



Essays and Debates in Mental Health

Towards a critical understanding of mutuality in mental healthcare: relationships, power and social capital

Introduction: mutuality, nursing and social capital

This paper explores the often neglected notion of mutuality in the context of mental healthcare. The idea that some kind of mutual exchange is beneficial in nurse–client relationships has a long history. It dates back at least to the work of Hildegard Peplau (1952), it has underlain a great many attempts to investigate nursing as a relational process, and it has informed many attempts to render care more compassionately and egalitarian. Whereas Dorothea Orem's (2001) classic formulation of nursing in terms of self-care deficits tended to emphasize systems over interpersonal details, her way of thinking emphasizes the agency of the client as an active self-carer. Thus, even where theories of nursing have focused on models and systems, they nevertheless rely on some sort of underlying negotiation between client and nurse as to what self-care activities can be attempted, and how the client's role in caring for themselves can expand as recovery proceeds.

The idea of practitioners and clients engaging in a reciprocal, mutually beneficial relationship can also be found in a variety of service user involvement initiatives and attempts at co-production of services and solutions. The search terms 'nurse' and 'mutual' yield over a thousand 'hits' in Scopus, and over 1500 in Web of Knowledge, as of May 2015. Yet there are few attempts to examine the notion systematically or critically. There is a desire on the part of some of mental health nursing's key thinkers to consider the construct more closely. For example Barker & Buchanan-Barker (2004, p. 32) lament that the mutuality inherent in the nurturing process has often been overlooked. Mutuality underlies their well-known 'Tidal Model' inasmuch as they stress the value of collaborative working, especially

where this involves working with the person's story, and the conjoint exploration of the person's 'world of experience'.

Accordingly, it is valuable to explore what the concept involves, how it has been deployed in the field of mental health nursing, assess its limitations and examine how discussions of mutuality may be taken forward in the future. This critical examination of the construct of mutuality as it is deployed in the literature on mental health nursing is timely in order to explore how more egalitarian modes of mutuality may be cultivated in nursing and how people may be fully empowered to help one another in relation to their mental health. Nurses would benefit from being able to think and act more effectively so as to overcome barriers to mutualistic working with clients, especially where these involve power or entrenched institutional arrangements.

To address this, in an attempt to understand the relationship between mutualistic encounters and the social and institutional context within which they are embedded, I will examine the relationship between the idea of mutuality and that of social capital. The concept of social capital is a vital one to consider in relation to mutuality because it enables us to grasp the otherwise neglected dimensions of power and status that pervade many social relationships. The idea of social capital has been gaining ground in social science approaches to nursing where the value of social relationships is being examined. Social capital theory provides a way of making sense of how power relationships can influence the potential for mutuality, and how mutuality can be seen within broader social frameworks.

Towards a definition of mutuality in mental health nursing

In attempting to come to an understanding of mutuality, it is noteworthy that although the term is frequently used, it is often not defined explicitly. Some of the few explicit attempts within the mental health nursing literature include Hedelin & Jonsson (2003), Jeon (2004) and Briant & Freshwater

(1998). In their study of mutuality in the lives of depressed older women, Hedelin & Jonsson (2003, p. 318) define mutuality 'as interdependence and influence in the relationships with others and the view of self'. For participants in their study, having one's existence and value confirmed through one's relationships with others was a major constituent of mental health. In Jeon's (2004, p. 128) study of nurses and depressed clients, she defines mutuality as involving 'high levels of empathy, collaboration, equality, and interdependency'. Briant & Freshwater (1998, p. 211) write of a 'mutual alliance [which] relies on individuals relating to both themselves and others as whole persons'. For nurses practising psychotherapy in Speirs & Wood's (2010) study the establishment of mutuality was believed to be a key initial stage in the process.

Beyond nursing, in the context of voluntary groups, Love (2007) says that mutuality is based on reciprocal relationships that people enter into with one another so as to pursue a common purpose. In peer support, Bassett *et al.* (2010) identify mutuality as a key element. From a perspective within philosophy, Bratman (1992, p. 328) discusses what he calls 'mutual responsiveness', denoting that the participants are responsive to the intentions and actions of each other, in awareness that the other is attempting to do the same.

Thus, mutuality is a concept that links a number of different domains of activity where mental health is a focus. Although conceived of and enacted differently in specific local circumstances, there are some features of the concept that tend to recur in different contexts. Prominent among these is a sense that not only is mutuality beneficial, but it involves reciprocal transactions and exchanges, mutual influence and responsiveness, interdependency and a sense of common purpose, exercised in an egalitarian manner (Crawford *et al.* 2013).

But how equitable can relationships be between nurses and clients in mental health settings? Despite the favourable accounts of mutuality in the nursing literature and high hopes for the benefits of mutuality in caring and therapeutic relationships, there are some indications that mutuality may be hard to achieve in the full sense of the term.

