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# THE DANGERS OF ABSOLUTE CERTAINTY IN MENTAL-BEHAVIORAL HEALTH PRACTICE: A CRITICAL REFLEXIVE ANALYSIS

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## ABSTRACT

This analysis examines the risks that arise when professional knowledge in mental-behavioral health is treated as certain or unquestionable. While established theories and practices offer valuable guidance, they are shaped by history and culture (Foucault, 1988; Haraway, 1988). Using insights from different professional fields, clinical work, and personal reflection, this article explores how knowledge that is treated as fixed, complete, or unquestionable can unintentionally obscure complexity, overlook lived experiences, and reinforce dominant ways of thinking in clinical and educational settings (Mullan, 2023). While a degree of understanding is necessary for practice, knowledge is never complete or neutral and is always shaped by context. Here, "absolute certainty" refers to privileging authority and standardization over relationships and context. It also involves the uncritical acceptance and application of professional knowledge as fixed, universal, and context-independent, often prioritizing standardized frameworks over cultural, relational, and situational understanding.

In this view, "best practice" means using assessments and interventions that are culturally relevant, grounded in context, and developed in collaboration with those being served, while attending to power and social structures (Linklater, 2014; Mullan, 2023). The article does not reject scientific knowledge; rather, it calls for a human-centered approach grounded in humility, curiosity, and intentionality. It argues that ethical practice emerges from a willingness to understand knowledge as relational and evolving, not solely from technical expertise (Wampold & Imel, 2015). By reframing uncertainty as a marker of integrity rather than weakness, the field can move toward greater inclusivity, cultural responsiveness, and authentic human connection.

## KEY WORDS

Epistemic certainty; Reflexivity; Mental-behavioral health; Cultural humility; Qualitative inquiry; Decolonizing practice; Clinical ethics

## Introduction

As I have grown older, I have come to see more clearly that people hold multiple experiences shaped by different narratives, each grounded in specific times and contexts. Dominant narratives often remain in place until new knowledge or experiences challenge them. I have learned that knowledge, while powerful and meaningful, is never final. It is often shaped by shifting social, cultural, and historical forces, as well as by power structures

and perception. Like knowledge, skills and social norms are not fixed (Haraway, 1988); they evolve over time in response to events, values, culture, and growing awareness (Gelfand et al., 2024).

I have encountered mental-behavioral health from multiple positions. Growing up in poverty and within family and community violence, and later experiencing homelessness and addiction, I first engaged in the field as someone receiving care. Looking back, certain moments stand out.

My father died during my childhood. As an introverted child, I entered a prolonged period of silence that concerned my mother and teachers, leading to multiple psychological and psychiatric assessments. Yet, I experienced myself as stable and unchanged during this time. My silence was shaped, in part, by my relationship with my father, where physical absence had already been a recurring reality. Only later did I come to understand that my silence was interpreted primarily as emotional suppression, with little attention to its broader context.

In my early to mid-thirties, I participated in counseling with licensed clinicians. During this time, when I expressed that I was "doing okay," it was often interpreted as emotional suppression rather than as self-regulation or hope. Similarly, my silences were frequently understood as denial or resistance, rather than as space for reflection and meaning-making.

Looking back, it became clear that these interpretations were shaped not only by implicit bias but also by dominant psychoanalytic and clinical paradigms that privilege observable affect over lived context (Crapanzano et al., 2023; Meidert et al., 2023). Within these frameworks, silence, composure, and measured responses were often read as indicators of pathology rather than as potentially adaptive, strength-based responses to loss, instability, and threat. What was frequently overlooked was that my responses supported survival, coherence, and meaning-making within environments marked by poverty, violence, disrupted attachment, and collective trauma. Rather than reflecting dysfunction, these responses often represented forms of self-regulation, internal organization, and psychological intelligence emerging in relation to real conditions. By repeatedly reducing such responses to diagnostic categories, professional interpretations obscured the broader structural, relational, and historical forces shaping my experiences. These moments revealed that professional knowledge, while often well-intentioned, is neither neutral nor complete; it is commonly shaped by theoretical commitments, professional assumptions, and institutional norms that can transform resilience into pathology and adaptation into disorder (Horwitz & Wakefield, 2007; Kleinman, 1988).

Over time, and through more than 30 years of professional experience, I have come to the other side of the coin, first as a mental-behavioral health practitioner across varied contexts and later as a university instructor who continues to engage in the field. Through these combined personal and professional experiences, I have witnessed the profound complexities, uncertainties, and ethical responsibilities within mental-behavioral health.

