



Exploring the relationship between caring, love and intimacy in nursing

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ABSTRACT

The paper utilises the five distinct perspectives on caring proposed by Morse et al (1990) to illustrate the relationship between love, intimacy and caring. Two distinct types of love, namely *agape* (altruism/charity) and *filia* (brotherly love) are utilised in nursing. Only some caring relationships with patients reach an intimate level, and this is determined by patient characteristics that the nurse responds to. It is concluded that caring as a moral imperative is the most relevant to discussions on caring in nursing and the perspective on which the other four viewpoints hinge.

Introduction

My interest in caring, love and intimacy in nursing was fuelled by an incident many years ago. A student nurse was very upset and trying to hide her tears on the corridor after a teenage boy we had nursed died of cancer. Another student nurse approached me. She was confused about her colleague's reaction to the death of this boy. She said that she was told that nurses should not get emotionally involved with their patients and to do so was considered 'unprofessional'. She had been told that a 'good nurse' does not cry, and does not get drawn into a close relationship with patients. Instead, a 'good nurse' remains calm, keeps a professional distance and remains in control emotionally.

This incident prompted many years of thought on how nurses expect other nurses to interact with patients, and how nurses find an appropriate balance between involvement and detachment in their relationships with patients.

Love and intimacy are concepts, which fit into discussions on caring. Thus my reason for discussing them together in this paper. But why write about caring, love and intimacy when so much about caring has been written before? Paley (2002) argues that caring is a permanently elusive concept. He also asserts that trying to pin down caring knowledge in nursing is "an endless project, whose monotony is matched only by its usefulness" (Paley, 2001 p.196). I have to ask if he would have such a view of caring if he had personal experience of caring relationships with patients as all nurses do? Nevertheless, I do agree that caring is an elusive concept, but that does not mean that a pursuit of its meaning should cease. This paper is written with a desire to keep

discussions on caring alive. I argue that caring, love and intimacy are at the heart of the therapeutic relationships nurses engage with patients and represents “everyday” nursing practice, which is complex and often taken-for-granted (McLeod 1994).

Humanistic philosophy of the 1960s penetrated nursing theory and promoted the concept of a relationship between the nurse and the patient as achievable (Aranda, 2001). Salvage (1990) calls this the ‘New’ nursing ideology, i.e. one that believes in the one-to-one relationship between the nurse and patient as being the foundation of nursing practice. Bradshaw (1995) however argues that the empowerment of ‘New Nursing’ clearly is dependent on what she calls a destruction of “Old Nursing”, and she questions if nursing has really advanced if the psychodynamic approach to nursing care has marginalized the practical tasks and techniques of physical care.

Caring

Caring is not exclusive to nursing. However, the writings of nurse theorists has adopted it as a core concept and has attempted to identify the caring specific to nursing, not found in other caring professions (Gadow, 1980). It is not surprising therefore that there is much debate in nursing literature as to what caring is.

Morse et al (1990) identified thirty-five different definitions of caring, and exposed five viewpoints on caring, namely, caring as a moral imperative, caring as an affect, caring as a human trait, caring as an interpersonal relationship and caring as a therapeutic intervention. I find these five viewpoints useful and have utilised them as a structure on which to base my discussion.

Some of these viewpoints on caring mirror caring viewpoints in other “caring professions”. Others have an added dimension of “love”. The issue of love in caring is central to this discussion. Nursing has attempted to bring love into the public realm by embracing caring as its primary responsibility (Dunlop, 1986), and it remains a central theme in current discussion on caring in nursing (Stickley and Freshwater 2002, Watson 2003).

Love and caring

Earlier writings on caring and love suggest that caring involves a form of love (Dunlop, 1986). However, Bevis (1988) distinguishes between love and caring and argues that in caring both persons must be served, whereas with love, “...one may be altruistic and self sacrificing by giving up one’s own needs in the service of to the benefit of another” (p. 56). This view of love fits with the view expressed by nurses in a study by Fitzgerald and van Hooft (2000). Their focus group study of nine nurses revealed that nurses understood love in nursing as “going beyond” (p.485) the traditional duty of care and the willingness and commitment “to want the good of the other before the self” (Fitzgerald and van Hooft, 2000 p. 482).

Caring as a therapeutic intervention

Returning to the five viewpoints on caring identified by Morse et al (1990), the view of caring as a therapeutic intervention is the least related to intimacy. This viewpoint is patient-centered and argues that the nurse adapts his/her caring actions to suit the needs of the patient, and the nurse’s feelings are not regarded (Morse et al, 1990).

