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Feature

The art of loving and the therapeutic relationship

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The art of loving and the therapeutic relationship

Contemporary developments in nursing and health-care, which emphasise evidence-based and outcome-oriented practice often fail to recognise the centrality of the caring relationship in everyday practice. This paper aims to examine the therapeutic role of the nurse within the context of an increasingly technicalized and bureaucratic healthcare system. Focusing on the importance of love and its healing potential, we intend to raise awareness of some difficult and often polemic arguments pertaining to the concept of clinical caritas. We return to the fundamental question: why do people enter nursing? In doing so we explore the concept of caring utilising theoretical and experiential examples to illustrate ways in which healthcare systems can both drain and nurture the practitioners' capacity to care. A framework for developing the art of loving within nursing care is presented, which emphasises the balance between discipline, concentration, patience, concern and activity. We conclude by outlining the boundaries in which genuine love may be expressed within the parameters of a professional role.

Key words: agape, care, caritas, love, therapeutic relationship.

Reviewing recent literature indicates that the word 'love' has all but vanished from the nursing arena in the UK, except that is, where difficulties arise within the nurse–patient relationship. Hence love is discussed in relation to boundary transgressions (Holyoake 1998; Norman 2000), erotic transference and countertransference, and power dynamics (Norman 2000). There are however, some notable exceptions in other countries. Specific references to love in the context of the nurse–patient relationship which explore its therapeutic and healing value can be found in the American literature (see for example Green and Shellenberger 1996; Riley 1996; Watson 1998) and Canadian literature (Roach 1987), with Australian (Fitzgerald 1998) and Scandinavian authors also contributing to the debate (Severinsson 1995; Matilainen 1999).

It is interesting to note that the same review revealed that other health-related professions, namely counselling and psychotherapy, used the term freely in their discussions around the therapeutic relationship. This raises questions regarding the use of the term within the nursing sphere, particularly in the UK, but also more broadly. Is it that love is a taboo subject in nursing? What is the hesitation with using the L word in professional settings? Perhaps nursing uses different language to express its own version of love and if so what is the interface with other professions? Or is it simply that within the current climate of evidence-based practice, clinical outcomes and national standards the value of human relationships (which is not necessarily a measurable phenomenon) and the associated emotion is lost. More importantly, of what significance would a clinical outcome be without love? That is to ask: is love a necessary component of the nurse–patient relationship? In order to begin to answer such a question we first need to return to the concept of love itself. The following section examines the emotion of love, attempting to signpost some of the deep experiences of love, intimacy and connection, which are often hard to portray and are only hesitatingly acknowledged within nursing. The concept of love is vast and for the purposes of this paper we have not attempted to analyse the notion of romantic love and its associated emotions, such as sentimentality.

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Neither do we attempt to explicate the power dynamics inherent within loving relationships. These issues are addressed in a subsequent paper and are written about in detail in other works (Freshwater and Robertson 2002).

THE SOCIAL AND HISTORICAL CONTEXT OF LOVE

Although the term 'love' is freely used in everyday language, literature, arts and media, the concept itself is elusive and not easily defined. Fromm (1957) in his seminal work *The art of loving* argues that one of the problems of our language is that we make one word express an entire range of emotions. Hence love expands from affection to the deepest active relationship. Several writers attempt to articulate their own understanding of love. Tillich (1960), for example, described love as the moving power of life, while Peck (1990, 85) defines love as 'the will to extend one's self for the purpose of nurturing one's own or another's spiritual growth'.

These definitions however, are bound by the English language. Other languages, classical Greek for example, make distinctions between love that is associated with Eros and that of agape, a nonerotic pure love that seeks nothing in return with clear differentiation between erotic and maternal love (Fromm 1957; Haule 1996). Agape can be aligned with altruistic love, in which an individual can care for a complete stranger, as if that stranger were family. In this sense agape accepts that we are all, in some way, related. For example, it is not uncommon for nurses to experience feelings of love toward a patient. This is not dissimilar to the notion of love in caring that Simone Roach (1987) speaks of when she outlines nursing as caring. Roach proposes that to be human is to be caring. Erotic love however, has a different quality; it is both exciting and sexual, involving the temporary loss of self through the symbiotic merging with another. As such, erotic love is exclusive and initially selfish. It is driven by a need for satisfaction and will give in order to receive. Erotic love invariably needs physical satisfaction.