A central concern has been what I have come to understand as the danger of promoting or proclaiming, consciously or unconsciously, professional knowledge, skills, norms, or narratives as absolute certainty. Here, absolute certainty refers to the presentation of information as fixed, complete, or beyond question, detached from context, power structures, and perspective. In practice, this orientation can function to stabilize identity, maintain authority, and suppress complexity, contradiction, or alternative ways of knowing and being. When knowledge, skills, or narratives are treated in this way, I have observed that social systems are often protected, while human dignity and contextual realities are overlooked or dismissed (Brown, 2021; Horwitz & Wakefield, 2007). One way this can manifest is through a decline in the depth of listening required to meet individual and community needs, alongside the subtle reinforcement of conditions that contribute to ongoing marginalization (Haraway, 1988).

This article is informed by a critical reflexive approach that integrates lived experience, clinical practice, and interdisciplinary scholarship to examine how knowledge, when it is interpreted and applied as fixed and complete within mental-behavioral health contexts, can obscure complexity, shape interpretations of experience, and influence whose realities are recognized or dismissed. It contributes to qualitative health research by exploring how epistemic certainty can operate in practice and by highlighting reflexivity, humility, and contextual attunement as important to ethical and responsive care.

## Methodological and Theoretical Positioning

This work is situated within qualitative and interpretive traditions that emphasize reflexivity, narrative meaning making, and the co-construction of knowledge. Rather than presenting empirical findings, this article offers a critical reflexive analysis, drawing on lived experience, clinical encounters, and interdisciplinary scholarship to examine how epistemic assumptions can shape practice.

Reflexivity, understood here as an ongoing awareness of how one's social positionality, intersecting identities, experiences, and assumptions shape interpretation, is central to this inquiry. My experiences as both a recipient of services and later as a practitioner and university educator inform this analysis, not merely as personal narrative, but as situated forms of knowledge shaped by sociocultural, historical, and institutional contexts.

In this way, the analysis does not seek generalizability, but rather depth of understanding, offering insight into how knowledge can be experienced, interpreted, and enacted within real-world contexts. While this analysis is grounded in reflexive and interpretive traditions, these epistemic concerns did not emerge in abstraction. They are rooted in lived encounters with knowledge as it is taught, internalized, and often reproduced as unquestioned truth. The following content illustrate how such patterns began to take shape early in my life and education, long before they were recognized within my professional practice.

### *Mind Colonization Through Absolute Certainty*

There was a time in my life when I lived under a deeply rooted assumption that those who came before me, including teachers, historians, writers, theorists, researchers, and scientists, already knew the truth. I believed that truth had been discovered, settled, and embedded into our collective understanding. This sense of certainty was largely shaped through my K–12 education, particularly in history and social studies classrooms. Similar patterns continued throughout much of my higher education and later resurfaced in my experiences within the field of mental-behavioral health, leading to what I now recognize as a form of *mind colonization*. The following examples illustrate how this pattern of presenting knowledge as certain has appeared across historical, cultural, and scientific contexts:

• Through my educational experiences, I was taught that Christopher Columbus "discovered" America in 1492. Information about the sophisticated and enduring Indigenous civilizations that existed long before Columbus's arrival, more accurately, his invasion of already inhabited lands, was often omitted, suppressed, or minimized. Increasing engagement with historical and Indigenous scholarship revealed that the language of discovery functioned not as a neutral descriptor, but as an ideological and legal framework that legitimized conquest, justified dispossession, and erased the presence, sovereignty, and humanity of First Nations peoples who had lived on and stewarded these lands for generations (Dunbar-Ortiz, 2014; Linklater 2014).

• A related example emerges in how I was taught that Abraham Lincoln's primary motivation for the Civil War was the abolition of slavery. This narrative was presented as a settled truth rather than a simplified account shaped by power, politics, and historical framing. Only through deeper engagement did I come to recognize the broader complexity: historical evidence suggests that Lincoln held racist beliefs and that his central aim was the preservation of the Union, while the abolition of slavery emerged, in part, as a strategic wartime measure rather than solely as an unambiguous moral stance (Lincoln, 1862/1953). Moral clarity appears to have been, at least in part, retroactively imposed to stabilize national identity and reconcile unresolved contradictions within the United States' historical narrative.

• This same pattern is reflected in the celebration of "Thanksgiving," often taught as a harmonious meal shared between Pilgrims and First Nations peoples. This narrative seems to have functioned to obscure genocide, broken treaties, stolen land, cultural displacement, and forced assimilation (Linklater, 2014). It was not presented as interpretation, but as unquestionable truth. Knowledge that is presented as absolute certainty is rarely acknowledged as partial, contested, or incomplete, a pattern well documented in analyses of power and knowledge production (Foucault, 1988).

