to McWilliams (2011), splitting is the desire to simplify complex situations into good or bad. Culturally, splitting is evident in narratives of good versus evil or God versus the devil. However, splitting always entails a distortion of reality, as only one aspect of a person, object, or experience, is recognised (McWilliams, 2011). Therefore, dualities create a roadblock by oversimplifying, resulting in losing the complexity and depth available if both poles or extremes were considered part of the whole. Exercising negative capability, the ability to sit with uncertainties and doubts without foreclosing into premature knowing, is a prerequisite to holding the complexities of the whole without splitting.

[8] In this dissertation, I also use the words "dualism," "dichotomy," "reductionism," "polarity," and "paradox" interchangeably

[9] Negative capability can be viewed as a paradox or ambiguity. The term "capable" suggests proficiency, while "negative" suggests a lack.

In exploring dualities and paradoxes, I discovered Victor Schermer's (Schermer, 2014) "Dimensions and dualities: the architecture of psychoanalytic interpretation." His chapter proved fertile in anchoring my processing and thinking around dualities. Schermer (2014) utilised philosophical hermeneutics to explore dualities or polarities and the ways they express in psychoanalytic psychotherapy. I applied Schermer's (2014) structure to explore the numerous dualisms arising within my research and to understand the roadblock arising from dualities. The first duality is implicit/explicit.

***Implicit/explicit***

Schermer (2014) first duality is implicit non-verbal versus explicit verbal expression. Interpretations are a reiteration of what is already alive in the patient's lived experience. Similarly, patient stories are verbal expressions of personal meaning-making and have been co-emerging since the beginning of life (Broom et al., 2012). Implicit meanings can match patients' explicit physical symptoms and their stories; however, the similarity of patients' physical symptoms and their stories is not always immediately obvious (Broom, 2007). The patient may not have heard their verbalised implied meaning or symbol until it is presented as an interpretation by the therapist (Broom, 2007). Additionally, a patient's ability to use any interpretation depends on their readiness to receive it and their perception of each interpretation's usefulness.

***Here and now/life narrative***

Schermer (2014) constructed a second duality in which one polarity is the interpretation of here and now transference in therapy; the opposite polarity is the patients' history, culture and lived experience comprising dreams, memories, biography, life narrative, and coping mechanisms outside of the room. The WPTA perceives here and now transference in the therapy room, and cultural and historical story elements as co-emergent. Both are present in the patient's story and symptomology.

***Objective/subjective***

According to Schermer (2014), the objective/subjective polarity has troubled psychoanalysis from the beginning. Issues of consciousness, metaphysics, and Cartesian mind-body dualism are at the core of Western culture. There remains a polarity in psychotherapy that moves between understanding each client's inner world and a detached observation of the client. This polarity is objective explanation versus subjective experience, expression, and understanding (Schermer, 2014). As discussed earlier, biomedicine is embedded in an objective explanation of illness,

mainly ignoring the subjective pole, while psychotherapy, the study of inner life, favours subjective experience (Broom, 2016a).

When the therapist listens without memory, desire, or understanding (Bion, 1970), the subject-object polarity disintegrates. The WPTA, with its foundation in the co-emergence of all aspects of personhood, advocates working to dissolve the subjective/objective polarities within biomedicine.

***Attunement/difference***

Apparent in child development is the polarity of empathy and attunement versus radical difference (Schermer, 2014). The baby needs an empathetic mother to engage through mirroring facial expressions, gestures, and sounds. Without empathic interchange, the baby's emotional development and ability to individuate is interrupted as the child grows and separates from the mother. The dyad steps back from empathy and attunement and moves towards understanding the mind and emotions of the other. This developmental step can lead to complicated feelings of separateness in both mother and child. Paradoxically, to understand the subjectivity of the other, we need to feel our difference (Schermer, 2014). In the WPTA, this polarity is represented by patients being offered the best scientific medical interventions alongside listening for the unique differences echoing in each patient's story. Biomedicine uses the pole of attunement by using essentialisation to find a pattern in symptoms, enabling a diagnosis. Biomedicine is not concerned with finding individual differences in symptoms.

***Construction/destruction***

Interpretations within psychotherapy are intended to add to self-knowledge by uncovering each client's paradoxes and ambiguities. Interpretations are simultaneously constructive and destructive, expanding the client's ability to tolerate absence and unknowns or capacity for tolerating uncertainty. For self-development, Schermer (2014) maintained that people confront the poles of presence/absence, structure/ambiguity and construction/deconstruction and destruction. We are frightened of unknowns, as the creation of new is often blocked until the old is deconstructed. Broom (2016b) advocated deconstructing old beliefs through a process he named "midwifing." *Midwifing* refers to deconstructing entrenched biomedical beliefs and providing education, assisting patients to release resistance and engage in the WPTA. Patients are reassured that the WPTA attends medically to symptoms while also attending to subjective elements of their unique personhood.

***Spirituality/science***

The work of Freud and Jung illustrates the spirituality/science polarity (Schermer, 2014). While Jung focused on the mystical, spiritual facets of the psyche, Freud focused on a biomedical view, in which biological drives rule the psyche. The mystical and rationalist outlooks can stand shoulder to shoulder in a postmodern world, allowing both poles to be explored (Vattimo & D'Agostini, 2010). Bion's wrestling with each pole is evident in his work. His grid (Bion, 1984a), comprising letters, Greek symbols, and mathematical signs, represents the scientific pole. The spiritual pole is expressed in his concept of O, and his belief that the unconscious cannot be grasped by memory, desire, or understanding.

The creation of the WPTA grapples with the polarity of spirituality versus science. Broom, trained first as a medical doctor, used medical science alongside subjective elements of personhood, including the spiritual, to attend to physical illness (Broom, 1997, 2000, 2002, 2007, 2010, 2011, 2016a, 2016b; Broom et al., 2012; Broom & Joyce, 2013; Lindsay et al., 2015). Broom dedicated one chapter of his work to physical symptoms that co-emerge with transpersonal meaning (Broom, 2007, pp. 189 - 203). He acknowledged the difficulty of gaining a common understanding of spirituality. For some, this involves a supreme being, such as God; for others, it is formal religion; for some, it is a connection with something bigger than themselves, while another group would explain spirituality as reflected in nature or beauty. Broom (2007) postulated that Pākehā New Zealanders have historically accepted the role of spirituality when the spirituality belonged to other, for example, to Māori. Spirituality is becoming increasingly widespread and acceptable, making it easier for people to own their spirituality. Meaning is at the centre of spirituality; therefore, any consideration of meaning in disease must include spiritual elements (Broom, 2007).

Dualities, reductionism, paradox, dichotomies, and polarities, were all interwoven throughout the literature reviewed, and resulted in an either/or splits focusing on one polarity while ignoring the other. Furthermore, dichotomies created a rush to premature knowing, preventing staying with the unknowns or exercising negative capability. For patients suffering chronicity, this is unhelpful, as it closes down the space for new learning or understanding of their illness.

I agree with Schermer (2014), that dualities are best viewed not as concrete polarities but as dialogical flux elements. Winnicott (1971) appreciated the usefulness of uncertainty and formlessness and asked that the paradox "be accepted, tolerated and not resolved" (p. 53). Likewise, Bion's (1970) interpretation of negative capability asks that we not inflict certainties onto uncertain situations. Therefore, the ability to consider both poles of any duality as parts of

a whole rather than an either/or dichotomy could be considered an expression of negative capability. Furthermore, I found that there is no need to solve the opposing forces evident in any duality; rather, the task is to understand that both poles hold information vital to understanding the complexity of the whole picture; this understanding has helped in my work with clients suffering chronicity. Next, I explore the final roadblock of -K and dispersal, but, first, I outline the difficulty of staying with uncertainty.

