

## Ways of Knowing and Unknowing in Psychotherapy and Clinical Practice

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### Abstract

Carper's theory is used to explicate and illustrate ways of knowing in psychotherapy and clinical practice. White and Munhall's expansion of Carper's theory, particularly the pattern of unknowing, is highlighted to explore psychotherapeutic intervention to illustrate context, intersubjectivity, and new perspectives leading to confidence and change. A creative encounter using poetry in psychotherapy with a bereaved caregiver who subsequently becomes a widow provides a lesson in hope versus hopelessness and is used to elucidate the process of how one struggles with despair to yield to the return of hope. The potential for growth through mutuality and reciprocity for both the patient and the nurse as embedded with the context of healing relationships is explored. Integrated case narrative and analysis includes the expertise of a psychiatric nurse practitioner over a one-year period.

**Keywords:** Carper; Mental health; Hope; Psychotherapy; Bereavement; Psychiatric; Nursing

### Introduction

Carper's ways of knowing in nursing--empirics, esthetics, personal knowing, and ethics, provide a guide to holistic practice, education, and research. These ways of knowing bond to form a structure of knowing [1]. Since Carper first published her theory, these ways of knowing have been expanded upon by other theorists. White describes an additional way of knowing, the sociopolitical context—a way of knowing derived from interpretive and critical traditions as a context in which to frame the four patterns of knowing [2]. Munhall built on Carper's work and described 'unknowing' as a pattern of knowing. Unknowing, a condition of openness and essential to intersubjectivity and perspective, leads to confidence and change [3]. When Carper's work was published, it was considered as a shift in thinking from a reductionist perspective to a more humanistic view of nursing, illustrating the complexities and diversities of nursing knowledge [4].

Reflection allows one to look back and observe our experiences in a way that validates the kind of care we give and encourages the nurse to continue to care because of evident and meaningful patient and family responses. It is the purpose of this paper to look back or reflect on an evolving patient encounter consisting of weekly psychotherapy sessions over a period of one year which illustrates Carper, White, and Munhall's contributions to nursing of these ways of knowing which describe the ways nurses care.

An encounter with a bereaved caregiver who subsequently becomes a widow is used. In this article, the process of how one struggles with despair and loss to experience the return of hope through the process of psychotherapy is explored. Integrated case narrative includes the expertise of a psychiatric nurse practitioner over a one-year period and includes data collection methods that are common for advanced practice nurses in mental health to utilize in professional practice. These include interviews, observational techniques, review of the medical and psychiatric history, session notes, the interpretation and analysis of these data, and psychiatric mental health guidelines for

nursing assessment and intervention methods and expected outcomes. Additionally, and with respect for the expanded ideas of Munhall and White the use of poetry is used in psychotherapy to elicit, evoke, and explore feeling and personal meaning [2,3]. A combination of supportive, psychodynamic, and cognitive-behavioral strategies was employed while using poetry as session focus to regenerate hope, personal knowing and unknowing. This eclectic approach to psychotherapy provides effective, compassionate care while considering the patient's individuality, the context for her grief, and its complexity and interrelatedness with early life learning.

### Empirical Relationships Between Hope and Bereavement

Empirical knowledge comes from theory and research that describes, explains, and predicts knowledge and that constitutes the science of nursing [5]. Research examining the measurable relationship between hope and bereavement, depression, or other variables can be categorized within the framework developed by Carper's first fundamental pattern of knowing in nursing, which is the empirical, factual, and descriptive nature of knowledge [1].

The hope theories developed by Synder and Herth have offered a practical way of conceptualizing hope as a cognitive construct with a wide range of social, emotional, and physical benefits and outcomes [6,7]. Interestingly enough, however, a strong causal link among hopefulness and these positive outcomes has not been established or described in the literature [8]. In a meta-analysis of hope enhancement strategies in clinical and community settings, these authors suggest that the correlations between hope and psychological benefits may run in an opposite direction [8]. Although theorists have speculated that increased hopefulness produces beneficial outcomes which have not been evidenced through research studies, Weis and Speridakos suggest that hope may just be a byproduct rather than a determinant of goal attainment and, therefore, can be increased through intervention. In other words, the byproduct of psychotherapy as a means to cope with illness and loss, adjust psychosocially in its aftermath, and problem solve socially and emotionally may be hope itself.