• The pattern extends further into ideological frameworks such as the doctrine of Manifest Destiny, which framed westward expansion as divinely ordained and inevitable, thereby justifying massacres, land theft, and cultural annihilation. It is now clear that this so-called destiny was not a natural law, but a dominant narrative imposed to rationalize violence and dispossession (Stephanson, 1995).

• Perhaps one of the most devastating consequences of this pattern emerged through early scientific claims of racial hierarchy. Slavery, segregation, and eugenics were justified through assertions that race was biological and scientifically proven, producing categories of "superior" and "inferior" human beings. These claims did not remain theoretical; they became embedded in laws, institutions, educational systems, and medical practices, shaping how people were treated, valued, and governed. History has since shown that science is not neutral when it is shaped by ideological commitments and power structures (Haraway, 1988; Rose, 2007). The effects of these claims have been far-reaching and persistent, continuing to influence patterns of inequity in areas such as healthcare access, diagnostic practices, housing, education, and criminal justice. For example, disparities in maternal mortality among Black women in the United States reflect not only present-day conditions, but also longstanding assumptions about biological difference and pain tolerance that can shape clinical decision making and the quality of care received (Njoku et al., 2023). These enduring patterns illustrate how knowledge once presented as absolute certainty can continue to structure systems, perceptions, and outcomes long after the original claims have been challenged or disproven. Dismantling these effects requires not only correcting misinformation, but also critically examining how such assumptions remain embedded in contemporary practices and institutions.

• This pattern is also evident in the construction of national identity through terms such as "American," a word that, while geographically referring to multiple continents, is often used exclusively to identify the United States. This narrowing of meaning simplifies a complex reality and reinforces a singular national identity while obscuring the histories, peoples, and nations across the Americas. It also shapes how belonging is defined, often positioning those who migrate to the United States, even under conditions of need, as outsiders rather than as part of a broader human and regional continuum.

• Similarly, the myth of meritocracy, the belief that hard work alone determines success, reduces complex social realities to individual effort. In my personal and professional experience, this narrative has reinforced individualism while obscuring the roles of structural racism, sexism, heterosexism, ableism, inherited wealth, redlining, immigration policy, and other forms of systemic inequality. It has often overlooked how individuals experience disadvantage across intersecting systems of power, where race, gender, sexuality, ability, and class often interact to shape lived realities. As a result, responsibility is frequently shifted away from systems and placed primarily on individuals, often masking the structural conditions that shape opportunity, constraint, and lived outcomes (Brown, 2021; Foucault, 1988).

Taken together, these experiences illustrate a recurring pattern in which dominant forms of knowledge and social norms have failed to represent the full complexity of lived reality. This pattern is not uncommon and requires humility, curiosity, and mindful intentionality to be recognized and continually addressed. In my experience, incomplete narratives and inaccurate information persist not because they are uncontested, but because they continue to be taught and repeated as unquestionable truths.

I have observed that systems of social prestige, economic wealth, and political privilege often grant definitional power to certain individuals and groups, enabling them to shape dominant sociocultural and political narratives. When knowledge is framed or assumed as fixed or certain, it can limit inquiry, normalize power structures, and lead individuals to internalize systemic outcomes as personal failures (Foucault, 1988). Thus, the continued promotion of certain ideas, despite evidence that challenges them, appears to function as a recurring societal pattern that sustains systems of power and dominance. Research suggests that individuals often require stronger justification to endorse change than to maintain existing norms and structures, contributing to the persistence of ideas even in the face of disconfirming evidence (Blanchar et al., 2024).

It is vital to recognize and address this socio-political pattern when it manifests in the field of mental-behavioral health to prevent services from becoming vehicles that reinforce inequity and dominant narratives at the expense of marginalized voices and lived realities. While some colleagues with whom I have been in

dialogue suggest that these tendencies are deeply embedded in our nervous systems and social structures, and therefore extremely difficult to change, my experience leads me to propose that humility, curiosity, and mindful, intentional practices that continually question what we assume to be true, both within ourselves and within our collective systems, can, over time, open space for transformation, even within what feels most entrenched.

The aforementioned patterns are not limited to history or public discourse. They have often persisted within contemporary systems, including mental-behavioral health, where epistemological assumptions about certainty can shape how human experience is understood, interpreted, and acted upon.

