



FEATURE ARTICLE

Unknowing: A potential common factor in successful engagement and psychotherapy with people who have complex psychosocial needs

Richard Lakeman^{1,2}

¹School of Health & Human Sciences, Southern Cross University, Lismore, New South Wales, and

²Acute Care Team, Emergency Department, Queensland Health, Cairns, Queensland, Australia

ABSTRACT: *Mental health nurses have a demonstrated capacity to work with people who have complex mental health and social problems in a respectful and non-coercive way for lengthy periods of time. Despite contributing to positive outcomes, nurses are rarely described as possessing psychotherapeutic skills or having advanced knowledge. More often, they are described as being instrumental to medicine, and nurses are socialized into not overstepping their subordinate position relative to medicine by claiming to know too much. Paradoxically, this position of unknowing, when employed mindfully, could be a critical ingredient in fostering therapeutic relationships with otherwise difficult-to-engage people. The concept of unknowing is explored with reference to different schools of psychotherapy. Adopting an unknowing stance, that is, not prematurely assuming to know what the person's problem is, nor the best way to help, might enable a deeper and more authentic understanding of the person's experience to emerge over time.*

KEY WORDS: *humility, mental health nursing, phenomenology, psychotherapy, unknowing.*

INTRODUCTION

Psychotherapy works for most people, and for most problems no one form of psychotherapy has been found to be greatly superior to another (Sparks *et al.* 2008). This observation has come to be known as the 'dodo bird verdict', a quote from Alice in Wonderland, in which the dodo bird states after judging the race: 'Everyone has won, so all shall have prizes' (Rosenzweig 1936). This has led to a pursuit, at least in academic and research circles, to identify 'common factors' across psychotherapies that contribute to positive outcomes (Luborsky *et al.* 2002). In the present study, it is argued that 'unknowing' might be one such factor worthy of exploration.

It might be that some therapeutic approaches do prove to be better than others for some specific problems (although demonstrating that can be a challenge) (Beutler 2002). However, it is more certain that not every school of therapy actually gets prizes, and some professions are valued more highly than others for the knowledge they claim to possess and the therapeutic potential they are assumed to have. In the hierarchically-stratified professional world of mental health service provision, a quote from George Orwell's *Animal Farm* might be more apt: 'All animals are equal, but *some animals are more equal than others*'. Particular professions are assumed to be the most helpful and rewarded accordingly, and particular schools of talking therapies are considered more 'evidence based' because of their capacity to be manualized; tailored for particular circumscribed problems; and readily subject to randomized, controlled trials. They provide a way of knowing that is highly valued in mental health care. Mental health nursing, in contrast, struggles to be valued and to articulate a unique knowledge base.

Correspondence: Richard Lakeman, School of Health and Human Sciences, Southern Cross University, PO Box 157, 2480 Lismore, NSW, Australia. Email: richard.lakeman@scu.edu.au

Richard Lakeman, DipNsg, BN, BA Hons, MMH (psychotherapy), DNSci, FACMHN.

Accepted February 2014.

For socio-political reasons, mental health nurses are often compelled to assume or convey an unknowing stance; paradoxically, this might contribute to building therapeutic relationships.

KNOWING AND THE SOCIO-POLITICAL LANDSCAPE OF MENTAL HEALTH CARE

In the helping professions, as in many spheres of life, we crave certainty, or at least predictability. One seeks the services of a health professional in the hope that they will know what is wrong and how to fix it. Health professionals are expected to assess, diagnose, and treat problems, or at least play a role in this process. Medicine, the archetypal health profession, derives its authority from being able to diagnose or name a problem (Jutel 2009). The correct treatment is presumed to follow an accurate diagnosis, which in turn leads to the best outcome. However, as Insel (2012) noted, there is no evidence to support the assumption that patients with the same psychiatric diagnosis share the same pathophysiology and ought to respond in the same way to a given treatment. While authoritative guidelines assert the importance of accurate diagnoses and the efficacy of treatment for common mental health problems (World Health Organization 2012), other commentators acknowledge that diagnoses tell us nothing about a person's experience, little about causation, and provide a poor guide to interventions or treatment in the mental health field (Macneil *et al.* 2012).