**Roadblock 3 – Anti-knowing and dispersal (defences against uncertainty)**

***Staying with uncertainty***

> …without any irritable reaching after fact and reason—Coleridge, for instance, would let go by a fine isolated verisimilitude caught from the Penetralium of mystery, from being incapable of remaining content with half-knowledge (Keats, 2005, p. 60).

Critical in Keats' understanding of negative capability is the ability to remain in a state of uncertainty and doubt "without irritable reaching after fact and reason…from being incapable of remaining content with half-knowledge" (Keats, 2005, p. 60). Why is it that we struggle to stay with uncertainty? In my clinical work, I have noticed that patients, some of whom had not found significant improvement in their symptoms using a purely biomedical approach, expressed a desire to explore the WPTA. However, these same patients struggled to contain the uncertainty and doubt aroused when they moved away from strictly biomedical interventions. The WPTA utilises best-practice medical knowledge alongside increasing the patient's capacity to discover the unique story elements in their illness, so the patients' biomedical treatments did not change. Also, midwifing, to alleviate any potential discomfort with this unfamiliar approach, was employed before moving to the WPTA (Broom, 2016a). Examples I encountered of struggling to contain uncertainty evoked by the WPTA, were demanding additional biomedical appointments with physicians who had done all they could to help the patient, patients insisting on a change of medication when all appropriate medications had been trialled and prescribed, or the terror of their illness escalating at night, resulting in the patient presenting at A&E. Curious about what lay beneath the surface, I explored the literature and discovered Bion's (1984a) concept of minus knowledge (-K), which describes thought processes that substitute for thinking, such as prematurely reaching for certainty in times of emotional distress. -K and dispersal, outlined next, are defences against the emotional experience encountered in the space between knowing and not knowing.

### *The emotional experience in the space between knowing and not knowing*

The edge of knowledge is often conflated with the edge of competence, which in Western culture, where expertise and competence are valued, can induce panic, confusion, and even terror. The edge of knowledge is akin to feeling lost in a dense fog, the cloud of unknowing. The fog cannot be viewed from a distance, giving it external shape and form. Instead, it is viewed from within, leaving no concept of size, shape, or depth (Walsh, 1981). Bion (1965), borrowing from St John of the Cross (2010), called this fog the dark night of the soul, alluding to a night so dark, nothing is seen or recognised, evoking a sense of danger, terror, and bewilderment. Learning, described by Bion as the growth of the mind, occurs at the edge of knowing and not knowing (French & Simpson, 2000). Therefore, new learning and insight may emerge if we can stay with an emotional experience on the edge between knowing and not knowing, and maintain curiosity. However, with no guarantee of or timeline for new learning, and given the depth and complexity of the feelings experienced on the edge, we may seek to rid ourselves of this powerful sense of not knowing. Theoretical discussion cannot adequately recreate the terror experienced at the edge. It evoked my experience of confusion and spinning, described in Chapter three, of being lost in the not knowing, inherent in the hermeneutic circle. This was difficult, even as I studied the phenomenon of not knowing. Therefore, returning to the lived experience of chronic illness, pain, fear and isolation, it is understandable that sufferers find it difficult to stay with their suffering and use the WPTA as a place of potential, often choosing instead, to employ the defences of anti-knowing or dispersal.

### *Minus knowledge (-K)*

Not knowing is respected as a place of potential. It evokes an openness to creation and learning. Bion (1967) highlighted this when he wrote, "the only point of importance in any session is the unknown" (p. 272). Conversely, Bion's concept of -K alludes to mental processes that inhibit or substitute for thinking. Thus -K can be regarded as anti-knowing (Fisher, 2006) rather than not knowing, and is considered detrimental to new learning. Anti-knowing closes down the thinking space with substitutes for thinking such as certainty or reaching a premature answer (Bell, 2010). -K is a decision to stay in ignorance and avoid new awareness (Green, 1998, p. 659). A -K answer brings the open process of questioning to an end, with "someone who KNOWS filling the empty space" (Bion, 1990, p. 578), effectively ending curiosity and the anxiety and fear experienced on the edge between knowing and not knowing. Bion illustrated this with Maurice Blanchot's words, "the answer is the misfortune or disease of curiosity - it kills it" (as cited by Bion, 1978, pp. 21-22). Bion referred to a lack of enquiry or curiosity as a “dark night” to K (Bion, 1965, p.

159). Fear, anxiety, envy, and hate, are the emotions found at the core of -K. This intense feeling state can lead to what Needleman (1990) termed “dispersal.”

### *Dispersal*

*Dispersal* is defined "as a flight from the anxiety of meeting the unknown" (Needleman, 1990, p. 167). The result of -K is often dispersal. To escape uncertainty, we disperse into "explanations, emotional reactions or physical action" (Needleman, 1990, p. 167). We may rush to plan or rearrange the problem, perhaps breaking it into small pieces, or take decisive action (French, 2001). In biomedicine or psychotherapy, we may rush to diagnose or find a definitive answer. While these activities feel like work, they are fundamentally off task (Bion, 1961). Learning stimulates uncertainty and anxiety. Dispersal defends against feeling our incompetence and ignorance. While dispersal is understandable, it is counterproductive, as it closes down the thinking and potential to discover something new in the uncomfortable space between knowing and not knowing. Bion (1992), summed this up when he wrote that "the temptation is always to terminate prematurely the stage of uncertainty and doubt" (p. 290).

## Chapter summary

The literature uncovered three themes that formed roadblocks to understanding how negative capability may support an understanding of the complexity of chronicity when working with the WPTA. These are: the culture of biomedicine, dualities/dichotomies and anti-knowing/dispersal. First, the findings highlighted the values of performance, decisive action, cost efficiency, individuality, expertise, and diagnosis, evident in our Western biomedical culture. The roadblock these values pose was considered next, in relation to complex chronic conditions and concepts including WPTA and negative capability, which require a more open, allowing mindset. The roadblock of dichotomy/duality was then explored, including our human tendency to split, consider a dichotomy an either/or choice, or focus on one polarity and exclude the other. Moreover, the roadblock of dichotomy prevents staying with uncertainties long enough to consider both poles and their contribution to the whole. Finally, the literature suggested that the roadblock of -K and dispersal are commonly employed to defend against our difficulty in staying with uncertainties or unknowns. In Chapter five, the focus of the findings shifts to themes emerging from the literature, that can form bridges to cross the roadblocks presented in this current chapter.

## Chapter 5. Findings: Building Bridges

### Introduction

Chapter four explored the obstacles or roadblocks that emerged from my research. The current chapter explores the bridges discovered in the literature that can be used to overcome the roadblocks to using negative capability to understand chronicity's complexity, when working with the whole person treatment approach. Four main components needed to build each bridge were identified in the literature, and explored in the current chapter: developing an internal container, curiosity, the ability to doubt, and patient waiting.