Watson (1998) adds a further dimension to the notion of love in caring in the development of 'clinical caritas'. Caritas is a Latin word related to the words charity, caring and cherish. Having the connotation of preciousness, its meaning is close to the idea of regard, love and esteem. In deconstructing this notion further we discover that the term charity is also today devoid of its original meaning. Historically the term charity was used interchangeably with love, indeed in the King James version of the New Testament the word charity is used to describe both the state of and the manifestation of love through caring for another. In contrast, contemporary notions of charity are reduced to organisational activities, although these are often voluntarily given which could be construed as an act of love. These are important distinctions to make, as love is often misunderstood as sexual desire. This may offer some explanation as to the focus of the literature being primarily devoted to such concerns as boundary transgressions and the protection of vulnerable patients. From this point of view love is not only commodified (seen as an objective tool rather than a subjective experience) but also runs the risk of being pathologised.

In summary, it would seem that there is no longer an adequate word which describes the acceptable and appropriate love of a person for the people in his/her community. Other than the casual use of the word love or its application to intimate relationships, the concept of love in a wider sense has virtually been marginalised in Western society. It is therefore understandable that the notion of the nurse's love for her patient is a misunderstood concept.

LOVE: COMMODITY OR CURE?

In Western society, we tend to think of love as something we can acquire rather than something we can give (Fitzgerald 1998). Many authors argue that to give and receive love is essential for being human, indeed it might be argued that love is the most important experience of human existence (Fromm 1957; Rogers 1957; Maslow 1970). Psychological theories of human development concur that unconditional love is vital to the development of the individual. Humanistic theorists focus on the role of authenticity, genuineness and empathic understanding (Rogers 1957); psychoanalytic theorists concentrate on holding and containing in the development of a true self (Winnicott 1971; Klein 1975), while Behavioural Schools of thinking speak of positive reinforcement (Skinner 1958; Beck 1979). What all these theoretical frameworks have in common is the general consensus that love is fundamental to human experience. Fromm (1957), in line with other developmental theorists, points out that the absence of love is aloneness, isolation and despair. Conversely Siegel (1986) argues that love heals:

> If I told patients to raise their blood levels of immune globulins or killer T cells, no one would know how. But if I can teach them to love themselves and others fully, the same change happens automatically. The truth is: love heals. (181).

The giving and receiving of love is something that is embedded within everyday nursing and caring practices. Many of our actions and assumptions are founded on love, but often not explicitly linked to it. Thus love itself is not taboo, although there may be a problem with the terminology itself,

but importantly there is confusion around the different manifestations of love that causes people to find alternative ways to articulate their caring. Such confusion invariably leads to feelings of fear and embarrassment, which in turn can lead to the expression of love being denied or buried, thus affecting the practitioners' ability to engage in a meaningful therapeutic relationship.

LOVE IN THE THERAPEUTIC RELATIONSHIP

Although the notion of a therapeutic relationship originated in counselling and psychotherapy, it is also seen as an essential component of all branches of nursing and indeed is a central feature of many health-related disciplines (McMahon and Pearson 1998; Freshwater 2002). This in itself is a source of much confusion, and while we do not wish to elaborate further upon this issue within the context of the current debate, it is a subject that we would urge the reader to pursue in order to fully grasp the meaning our of argument (for further reading in this area see Clarkson 1995; Forchuk 1995; Ersser 1998). Suffice it to say that the recent professionalisation of both counselling and psychotherapy has meant that the lack of empirical research findings to substantiate what is understood by the concept of a therapeutic relationship is slowly being addressed. This may serve to clarify some of the less well understood aspects of the therapeutic alliance.

As previously mentioned, psychological theorists widely acknowledged the need for love in child development (Winnicott 1971; Klein 1975). Carl Rogers (1957), however, did not stop there; he went on to develop a theory of human potential, which placed the need for love at the core of human experience and development. Rogers believed that clients could find healing within themselves if they could find certain qualities within the therapist. If the client could feel accepted and valued, they could grow and change. Rogers listed these as core conditions for the therapeutic relationship to be effective:

1 Two people are in psychological contact.
2 The first (the client) is in a state of incongruence, vulnerable and anxious.
3 The second (the counsellor) is congruent in the relationship.
4 The counsellor experiences unconditional positive regard for the client.
5 The counsellor experiences an empathic understanding of the client's internal frame of reference and endeavours to communicate this to the client.
6 The communication of the empathic understanding and unconditional positive regard is achieved.