***Absolute Certainty and Mental-Behavioral Health***

Mental-behavioral health does not exist outside the epistemological, historical, and cultural frameworks through which individuals are taught to understand themselves and the world (Engel, 1977; Rose, 2007). When certainty promotes dominant narratives about identity, success, morality, and worth, it can also shape how distress is experienced, interpreted, diagnosed, and treated.

In my years of experience as a clinical mental-behavioral practitioner, I have borne witness to cases in which emotional pain has been interpreted primarily as individual pathology, with far less consideration given to its emergence in response to exclusion, systemic oppression, or structural contradictions (Mullan, 2023; World Health Organization, 2022). For example, I have observed instances in which individuals experiencing significant stress and anxiety following job loss or financial instability were diagnosed with anxiety disorders, despite the clear connection between their distress and material conditions such as economic insecurity, limited access to resources, or systemic barriers to employment. In such cases, responses that may reflect understandable reactions to uncertainty, loss, and instability were, at times, interpreted through a clinical lens as symptoms requiring intervention, rather than as meaningful responses to broader social and economic realities.

Similarly, I have witnessed how trauma responses shaped by prolonged exposure to violence, instability, or marginalization have been framed as maladaptive pathology, rather than as adaptive responses to threatening or unpredictable environments. Hypervigilance, emotional withdrawal, or difficulty trusting others, for example, can be understood as forms of protection and survival. Yet, when interpreted without sufficient attention to context, these responses may be labeled as dysfunction, often obscuring the conditions that gave rise to them (Mullan, 2023).

Notably, my personal and professional experience indicates that colonized knowledge does not remain abstract; it often becomes embodied, shaping self-concept, emotional regulation, coping strategies, and the meanings individuals assign to their pain (Johnson, 2023). When individuals are repeatedly exposed to interpretations of their experiences as disordered or deficient, they may begin to internalize these meanings, understanding themselves through frameworks that do not fully reflect their lived realities.

Within mental-behavioral health systems, this orientation has often meant prioritizing adaptation to unjust conditions over critical inquiry into those conditions themselves (Fernando, 2017). Symptoms have often been isolated from context, resilience has frequently been demanded without repair, and it has not been uncommon for responsibility for healing to be placed disproportionately on individuals, while structural harm remains insufficiently examined (Brown, 2021; Linklater, 2014; Mullan, 2023). As a practitioner and university educator, I have witnessed how absolute certainty can, and often does, reproduce itself both clinically and educationally, limiting curiosity and reinforcing hierarchies of expertise that can silence lived experience. This is particularly concerning given that no two experiences are the same, and the absence of such recognition can contribute to the continued privileging of some communities and the marginalization of others.

Given the tendency of socio-political patterns to influence professional service fields such as mental-behavioral health, applying a decolonizing or anti-oppressive framework when providing or promoting mental-behavioral health services may be both appropriate and necessary (Tuck & Yang, 2012). Here, a decolonizing or anti-oppressive framework refers to approaches that critically examine and seek to transform power relations embedded within knowledge, practice, and institutions. Decolonizing the mental-behavioral health field

involves intentionally examining and dismantling dominant frameworks, assumptions, and practices that privilege Western, Eurocentric models of knowledge and healing while dismissing, neglecting, or undervaluing diverse cultural, historical, and lived ways of understanding wellness, distress, and care (Mullan 2023). As professionals in the field, it is our responsibility to question the certainty with which knowledge has been constructed, transmitted, and enforced, both within the profession and within the minds of those it seeks to serve.

While these patterns of certainty are deeply embedded in contemporary systems, my understanding of knowledge has also been shaped by forms of wisdom that exist outside formal institutions. These teachings offered an alternative orientation, one grounded not in fixed truths, but in movement, relational awareness, and openness to continual learning.

***Ancient Wisdom***

Growing up, my maternal great-grandfather, known in our community as a curandero (a.k.a traditional folk healer), often reminded us that knowledge was never absolute. He used the hummingbird as a metaphor, always moving, never lingering too long in one place, seeking nourishment and groundedness through new experiences and deepened awareness.

In reflecting on these teachings, I have come to understand them not only as cultural or familial wisdom, but as an epistemological orientation, one that resists fixed knowledge and instead embraces learning as fluid, relational, and continuously evolving. This stands in contrast to certainty-based frameworks that position knowledge as complete, stable, and universally applicable.

Over time, this understanding deepened. Years later, I recognized that my maternal great-grandfather was teaching about humility, curiosity, and mindful intentionality, remaining open rather than fixed in certainty. The hummingbird's movement reflects an approach to knowing that does not settle into permanence or finality, but instead remains responsive to context, change, and relationship. In this way, it offers a living contrast to forms of absolute certainty that seek to stabilize meaning and authority, often at the expense of complexity and lived experience.