### Developing an internal container - bridge foundations 1

It became clear from my research that the foundation to building a bridge to overcome the roadblocks inhibiting the utilisation of negative capability to explore the complexity of chronicity through the WTPA, is in the process of developing an internal container. The process of developing an internal container begins in the mother/infant dyad. First, the mother accurately translates and returns thinkable thoughts to the infant. Then, with repetition, the infant learns to translate their own raw data for themselves (Cartwright, 2010). Thus, the mother initially constructs the container between mother and infant. Eventually, nurtured by dynamic curiosity and welcoming the expression of all affect, the container becomes a co-creation between mother and infant. Ultimately, the child can internalise and maintain this active, thinking container, without the mother's physical presence (Biran, 2015).

Thinking begins in the mother/infant dyad with β elements or things that cannot be thought. The ability to contain our own emotion and the emotion of another is central to transforming tumultuous, uncertain emotion, into manageable or bearable thought. Therefore, Bion attributed the ability to contain as fundamental to the ability to think (French & Simpson, 2005). Container/contained is the mechanism through which individuals make meaning, and is regarded as Bion's most evolved theory of thinking, explaining the process through which the unthinkable becomes thinkable. It is equated to thinking itself (Sandler, 2005).

The ability to stay with uncertainties and doubts without foreclosing into premature knowing suggests that holding a thinking space open is a cornerstone of negative capability. Our internal container organises our world, allows creative freedom, and enables us to acknowledge our limitations, and discern internal from external processes (Biran, 2015). Ogden (2004) credits our internal container with the faculty of curiosity and a capacity to dream. An internal container

enables us to hold our experiences lightly, derive knowledge, self-knowledge, and pleasure, from our experiences, and to play (Biran, 2015). The centrality of our internal container to negative capability, understanding the complexity of chronicity and WPTA, is illuminated in these traits. Moreover, without creative freedom, curiosity, self-knowledge, the ability to dream, think and play, it would not be possible to sit with uncertainties and doubts, that is, to exercise negative capability or to engage with the WPTA.

The WPTA is a way of practising that welcomes all aspects of personhood. However, without thought and an internal container, it is difficult to imagine being able to hold all aspects of personhood in mind as advocated by the WPTA, or to challenge the predominant bio-medical model, or contain the internal discomfort such a challenge would evoke. Thus, without a developed container/contained relationship, it is hard to envision the implementation of the WPTA.

***Disruption to the container/contained relationship***

Disruptions to the container/contained relationship and the development of an internal container can arise in two key ways—the first occurs when the mother cannot accurately translate her infant's β-elements. An inaccurate translation leads to confusion in the infant (Biran, 2015). If, for example, the infant is in pain and the mother believes it is cold and wraps her infant warmly, the infant becomes further distressed. As a result, the infant's β-elements are not transformed into thinkable thoughts but are returned to the infant as a nameless dread, leaving the infant in a worse position, a state of meaningless fear (Bion, 1984a). The mother's inability to contain may be the result of never having developed her own internal container.

The second critical way disruptions can occur in developing an internal container is found in Bion's belief that the container is a co-creation. The emphasis is on the mother as the container, and the infant as the contained. However, it is acknowledged that the infant plays a pivotal role in bringing the container to fruition (Biran, 2015). Container/contained is a dynamic relationship in which the infant impacts on the mother's facility to contain. For example, the mother's ability to contain is hampered when the infant is ill, in pain, or discontented. Conversely, the mother's ability to contain is enhanced when the infant is smiling, relaxed, responsive, and satisfied. In this way, the contained shapes the container. Thus, the contained becomes a co-creation between mother and infant (Biran, 2015).

While the theory of container/contained does not overtly discuss chronicity, chronic illness is challenging to think about and to contain; therefore, I believe Bion's conceptualisation of

container/contained applies. Chronicity evokes β-elements, including fear, as ongoing illness can threaten life itself. A chronically ill infant/child may be in pain, distressed, and unable to settle or be soothed. While a mother with a well developed internal container will manage a child with a short term illness, I wonder about her capacity to cope with chronicity. Will the struggle with chronicity leave the child with a sense of being difficult, too much, or even uncontainable? It seems an oversimplification to suggest that a container/contained relationship, in the context as a foundation for thought, would enable negative capability under trying circumstances such as chronic ill-health. However, without an adequate internalised container, the development of thought is hindered, rendering it impossible to utilise negative capability.

An internal container enables individuals to contain and think about their own β-elements. I wonder about the limits of an internal containing function. Can all issues be contained by a well-developed internal container, or does even a well-cultivated internal container reach limits beyond which containing becomes difficult? As discussed, Bion saw container/contained as a co-creation, noting that the infant impacted on the mother's ability to contain. This suggests that infants who suffer chronic childhood illness erode the mother's ability to contain, perhaps leading the infant to internalise “a nameless dread” (Bion, 1984a) of a sense their illness is uncontainable, in a way that would not occur in a generally healthy child. I noticed clients who wrestled to contain the frightening affect of their chronic illness, alongside their physical pain/illness, experiencing a lack of faith in their bodies’ ability to contain that pain/illness. I wondered about the containing function of our physical bodies. Can chronicity lead to an inability to contain, resulting in an inability to exercise negative capability?

Psychotherapy offers the opportunity for new relational experiences. Next, I consider mechanisms available for those not fortunate enough to develop an undisrupted container/contained relationship within the mother/infant dyad. To do this, I draw on Biran (2015) to assist, as his interpretation of Bion's writings into five categories of container/contained has helped me incorporate the theory into my practice. Biran's (2015) first two categories of container/contained are the mother as the original container and internal container, which I have already outlined. Next, I highlight the remaining three categories: the client-therapist relationship, the word, and the community or group.

***The client-therapist relationship***

The therapist, like the mother, acts as the container, and the client, the contained (Biran, 2015). For clients with a mother unable to contain, or whose ability to contain was disrupted by chronicity, therapy can offer a new relational opportunity to experience the therapist as a

benevolent container/mother and ultimately help them develop an internal container. Bion (1970) encouraged therapists' to listen without memory or desire, and clear mental space for the client's thoughts, feelings, and dreams, enabling them to tell their story without focusing on outcome or theory. By utilising transference/countertransference dynamics, the therapists' role is to contain the β-elements remaining from infancy that are too harmful for the client to bear alone (Bion, 1970). The therapist, acting as a vacant container, utilises reverie and translation to weather the client's affect. That is, the therapist acts as the mother, and utilises alpha-elements to translate the client's terrifying, unthinkable β-elements. The therapist, providing an active container, holds hope, thinks and creatively engages with the client's β-elements before returning them to the client as thinkable thoughts (Biran, 2015). The word, along with communities and groups, also affords opportunities to contain.

**The ability of the word to contain**

The idea of *the word* is essential in psychotherapy, often referred to as the "talking cure." Language or the word, can give structure and form to previously unnameable things (Waddell, 2002). The word can clarify, arrange, and calm (Biran, 2015). In this way, the word can comfort and illuminate. Therapists can assist clients in learning how to express affect in words, giving shape to previously inexpressible feelings. Expanding the word as a container is especially useful in those with alexithymia, who struggle to verbalise their feelings. Being able to name an affect, or illness, or the impact of illness, may help to contain and understand the illness.

Nevertheless, the word cannot capture everything. It has restrictions. Things that cannot be verbalised stay external to this container. Extremes of experience, both positive and negative, are amongst those for which words can often not be found. Aspects of human experience, such as positive divine experience and indescribably negative experiences of horror, abuse, and carnage, all lie outside the capability of the word to contain (Biran, 2015). The notion that the unnameable will lie outside the word's ability to contain includes preverbal experience, as it occurred before language development. Consequently, the experience of infant chronicity may be unnameable.

