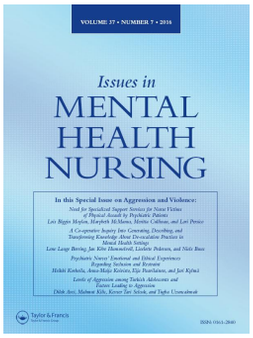

Issues in Mental Health Nursing

ISSN: 0161-2840 (Print) 1096-4673 (Online) Journal homepage: http://www.tandfonline.com/loi/imhn20

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To cite this article: Richard Lakeman (2018): The Myth of the Well-Known Client, Issues in Mental Health Nursing, DOI: 10.1080/01612840.2018.1455119

To link to this article: https://doi.org/10.1080/01612840.2018.1455119

Published online: 22 May 2018.

ISSUES IN MENTAL HEALTH NURSING
https://doi.org/10.1080/01612840.2018.1455119

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COMMENTS, CRITIQUE, AND INSPIRATION COLUMN

The Myth of the Well-Known Client

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ABSTRACT

A common idiomatic phrase in mental health care is "well known" client, patient, or service user. This phrase is often followed by "to mental health services" or some such, suggesting that a "service" can really know anything. Notwithstanding mental health services, especially public ones are a repository for a lot of information, such as facts about people, their service use, diagnosis, notes and assessments of various kinds; this conglomeration of information is not knowing, any more than a library may be "knowing". Knowing is a distinctly human activity. This paper will argue that this phrase is arrogant, a signifier of ignorance and ought to be relegated to history or back room banter with phrases like "frequent flyer", "bed seeker" and other derogatory and objectifying language.

The phrase "well-known" client may be found written on assessments, or communicated verbally via handovers to other professionals. It is clearly a communicative linguistic device rather than "a note to self". If a person really knows another they don't need to declare it. A counsellor or psychotherapist who has no need to routinely share their progress notes or process recordings is not likely to write "well known to me". Indeed, in as much as psychotherapy or counselling is at least in part the essence of really getting to know someone, such a note might indicate that the job is done and the person is recovered. This is not the context or situation in which "well-known" client is used. It is more typically used when the person has presented in crisis, is being admitted to hospital, and during the perfunctory review or handover in acute services.

Following a declaration that a client is "well-known" it would be reasonable to expect an erudite problem formulation, the sharing of an insightful synthesis of the assumed deep wellsprings of collective knowledge about the person, and a clear and decisive plan to address whatever problems are so well-known and presumed obvious to everyone. This is rarely, if ever the case. What follows is generally a minimalist, patchy, scant, selection of facts, assumptions and suppositions. The "well-known" client doesn't need a rehash of their "well-known" history although "cut and paste" from previous assessments often fleshes out the notes. The replication, repetition and rehearsal of presumed key facts that the modern electronic record enables may foster the myth that the person is really well known.

The appellation "well-known" may be a euphemism or short hand for frequent presenter, chronic or long-term user, recidivist, treatment resistant or some other shared understanding between the communicator and a local audience. If stated overtly this may be fine. However, being "well-known" in clinical discourse connotes much more than that. In clinical discourse it also suggests more than the colloquial usage as in the passing knowledge or familiarity with a "well-known" public figure or celebrity. To know someone well is not only to have met them before and to have some passing knowledge and familiarity with them; it suggests a comprehensive understanding of the person, their context, history, culture, and web of relationships. In ordinary parlance we may know a lot of people; most people would claim to know well a much smaller number, perhaps reserving such terms for family, close friends, intimate acquaintances, lovers and close colleagues. In this sense, most clients of mental health service users are not well known at all.

There are of course different kinds and forms of knowledge and a branch of philosophy called epistemology given to the theory of knowledge. The casual declaration of someone being well-known disregards many hundreds of years of philosophy and theory. Every health discipline is concerned with ways of knowing, how knowledge is acquired and translated into action or put to use (Shaw, 2009). Knowing connotes having a solid base to structure an action or way of being (Zander, 2007, p.7). Health professionals acquire knowledge to enable them to undertake their function. As Carper (1999) famously observed there are a number of patterns of knowing including empirics, aesthetics, ethics and personal knowledge. This amalgam of acquired knowledge shapes the health professional, their world view and how they encounter people they serve. To know someone as a nurse, a physician, a family member or as a lover is to know them in very different (and sometimes quite incompatible) ways. Furthermore, how we know is also bounded by gender, culture and class (Luttrell, 1989). Our knowledge of others is always coloured by who we are as people. To say that someone is well-known to mental health services presupposes that all have sufficient knowledge and understanding of that person to act in a way that is healing and helpful. That is, the person is not merely diagnosed but a shared and