These teachings have shaped how I currently perceive complex human systems, and the mental-behavioral health field is no exception. Mental-behavioral health, like other living systems, must resist singular definitions and static interpretations in order to honor the diversity of human experience, promote fairness, and avoid disparities in care. Mental-behavioral health is influenced not by one factor alone, but by a combination of biological, social, economic, environmental, and structural determinants (Centers for Disease Control and Prevention, 2022; Kambeitz & Meyer-Lindenberg, 2025). Furthermore, over time, we have come to understand that individuals respond differently to these determinants across the lifespan, shaped by development, culture, environment, and historical contexts (Bronfenbrenner, 1979; Halfon & Forrest, 2018). Such understanding is critical to promoting services that are sensitive, guided by humility, attentive to the uniqueness of each experience, and relationally grounded.

When applied to practice, this orientation invites practitioners to remain open, attentive, and responsive, recognizing that understanding emerges through relationship rather than from the application of fixed or universal truths. When such relational and non-fixed approaches are absent or dismissed, the consequences within mental-behavioral health practice are likely to become more visible.

***Consequences of Absolute Certainty***

In my years of practice in the field of mental-behavioral health, it has not been uncommon to observe how assumptions of "knowing best" or adherence to "best practices" have often favored professional frameworks that support and sustain the beliefs, values, and practices of dominant cultures (Linklater, 2014; Mullan, 2023). This pattern has often reminded me of my maternal great-grandfather and how forms of ancient or community-based wisdom are frequently dismissed in contemporary practice.

One consequence of the absolute certainty that seems to be promoted, intentionally or unintentionally, is the dismissal of human complexity when approaches are treated as neutral or universally applicable. As a result, cultural context and relational nuance are often overlooked, and over-pathologization has not been uncommon (Haraway, 1988; Rose, 2007), with direct consequences for the lives of those mental-behavioral health practitioners seek to serve.

These patterns have been reflected in my own professional experiences. One situation that has stayed with me occurred when I had to refer a monolingual client due to a high caseload. The client had expressed severe fear related to undocumented immigration status, had recently arrived in the area, and reported having no connection to community resources. When I later encountered the client by chance in a store, she shared that during a 30-minute assessment, she had been diagnosed with an anxiety disorder and prescribed medication. According to her account, the assessment focused primarily on symptom identification, while questions about legal status, migration-related stressors, and access to community and social supports were not explored.

In this context, it remained unclear whether the client's distress required a clinical diagnosis or whether she may have benefited from emotional support, validation, and connection to community-based resources. This experience, from my perspective, illustrates how diagnostic certainty, when prioritized over contextual inquiry, can inadvertently narrow the understanding of distress. Taken together, this experience suggests that decolonizing the mental-behavioral health field is not merely a theoretical stance, but a practical consideration for ensuring that care remains responsive to lived realities, structural conditions, and culturally grounded forms of healing.

The dynamics shared above are not isolated to individual cases but appear to be embedded within broader professional cultures. While this is not surprising given the politics often embedded in licensure, professional reputation, and status within mental-behavioral health systems, I have encountered professional spaces in which clinical effectiveness is implicitly or explicitly linked primarily to licensure. Although licensure reflects formal training, ethical accountability, and regulatory oversight, in my experience, it does not automatically confer relational capacity, cultural humility, or community trust. Contemporary research has consistently demonstrated that therapeutic effectiveness is strongly associated with relational factors such as the quality of the therapeutic alliance, clinician responsiveness, and interpersonal attunement (Flückiger et al., 2018).

Assumptions of "knowing best" or "best practices," often rooted in absolute certainty, also surface in the privileging of particular theoretical frameworks. This became evident to me during a professional dialogue with a colleague who strongly defended Cognitive Behavioral Therapy (CBT) as universally appropriate, despite concerns that it can misinterpret or misunderstand some clients' experiences when applied "neutrally." In that exchange, difficulty arose when CBT was framed as a culturally neutral theory, rather than being acknowledged for its strengths while also being understood as historically situated and context-dependent, and therefore not necessarily universally applicable. Such discussions raise important questions when culturally bound definitions of rationality go unquestioned. Research in cultural psychiatry underscores that behaviors or beliefs sometimes labeled irrational in Western clinical frameworks may instead reflect adaptive responses to social and historical conditions, shaped by cultural context and exposure to structural harm (Brown, 2021; Fernando, 2017; Kirmayer & Ryder, 2016).