***The containing aspect of the community, group, and society***

The previously discussed aspects of container/contained focused more on internal-process, while this aspect considers the containing function of external groups. The role of a good group is to contain both complex material and differences within members without disintegrating (Biran, 2015). According to Bion (1970), containment is necessary in order for groups to grow. I

noticed chronically ill clients utilised groups such as the medical profession, workplaces, and A&E, as containers. Physicians, medications, and medical procedures may provide a container for chronically ill patients. However, an internal containing function, or the containment of the word, may prove elusive, particularly at night, when other support systems such as family, friends, and therapists, may be unavailable. In these circumstances, A&E may be utilised by a patient overwhelmed by chronicity as a container of last resort.

I became interested in the role of workplaces as containers when several clients' ill health necessitated their resignations from their jobs. Workplaces may struggle to accommodate chronic illness, yet the loss of a workplace can leave patients without the structure of a work day, a sense of contribution, or the social container of work. Thus, while some patients are too ill to work, they may benefit by staying connected to workplaces through social or cultural groups. Others might be better served by workplaces accommodating their illness with means such as flexible part-time working hours, or working from home.

Bion (1970) referred to groups as the establishment, and new thinkers as the genius, mystic, or messiah. The establishment would initially reject any new thinking as a threat. Eventually, the group evolves to incorporate new thinking (Biran, 2015), and new thinking challenges the establishment. The WPTA presents a challenge to biomedical thinking. While the concepts endorsed by the WPTA, such as including all aspects of personhood, may seem intuitive, they can prove surprisingly difficult to integrate against a culture of dualistic biomedical thinking.

Without an internal container to digest and transform β-elements and contain feelings of bewilderment, danger, or even terror, as highlighted in Chapter four and encountered at the edge between knowing and not knowing, it is impossible to utilise negative capability. In this way, developing an internal container is foundational to building the bridge needed to cross the roadblocks outlined in that chapter. With the foundation of our bridge in place, I now focus on themes that emerged from the literature that add further components to build the bridge: curiosity and knowledge, the ability to doubt, and patient waiting.

**Curiosity and knowledge – components for bridge construction 2**

Curiosity, the desire to know or learn about something or someone, is the driver behind the quest for self-knowledge and makes up one of the materials needed to construct the top of our bridge. Self-knowledge is widely considered to be the bedrock of psychotherapy. In his early writing, Bion (1958, 1959) discussed curiosity. By 1962, Bion (1962a) had replaced the term "curiosity" with the more nuanced term, "knowledge" (K). Fisher (2006) postulated that Bion

identified the emotional experience of K as a feeling of curiosity. The change in terminology may have been to avoid associations with terms such as “snoop,” “pry,” “nosey” and so forth (Fisher, 2006, p. 1222). However, curiosity was not simply substituted for K. Instead, K was an expansion of curiosity, where K is associated with feeling curious. Fisher (2006) asserted that curiosity was the crucial impulse in Freud's (1922/2011) reality principle.

The therapist engages in the emotional experience of curiosity by wanting to know the patient. The intention is to enable the patient to internalise the therapeutic relationship, the experience of curiosity, of wanting to know, understand, and accept the self, creating an impulse to self-knowledge. The drive to K is the essential element of a therapy session; therefore, psychoanalysis itself could be thought of as an expression of K (Bion, 1963).

Any quest for K begins with curiosity and questions. Bion understood that there are two types of answer to any question; the answer designed to close the questioning, discussed in the -K section of this dissertation, and the answer in K that keeps the questioning, curiosity, and learning alive. Bion urged to "keep your questions in good repair" (Bion, 1977, as cited by Reiner, 2012, p. xvii), meaning the answer in K can be understood as a working hypothesis designed to evoke more questions and areas of exploration in the quest for self-knowledge. Self-knowledge is considered a lifelong journey, rather than a destination.

Curiosity is essential in the WPTA to understand each client's unique story and to ignite the client's pursuit of self-knowledge. Curiosity enables the dyad (client and therapist) to make potential links between the client's life story and illness history without holding too tightly to the notion of finding one answer. The K impulse is a vital component of negative capability, and curiosity enables us to sit with unknowns without foreclosing into premature knowing. The desire for K enables the dyad to remain curious, tolerate not knowing, and understand that each answer provides a new hypothesis, generating further questions and sustaining curiosity. In this way, curiosity/K provides an essential component to build the bridge across all three roadblocks encountered in understanding the complexity of chronicity when working with the WPTA. Next, I move my focus to the ability to doubt.

**The ability to doubt – component for bridge construction 3**

> …is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason… (Keats, 2005, p. 60)

The ability to doubt has been a crucial part of innovation, and welcomed by creative thinkers in religion, psychoanalysis, philosophy, science, and the arts, and provides the next building block

in forming our bridge. True scientists are doubters, seeking to disprove their most loved theories, yet the freedom to doubt is only available "when the black medieval clouds of certainty" (Israelstam, 2009, p. 18) are kept at bay. These clouds of certainty flourish in environments of fear, anxiety, and concrete thinking. The freedom to explore doubts and uncertainties encourages innovative, reflexive, and symbolic thinking, whereas certainty crushes reflexivity and symbolic thinking. A doubting state of mind is crucial in a psychotherapeutic relationship. The ability to hold the frustrations of doubt is considered a developmental achievement (Israelstam, 2009). Freud (1912) expressed this capacity as “evenly-suspended attention” (p. 119). Klein (1946), in her work with infants, contended that when the infant can understand the good nourishing breast and the bad withholding breast as the same breast, the infant is in the depressive position. Developmentally, the infant can tolerate anxieties and frustrations and hold the two positions (good breast/bad breast) without splitting or projection. Thus, the baby is said to have developed a capacity to doubt (Israelstam, 2009). The WPTA focuses on the symptoms and symbolism of each patient's unique story; this would not be possible without the capacity to keep certainty at bay, remain reflexive, and engage with doubt.

The usefulness of uncertainty and formlessness was understood by Winnicott (1971) when he suggested that a paradox be accepted, tolerated, and respected, and not resolved. Winnicott (1971) believed play and doubt enjoy a reciprocal relationship. To explore through play, the child needs to develop a capacity to be in the in-between, or the potential space between knowing and not knowing, to have developed the ability to doubt. Freud, Klein, and Bion, all believed absence and frustration play a crucial role in the development of thought. Bion illustrated this when he wrote that "tolerance of frustration is essential for thought development […] The absent object/breast gives the child his/her first opportunity to know reality through thought" (Bion, 1984a, p. 30). The contention that the infant understands that the good and bad breast is the same breast is a developmental stage, and Winnicott's assertion that the child utilises the space in between knowing and not knowing, both illustrate that the ability to doubt provides is essential to help construct the bridge over dichotomies and dualities. The subjective and objective straddled by the WPTA represent a dichotomy; therefore, the ability to doubt is essential to engaging in the WPTA.

Bion most clearly articulated the potential to doubt in his process of negative capability, the capacity to eschew memory, understanding, and desire, and tolerate frustration and doubt. Bion could have written about the therapist's capacity for doubt rather than writing about negative capability (Israelstam, 2009). At the core of negative capability is tolerating the doubt found on the edge between knowing and not knowing. The capacity to doubt is a precursor to developing

an internal container (Israelstam, 2009). Symbolic thinking develops through the tensions inherent in the in-between, alongside the therapists' capacity for doubt. Therefore, the ability to doubt facilitates an understanding of the WPTA, as doubt is necessary for holding the complexity of chronicity and the different aspects of the whole person in mind.