Unfortunately Roger's theory has been reduced in the literature to the 'three core conditions' of acceptance (unconditional positive regard), empathy and genuineness. This unconditional love is, in effect, equal to the notion of agape as previously described by others in this paper. One eminent British counselling writer, Thorne (1991), recognises Rogers' core conditions as the provision of love within the therapeutic relationship. This is a bold stance for Thorne to take, because many therapists today would publicly shy away from the idea that love has any place in therapy except insofar as it concerns erotic transference or countertransference (Clarkson 1995). Clarkson herself recognises the closeness of the love dilemma to the therapist's work commenting that: 'We are required to act constantly in the arena of love, yet renounce all personal gratification; we work in one of the most potent cauldrons of intimacy, yet we are prohibited to drink from it' (25).

If Rogers' concept of unconditional positive regard actually equals love, as we are led to believe, it could be argued that Rogers has done much to exorcise the term from the vocabulary of the therapy world. Unconditional positive regard may easily be viewed as a skill or technique, which diminishes the potency of love in its original form.

It seems to be reasonable to assume then that therapists regularly fall in love with their clients but retain ego-boundaries in order to prevent unnecessary complications within the relationship and to further prevent abuse. It could even be argued that it is essential for the therapist to love a client. Without love, the therapy is meaningless. If it does become successful then the therapeutic relationship will become a mutually loving one (Peck 1990). It is perhaps pertinent here to observe that the idea of falling in love with one's client is clearly linked to what Fromm (1957) called mature love, and requires the therapist to hold certain characteristics, some of which include self-awareness, self-monitoring and skills of reflective practice. These are developed through such forums as clinical supervision, personal therapy and experiential training, which focus on the needs of the learner as opposed to the needs of the organisation.

LOVE IN THE CONTEXT OF NURSING

Nurses are not immune from the potential of falling in love with their patients. It is up to the practitioner to decide how to respond with their emotions, will and volition. For those who are ill and in some way dependent upon the care and dedication of a nurse, the chemistry can be a potent blend for sexual interest to take hold. The caring, or therapeutic relationship, as we have already mentioned, is viewed as

essential to the healing process of the patient and as such it could be argued that in order to facilitate a caring relationship, the practitioner must be able to love (without falling in love). But herein lies another concern for many practitioners engaged in the increasingly technologised relationship that is caring. Many nurses, feeling disillusioned, are not only seeking to rediscover the roots of their caring (witness the rise of a new *Journal of International Human Caring*) but sadly are often so dispirited with their work that they leave the profession all together.

While 'care' becomes the responsibility of the machine, the nurses' act of care may be reduced to the pressing of buttons and the monitoring of digital symbols. For as Higgs (2001) comments, 'Technology has either the potential to serve us or to depersonalise our knowledge and practice', hence the challenge is to 'use and not be used' (123).

In recent years in the UK the Department of Health has hugely invested in implementing programmes of cognitive behavioural therapy (CBT) for people with mental health problems following research reports that this approach is most useful for people with schizophrenia. Mental health nurses up and down the country have acquired the Thorn diploma, which enables them to practice psychosocial-social interventions more effectively. While not wanting to criticise this training and the work these nurses do, one is left with a sense that the Department of Health is keen to resource initiatives which ('research has shown') bring results. Ironically, it may not be the CBT which actually works, but rather the increased time nurses spend with their clients and the building of a therapeutic relationship (Repper 2000; Johnstone 2001). While CBT offers one framework for developing a therapeutic relationship, we would argue that what is needed is a re-enchantment of the therapeutic nature of nursing. Thus, we propose one way of moving this forward is to foster a therapeutic alliance that is founded within love.

A FRAMEWORK FOR DEVELOPING THE ART OF LOVE WITHIN NURSING CARE

Although it is not possible to teach 'how to love', it is possible to liberate the existing love within; enabling love to happen. Although love is not a skill or a commodity, we can exercise control over whether or not we allow our love to become revealed. In this sense it is possible to practice love. In Fromm's words: we can practise the art of loving. Fromm proposes certain general requirements for practising love; these are discipline, concentration, patience, concern and activity. We adapt Fromm's requirements and apply them to the art of practising love in nursing.