Limits to mutuality: power, institutions and professionalism

First, let us deal with a philosophical concern about how apparent mutuality may be tilted in favour of

more powerful interests in mental health contexts. To illustrate this, let us consider the work of theologian and philosopher Martin Buber. He is well known for his popularization of the so-called 'I-thou' relationship, which has been of interest to scholars of nursing (Briant & Freshwater 1998). Buber believed that the human condition was one of dialogue or encounter with others. The mutual, holistic existence of two beings in the 'I-thou' encounter was fundamentally different from the contrasting 'I-it' relationship where the other is seen as something to be used and experienced (Buber 1948, 1965). There are parallels between this and many well-known therapeutic principles such as the equal worth of the client, the client's right to respect and the client's right to be treated as a 'thou' (Burstow 1987). In his later writings Buber himself points out that these principles are vital in psychotherapy (Buber 1974, pp. 93–97). Yet he was critical of the assumption that therapy could easily be an equitable relationship. There would be differences from the very first moment of contact. As Buber said of the client: 'He comes for help to you. You don't come for help to him' (Buber *et al.* 1965, p. 171). In dialogue with Carl Rogers, Buber maintained that therapies cannot be equal because it is the client's experience that is under scrutiny and not the therapist's. By contrast, the details of the therapist's life are not picked over (Buber *et al.* 1965). This inequality was what Buber referred to as the 'normative limits of mutuality'. Thus in this view the potential for mutuality is restricted by the surrounding structure of social relationships, professional expectations and boundaries, and the relative powers of the people in the social situation. The unequal nature of relationships in the social field highlighted by Buber is also noted by many later critical theorists of mental healthcare (e.g. Bracken & Thomas 2005; Cohen & Timimi 2008).

This point about the different powers of the participants in a mental health encounter and the direction of the therapeutic gaze towards the client is a significant challenge to the egalitarian ideas about mutuality in much of the literature on the subject so far. In order to get to grips with this potential for inequality, some new ways of thinking about the relative powers of clients and mental healthcare providers are needed.

In addition to this impediment to egalitarian mutuality in terms of power differentials there are sometimes organizational, professional and institutional barriers to mutuality. Despite the fact that a

number of claims have been made about the benefits of mutuality in mental healthcare, the kinds of practices or exchanges involved have not always been a welcome addition to the institutional practice of mental health. Often, concerns about professionalism or boundaries are paramount, and may limit, or at least shape, the nature of mutuality achievable. For example, in Alexander & Charles's (2009) study, participants were frequently aware that the practice of mutuality could be at odds with what they had been taught concerning ethics and boundaries in practitioner–client relationships. Hence, constraints on the degree to which health professionals can enjoy mutual relationships with clients then can arise from training, and from widely held ideas about professionalism.

Furthermore, ideals of mutuality may take second place to concerns about risk management and containment, and mental healthcare may involve significant elements of coercion (Collier & Stickley 2010). Mutuality may founder on these kinds of institutional barriers (Menzies-Lyth 1970, Briant & Freshwater 1998). It could therefore be argued that there are powerful forces at work to impede mutuality in mental healthcare. In a sense, it has to find a way of existing despite the limitations often placed upon it by professional and institutional life. Once again, it is important for nurses concerned to make relationships with their clients more egalitarian to have a way of thinking about the social field, which takes account of differences in power, ingrained institutional and professional practice and places the interpersonal aspects of mental health nursing in their social context.

Thinking around the barriers: mutuality and social capital

In order to achieve some degree of mutuality in therapeutic situations, it is valuable to be able to think systematically and rigorously about what may be getting in the way of beneficial mutual relationships. An important part of this involves developing a more sociologically nuanced way of conceiving mutuality, which is sensitive to the relative powers of the actors involved. So far, there have been few conceptual tools available to tease out how the broader patterns of social life inform therapeutic mutuality, or how these attempts at mutuality may be contoured by patterns of power and inequality. Consequently, it is appropriate to consider how our awareness of mutuality can be enhanced by under-

standing it in relation to the concept of social capital. Social capital has been gaining ground as a way of making sense of social relationships, social support and nursing (Looman & Lindeke 2005, Read 2014). Within the sociological tradition the key thinkers of social capital – Pierre Bourdieu (1986), James Coleman (1990) and Robert Putnam (2000) – all emphasize the importance of social networks and relationships in affording mutuality. Factors such as norms, trust, obligations, reciprocity and sanctions are involved, all of which form aspects of social capital. As Winter (2000, p. 24) reminds us, this is because 'social capital is a social product demanding social interaction'. Schneider (2009, p. 647) goes further and highlights the 'mutual, reciprocal relationships' in which social capital originates. In other words, social capital involves connections with others and the participants deriving mutual benefit from these connections (White 2002, Field 2003). Bourdieu provides a widely quoted definition of the concept. Social capital is the:

... aggregate of the actual and potential resources which are linked to possession of a durable network of more or less institutionalised relationships of mutual acquaintance and recognition – or in other words, membership in a group (Bourdieu 1986, p. 249).