Bion sanctioned the use of doubt as an analytic tool when he advocated nurturing our negative capability, that is, tolerating the doubt inherent on the edge between knowing and not knowing. Doubt is needed for the development of symbolic thinking (Israelstam, 2009). Western medicine cannot explain the highly symbolic nature of personal meanings and their expression in disease (Broom, 2007). Broom could have been applying Bion's concept of negative capability when he urged listening to the patient's unique story, listening for the echoes surrounding the contributing factors of illness in each individual, and waiting for meaning to emerge. If certainty were less prized in Western culture and biomedicine, perhaps we would open up a space to doubt, to sit in the in-between, and question the cultural constructs of a Western biomedical perspective. Holding a space to doubt would allow sitting with both poles of a dichotomy without foreclosing into premature knowing, or dispersing into action. Thus, the ability to doubt is useful in building the bridge to cross the roadblocks encountered on the road to utilising negative capability to facilitate understanding the WPTA when working with chronicity. Next, I investigate the theme of patient waiting.

**Patience/waiting or patient waiting – component for bridge construction 4**

> …and at once it struck me what quality went to form a Man of Achievement, especially in Literature, and which Shakespeare possessed so enormously — I mean Negative Capability… (Keats, 2005, p. 60)

Interwoven throughout the literature on negative capability is the theme of patience/waiting, which adds the final component needed to construct our bridge. Patience expresses the essence of negative capability (Simpson & French, 2006). Achievement was linked to negative capability by Keats (2005) in his 1817 letter to his brothers, when he that suggested the ability to sit with uncertainty and doubt led to achievement. Likewise, Bion encouraged patience and waiting as precursors to achievement (Simpson & French, 2006). Eisold (2000) agreed, and defined *negative capability* as "precisely the ability to tolerate anxiety and fear, to stay in the place of uncertainty in order to allow for the emergence of new thoughts or perceptions" (p. 65). Negative capability encourages an environment that contains uncertainty. It supports patient waiting, generating a mental and emotional space where new ideas may arise without any guarantee of when or even if innovative ideas or thoughts may emerge (Simpson et al., 2002). The generation of original thought may be derailed by the anxiety and concrete thinking

engendered by anti-knowing. Psychoanalysis can be seen as the "art of hope, faith and waiting" (Civitarese, 2019, p. 759), suggesting Bion's understanding of negative capability could be a fresh way to understand analytic listening.

Through our Western cultural lens, negative capability is associated with the lower status activities of patience and waiting, alongside tolerating anxiety and frustration—Western culture prizes more active pursuits, such as asking, knowing, intervention, and decision making. Negative capability is intrinsically unmeasurable, suggesting it will atrophy in a culture focused on measurement and outcome. Eigen (1993) reframed the notion of patience and waiting as passive activities, when he combined patience and waiting, and described patient waiting as "not dead or inert but intensely alive and accurate" (p. 12).

Patient waiting is not an idle process. It is staying focused and present with the task or not knowing at hand. Moreover, it is an active waiting or alive waiting, on the edge of knowing and not knowing, where we work to stay connected with our not knowing, rather than dispersing from not knowing. As a result, a new understanding or insight may emerge.

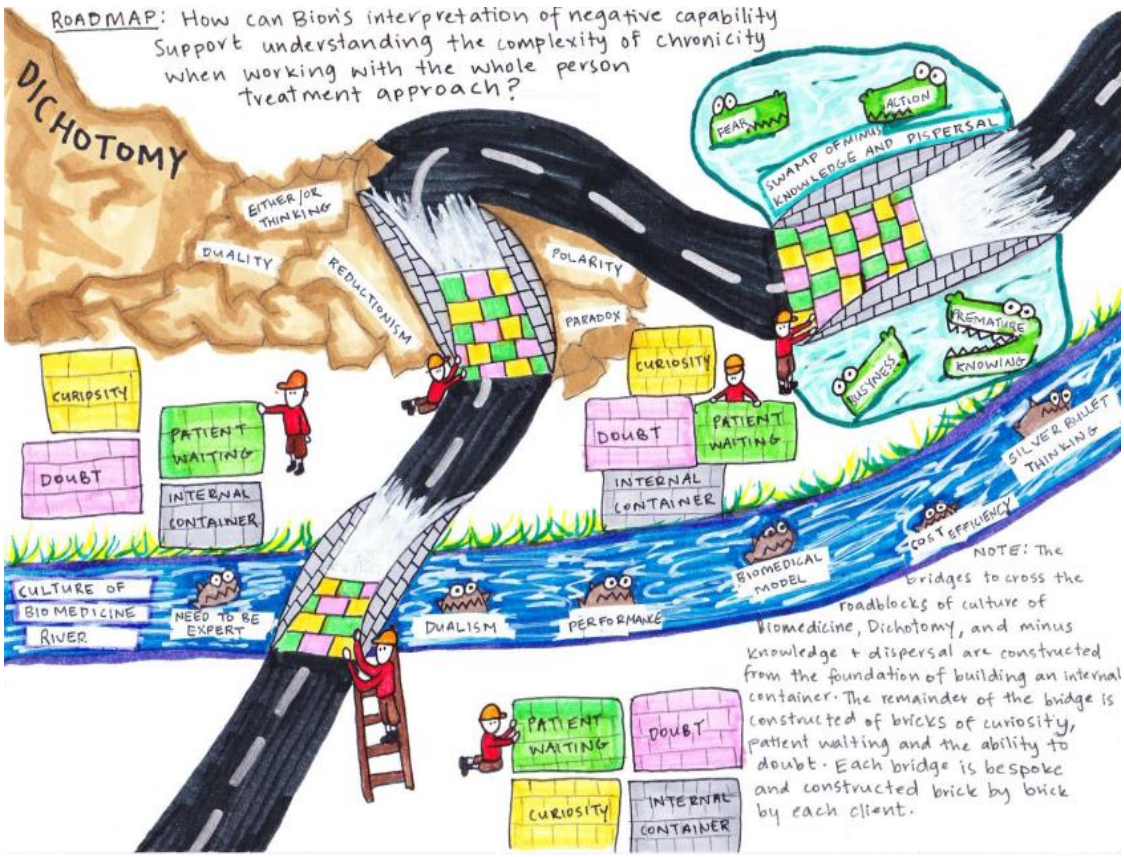
Broom (2007) advocated *alive waiting* when he suggested listening for the echoes or waiting for the individual links that may result in new insight, to emerge in a patient's illness history and life story. The concept of *patient waiting* as an active process supports the idea that understanding negative capability can facilitate the WPTA. It suggests that tolerating doubts and uncertainties without dispersing into action is an active process. Patient waiting can assist in understanding the complexity of chronicity by staying connected to the unknowns and waiting for a new understanding to develop. Similarly, patient waiting can assist in holding both poles of a dichotomy without falling into premature knowing or dispersing into action.

**Roadmap**

Having reflected on the seven themes outlined in chapter four and the current chapter I found it useful to think about these findings as a roadmap (see Figure 1). This roadmap is made up of a roadway, three roadblocks and four components or pallets of bricks need to construct bridges to cross the roadblocks. The use of negative capability to support understandings of the complexity of chronicity when working with the whole person treatment approach (WPTA) formed the roadway; along the road, we encounter roadblocks and the bridges that facilitate crossing these roadblocks. Three roadblocks were encountered on the roadway: the culture of biomedicine, dualities/dichotomies, and finally, -K and dispersal.