Discipline

As with the development of any art, the art of loving needs to be developed in a disciplined way. We would encourage the nurse to take seriously the challenge of loving her patients and consider the discipline and commitment required to achieve genuine love toward the people for whom she cares. The discipline required in the development of the practice of love is greater than that which is required for a more familiar art such as embroidery or life-drawing; to allow our love to be manifest affects every aspect of our lives. By allowing ourselves to be in touch with our loving feelings while at work, we may experience vulnerability. Discipline is required to keep ourselves in check and not allow our feelings of vulnerability to swamp us, that is to say that the nurse who practises the art of loving needs to look after herself. What is called for is a self-awareness which can hold the loving feelings and exercise the communication of love within appropriate professional boundaries. Hence, the nurse needs to make time to reflect upon these experiences. Through the reflective lens the practitioner may not only 'come to see the world differently' but may also 'come to act differently' (Johns 1998, 2) asserting such concepts as love and caritas in their 'sacred seeing' (Watson 1998, 219).

Concentration

Toward the end of his life, the pre-Raphaelite artist Holman Hunt could draw a perfect circle completely freehand. 'How lucky you are to be able to do that', somebody once commented. 'It is not by luck that I can draw this circle, but by 40 years of practice,' Hunt replied. In order to practise the art of loving the nurse needs to practise concentration. It took Holman Hunt many years to achieve his perfect circle. He made thousands of mistakes before the perfect formation emerged. We all make mistakes in every art that we learn. How easy it is to say the wrong word, or give the wrong look, when we intended warmth and friendship. Because we sometimes fail we should not be deterred from refining our art. We need to concentrate, in any given situation, the best and appropriate way to express our love. When we make mistakes we need the will to reflect and consider what could have been different.

Patience

The development of any art requires patience. There are no quick results in personal development and we need to develop an inner philosophy, one that is wilful and does not easily give up. As our society becomes faster in terms of

production, travel and communication, so people become less patient. Our society demands quick results and seeks redress when it is not satisfied. Computers, which were considered incredibly fast only a few years ago, are now being consigned to the rubbish heap. Sadly, it seems human values are increasingly being determined by economic values. The art of loving will not be determined by economic values (Fromm 1957), for what are often the most precious values of those for whom she cares are not material or financial; our patients and clients are people like ourselves in need of love.

Concern

The development of the art of loving cannot be refined without genuine concern for love and genuine concern for those in our care. The practice of clinical caritas is serious business. If, as we propose, love is an essential ingredient for human existence, to demonstrate love in practice is of critical concern. It is possible therefore for nurses to offer so much more to the healing process than merely providing physical care. The expression of love in the therapeutic relationship automatically caters for the needs of the whole person. Where nurses are genuinely concerned for the whole person, love is evident and the prospect for healing increases.

Activity

It is our experience that student nurses often explain their journey into nursing as a calling (Noddings and Shore 1984). Their desire to genuinely care for people in need is admirable. All too often however, this innocent altruism is challenged by the attitudes of more experienced and, at times, more cynical colleagues. We are not aware of any research into client engagement with student nurses in mental health nursing, although it is evident on acute mental health wards that patients may confide with student nurses more easily than qualified staff. People coming into the nursing profession may find it easier to practise the activity of the art of loving simply because the art has not been suppressed by professional socialisation. Fromm provides us with a challenge in order to develop the art of loving: 'If one wants to become a master in any art, one's whole life must be devoted to it, or at least related to it'. (Fromm 1957, 86).

THE LOVE OF AN ADVOCATE

Because so much of nursing is directly related to caring for people, the profession provides a perfect opportunity for the individual to master the art of loving and indeed there are many examples of such acts of love.

Few of the nursing staff actually liked Rita. Being detained on a section of the Mental Health Act she tested every boundary to the limit. If she were allowed off the ward for 10 minutes she would make a beeline for the local pub and be gone for hours. Rita's community nurse believed that Rita was behaving the way she was because of the way she was constantly being punished on the ward. Rita, he argued, was caught in a viscious circle. When he was alone with her for individual sessions, she would weep with frustration and anger. Rita knew that her community nurse understood her situation and actually cared enough about her to sit down for an hour and listen to her. The nurse maintained a busy caseload and would spend his evenings catching up with paper work, in his own time. At the review tribunal Rita's nurse advocated for her with tears in his eyes, appealing to the tribunal to share his view of Rita's situation. Against all the odds, Rita's section was repealed and a discharge package was arranged. Rita's nurse noticed the angry stare of the consultant and the ward nurses. He knew that he had not 'towed the party line' and had 'gone against the grain'. He also knew that he had satisfied his conscience and his love for Rita had ultimately won the day.