For the broad and complex constellation of symptoms, problems of living, and difficulties relating that constitute mental illness, the idea that one might rapidly know what is wrong and know what to do to 'treat' the illness in the manner of a general medical problem is an illusion (Jureidini, 2012). Nevertheless, the idea that medical science and diagnostic reasoning have provided the tools to address mental illness is embedded in the ideology, culture, and discourse of health services, and the hierarchical structure of power and privilege therein (Lakeman 2013b). Medicine is presumed to be grounded in hard sciences, and is believed to cure, heal, or relieve distress, whereas nursing is presumed to have little by way of special knowledge, and assumes roles instrumental to medicine or other ethereal caring functions.

Assumptions about the possession of knowledge and the potential therapeutic agency of occupations are embedded in public policy. For example, in Australia, the Mental Health Nurse Incentive Program (MHNIP) was initiated in Australia to enable psychiatrists and general practitioners to engage mental health nurses 'to assist in the provision of coordinated clinical care

for people with severe mental health disorders' (sic) (Department of Human Services 2013). Nurses in the programme specifications are not described as having any independent therapeutic value, and it is suggested that they work collaboratively to 'provide services such as monitoring a patient's mental state, medication management and improving links to other health professionals' (Department of Human Services 2013).

Unlike other programmes in which allied health professionals can at least receive a referral from a medical doctor and independently bill the government, as well as charge the person for the services required, the incentive payments (which are to cover all costs and have not increased since the commencement of the programme) are essentially for doctors to employ nurses. This is highly symbolic of the instrumental relationship that nurses are presumed to have with medicine, and the rather impoverished view of what is needed to help people who have come to have 'severe mental health disorders' (sic) and 'significant disability' (Department of Human Services 2013).

Despite the discriminatory nature of the way nurses are treated in the MHNIP, over 500 nurses have chosen to work within the programme, which enables them to work outside of the structures of state health systems, and maintain relationships with people who have highly complex needs for as long as is necessary. Nurses who work in the programme are highly educated and experienced, with all having postgraduate qualifications, and the majority have received training in some form of psychotherapy (Lakeman *et al.* 2013), affording the opportunity to provide long-term psychotherapy or counselling for people as needed (Shanley & Jubb-Shanley 2012). While the MHNIP has not been evaluated using controlled trials, there are indications that the outcomes for most people include improved social and occupational functioning, enhanced community participation, reduced psychiatric symptoms, and reduced use of mental health services (Health Management Advisers 2012; Lakeman 2013a; Lakeman & Bradbury 2013). Arguably, the outcomes appear so good that they could not reasonably be explained by compliance with a medically-formulated treatment plan or a brokerage form of case management.

THE COMPETENT BUT UNKNOWING NURSE

What was fairly consistently found in interviews with nurses in the programme (Hurley *et al.* 2014), and also consistent with the programme specification, was that nurses made no claims that what they did was therapeutic.

They would talk about positive outcomes, but did not make any claims about personal therapeutic efficacy. It might be necessary for nurses to maintain this attitude of humility to ensure that the delicate power balance between medical doctor and nurse is maintained, but regardless, the position of not knowing exactly what is wrong, what needs to be done, and not prematurely ascribing a particular intervention as being responsible for an outcome might be common factors that might contribute to positive outcomes. Like other programmes that involve the provision of complex client-centred and individually-tailored packages, it is also exceptionally difficult to isolate the critical ingredients that have made a difference to an individual, let alone generalize to a wider, heterogeneous population of service users.