A patient sits in a psychotherapy session crying inconsolably stating, "There is no hope, and with no hope for him, there is no hope for me." As a bereaved caregiver to her husband, now in the end stage of lung cancer, she knew his death was imminent. She identifies hope as what she lacks and the source of her distress. Farran, Herth and Popovich's work assists our understanding that the personal meaning and significance of hope depends upon an individual's life circumstance, one's personal philosophy about hope, and its relative degree in our life circumstances [9]. "Hope constitutes a delicate balance of experiencing the pain of difficult life experiences, sensing an interconnectedness with others, drawing upon one's spiritual or transcendent nature, and maintaining a rational or mindful approach for responding to these life experiences" [9]. Farran and colleagues conceptualize four key components of hope: (a) the experiential process as part of being human while allowing imaginative possibilities to occur; (b) a spiritual/transcendent process in which the patient grows; (c) a rational thought process with goals and needed resources (physical, emotional, and social); and d) a relational process with hope exchanged and influenced by another's hope, presence, communications, and strength [9].

### **Aesthetics: The Human Experience of Hope as the Art of Nursing**

The aesthetic approach, or the art of nursing, encourages the exploration, examination, and appreciation of the human experience of health and illness. This pattern of aesthetic knowing emphasizes the nurse's perception of what is significant in the patient's behavior. In applying the aesthetic approach, we consider that paradoxically, this patient's husband, until he became very ill, had always cared for her. He did the cleaning, cooking, organizing, and caring for her mother who lives with dementia. She was one of six children who was raised in an atmosphere of emotional and physical neglect. She grew up in a chaotic home where she was not shown how to complete basic tasks of self-care, how to understand her own feelings, or how to understand her mother who demonstrated erratic mood swings and behaviors. Now her mother was even harder to understand as she lived with dementia. Her father was not present in her life from a very age, and she had no memory of him. Her mother had turbulent and sometimes violent relationships with various men throughout her young life. She had no stable representations of consistent caring others in her early life. Her husband formed a bridge by the way he cared for others to a new way of understanding life and herself. "He filled her with hope," she would say, "about her life and love." It was my hope that a completed grief process would yield the re-emergence of her hope, his gift to her, and the meaning of their relationship.

In our therapy sessions, hope as a source of consolation in the bereavement therapy process was perceived as that which she was seeking. Reminding the patient that a coin has a flip side or that a magnetic field has a positive and negative pole, it is the work of psychotherapy to look at both sides of an issue. This process emphasized the letting go of hopelessness by making connections with the hopelessness she felt in her early life and how her husband had assisted her in letting go of her hopelessness. She was able to identify that her husband had always been a source of hope to her in her past and in her marriage. The process of psychotherapy identified ways she could continue his gift of hope to her, because it now was an integral part of her, and as a way to honor his life within all of its many meanings. She was able to understand that, initially and in her present

grief state, it was difficult for her to access this part of herself but felt hope she one day might be able to again.

### **Personal Knowledge: The Subjective Metaphorical Nature of Hope**

"I have no hope," she would state over and over again. In this phase of treatment, we worked toward developing a fuller understanding of the meaning of hope. When I reflected back to her that she always seemed to think of or use hope as a noun, she agreed to explore the idea of hope as a verb. She began to explore hope on her own, and each week would come in to therapy with something she had read or something she had written about hope. Her soft voice would quote poetry: "Hope is the thing with feathers that perches in the soul . . . [10] and reveal new perspectives of hope in this part of her treatment. One day she said that even her voice sounded more hopeful. More hopeful still, she said, "now I have to think of hope as an adjective or adverb describing the way I am beginning to live."

### **Ethics: The Use of Hope to Envision a Future**

This woman was one of six children of the mother for whom she now provided care. The ethical pattern in nursing emphasizes matters of obligation and distinctions between right and wrong [1]. Until now, this patient saw no alternatives to her caring for her mother all alone. She said her siblings simply refused to care for her. In this phase of therapy, she worked with each of her siblings to arrive at an ethical decision related to her mother's care. Her mother's care had obviously reached a level of need that no single person could meet. She consulted her siblings saying that she was not necessarily asking anybody to take over or even help with her care (although she was not necessarily ruling this out either) but that she was asking for their help in evaluating what was best for all of them and for her mother. With this approach, she found that they were able to participate in making a decision about her care that resulted in finding a skilled nursing facility for her mother where she is quite comfortable. This patient begins to report that her heart is filled with hope for her mother's remaining days. Discovering that the nursing staff understands her mother's needs and is responsive to them, this patient has been relieved of much guilt that she was not able to give her mother what she needed by herself. As a child, she felt alone and helpless in understanding what her mother wanted from her, struggled hard to discern without guidance from her mother what might help, and felt failure when her mother was unhappy with her.