Caring as an affect

Theorists approaching caring from the viewpoint of an affect describe caring as a feeling of compassion, which motivates the nurse to provide care for the patient (Morse et al, 1990). With regard to intimacy, nurses invest themselves in their interpersonal relationships with patients. Carmody (1988) argues that the nurse brings the “gift of self” when caring for patients (p. 153). This view appears to suggest equating caring with a form of love. Indeed, McCance et al (1997) argues that to care and care for, implies to “love” (McCance et al, 1997).

The ‘love’ referred to in nursing discussions has a prevailing spiritual dimension. Love is used as a charitable affection of one human being for another in so far as it is driven by an understanding of their common relationship to the Supreme Being (God) (Meehan, 2003). However, the love Meehan (2003) refers to is one of *disinterest*, which is a love of a neutral and detached nature. This disinterested love is an aspect of a particular type of Irish nursing which evolved in the 19th century , known as “careful nursing”, which consisted of physical care and emotional consolation provided from a spiritual perspective (Meehan, 2003). This disinterested love is like the “self-giving love” rooted in a spiritual dimension promoted by the “Old Nursing” mentioned earlier (Bradshaw, 1995).

The disinterested love promoted in careful nursing is compared to charity or *agape* (Meehan, 2003). Bevis (1981) likens *Agape* with altruism, and argues that caring is similar to a blend of *Agape* and another view of love from ancient Greek literature, *Filia*, or brotherly love (expressed in affection and friendship). Similarly, Stickley and Freshwater (2002) align *Agape* with altruistic love, whereby an individual can care for

a complete stranger, as if they were a family member. Richard Titmuss raised this issue in his book originally published in 1970, which examined the gift of giving life (via voluntary blood donation) to strangers (Titmuss 2002).

The view of *Filia* expressed by Bevis (1981) is worthy of closer examination. Olsen (1992) draws on Aristotle's assertion that friendship appears to involve the giving rather than the receiving of affection. This would provide some explanation of the view that caring and love are different (Fitzgerald and van Hooft, 2000).

Caring as a moral imperative

The view of caring from a moral imperative considers that ethics and morality in nursing are conceived and experienced on what Hess (2003) describes as the "playing field of relationship" (p. 139). Caring from a moral imperative was central to caring in the "Old Nursing", where the importance of excellent physical care was embedded in the nurse-patient relationship which was itself rooted in an objective moral support (Bradshaw, 1995).

The moral aspect of caring explored in Watson's (1988) *Theory of Human Care* highlights the reciprocal and interactive element of caring. Watson also argues that through caring the nurse grows mentally and spiritually. This mirrors the consequences for nurses following intimate relationships with patients, where Schubert (1989) found that it resulted in greater self-awareness for the nurse.

Other theorists that emphasise the moral and relational aspects of caring include Noddings (1984) and Gadow (1985). All three theorists of caring (Watson's,

Nodding's, and Gadow's) emphasise the mutuality and reciprocity of the caring relationship, but of the three, the work of Gadow (1985) is particularly useful to discussions on caring from a moral perspective. She proposes that the caring relationship protects the patient from being abridged to the position of an object. The use of the term 'object' in this context prompts the need to highlight that in nursing, the "subject becomes part of the object" (Perry, 2004, p.70) as both the patient and nurse have the potential for transformation through the nursing encounter through their existence as "human persons of consciously developing unity" (Perry, 2004, p.70). This transformation is alluded to by some theorists as a form of transcendence (Watson, 1988).

Caring as a moral perspective also fits with the views of the French philosopher Marcel (1889-1973) who proposes that with intersubjectivity, the uniqueness and individuality of both the nurse and patient is retained (Carmody, 1988). This view accommodates the human science perspective of intersubjectivity, where the boundaries that constitute self are surrendered in order that an inclusive engagement between knower and known is achieved (Pierson, 1999).

The other view of intersubjectivity is one clearly influenced by Cartesian legacy (where objectivity is paramount), and is also evident in discussions on intimacy in nursing. Williams (2001) questions if theoretical writings regarding intimacy in practice actually represent over-involvement. Morse (1991) describes the 'over-involved' relationship as one where the patient and nurse mutually respect, trust and care for each other. It can be seen therefore, that when intimacy in the nurse-patient relationship is embraced as desirable, it fits into the human science domain of

intersubjectivity. Whereas, when viewed as an ‘over-involved’ relationship with the need for boundaries between nurse and patient, it is clearly influenced by Cartesian legacy. However, Paley (2002) argues that nurse theorists have striven for moral supremacy over the medical profession in their writings on caring. Drawing on the work of the German philosopher Nietzsche (1844-1900), he argues that caring is not a real virtue but more of a vice. He asserts that the ideology of caring is motivated by resentment and represents an attack on the ‘medical-scientific model’ with the aim to establish nursing’s superiority, and argues that the emotional distance between the medical professional and the patient has been reinterpreted by nurse theorists as a form of indifference.