Nurses have long been interested in different ways of knowing, perhaps in part because science does not provide a particularly good account of what nurses do, and can only partially inform what one might recognize as good nursing. Carper (1978) proposed four patterns of knowing in nursing: empirics or the science of nursing, aesthetic knowing or the art of nursing, personal knowing or self-knowledge focused on authenticity and congruency in relationship to others, and ethical patterns of knowing. These different ways of knowing reflect different conceptions about reality and practice (ontology) and different ways of understanding or grasping the world (epistemology). Munhall (1993) suggested that nurses need to sometimes mobilize a pattern of ‘unknowing’, whereby the nurse appreciates that they cannot know the other’s subjectivity or what a situation might mean to them. This unknowing stance enables the process of ‘coming to know’ the other in an authentic, empathic way. Unknowing, in this sense, does not mean being ignorant, unwitting, careless, or being without hope or confidence that a person might resolve their problems, rather, as Cotton and Roden (2006, p. 337) noted, ‘Unknowing requires an openness and sensitivity to the lived experience’ in balance with other ways of knowing.

UNKNOWING AS A NECESSARY CONDITION TO COMING TO KNOW THE OTHER

The philosophy and practice of phenomenology as both a research enterprise and method of praxis assume the impossibility of ever truly knowing the other person. Existential phenomenology, in particular, has an affinity with many schools of counselling and psychotherapy that aim to understand a person’s experiences of their world, rather than generate or apply explanatory laws. The exist-

tential therapist seeks to convey empathic understanding, rather than statistical explanation (Osborne 1990). However, the preconceptions of the researcher or practitioner might act as an impediment to a genuine apprehension and description of the experience of the other (Lopez & Willis 2004). In phenomenological research, the researcher aspires to acknowledge their own subjective knowledge and assumptions, and to ‘bracket’ or put their preconceptions aside in the interest of being open to the experience of the other. Bracketing enables reflection on the perspective that the researcher or practitioner brings to the analysis of the data. Spinelli (1994) explained that existential-phenomenological therapists attempt to explore the experience of the world of the other, but it is always an attempt that can be more or less adequate, as the therapist can never fully bracket their personal experience.

Being open to the lived experience of the other means listening in a different way, not for symptoms or for utterances that confirm a hunch about what is wrong. This is a different approach to that generally required of staff in mental health services, in which a medical ideology tends to dominate, and considerable effort is made to assess, diagnose, and treat people. In this context, Jureidini (2012) described psychiatric diagnosis as ‘unexplanations’, in that they both fail to offer an explanation for people’s problems and they get in the way of genuine understanding.

Kendell and Jablensky (2003) stated that diagnoses are justified only when they provide a useful framework for organizing and explaining clinical experience in order to guide decisions about treatment, and thereby influence outcomes. An astute assessment, accurate diagnosis, and medical treatment rarely yield a cure, and this is especially so for the most prototypic of psychiatric diagnoses (e.g. schizophrenia). Many people have been, and continue to be failed by a traditional medical approach to their problems, regardless of how accurate the diagnosis might be. Thus, health-care teams ought to assume a humble position in relation to the client, and be open to discovering and formulating problems in new ways (Macneil *et al.* 2012). That is, ‘not knowing’ or presuming to know what is wrong, but rather cultivating an attitude of enquiry aiming to discover or getting to know the individual as a unique person, and what needs to be done to make things right in their unique psychosocial context.

Being received, understood, and accepted just as one is, without judgment, was considered by Carl Rogers (1961) as the fundamental or necessary condition for growth and personality change. Rogers (1961, p. 130)

eloquently explained that it is not enough just for the therapist to be open, but for the person to experience the condition of being received:

Whatever his feelings – fear, despair, insecurity, anger, whatever his mode of expression – silence, gestures, tears, or words, whatever he finds himself being in this moment, he senses that he is psychologically received, just as he is by the therapist.

Rogers (1961, p. 207) hypothesized that this acceptance of the person as unique by the therapist leads to an increased acceptance of self by the client. Rogers (1957) further suggested that the acceptance of the person's internal frame of reference and the communication to the client of the therapist's empathic understanding and unconditional positive regard over a period of time are sufficient for constructive personality change to occur. Nurses and others do important work to directly address people's needs for welfare, medical treatment, and housing, as well as facilitating other basic needs. However, what might be pivotal to good clinical outcomes is the conveyance of non-judgmental, positive regard and acceptance of the person as she or he presents, which Rogers (1957) suggested is necessary for growth and change.