In the illustration of the bridges in the roadmap (Figure 1), the bridges are constructed with bricks, indicating that bridges to overcome the roadblocks cannot simply be craned into place, but are ideally constructed brick by brick. The construction of the bridges is a meticulous process that draws on bricks from all four components or themes found in the current chapter: the foundation of developing an internal container, along with a combination of curiosity, the ability to doubt, and patient waiting make up the remainder of the bricks that construct each bridge. Nevertheless, once the bridge is in place, it represents a skill set that remains for life and can be applied much more rapidly to future roadblocks encountered on the roadway.

**Figure 1:** *Roadmap Illustrating how Bion's Interpretation of Negative Capability can Support Understandings of the Complexity of Chronicity when Working with the WPTA*




**Chapter summary**

The themes outlined in Chapter five, developing an internal container, curiosity and knowledge, the ability to doubt, and patient waiting, form the foundations and bricks needed to construct a bridge over the three roadblocks uncovered in Chapter four. The relationship between the roadblocks and the construction of the bridges are illustrated in the Roadmap (figure 1). These bridges facilitate holding the whole person in mind when working with chronicity. The bridge building elements highlighted in the current chapter, support negative capability and may be

viewed as a clinical pathway to increasing a client's capacity for negative capability. Working psychotherapeutically with a patient to develop an internal container and increase their capacity for curiosity and K, doubt, and patient waiting, will build the patient's ability to sit with unknowns without falling into -K or dispersal.

# Chapter 6. Discussion

## Introduction

In this chapter, I summarise my research findings before highlighting the implications of my research and considering potential areas for future research arising from this study. Next, I consider the strengths and limitations of my research before offering my concluding thoughts.

## Summary of findings

### *Roadmap*

A hermeneutic exploration of the literature reviewed for this research revealed seven themes that formed the roadmap outlined in Chapters four and five. The roadmap comprises a roadway paved with my research question: how can Bion's interpretation of negative capability support understanding the complexity of chronicity when working with the whole person treatment approach? Along the roadway, three roadblocks that obstruct utilising negative capability to understand the complexity of chronicity when working with the WPTA are encountered. These three roadblocks were explored in Chapter four: the culture of biomedicine, dichotomies/dualities and finally, -K and dispersal. In Chapter five, the building materials necessary to build bridges over the roadblocks were highlighted. The foundation of any bridge on this roadway is the development of an internal containing function. The pallets of bricks needed to complete the construction of the bridges are curiosity/K, the ability to doubt, and patient waiting. Critically, each bridge is designed by the client utilising all four building materials to create a bespoke bridge, painstakingly constructed, brick by brick.

### *Roadblocks*

The first roadblock encountered on the roadway is the culture of biomedicine. Biomedicine is based on Cartesian dualism, believing that mind and body are separate entities (Gobert, 2013). Essentialisation, as discussed in Chapter four, is employed to look for patterns in symptomology and disregard symptoms that do not fit the diagnosis. Furthermore, essentialisation and EBP attempt to take the uncertainties out of diagnosis, resulting in imposing sometimes premature certainties (-K) on patients' conditions. The research suggests that our Western cultural expectation that the physician is an expert, reinforces our inability to sit with doubts and uncertainties regarding chronicity.

Due to the culture of biomedicine, both physicians and their patients are often uncomfortable sitting with uncertainty. If the doctor cannot provide certainty in the form of a prescription, referral, surgery, explanation or diagnosis, patients frequently believe the doctor is incompetent. This leads to the fantasy of the silver bullet, the belief that if the doctor were competent enough, a solution would be found, placing responsibility with the physician and alleviating the patient of any obligation for finding solutions to their own chronicity. Furthermore, biomedical training, both therapeutic and medical, discourages sitting with unknowns. Physicians tend to shy away from mind-based elements, while therapists retreat from physical symptoms. This research highlighted that some chronic illnesses have their genesis in a time or place outside the individual (Broom, 2007). As discussed in Chapter four, the biomedical lens can only see or understand a disease that originates in the *I am*; chronicity originating in the *we are*, remains unseen by biomedicine.

Exploring the culture of biomedicine has helped me, as a therapist, to understand the palpable resistance patients may experience when asked to explore another model of treatment. Furthermore, the WPTA is culturally unfamiliar, and asks patients to reflect deeply on their illness. At times, as a therapist, I felt resistance to using the WPTA. My lived experience of chronicity along with my conditioning to accept biomedicine, resulted in my resistance, so I was almost colluding with my clients' resistance. These experiences crystalised how the culture of biomedicine creates a roadblock to utilising negative capability to understand the complexity of chronicity when working with the WPTA.

As explored in Chapter four, the second roadblock met on the roadway is dichotomies and dualities. Our Western and biomedical lenses present mind/body as a paradox, so we are less able to contain uncertainty when faced with paradoxical dilemmas (Behal, 2014). This makes it difficult for Western WPTA patients to apply a lens other than biomedical, to their chronicity. Moreover, our cultural heritage provides the framework through which we learn to process health as an either/or dichotomy. For example, we are either healthy or unhealthy, which obstructs our ability to keep the whole experience or person in mind.

Dichotomies are both a part of the human experience and a defence mechanism. Dichotomies such as well/unwell, mind/body, and objective/subjective, are tools commonly used by both physicians and patients to simplify complex chronicity. Furthermore, such simplification undermines the complexity and reality of chronicity. While dualities are not dangerous in themselves, if we view any duality as an either/or choice, rather than as co-existing poles, we restrict our view and exclude the possibility of using the WPTA, which requires an openness to all aspects of humanity, alongside the physical. Additionally, viewing a dichotomy as an either/or

choice inserts a premature knowing by automatically excluding half of the available information from being considered. In the example of mind/body or objective/subjective, excluding all mind and subjective aspects of illness restricts our view, making it harder to see the whole picture. Excluding half the available information could be understood as the defence of false knowing or -K, effectively preventing sitting with the unknowns or engaging with negative capability, which limits the potential to understand the complexity of chronicity and the use of the WPTA. The WPTA requires an openness to exploring chronicity through the lenses of both objectivity and subjectivity.

In contrast, dichotomies act to close down the potential for openness. Exploring the roadblock of dichotomies and dualities have helped in my client work by understanding that there is no need to solve the opposing forces evident in any duality. Instead, the task is to understand that both poles hold information vital to understanding the whole. Nonetheless, dichotomies create the second roadblock to utilising negative capability to understand the complexity of chronicity when working with the WPTA.

The final roadblocks revealed on the roadway were the defences of -K (Bion, 1984a) and dispersal (Needleman, 1990). As discussed in Chapter four, these defences are employed to flee the uncomfortable edge between knowing and not knowing, with action or premature certainty (-K), to alleviate our discomfort with uncertainty or unknowns. Moreover, -K and dispersal hinder our ability to process complex and uncertain situations such as chronicity. This awareness has helped to recognise my clients' use of these commonly employed defences.

Too often, Western culture and biomedicine demand competence and expertise, which is measured in instant knowing. In the case of chronicity, this may be problematic as it closes down the thinking space, by dispersing into action in the form of premature diagnosis, or -K, rather than staying with the unknowns and allowing new thoughts to emerge regarding each patient's chronicity. Dispersal from not knowing and -K create roadblocks on the road to employing negative capability to understand the complexity of each patient's chronicity when working with the WPTA.