In my view, overconfidence, divorced from humility and curiosity, increases the risk of misdiagnosis, ineffective intervention, and ultimately harm. Cognitive biases, such as confirmation bias, the tendency to favor information that confirms existing beliefs while overlooking disconfirming evidence, can further entrench these risks by narrowing perception and discouraging reflection (Kahneman, 2011; Kambeitz & Meyer-Lindenberg, 2025). When certainty replaces inquiry, standardized approaches can override individualized, culturally responsive care. In this way, absolute certainty erodes the very qualities (e.g., curiosity, responsiveness, and relational attunement) that ethical and effective mental-behavioral health practice often requires.

## Discussion

### *The Practice of Not Fully Knowing*

From my earlier experiences in the field of mental-behavioral health, I still recall how often mental health was framed as separate from the body, and how commonly cultural displacement and sociopolitical discriminatory forces were ignored, privileging cognition and diagnosis over lived experience. Contemporary frameworks, however, have increasingly recognized the interconnected relationships among mind, body,

behavior, and a person or group's sense of social-cultural encounters, though integration often remains uneven (Engel, 1977; Johnson, 2023; van der Kolk, 2014).

Over more than 30 years of work across diverse mental-behavioral health settings, I have observed a recurring pattern in assessment practices. While cultural components such as ethnicity, gender, sexual orientation, and socioeconomic status are routinely, though not necessarily comprehensively, assessed, other culturally situated dimensions, including meaning-making systems, ancestral knowledge, collective worldviews, and the lived complexity of intersecting identities shaped by culture, spirituality, community belonging, and historical experience, are explored less consistently or only partially. Equally important, the ways in which individuals are positioned within systems of oppression and privilege, and how these positions shape access to resources, exposure to stress, and lived experience, have been often insufficiently examined or absent from assessment processes.

When assessment practices are limited in this way, interventions may also become limited, focusing on symptom reduction without fully addressing the broader conditions contributing to distress or need. For example, a child exhibiting difficulty concentrating in school may be evaluated primarily for attention-related disorders, while factors such as housing instability, food insecurity, or chronic stress within the family may be insufficiently explored. Similarly, individuals from marginalized communities who express mistrust of institutions may be understood as resistant or noncompliant, rather than as responding to historical and ongoing experiences of discrimination. In both cases, interventions may focus on modifying individual behavior, while the structural and relational conditions shaping those experiences remain inadequately addressed.

In contrast, more comprehensive and contextually grounded assessments can support more responsive, meaningful, and effective interventions by helping practitioners understand not only what an individual is experiencing, but why those experiences are occurring within specific social, cultural, and structural contexts. Without such depth, there is a risk that interventions function as short-term or often surface-level responses, addressing immediate symptoms while leaving underlying conditions unexamined and unchanged.

These assessment patterns do not occur in isolation. They appear to be influenced by multiple factors, including time constraints imposed by service delivery, practitioners' limited autonomy within institutional settings, and assessment requirements shaped by insurance reimbursement structures. Within these conditions, assessment practices may become oriented toward efficiency, standardization, and documentation requirements, sometimes at the expense of relational depth and contextual understanding.

I have borne witness to how some agencies and practitioners rely on tools such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 2022; Carlew & Zartman, 2017) as definitive authorities rather than as provisional constructs. The tools themselves are not necessarily the issue; rather, it is the uncritical authority granted to them, particularly when their use is not accompanied by deeper inquiry beyond presenting symptoms and underlying assumptions. Despite ongoing movement toward dimensional and developmental models, tensions between validity and utility have persisted (Kendell & Jablensky, 2003; Carlew & Zartman, 2016), reinforcing orientations that privilege standardization over relational attunement (Hyman, 2010).

From this perspective, practicing from a stance of not fully knowing does not reject established knowledge and skills within mental-behavioral health. Rather, it involves holding such knowledge with humility, recognizing its historical, cultural, and ideological positioning. This orientation aligns with qualitative

approaches that prioritize meaning-making, relational depth, and context as central to understanding human experience.

***Practicing Mental-Behavioral Health with Curiosity***

The issue is not confidence in one's knowledge or skill; it is the unexamined belief that knowledge is complete, final, and universally applicable (Haraway, 1988). When certainty replaces inquiry, it can foster dogmatism, ethnocentrism, and rigid adherence to dominant frameworks, limiting responsiveness to difference and emerging evidence (Kahneman, 2011). In a field where human lives and well-being are at stake, such rigidity carries ethical consequences.