### **Sociopolitical: The Interrelatedness of Thought, Belief, Feeling, and Creation**

This pattern concerns the interrelatedness of the patterns, questions assumptions about knowledge, and offers individual voice and expression [2]. This woman had learned as a young child to feel powerless. She grew up with few resources in a very poor community. She was not encouraged to further her education or to even think that it might be possible for a woman to do so. Slowly over the course of therapy, she began to see the power she did have and could use without guilt. Upon realizing that it was not only needed, but, in fact, ethical that her siblings were involved in the decision about her mother's care, she accessed a new sense of power that she could make change in her life. This awareness also increased a sense of hope in her future.

Her grief did not permit her to have hope nor to see how truly competent she is apart from her husband. She had been involved in his care by making critical medical decisions, assisting with his activities of daily living, and giving him increasingly complex care and treatment for his illness in their home; yet without hope she was not able to see the gift her husband had left her—that it was he who encouraged, modeled, and later gave her the opportunity to utilize her inherent and developed strengths to release her competence and empathy. In a sense, he represented her missing parent and the nurturance and guidance she had not received as a child.

### Unknowing: The Intersubjective and Spiritual Space of Relationship

Mutuality appears to be the expression of our social nature as humans, and a form of communion with another person. Because mutuality represents a continuum of shared experience, it becomes that which binds us to one another in our human condition. Almost 40 years ago, Pellegrino and Thomasma proposed a system of medicine in which the center is relationship, and the purpose of this relationship is healing rather than fixing [11]. This system is contrasted with but does not deny the reductionist perspective of the importance of technical and technological competence derived from scientific knowledge. Scott and colleagues [12] advocate for an alternative philosophy of medicine founded on the concept of healing relationships based on the ethical and philosophical work of Pellegrino and Thomasma, and Martin Buber's philosophical work on the nature of relationships. The Human Relationship Model, developed by Scott and colleagues, is characterized by dialog and mutuality. The model recognizes that there is some asymmetry in the mutuality of the therapeutic relationship as the nurse clinician needs to be able to demonstrate emotional self-regulation or assume a higher functioning role from the beginning. Miller stresses that mutual and meaningful interchange with others is essential for psychological growth [13-15]. Miller's Relational-Cultural Theory has led a strong and persuasive movement away from separation toward a psychology of connection with important implications, not only for individual psychotherapy and clinical practice, but for social change.

Reciprocity involves joining together in a shared goal. Joining this patient in her process of exploring her pain through psychotherapy was the hope that she may find its relief. It is important for this type of psychotherapy that the therapist be substantive and authentic, using something similar to an I-Thou type dialogue [16] about the patient's life so that the patient could use the process to find hope in the possibilities of growth through loss. Buber speaks of relationship as a process of mutuality and reciprocity of an I and an internal Thou [16]. The therapist needs to be transparent enough so that the patient can access herself initially through the process of transference in which the therapist is perceived as hopeful and open. In this regard, it is important that the therapist has explored her own defenses and unconscious beliefs about hope to free and heal her own illusions and disillusion about hope concerning her own life and clinical practice. As such, psychotherapists grow with their patients as our patients may present us with material for our own personal and professional growth.

In this case, a process of exploration and regeneration was used to transform the pain of loss into a source of strength, courage, and resilience. Klein noted that suffering can lead to further maturation of character while Pollock used the phrase "mourning liberation" to describe the way we may use the grieving process as a gateway to creative, freeing expression, and growth. The psychotherapist, then,

becomes a facilitator of this process by using Emily Dickinson's spirit through her writing. This sharing, which is observed, responded to, and experienced with other, is precisely what is key to facilitating the letting-go process of mourning.