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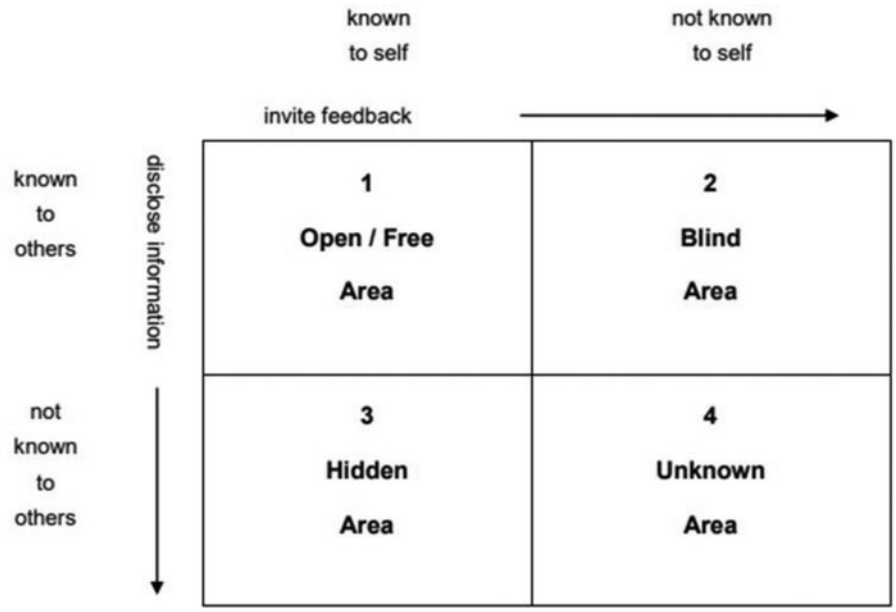

Figure 1. The johari window. (Source: Luft & Ingham, 1961)

clear formulation of the problem or issues at hand is developed in accord with the knowledge of all involved in the care of the person.

Declaring a person "well-known" is an act which forecloses on the need to spend further effort getting to know the person and understanding them. In an audit of files in one adult mental health service exploring family participation, it was noted that when the term "well known" was used in the clinical file it was rare for family members to have any communication with mental health services or even be notified that a family member was admitted to hospital (Lakeman, 2008). This was confirmed by family members who noted that the more frequently or longer an individual was connected to services, the less knowledge and connection the services had with the person's family or social network. Those that were considered "well-known" tended not to be. Connecting with, getting to know and developing understanding is or ought to be an ongoing process and is at the heart of assessment (Shea, 2017) and few would contest that it is fundamental to good mental health care. To declare that someone is well-known and not build and enact a formulation which solves the problem suggests that there is something unknown, undiscovered or not understood.

Making the unconscious known is the mechanism of change if not cure in psychoanalytical psychotherapy and developing an understanding of oneself is the end goal of almost every psychotherapeutic approach from mindfulness to cognitive behavioural therapy. All approaches assume that this knowledge and understanding takes time to develop. Elegant in its simplicity the Johari Window illustrated in Figure 1 (Luft & Ingham, 1961) suggests that knowledge of self is like a window with four panes — Parts that are known to self and others, and parts which are not known to self and others. No one is an open window, and this may especially be the case for those that use mental health services. Furthermore, health professionals, and even organisations have blind spots. The awareness that a person is considered "well-known" ought to prompt the individual or team to consider what they don't know or what they are not seeing.

Even in a service where the ideology is primarily reductionist and biomedical (i.e. health professionals perceive they just need to gather sufficient facts, or clinical knowledge about a person to arrive at a diagnosis to inform treatment) the therapeutic alliance (connecting with someone as a person) is widely acknowledged as pivotal in treatment outcome even for those considered to have severe mental illness (Goldsmith, Lewis, Dunn, & Bentall, 2015). The foundations of a therapeutic alliance are curiosity, expressions of interest, a communicated desire to really know and build understanding. Humility, or even the concept of 'unknowing' (Lakeman, 2014) may be a better stance than assuming to know a service user well or assuming to know what is wrong with them and how to fix them. Recently attempts have been made to elucidate what makes 'open dialogue' different from other conversations and so powerful in assisting people recover from psychosis. Galbusera and Kyselo, (2018) explain that understanding is an ongoing process which emerges through dialogue and is never arrived at all at once.

This paper exhorts the clinician who feels some compulsion to claim that a client is well-known to take pause and consider how much they really know; to maintain an openness and curiosity about the person and consider the possibility that there is a part of the other that they are not seeing. The clinician may still have confidence and maintain hope in helping the person but knowing and understanding is an ongoing process. Even a service user who is familiar should be met with a desire to get to know them better.

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