***Bridge-building materials***

The literature reviewed for this research also uncovered four essential building materials needed to construct each bridge to overcome the roadblocks encountered. These were: developing an internal container, curiosity/K, the ability to doubt, and patient waiting.

Developing an internal container forms the foundation upon which any bridge is built. Beginning in the mother-infant dyad, an internal container is developed in relationship with the mother through the functions of translation and reverie (Bion, 1984a). Discussed in Chapters one and five, the mother translates β-elements for her infant into digestible α-elements (Bion, 1970; Biran, 2015). Without a well-developed internal container, people cannot sit with uncertainties and doubts, which is necessary to facilitate negative capability and understand the complexity of chronicity when working with the WPTA. For those who did not have a mother able to facilitate the development of their internal container, it is possible to establish this container in a therapeutic dyad. Therapists can provide a maternal function, transforming β-elements into α-elements. As discussed in Chapter five, external factors such as the word and community, groups, and society, can also provide a containing function. The development of an internal container provides the foundation for constructing the bridges needed to cross the roadblocks (as illustrated in Chapter five).

In my clinical practice, I have worked to enable patients to stay with their own frightening β-elements. In chronicity, β-elements may manifest as a fear of symptoms becoming worse or never recovering, or a fear of death itself. If patients can develop an internal container, the transformation of their β-elements into manageable α-elements is possible. Moreover, developing an internal container allows patients space to think about their chronicity and explore the WPTA without falling into either/or thinking or employing the defences of -K and dispersal.

Curiosity/K provides a necessary pallet of bricks to build on to the foundation of any bridge. Curiosity/K facilitates negative capability by enabling individuals to tolerate unknowns, keep questioning their chronicity, and understand that each answer presents a new hypothesis. By applying curiosity, new thinking is encouraged, leading to further questioning and increased self-knowledge.

I have found that encouraging clients' curiosity helps to cultivate an understanding that chronicity is complex. Therefore, curiosity counteracts silver bullet thinking by understanding that there will not be one single solution to resolve their chronic illness. Moreover, I have noticed that encouraging clients to apply curiosity to their chronicity allowed them greater comfort in sitting with uncertainty, which facilitated their journey to questioning the relationship between their symptoms and life story, that is, to engage with the WPTA.

The ability to doubt provides the next pallet of bricks for building the bridge over our roadblocks. Negative capability clearly articulates the need to sit with uncertainties and doubt (Bion, 1970; Keats, 2005). In chronicity, patients describe reaching an uncomfortable place, a sense of impasse or misgiving of the current knowledge of their illness. The tolerance of frustration and welcoming of doubts creates an environment in which new thinking and learnings may emerge.

In my clinical practice, the ability to doubt is an essential tool in questioning the three roadblocks: the culture of biomedicine, dichotomies, and the use of -K and dispersal as defences. The ability to doubt our reliance on each of the three roadblocks opens the possibility for patients to explore new ways of thinking about their chronicity. Clients have described that questioning their fundamental beliefs about their illness has encouraged new thinking, understanding and enabled engagement with WPTA.

Patient waiting delivers the final pallet of bricks needed to construct bridges over the roadblocks encountered on the roadway. Patient waiting is at the heart of negative capability and represents a deliberate and unhurried process. Nonetheless, patient waiting is considered an active process (Eigen, 1993). Keats (2005) associated negative capability with achievement, and understood negative capability as providing a space from which original thought might emerge.

In clinical practice, patient waiting has provided a bridge to counteract the intense cultural impetus in both clients and myself, of performance, efficiency, and expertise. Patient waiting is essential in understanding the roadmap uncovered in this research. To bridge each roadblock, each client, supported by their therapist, builds their own customised bridge. The building materials remain the same, developing an internal container, curiosity/K, the ability to doubt, and patient waiting. Nevertheless, each client's combination of meticulously placed foundations and bricks will be of their unique construction, and no two bridges will be the same. Each client arrives with their own experience of chronicity and their own internal coping mechanisms. The roadmap provides a useful way to appreciate how each client is limited by each roadblock and served by each bridge-building component, allowing the therapist to assist clients in constructing their bespoke bridges.

## Implications

### *Implications for psychotherapists and medical professionals*

Potential implications of this research are that the roadmap discovered may be helpful for psychotherapists who work with chronically ill patients in a biomedical context. The roadmap illustrates the importance of negative capability in understanding the complexity of chronicity

when working with the WPTA. Naming the three roadblocks of the culture of biomedicine, dichotomies, and, -K and dispersal, may assist other practitioners in identifying these obstacles when they are encountered in clinical work. It may also help in understanding that these obstacles are commonplace when working with chronicity.

Recognising that creating an internal container is the first step to crossing any obstacle is important, as it give therapists a place to begin their work with chronically ill patients. Employing the approaches of curiosity/K, the ability to doubt, and patient waiting, may help patients navigate the obstacles encountered. Understanding that the bridges necessary to cross the roadblocks are constructed of bricks, indicates that the bridges cannot simply be craned into place as a quick fix to cross a roadblock. Instead, they must be constructed brick by brick. The construction of a bridge is a painstaking process involving developing skills over time. However, once the bridges are in place, they are solidly constructed, and represent a skill developed for life that can be applied to future roadblocks encountered on the roadway to utilising negative capability to understand the complexity of chronicity when working with the WPTA.

Practising WPTA is not confined to psychotherapists and physicians; the approach is also used by dieticians, physiotherapists, occupational therapists, massage therapists, and nurses (Broom & Joyce, 2013). Therefore, this research may help a wide range of healthcare practitioners to appreciate the commonality of the obstacles encountered to using the WPTA when working with chronicity, and offer suggested tools to overcome these obstacles.

***Implications for teaching psychotherapists and medical professionals***

The chronically ill present a challenge to current biomedical thinking; this research shows that a different approach may be useful. A potential implication of this research is in training psychotherapists and healthcare workers to work with the chronically ill. For psychotherapists, the literature suggests it may be helpful to enhance the ability to work with objective or physical symptoms and understand these as co-emergent with subjective elements (Broom, 2007). This challenges the biomedical notion favoured by many psychotherapists, as discussed in Chapter three, that the genesis of disease will be found in the subjective. Conversely, for other medical professionals working in a biomedical context, the challenge is to see the subjective as co-emergent with the objective, and allow a space for both.

The training implications of the roadmap are in providing a structure that helps to familiarise both psychotherapists and medical professionals with the likely roadblocks that may be

encountered in using the WPTA to work with chronicity. Additionally, the roadmap equips practitioners with the necessary tools to bridge these roadblocks.

***Implications for funders***

This research may also have implications for funding healthcare for the chronically ill, by suggesting a different approach for those who have already explored all biomedical options, but continue to be ill. As described in Chapter 4, chronically ill patients may get caught in a process in which they continually move from one specialist to another, seeking a cure for their illness. The implication for funders is that providing the chronically ill have their physicality attended to, funds that may traditionally have gone into repeating biomedical procedures, may be better diverted to practitioners working with the WPTA, as taking a different approach to chronicity may yield better patient outcomes.