Unknowing has a clear place on the part of therapists and helpers in schools of existential psychotherapy and the self-actualization movement generally. If our purpose as individuals is to find meaning, then it stands to reason that, at best, a therapist or nurse can be a guide in the process. They cannot know what is best, and cannot know what an experience means for another, nor should they attempt to force another to find particular meanings in their experience. Therein lies a risk of informing another that they have an illness or a medical problem, although nurses might circumvent the conundrum of pigeon holing people's experience into an illness category by discussing what it might mean to them to be told by another that they have an illness. Maslow (1972, p. 266) described the creative person as possessing a child-like quality of innocence, whereby the person becomes 'unself-consciously absorbed or fascinated in the world outside the self which then means "not trying to have an effect on the onlooker", without guile or design'. The creative, self-actualizing person does not try and change the other. Germana (2007) argued that this creative attitude is akin to the virtue of uncertainty. It is a virtue to be well-informed and instructed, and have ready availability of skill and experience. However, through the cultivation of a 'renewed innocence' or uncertainty, we are moved to explore the unfamiliar more earnestly. Being uncertain or unknowing

can assist in finding creative solutions to problems, rather than attempting to fit the person into a predetermined category of problem and solution.

UNKNOWING IN PSYCHIATRIC CRISES

The creative attitude of uncertainty on the part of the helper is not just acknowledged as useful for assisting people towards actualization or human flourishing. Franklin (1992) described balancing being unknowing with knowing as a basic condition of psychoanalytic inquiry. The stance is also considered important in some effective approaches to psychiatric crises or emergencies. The open-dialogue approach to crisis intervention has been found to have achieved particularly impressive results with people presenting with psychosis (Aaltonen *et al.* 2011; Seikkula *et al.* 2006). This approach emphasizes 'tolerating uncertainty'; that is, the function of staff is not to provide solutions, but to facilitate processes, including open dialogue between all people involved in order to generate new understandings between people. In practical terms, the professional adopts a position of not presuming to know what the person's problem is. Open dialogue views social reality as constructed through dialogue, and shares this philosophical ground with narrative and solution-focused therapies (although the helper does not seek a preferred narrative or story over another). The therapist 'exercises an expertise in asking questions from a position of "not knowing" rather than asking questions that are informed by method and that demand specific answers' (Anderson & Goolishian 1992, p. 28). What the competent helper knows is how to ask questions to enable the person to develop their competency and expertise in describing and resolving their problems.

UNKNOWING, HUMILITY, AND NARRATIVE UNDERSTANDING AT THE HEART OF NURSING CARE

Extant mental health nursing theory tends to share an interest in the lived experience of the other and a constructionist view of reality. For example, the Tidal Model (Buchanan-Barker & Barker 2008), which represents a philosophy, values base, and set of nursing practices stresses valuing the lived experience of the person, and their language and expertise expressed through ordinary conversation. Practices include a careful choice of questions in order to clarify the meaning of experiences, and the assessment and plan is generally framed in the person's own language.

In some respects, the Tidal Model, with its humanistic and constructionist foundations, reflects something of a

paradox, as nurses more than any other discipline are the most closely aligned to medicine, and the positivist ideology that sees the main presenting problems as being psychiatric or medical, and treatment consisting of drugs in many contemporary settings. Nursing, at least on the face of it, is subordinate to medicine, and appears to be an extension of, or fulfils roles that are explicitly instrumental to, medicine. However, a substantial part of the therapeutic impact that nurses have (be they in community settings, where they might enjoy considerable autonomy, or in institutional settings dominated by medical ideology) is in assuming a stance of unknowing.

The medical doctor is presumed to know what is wrong and how best to help, not the nurse. The nurse is socialized into maintaining a deferential relationship to medical doctors, and not making competing knowledge claims. While this subordinate position might be oppressive and belie the real balance of expertise and experience in relationships, it nevertheless equips the nurse to be able to maintain a position of unknowing. That is, the nurse is in a good position to not assume to know what is best for the person, or even name/diagnose problems, but to genuinely attempt to meet and know the person in the context of their life. This is the essence of unknowing.