This sense of mutual recognition also inhabits formulations of the notion of mutuality in writings on mental health. For example Jessica Benjamin (1988) suggests that the need for recognition implied in the notion of mutuality yields some interesting tensions: recognition is a response from another person, which makes meaningful the feelings, intentions and actions of the self. *It allows that self to realize its agency and authorship in a tangible way.* But this recognition can only come from another whom we, in turn, recognize as a person in his or her own right (Benjamin 1988, p. 12). The parallels between mutuality and social capital – indeed their pivoting upon one another – is also argued for by Glover & Hemingway (2005):

The advantages conferred by social capital exist only insofar as one is recognised as a member of such a network by other members and recognises them in return. Reciprocity exists not as a general cultural norm, but rather as an expectation attached to membership in a specific network. . . . there is neither inherent equality between networks in the resources they make available to their members, nor inherent equality

of access among members within any specific networks (Glover & Hemingway 2005, p. 6).

Mutuality, then, has important affinities with social capital. They both involve mutual recognition between the social actors. In the case of social capital, mutuality is often defined by doing something – strengthening social networks, making resources available – and by its consequences and effects. Social capital then can be conceived as a bounded condition of mutuality that affords suitable conditions that enable things to happen in a particular way, consistent with the prevailing ‘rules of the game’ (Barth 1969, p. 15).

A further point of contact between the sociological traditions from which social capital is derived and the idea of mutuality in mental health settings appears when we consider Bourdieu’s (1977) interest in what he called ‘practice’. Practice here refers to the way in which human actors, complete with their different motives and intentions, actively produce and transform the social world they inhabit. In Bourdieu’s view, practice is an interplay between social structure and human agency mutually influencing one another in a dynamic relationship.

Of course, social capital, social networks and social support are not necessarily identical, and Abbott (2009) cautions us against making glib assumptions that one can be inferred from the other. Relationships may be adversarial or competitive as well as supportive or protective. However, a greater concern with mutuality can enhance and deepen thinking about social capital too. The kinds of mutuality that are afforded in social relationships will affect whether they yield the kind of social capital that enables the participants to make progress or enhance their resilience.

In a mental health nursing context, closely related to the idea of mutuality, practice also includes the way that the actors show their personal traits, characteristics and peculiarities. Tosone (2013) lays out the process:

the personal attributes of the clinician enter into the treatment relationship, both shaping and refining the process, and being influenced as a result of the interaction. There is ongoing mutuality in that both the client and clinician shape each other’s affect, thoughts and actions based on the interaction of their unique configurations of their subjectivities and interpersonal experiences. (Tosone 2013, p. 252).

In both psychotherapy and in social capital theory, mutuality is believed to be shaped by action and interaction. It is about doing something – reciprocating with others, shaping the destiny of social encounters to make them more inclusive, and configuring and reconfiguring experience.

Thus, a great many understandings of mutuality have stressed the interpersonal and intrapersonal aspects of the concept. For example Hostick & McClelland (2002, p. 114) proposed that a successful nurse–client relationship is comparable with any other successful relationship and is mutually beneficial for both the nurse and the client, containing ‘mutual trust, feeling comfortable with, testing out, respecting and being sensitive to each other’. Similarly, for Paterzon & Zderad (1976, p. 18) nursing is an ‘intersubjective transaction coloured and formed by the individual participants’. In this view nursing is an interhuman process involving nurturing, being nurtured and, as a corollary of this, a relationship: ‘the between’. In this account of mutuality, it may be experienced in the nurse–patient relationship, where each participant sees the other as a distinctive and unique individual.

Understanding the relationship between mutuality and social capital can also help illuminate the limitations and restrictions on mutuality mentioned above as more than just accidental failures. Rather, limitations on mutuality may reflect how in mental healthcare relationships are often set up in a context of power relations and established ways of doing things, so as to secure power and privilege for some groups at the expense of others. Sometimes activities that are apparently mutual may mask mutually contradictory material interests (Valsiner 2002).