This “attack” on the medical-scientific model came from the phenomenological perspective. The caring movement in nursing (e.g. the work of Benner & Wrubel, 1989) is greatly influenced by the German philosopher Martin Heidegger (1889-1976), who developed hermeneutic phenomenology as a philosophical methodology to uncover the meaning of being for humans. However, this influence is described as “ironic” as Paley (2002) reminds us that Heidegger was a member of the Nazi party for 11 years. However Magee (1998) also reminds us that it is romantic and childish to expect a great thinker such as Heidegger to be “morally admirable” (p. 210).

The moral imperative of caring in nursing is also evident in the clear association between caring and spirituality. While it is important to note that nursing grew out of the beliefs of Judaeo-Christianity (Roach 1984), and the ‘love’ referred to in caring can refer to God as love, as in the work of Mercey, who talks of God as the “ultimate Thou” (Carmody, 1988, p. 156). It must also not be forgotten that the Eastern

version of the beginning of nursing acknowledges Rofaida Bent Saad Al-Islamiah (also referred to as Koaiba Bent Saad), who accompanied the prophet Mohammed in his Islamic wars and organised women to care for the wounded (Meleis, 1997). So it would appear that the spiritual aspects of caring in nursing transcend religion.

What I think is central to discussions on caring as a moral imperative is the need to remain cognisant to the needs of patients. Bradshaw (1995) reminds us that patients are vulnerable and have needs that the nurse does not and patients depend on a relationship of trust where there is professional detachment within a bond of commitment and understanding.

Caring as an interpersonal interaction

The view of caring as an interpersonal interaction probably has the greatest relationship with intimacy. This viewpoint revolves around it being a mutual attempt of caring between the nurse and the patient. Gadow (1980) argues that the interpersonal context for care evolves as a creation of both the patient and the nurse, i.e. whole person with whole person. For caring to occur, both the nurse and patient must communicate openly with trust and respect for each other (Morse et al, 1990), and the nurse must engage with the patient in order to respond meaningfully to them (Morse et al, 1992). Caring therefore equates with involvement (Forrest, 1989), and involvement is also a related concept of intimacy (Dowling, 2003). Reciprocity is again central in this view of caring, as the nurse is also enriched through caring for the patient (Benner and Wrubel, 1989). Reciprocity is a central attribute of intimacy in nursing (Dowling, 2003). However, Reiman (1976) argues that the mutual revealing

of personal information is not what controls intimacy; it merely deepens and nurtures the caring that powers the intimacy.

This view of reciprocity however appears to be in opposition to the views of nurses in the study mentioned earlier by Fitzgerald and van Hooft (2000), who considered “love in nursing” as “the willingness and commitment of the nurse to want the good of the other before the self, without reciprocity” (p. 482). The reciprocity referred to here however, appears not to be the same as the mere mutual revealing of personal information (not withstanding that this is essential for the development of an intimate relationship) referred to above, but one of reciprocity of love.

Davies (1995) in a feminist analysis of role formation proposes that nurses should be neither distant nor involved (but engaged). Indeed, Carmack (1997) reports that nurses balance their engagement with detachment by not getting too involved or feeling responsible for the outcome. However, according to Gadow (1995), nursing expects participation in vulnerability, and argues that by participating in the vulnerability in others, nurses cultivate their own vulnerability. This should in turn promote intimacy. Nevertheless, Roberts and Snowball (1999) caution on the problems inherent in nurse-patient friendships as when nurses identify with patients, emotional demands on them result.

Caring as a human trait

The viewpoint of caring as a human trait relates closely to intimacy as caring is considered part of being human (Morse et al, 1990). Also, Griffin (1983) argues that the nurse develops an increased awareness of personal worth by caring for patients.

This perspective on caring has its origins in existential philosophy (McCance et al, 1997). It suggests a distinct type of subjective relationship between the nurse and patient, related to what the German religious philosopher Buber (1878-1965) termed an *I-Thou* relationship (Buber, 1970). However, this type of relationship is the antithesis to the expected “professional” relationship between nurses and patients. As mentioned earlier, Paley (2002) argues that such a relationship is an attempt by nursing to demonstrate moral ascendancy over medicine (whose relationship with patients is represented by a professional emotional distance).