**Further research**

Undertaking this research has sparked my curiosity for future research projects. A companion for the road of my research has been the global COVID-19 pandemic. Shortly after this project commenced, Aotearoa New Zealand entered its first national lockdown. As the research drew to a close, Auckland was entering week 13 of its fourth lockdown. As the world grappled with uncertainty, uncertainty became a key focus of my research. At times, the respite provided by lockdowns provided more space for my research, while at other times, my dispersal proved an obstacle to finishing this project. The pandemic has provided illustrations of many of the roadblocks described in Chapter four. For example, the predominance of biomedicine has come to the fore. Dichotomies and dualities played out as several splits reverberated around the world. For example, some believed in COVID-19 and some believed it to be a conspiracy theory or not as serious as reported; some believed in vaccination and some did not; some believed we should use lockdowns to keep the virus out of our country, and some believed in creating herd immunity. I wonder if some of these behaviours could be understood as dispersal: behaviours such as protests, people clashing - at times violently - with those who did not agree with them. We witnessed -K or premature knowing being used as a defence against the uncertainty we faced globally. There was no shortage of people who “know,” pontificating, perhaps prematurely. I wondered if using the bridge-building materials in the roadmap of developing an internal container, utilising curiosity/K, the ability to doubt, and patient waiting, could have facilitated greater holding of the uncertainty faced by the global community. Additionally, COVID-19 has created long COVID, and while we do not yet know how long the impacts of the

virus will last for those unlucky enough to suffer from long COVID, it would seem to have a new form of chronicity.

Potential expansions on the current research include:

- further research to assess the usefulness of the roadmap that has emerged from the current study;
- expanding on the elements revealed in the roadmap to look more closely at each element, for example, how a therapist might work with a client to expand their ability to work with dichotomy, and how to recognise the feeling of the edge and stay with it;
- as developing the capacity to stay at the uncomfortable edge between knowing and not knowing without employing the defences of -K and dispersal may allow new learning or understanding to emerge, further research could investigate how to develop the skills required to stay on the knowing/not knowing edge;
- exploring the potential for increasing the use of curiosity/K within healthcare, by encouraging questioning and seeking, rather than closing down the thinking space with premature answers;
- exploring ways to constructively encourage the capacity to doubt;
- determining ways to support therapists to develop a client's internal container, by recognising the importance of an internal container in transforming the frightening β-elements of chronicity into digestible α-elements;
- seeking ways to expand the biomedical model to make sense of illness originating outside the individual, in the *we are* rather than the *I am*;
- seeking ways to help patients and healthcare professionals to view dichotomies not as either/or scenarios, but as co-existing parts of a whole where both parts hold information vital to seeing the whole picture;
- determining how therapists can best work with doctors to facilitate positive outcomes using WPTA; and
- determining if patients seeing WPTA practitioners and those seeing a traditional biomedical practitioner, understand and experience their chronicity differently.

My ever-expanding list of potential future research wonderings reflects the essence of the bridge-building bricks of curiosity. This research, along with these wonderings, illustrates that all answers are hypotheses and do not provide an end to questioning, but lead to further questions.

**Strengths and limitations**

The roadmap revealed in the findings chapters may be useful for all practitioners who work with the chronically ill, for the future development of these practitioners, and potentially, for funding healthcare for the chronically ill. The roadblocks identified in the roadmap may have a familiar feel to the roadblocks experienced by those working with chronicity. I hope that by naming these roadblocks, they will become easier to recognise and discuss. Moreover, I consider the bridge-building materials uncovered are potentially helpful to practitioners coming up against the roadblocks, by providing a possible direction or starting point for deepening their work with patients, moving forward from any obstacle encountered.

As I step away from the research project, I can view my research from the outside. Much like the cloud described in Chapter four, I see the shape and form of the project and clearly understand the congruence of the decision to use a hermeneutic methodology. Hermeneutics asks the researcher to partner with the literature and become immersed in the body of literature to be reviewed, the researcher's process, and the historical consciousness. For me, this involved immersing myself in my past and present experiences of chronicity, and my clients' experiences of chronicity, alongside the body of literature to be reviewed. Hermeneutic circling felt akin to being lost inside the cloud described in Chapter four, unable to sense its scope or shape. A strength of the hermeneutic process is learning to trust the felt sense of discombobulation as an essential part of the process. This discombobulation proved especially useful in providing a lived experience of negative capability. The resultant changes of perspective and the emergence of new understandings culminated in the emergence of the roadmap.

As a psychotherapist working with chronicity, I consider that the findings of this research may be valuable to biomedical physicians working with chronic illness. However, due to the use of the researcher's subjectivity, hermeneutic research can be difficult to replicate. Given biomedicine's foundation in positivism and preference for evidence-based practices that are replicable, I wonder if my use of hermeneutic methodology may present a barrier to biomedical practitioners.

The university imposed limitations on the scope of this research project in terms of deadline, word count and supervision, naturally stifled certain lines of questioning, perhaps prematurely. Conversely, the strength of the university's restrictions was that other lines of questioning were more closely focused on.

Personally, the strength of this study has been the undoubted development of my negative capability. Sitting with a global pandemic, chronically ill patients and changing supervisors has developed my capacity to sit with constant uncertainty, increased my ability to doubt, exercise curiosity, and strengthen my internal container. In line with the research findings, I understand that these learnings will assist in my own bridge-building in the future. For this, I am grateful.

**Concluding thoughts**

I began this study with an intense familiarity of my own experience of chronicity, a growing familiarity with my clients' experiences of chronicity, a placement utilising the WPTA, and a desire to know more. Immersed in these four perspectives, I was left with a sense of a missing link that, for me, needed bridging. I wondered if my lack of words to articulate the missing link resulted from being too close to the phenomena I wished to research. Furthermore, I worried that my topic would prove too unwieldy to research within the confines of this project.

I felt drawn to choose a hermeneutic research methodology, and while I may not have fully understood the reasons for my choice at the time, it proved a serendipitous decision. Hermeneutics highlighted that historical consciousness lay at the heart of the research problem. Not only are we as individuals inextricably linked to our historical consciousnesses, but so too are the groups, organisations, and systems, for example biomedicine, that impact our lives. Furthermore, hermeneutics allowed me the time and space to explore the missing link between complex chronicity and the WPTA, which led me to discover the literature around negative capability. Once negative capability was identified, I was able to immerse myself in the uncertainties of my research project and lean into my methodology. Although the combination of working with negative capability alongside the experience of hermeneutic circling has at times been discombobulating, the project proved fruitful, with the eventual emergence of the roadmap, which for me, closes the missing link.

The roadmap identifies three significant obstacles to comprehending how the capacity for not knowing, or negative capability, may support understanding of the complexity of chronicity when working with the WPTA. The roadblocks encountered on the roadway are: the culture of biomedicine, our human tendency to treat dualities and dichotomies as either/or choices, and the final roadblock of the defences of -K and dispersal. Four vital bridge-building materials were identified. Firstly, the foundation of any bridge was formed by developing an internal container, while curiosity/K, the ability to doubt, and patient waiting, provided other essential bridge-building materials. Importantly, each client carefully constructs his or her own bespoke bridge.

I arrive at the end of my research project indelibly changed. This study has impacted my view of my own chronicity, the chronicity of my clients, and my understandings of the challenge of chronicity.

> I said to my soul, be still and wait without hope, for hope would be hope for the wrong thing; wait without love, for love would be love of the wrong thing; there is yet faith, but the faith and the love are all in the waiting. Wait without thought, for you are not ready for thought: So the darkness shall be the light, and the stillness the dancing. (Eliot, 2014, p. 31)

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