Why social capital theory and mutuality are better together: thinking through the implications

An important yet somewhat neglected element in discussions of mutuality is how these ideas might be applied in practice. So far, in the majority of publications where mutuality in nursing has been discussed, the advantages identified have been somewhat abstract. That is, for example, an awareness of mutuality has been promoted as a means of enhancing empathic reach, understanding common benefits and social justice (Drevdahl *et al.* 2001). Embracing mutuality may enable the nurse to give of him or herself, facilitating the capacity to ‘be with’ patients (Holopainen *et al.* 2014) as well as

facilitating connection in the relationship (Lane & Seraficia 2014). The benefits are said to exist in the quality of life (Hsiao *et al.* 2012), vocation and altruism (Carter 2014). Nurses can use connected knowing to learn about the patient's beliefs rather than imposing their own personal knowledge and truths (Lane & Seraficia 2014), and an appreciation of mutuality can help them provide holistic and community-based support (Balaam 2015). These somewhat abstract formulations fit in with the interpersonal and relational focus in many theories of nursing but may frustrate those seeking concrete action or practical implications.

The conventional position on mutuality then emphasizes personal or interpersonal aspects of the process rather than what may be taking place around it, or the context of power relations within which it might be embedded. Therefore, for those seeking to take action, a focus on social capital may be helpful, as it reminds us that 'it may be at least as important to intervene in relation to a person's social and family context as it is to engage in any more individually focused therapeutic work, if one is to promote their longer-term efficacy and social capability in a way that is sustainable' (Tew 2013, p. 371). If the dialogue between nurse and client remains solely within the 'intimate niche' of the I-thou relationship 'it will have no relevance to other agents in the therapeutic process' (Sieger *et al.* 2012, p. 487). To support families in their journey toward well-being, nurses need a way of thinking about the importance of social relations and their impact on mental health (Looman & Lindeke 2005). Sieger *et al.* (2012) goes so far as to say that interaction between nurse and client can succeed only if social sense of the action becomes accessible for both partners and the goals are revealed. She says that Bourdieu's approach provides a theoretical basis for this critical discourse.

Thus, the approach advocated here understands human agency to be embedded within a wider field of practice than is typically connoted when mutuality is discussed. Interpersonal relations emerge from earlier socialization, accumulated cultural knowledge and broader patterns of power relations. At the same time interpersonal processes are open to the possibility that novel action can be created via an intentional conversational engagement between acting agents in their social context. This can yield *new experiences* of dialogue and in-betweenness, via a reciprocal 'mode of communication that builds mutuality through awareness of

others and as an instance of unfolding interaction' (Eisenberg & Goodall 1993, Bohm 1996, Putnam & Fairhurst 2001, p. 116, Ballantyne 2004).

It is valuable also to understand the interpersonal processes of mutuality in terms of their contribution to social capital because the latter concept sensitizes us to the overall contours of the field, addressing questions such as who has the most legitimate knowledge, expertise and power in any setting. Bourdieu's treatment of social capital is tied to the notion of dominant interests and practices in a given field or context, and these can be used by individuals or groups to access other forms of capital to advance their social status. As we forge relationships with others, this often leads to changes in our social status or position. In particular, what has been termed bridging social capital is of particular value as it supports vertical exchange and enables people to 'get ahead' rather than just 'get by' (Usher 2006). As Bourdieu reminds us, it is through their relationships with one another that people are able to use their networks to advance their mutual interests through an 'accumulation of exchanges, obligations and shared identities' (Bourdieu 1993, p. 143). In this way we can begin to explain how mutuality can enable people to get ahead, make progress and enhance their own prospects for recovery.

Conclusion: mutuality as a kind of social capital

By seeing mutuality in terms of social capital, we can place in context and make sense of the various limitations on mutuality outlined above, whether these from the state, from practitioners' training or from limitations in working practices. Rather than representing a failure of interpersonal skill or authenticity, these limitations can be seen and tackled as systemic problems relating to the positions of the people involved in the social field.

Understanding mutuality in terms of social capital also highlights the mutual nature of all relationships, and if we acknowledge this in mental health nursing it enables practitioners to foster 'an awareness of the care their clients have and express towards them' (Alexander & Charles 2009, p. 20) as well as the care that practitioners exercise towards clients. Mutuality, as the word itself suggests, is a two-way street.

Within healthcare organizations, strong workplace social capital among nurses potentially

benefits nurses themselves, patients and organizations by fostering a culture of teamwork, support, cooperation and respect, enabling nurses to access shared resources to do their jobs more effectively (Read 2014). Lane & Seraficia (2014) go on to say that cultivating social capital in nursing is valuable given the contemporary emphasis on value-added care models of health-care delivery. The concept may also provide opportunities for strengthening and promoting interprofessional teamwork, collaboration and education. Social capital theory can enable health systems to enhance relationships among different organizational components that involve trust, cooperation and strong social ties (Sheingold & Sheingold 2013).

An understanding of the role and value of mutuality can help us appreciate and optimize the relationships (and hence the social capital) cultivated by nurses and clients. It is also possible in this way to appreciate how mutuality might be encouraged or discouraged by policy and training, and how these are shaped by power relations, by custom and practice and how mutuality can be liberating and life enhancing for clients and practitioners. The next challenge is to observe and assess how this growing interest in social capital in nursing plays out in practice.

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