Unknowing is also a communicative act. Nurses and others can readily arrive at a psychiatric diagnosis and generally know what diagnosis or formulations colleagues have arrived at. The nurse is well positioned to communicate this knowledge in a much more tentative way, rather than represent the knowledge as immutable fact. In psychotherapy research, it has been found that emphasizing empathic connection, working collaboratively on individualized treatment goals, and sharing assessment results with clients are much more productive at facilitating a working alliance and improving outcomes than traditional question-and-answer assessments (Hilsenroth *et al.* 2012). Nurses can, often do, and ought to, operate in this more collaborative way with clients.

Nurses (as in the aforementioned MHNIP) appear to have contributed to impressive outcomes for service users, although those contributions are often unacknowledged, and therefore, how they are achieved is seldom explored. It is increasingly recognized that the therapeutic alliance or the quality of the relationship between service user and health professional is a major variable in explaining outcomes of many types of treatment, but there are deficiencies in the conceptualization and measurement of this concept (Elvins & Green 2008). Crucially, the social position of the therapist, or role they are cast in to, is generally not considered in theorizing about therapeutic alliance. It might be that maintaining a position of

unknowing is helpful in particular phases of a relationship or more pivotal in particular roles, and this is worthy of further research. Unknowing might play a role in the nurse being able to engage with people who have complex needs in a psychotherapeutic relationship over lengthy periods of time, and pave the way for a deeper and authentic knowledge of the person.

REFERENCES

- Aaltonen, J., Seikkula, J. & Lehtinen, K. (2011). The comprehensive open-dialogue approach in Western Lapland: I. The incidence of non-affective psychosis and prodromal states. *Psychosis: Psychological, Social and Integrative Approaches*, 3, 179–191.
- Anderson, H. & Goolishian, H. (1992). The client is the expert: A not-knowing approach to therapy. In: S. McNamee & K. J. Gergen (Eds). *Therapy as Social Construction*. (pp. 25–39). London: Sage.
- Beutler, L. E. (2002). The dodo bird is extinct. *Clinical Psychology: Science and Practice*, 9 (1), 30–34.
- Buchanan-Barker, P. & Barker, P. J. (2008). The Tidal Commitments: Extending the value base of mental health recovery. *Journal of Psychiatric and Mental Health Nursing*, 15 (2), 93–100.
- Carper, B. A. (1978). Fundamental patterns of knowing in nursing. *Advances in Nursing Science*, 1 (1), 13–24.
- Cotton, A. H. & Roden, J. (2006). Using patterns of knowing in nursing as a possible framework for nursing care of homeless families with children. *Contemporary Nurse*, 23 (2), 331–341.
- Department of Human Services (2013). Mental Health Nurse Incentive Program [Cited 14 October 2013]. Available from: URL: <http://www.medicareaustralia.gov.au/provider/incentives/mhnip/index.jsp#N1006C>
- Elvins, R. & Green, J. (2008). The conceptualization and measurement of therapeutic alliance: An empirical review. *Clinical Psychology Review*, 28 (7), 1167–1187.
- Franklin, G. (1992). The contributions of being unknowing to psychoanalysis. *Psychoanalysis & Psychotherapy*, 10 (2), 127–141.
- Germana, J. (2007). Knowing and unknowing as cardinal virtues of the creative attitude. *The Humanistic Psychologist*, 35 (3), 247–251.
- Health Management Advisers (2012). Department of Health and Ageing: Evaluation of the Mental Health Nurse Incentive Program. [Cited 14 October 2013]. Available from: URL: <http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-e-evalnurs>
- Hilsenroth, M. J., Cromer, T. D. & Ackerman, S. J. (2012). How to make practical use of therapeutic alliance research in your clinical work. In: R. A. Levy, J. S. Ablon & H. Kaechele (Eds). *Psychodynamic Psychotherapy Research*. (pp. 361–380). New York: Humana Press.