She speaks of Emily Dickinson so psychotherapist looks to Emily Dickinson to find her and for her to find herself in her process. It is in this kind of exchange engaging both mutuality and reciprocity that, in the words of Kierkegaard [17], one "chooses oneself." (p.219). In this sense, all of our choices and commitments, small and great, involve the degree to which we regard or choose ourselves [18]. Initially, in this psychotherapeutic exchange, one had a sense she was rejecting herself as that which she thought defined her was missing. As the patient comes closer to knowing who she has become through reciprocity and mutuality of relationship with her husband and now through psychotherapeutic exchange, she is learning she continues to carry this new definition and evolution within her. It becomes a kind ascension for her personally and spiritually. She understands, in this sense, her husband has given rise to a process in herself and lives on through her. She is not living for him. She is free to be who she has become through the mutuality and reciprocity of exchange with him. It becomes possible to both meet and let go of her grief as it rises to show her what needs to be healed within her. Later as her process of grief continues, she becomes fearful her husband would no longer know her as she has changed so much. She worried that if he were to come back today, he would meet somebody very different, and it made her fearful. She makes familiar attempt again to reject herself. In this stage, we begin to move from the writing of Emily Dickinson to other writers. We learn together that grief, too, as is psychotherapy, is a process of many stages of letting go of what we thought we knew and a process of becoming who we know ourselves to be now. As a child, her feelings were not nurtured. She became immobilized by them in her adult life. There were many surprises along the way as she learned to greet her feelings as "welcomed guests" as described by Rumi, a 13th-century poet whose writings speak of deeply philosophical and spiritual themes [19]. Our psychotherapy began regularly to include passages from literary sources as springboards to explore her feelings:

### The Guest House

- by Rumi
- This being human is a guest house.  
Every morning a new arrival.  
A joy, a depression, a meanness,  
some momentary awareness comes  
as an unexpected visitor.
- Welcome and entertain them all!  
Even if they're a crowd of sorrows,  
who violently sweep your house  
empty of its furniture,  
still, treat each guest honorably.
- He may be clearing you out  
for some new delight.  
The dark thought, the shame, the malice,  
meet them at the door laughing,  
and invite them in.
- Be grateful for whoever comes,  
because each has been sent  
as a guide from beyond.

We use this writing as creative springboard again for her process of becoming less fearful of her feelings and as mutual and reciprocal exchange for opening to her feelings as teachers and messengers of what needed to be healed within her. We are careful not to put a happy face or superficial spin on her feelings but to greet them exactly as they present. She had much grief to process triggered now by her husband's death but also for a feeling self she had long denied. She is observed in this phase to process more quickly through her distressing feelings to more peaceful feelings and to return again without judgment of these feelings in subsequent cycles. She learns that grief comes in waves and becomes less fearful of engulfment by her feelings, as she had experienced her feelings with her mother in her early life. She reports that she understands now how she can laugh one minute and cry so hard in the next and that she feels, at times, happier and sadder than she has ever felt in her life. In the next session, she reports that she is aware that her husband's death has made her look at everything differently. She is aware of missing his presence still. However, by both, at times, confronting and subsequently being relieved and released of grief's strength, she reports that things as simple as the color of a leaf or the touch of a child seem more precious, and she is more willing to allow herself to truly feel it. She notes she is curious about these feelings, and her curiosity makes her feel more connected to a life she is less fearful of following. She reports herself as more hopeful, even a bit excited, at times, at what lies ahead. She quickly identifies fear's surface and makes the statement, "I know now how to yield to and face that, too. It's a moment; it's just a feeling, not something to be judged as right or wrong. I don't feel paralyzed by it anymore. That's huge for me. I am not afraid anymore of being alone."

## Discussion and Conclusion

Developing research questions as well as clinical interventions from an empirical, quantitative perspective include measuring hope, its correlations, explanations, offering differing perspectives, new questions, and ideas for hope research and hope interventions. Carper [1] recommended the further development of her model for generating and disseminating knowledge. White [2] suggested modification in incorporating empirical knowing that seeks not to generalize but rather to interpret or describe by using context-embedded stories to enrich understanding. This ontological position of the interpretive paradigm suggests multiple realities cannot be generalized and is an area to consider in expanding the model. As such, it can be appropriately applied to psychotherapy. The idea of unknowing becomes critical in psychotherapy, in particular, because some of our patient's distorted thinking is the product of learning acquired through the immature lens of a child, now an adult, that may lie at the base of their struggles with psychological and psychiatric problems. For the

nurse, it is an opportunity to examine his or her own constructed, unconscious beliefs and personal illusions about the phenomena in which she engages with patient in a process which offers both nurse and patient opportunity for healing and growth.

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