WAYS IN WHICH THE SYSTEM DRAINS THE WILL TO LOVE AND INHIBITS THE CAPACITY TO CARE

In many countries, especially where health-care is provided by the state, nurses work in terribly underfunded conditions. There is, at times, an impossible lack of resources. Nurses are invariably very busy. The time nurses can commit to their patients and clients appears to constantly diminish. Because of increasing technological and bureaucratic demands, it is easy for the nurse to unconsciously treat the patient as an object. All too easily the nurse can express her frustration and exhaustion in a negative way to the very person who needs her time and love the most, the patient. Indeed, patients can become an irritation because their demands can easily become a lower priority than the demands of a service, which in turn pays the salary. We may question the ethical implications of governments calling for greater consumer involvement without providing adequate resources in order to maintain the service. It is invariably the nurse who is on the immediate receiving end of consumer complaints and she is the one who becomes an object of blame when things go wrong. Little wonder then that practitioners experience fear in the delivery of their daily practice. One such fear, the fear of reprisal for demonstrating love, is completely understandable, especially from colleagues

who may feel intimidated or threatened by the nurse's ability to show care (Freshwater 1999). The nurse may be accused of being manipulative, weak or unprofessional. Indeed this is almost inevitable if the observer is not in contact with their own feelings and their own sense of humanity and care. Acts of love, however, should not be flaunted or boasted about, love is shy and as such our art of loving needs to be discrete and modest. Hence, loving acts are not played to an audience, but are normally appreciated in the silence of a genuinely caring relationship. Consequently, the rewards of loving are invisible.

FEAR OF OVER-INVOLVEMENT

Some people may not be familiar with some of the concepts of love discussed in this paper. Some may believe that an act of love equals falling in love. They may be afraid to demonstrate love for fear of attracting the unwanted attentions of their patients. Similarly, some may be afraid of showing love for fear of forming an attachment. Each discharge may bring a sense of loss. This might be doubly hard for those who work in palliative care, where each death may bring personal grief.

NOT KNOWING THE BOUNDARIES

We have all experienced love in one form or another. For many of us, these experiences are precious and the previous expressions of love toward us have helped to validate us as people. It is through loving relationships that we learn about the boundaries of loving relationships for the future. However, loving relationships also hold the potential for pain, this painful process can cause us to question our judgement about whom to trust and with to whom it is safe to express our love. Sometimes we do not trust ourselves to maintain proper and safe boundaries. We can, at times, feel so lonely and needy ourselves that we may be afraid to show our love for fear of falling in love with a person in our care. In order to maintain safe boundaries we need to know ourselves and reflect upon the lessons we have learned in the past with regard to love that we can apply in the present. One forum for engaging in this practice is that of clinical supervision (UKCC 1996; Bond and Holland 1998; Hawkins and Shohet 2000).

Nurses have been encouraged to provide and receive clinical supervision in the work place for over a decade now; despite this fact it remains patchy in its implementation and acceptance (Bishop and Freshwater 2000; Freshwater et al. 2001). Clinical supervision not only acts as a quality control measure but also as a support to practitioners. It holds the potential of being a nurturing environment within which, among other things, the art of caring and the art of loving can be fostered, examined, savoured, honoured and developed.

CONCLUSION

In summary, we realise that this paper raises many issues for further debate, not least the need to explore the complex dynamics of the nurse–patient relationship. Concerns such as over involvement, power dynamics and the patient's experience of receiving love merit further exploration.

It would appear that one of the most influential issues, when debating the significance of love in the context of nursing, is that of language. Changing language or terminology to assuage feelings of shame, embarrassment, shyness or fear will not address the fundamental question that this paper seeks to raise. Love is central to human existence and must have a place in the caring professions. As nursing practice becomes more and more defined by technological and a masculine mentality, nurses have the right to profess the significance of love in the therapeutic relationship.

The founders of the nursing profession would not have flinched at the concept of Christian love (charity) for their patients. The word 'love' has been socially minimised, leaving a void in the professional carers' vocabulary, which is at the heart of the raison d'etre of the profession. An under-resourced service which exhausts our ability to genuinely care means that patients become objects of the practitioner's resentment. Hence, the very people who need our care are those who ultimately suffer the consequences of inadequate funding.

Writing nearly 50 years ago, Fromm's words may be considered prophetic: 'People capable of love, under the present (capitalist) system, are necessarily the exceptions; love is by necessity a marginal phenomenon in present day Western society' (Fromm 1957, 103). Mental health problems are on a phenomenal global increase (World Health Organisation 2001); the world has been ravaged by war throughout the last century; would this be the case if civilisations learned to love more? The challenge of the development of the art of loving is needed for a change of heart and a commitment to changing the world; we may not be able to change all of it but we can certainly change our corner of it.

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