Mental-behavioral health practice can benefit from a balance between empirical evidence and lived experience, between scientific rigor and relational wisdom (Greenhalgh et al., 2015; Kambeitz & Meyer-Lindenberg, 2025). Data informs practice, but it does not replace empathy, cultural context, or reflective judgment. Teaching and/or practicing from a stance of ongoing curiosity invites educators and/or practitioners to continually examine assumptions, engage feedback, and remain open to learning from clients, communities, and evolving knowledge.

Promoting humility rather than dominance, curiosity rather than absolute certainty, and mindful intentionality rather than unexamined authority does not weaken the field; it strengthens it. Humility, curiosity, and mindful intentionality allow mental-behavioral health education and practice to remain responsive to complexity, diversity, and the evolving nature of human experience. By holding knowledge as provisional rather than absolute, the field can move toward more ethical, inclusive, and genuinely healing approaches, ones that honor both evidence and humanity. From this perspective, knowledge is not diminished by uncertainty; rather, it is made more ethical, responsive, and attuned to the complexity of human life.

## Implications for Practice: Moving Beyond Certainty

In mental-behavioral health, certainty is not located in fixed conclusions but in patterns of evidence that remain open to revision. What is often presented as definitive knowledge is more accurately understood as evolving, context-dependent understanding shaped by ongoing inquiry, lived experience, and shifting social realities. For instance, research consistently demonstrates that social, economic, and political environments significantly influence the mental wellness of individuals, groups, and communities (Brown, 2021; Foucault, 1988; Kambeitz & Meyer-Lindenberg, 2025). At the same time, these influences are not uniform; they are often experienced differently across contexts, identities, and lived realities (Linklater, 2024; Mullan, 2023).

If absolute certainty can obscure complexity, reinforce dominant frameworks, and limit responsiveness to lived experience, then the question becomes not only what must be understood, but how practice must shift in response. Moving beyond certainty does not require abandoning clinical knowledge or established frameworks. Rather, it calls for engaging them with humility, reflexivity, and contextual awareness. The following considerations emerge as practical extensions of this analysis:

- **Cultivating Critical and Reflexive Pedagogy**

  Educators can design and facilitate learning environments that prioritize inquiry over certainty, encouraging curiosity, critical analysis, and engagement with multiple ways of knowing. This includes examining how dominant cultural frameworks shape what is taught as "truth," while creating space for diverse perspectives and lived experiences that may challenge or expand traditional paradigms. Such pedagogy supports learners in recognizing how their own positionality and intersecting identities influence interpretation, decision-making, and practice. In practice, this may involve:

  - ✓ Inviting students to critically examine case studies from multiple cultural and theoretical perspectives, rather than presenting a single "correct" interpretation.
  - ✓ Incorporating counter-narratives and community-based knowledge alongside canonical texts.

- ✓ Asking reflective questions such as: *“What assumptions are we making about this client?”* or *“Whose knowledge is centered, and whose is missing?”*
- ✓ Creating assignments where students analyze how their own positionality and intersecting identities influence clinical interpretation and decision-making.

Such pedagogy supports learners in recognizing how their own positionality and intersecting identities influence interpretation, decision-making, and practice.

- **Slowing the Diagnostic Process**

When possible, practitioners can resist premature diagnostic closure by allowing space for fuller understanding. Slowing down the assessment process can create opportunities to explore context, history, and meaning before assigning clinical labels that may narrow interpretation. Practically, this may look like:

- ✓ Using provisional or rule-out diagnoses when appropriate, rather than finalizing labels in early sessions.
- ✓ Framing early sessions as information-gathering and relationship-building, not solely diagnostic determination.
- ✓ Asking open-ended questions such as: *“What has been happening in your life that might be contributing to how you feel?”*
- ✓ Allowing time to observe patterns over multiple sessions, especially when symptoms may be context-dependent.

This approach can help prevent the reduction of complex experiences into fixed categories too quickly.

- **Expanding Contextual Assessment**

Assessment practices can extend beyond symptom identification to include structural, cultural, relational, and historical factors shaping distress. This includes exploring migration experiences, community connections, systemic barriers, and lived realities that may not fit within standardized diagnostic frameworks. In practice, this may include:

- ✓ Integrating concrete questions about housing stability, employment, discrimination, and access to resources into assessments.
- ✓ Comprehensively exploring family systems, community networks, and cultural meaning-making practices.
- ✓ Asking: *“What stressors outside of you might be contributing to what you’re experiencing?”*
- ✓ Documenting contextual factors alongside symptoms in clinical formulations.

This broader lens can support more accurate understanding and more relevant intervention planning.