- Hurley, J., Browne, G., Lakeman, R., Angking, D. & Cashin, A. (2014). Released potential: A qualitative study of the Mental Health Nurse Incentive Program in Australia. *International Journal of Mental Health Nursing*, 23 (1), 17–23.
- Insel, T. R. (2012). Next-generation treatments for mental disorders. *Science Translational Medicine*, 4 (155), 155ps19.
- Jureidini, J. (2012). Explanations and unexplanations: Restoring meaning to psychiatry. *Australian & New Zealand Journal of Psychiatry*, 46 (3), 188–191.
- Jutel, A. (2009). Sociology of diagnosis: A preliminary review. *Sociology of Health & Illness*, 31 (2), 278–299.
- Kendell, R. & Jablensky, A. (2003). Distinguishing between the validity and utility of psychiatric diagnosis. *American Journal of Psychiatry*, 160 (1), 4–12.
- Lakeman, R. (2013a). Mental health nurses in primary care: Qualitative outcomes of the Mental Health Nurse Incentive Program. *International Journal of Mental Health Nursing*, 22 (5), 391–398.
- Lakeman, R. (2013b). Talking science and wishing for miracles: Understanding cultures of mental health practice. *International Journal of Mental Health Nursing*, 22 (2), 106–115.
- Lakeman, R. & Bradbury, J. (2013). Mental health nurses in primary care: Quantitative outcomes of the Mental Health Nurse Incentive Program. *Journal of Psychiatric and Mental Health Nursing*, doi: 10.1111/jpm.12089.
- Lakeman, R., Cashin, A. & Hurley, J. (2013). Values and valuing mental health nursing in primary care: What is wrong with the ‘before and on behalf of’ model? *Journal of Psychiatric and Mental Health Nursing*, doi: 10.1111/jpm.12117.
- Lopez, K. A. & Willis, D. G. (2004). Descriptive versus interpretive phenomenology: Their contributions to nursing knowledge. *Qualitative Health Research*, 14 (5), 726–735.
- Luborsky, L., Rosenthal, R., Diguier, L. *et al.* (2002). The dodo bird verdict is alive and well – mostly. *Clinical Psychology: Science and Practice*, 9 (1), 2–12.
- Macneil, C. A., Hasty, M. K., Conus, P. & Berk, M. (2012). Is diagnosis enough to guide interventions in mental health? Using case formulation in clinical practice. *BMC Medicine*, 10 (1), 111. doi: 10.1186/1741-7015-10-111.
- Maslow, A. H. (1972). *The Farther Reaches of Human Nature*. Penguin Group: New York, NY.
- Munhall, P. L. (1993). ‘Unknowing’: Toward another pattern of knowing in nursing. *Nursing Outlook*, 41 (3), 125–128.
- Osborne, J. W. (1990). Some basic existential-phenomenological research methodology for counsellors. *Canadian Journal of Counselling and Psychotherapy/Revue Canadienne De Counseling Et De Psychothérapie*, 24 (2), 79–91.
- Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21 (2), 95–103.
- Rogers, C. R. (1961). *On Becoming a Person: A Therapist’s View of Psychotherapy*. New York: Houghton Mifflin Co.
- Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry*, 6, 412–415.
- Seikkula, J., Aaltonen, J., Alakare, B., Haarakangas, K., Keränen, J. & Lehtinen, K. (2006). Five-year experience of first-episode nonaffective psychosis in open-dialogue approach: Treatment principles, follow-up outcomes, and two case studies. *Psychotherapy Research*, 16 (02), 214–228.
- Shanley, E. & Jubb-Shanley, M. (2012). Coping focus counselling in mental health nursing. *International Journal of Mental Health Nursing*, 21 (6), 504–512.
- Sparks, J. A., Duncan, B. L. & Miller, S. D. (2008). Common factors in psychotherapy. In: J. L. Lebow (Ed.). *Twenty-First Century Psychotherapies: Contemporary Approaches to Theory and Practice*. (pp. 453–497). Hoboken, NJ: Wiley & Sons.
- Spinelli, E. (1994). *Demystifying Therapy*. Ross-On-Wye: PCCS Books.
- World Health Organization (2012). Depression: Fact sheet 369 [Cited 10 October 2013]. Available from: URL: <http://www.who.int/mediacentre/factsheets/fs369/en/index.html>