How can these views of caring help nurses?

When writing this paper, I couldn't help asking myself if an awareness of the writings on caring helps nurses in their practice? Does an understanding of the various perspectives help to explain for nurses why and how they care? Of the five perspectives on caring proposed by Morse et al (1990), I think the view of caring as a moral imperative holds the greatest relevance for nurses. I argue this because the foundation of a caring relationship is essentially a moral one on which the other four perspectives rest. Moreover, patients are vulnerable and depend on a relationship of trust (Bradshaw, 1995).

I also argue that nurses need to care to be fulfilled in their role. However, despite my assertion earlier that caring is “everyday”, only a few caring relationships with patients ever become close in the intimate sense (Savage 1995). Boyle (2000) argues that nurses encounter “special” patients and families who have crossed the boundaries and “...become more to us than others” (p.916). The findings of Allan (2001) suggest that intimate relationships occur as a result of patient action rather than being

initiated by nurses. Moreover, a grounded theory study of nurse-patient interaction by Yow (1992) found that only one participant (n=20) felt close to and remembered the names of nurses who asked her about her family or shared personal information. This suggests that personal qualities of individual patients may promote nurses towards intimacy with them. However, this presents issues when viewing caring from a moral imperative as the impetus to care is contextual and based on morally irrelevant factors such as liking (Olsen, 1992). Nevertheless, it is important to note at this point that being a patient brings with it the burden of an intensified sensitivity (vanKaam, 1959), and perhaps nurses are drawn more to care for individuals who are needy of such care. An interesting study which utilised a phenomenological design reveals that nurses bring out their caring intentions when patients are in dire circumstances, have multiple, psychosocial problems, rely on the nurse and are alert and personable (Kahn & Steeves, 1988). However, Kahn and Steeves (1988) also report that caring is limited by patients' actions that cause problems, patients' unwillingness to communicate and patients' poor self-images. This all suggests that the personal qualities of the patient may indeed be the catalyst to whether the nurse engages in an intimate relationship with them, and as May (1993) argues, the extent to which the nurse invests in interpersonal relationships with patients is a personal choice.

After that, it is a blending of the "nurse readiness" and "client comfort" that is required for intimacy to occur, which is achieved by the "nurse communicating caring" and the "client negotiating for comfort" (Schubert 1989, p. 126). (Schubert's study of intimacy involved a small group of nurse practitioners that practiced privately as holistic masseurs). Schubert's findings of intimacy requiring "nurse

readiness” mirror the view of Carmody (1988) who in an analysis of the work of Gabriel Marcel, suggests that in developing a nurse-patient relationship, the nurse maintains “...a readiness to receive the patient as a gift...” (p. 153). Carmody (1988) highlights that in Marcel’s philosophy, when individuals are “present” for each other, they are being “available”. Maybe then, nurses need at times to care deeply in a loving intimate sense to fulfil a personal moral need?

Conclusion

The literature suggests that “love” is both essential to caring and simultaneously distinct from it. Caring in nursing appears to suggest meeting a moral duty to all patients equally (Olsen 1992). Simultaneously, love is particularistic, as it suggests an intimate friendship developing between the nurse with some “special” patients only. Olsen (1992), drawing on the work of Cassian (a monk from the early Christian period circa 400 AD) argues that “as long as some minimum level of caring is distributed to all, the nurse is free to have special feelings for some” (p.1024). Love and caring therefore exist side-by-side in nursing. Some patients just mobilise intense caring from nurses which is of an intimate and loving nature.

In conclusion, I argue that caring in nursing is on a continuum and nurses move along all parts of this continuum from engagement to detachment, depending on the patient being cared for. A type of magnet, made up of the patient’s personality, needs, and vulnerability, forces the ‘pull’ towards the engaged and intimate end of the continuum. What keeps the nurse on the continuum is a moral imperative that upholds the needs of the patient as paramount.

Key points

- Love is both an aspect of caring and simultaneously distinct from it.
- Love and caring in nursing provide opportunities for intimacy.
- Love in nursing can be in the form of *agape* (altruism/charity) or *filia* (brotherly love)
- *Agape* represents “*disinterested love*” as promoted in “Old Nursing”.
- *Filia* reflects the human science perspective of intersubjectivity, and promotes intimacy in “New Nursing”.
- Caring in nursing is predominantly a moral imperative on which all other viewpoints are hinged.
- Personal qualities of patients promote nurses to care in an engaged or a detached manner.

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