- **Centering Client Meaning-Making**

Rather than privileging clinical interpretation as primary, practitioners can more intentionally center how individuals understand their own experiences. This shift recognizes clients not as subjects of assessment, but as active meaning-makers whose interpretations are essential to ethical care. Practically, this may involve:

- ✓ Asking: *“How do you make sense of what you’re experiencing?”*
- ✓ Inviting clients to co-create goals and interpretations, rather than imposing them.
- ✓ Reflecting language back to clients using their own words, not just clinical terminology.
- ✓ Recognizing that different cultural frameworks may define distress, healing, and wellness differently.

This approach can strengthen engagement, trust, and relevance of care.

- **Engaging the *DSM* as Provisional, Not Definitive**

Diagnostic frameworks such as the *DSM* can be approached as tools rather than truths, useful for communication and coordination, yet limited in their ability to fully capture human experience. Holding diagnosis as provisional allows for flexibility, revision, and responsiveness over time. In practice:

✓ Use diagnosis as a working hypothesis, not a fixed identity.
✓ Revisit and revise diagnoses as new information emerges.
✓ Explain to clients that diagnoses are frameworks, not definitive explanations of who they are.
✓ Pair diagnosis with narrative or contextual formulations.

This helps prevent over-identification with labels and supports more nuanced care.

- **Strengthening Relational Practice**

Given the strong evidence supporting the importance of therapeutic alliance, practitioners can prioritize relational attunement, responsiveness, and trust-building as central components of care, rather than secondary to technique or model adherence. Practically, this can include:

✓ Attuning to tone, pacing, and emotional cues, not just content.
✓ Repairing misunderstandings when they occur.
✓ Being transparent about uncertainty when appropriate.
✓ Valuing the relationship itself as a primary mechanism of healing, not just a context for intervention.

This can align care with what research consistently shows: relationship matters deeply.

- **Integrating Reflexivity into Practice and Education**

Practitioners and educators can engage in ongoing self-reflection regarding how their own assumptions, training, and positionalities shape interpretation and decision-making. Reflexivity becomes not an abstract concept, but an active and continuous practice. In practice:

✓ Engaging in regular supervision or consultation that includes reflection on bias and assumptions.
✓ Asking oneself: *"How might my background influence how I am understanding this situation?"*
✓ Keeping reflective notes on moments of certainty, discomfort, or strong reaction.
✓ Incorporating reflexivity into teaching through journals, discussion, and critical dialogue.

This can help prevent unexamined assumptions from shaping care.

- **Reconsidering Systems and Institutional Pressures**

At a broader level, systems of care may benefit from examining how time constraints, reimbursement structures, and institutional expectations reinforce rapid diagnosis and standardized approaches. Creating space for more relational and contextually grounded care is likely to require structural shifts, not only individual changes. Practically, this can involve:

✓ Advocating for longer intake sessions or multi-session assessments.
✓ Developing documentation practices that include contextual and narrative information, not just symptom checklists.
✓ Encouraging agencies to recognize the value of relational and preventive care, not only billable interventions.
✓ Engaging in policy or organizational discussions about how systems shape practice.

This can recognize that meaningful change requires both individual awareness and systemic transformation.

These practices do not eliminate uncertainty; they work with it. The suggestions are not intended to promote an absolute way of addressing the issue or need in question, but rather to offer foundational practices. In doing so, they open possibilities for care that is more responsive, culturally grounded, and aligned with the complexity of human experience. In this way, moving beyond certainty becomes not a rejection of knowledge, but a reorientation toward more ethical, relational, and contextually grounded forms of practice.

## Conclusion

Absolute certainty is deeply tempting, particularly in professional contexts, where it is often intertwined with confidence and competence. In a field shaped by ambiguity, certainty can offer comfort and the illusion of control. Yet, when held too tightly, it becomes confining.

As I continue to grow and learn through my experiences in the field of mental-behavioral health, I have come to recognize that knowing is not a destination, but a relationship, one that requires responsibility more than mastery, curiosity rather than total certainty, and an honoring of the lived experiences of the individuals and communities with whom one works. Ethical knowing resists the universalization of provisional insights and remains open to revision.

Perhaps the most radical requirement of knowledge within the context of the mental-behavioral health field is the willingness to admit uncertainty. "I do not totally know" is not a failure; it is an act of integrity that creates space for ongoing inquiry, learning, and relational engagement. In this way, qualitative inquiry becomes not only a method of investigation, but a stance, one that resists premature closure, honors complexity, and sustains ethical responsiveness to human experience. When taken into practice, this stance invites more thoughtful assessment, more responsive intervention, and a deeper commitment to understanding individuals within the fullness of their contexts.

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