Mutuality in health care: review, concept analysis and ways forward

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Aims and objectives. This paper aims to critically investigate the notion of mutuality in nursing, and explore how to resolve the tension between individualised accounts of mutuality and institutional and political factors.

Background. The concept of mutuality underlies many theories and models of nursing yet this does not capture the power relations in health care or institutional constraints on mutuality.

Design. This is a position paper informed by a narrative literature review.

Methods. A search of the Scopus, PubMed, Web of Knowledge and CINAHL databases for the terms mutual, mutuality and nursing was conducted, to capture English language literature published from 1990 to mid-2015.

Results. There is a large literature discussing the nature and value of mutual exchange and mutuality. There is acknowledgement of institutional and professional constraints which limit the potential of mutuality. Yet there is often a reluctance to engage with critical thinking which emphasises the inequalities of power in health care situations. Accordingly, the notion of social capital is introduced, which emphasises the role of social relationships which individuals and groups can deploy to their advantage. Finally the paper explores how new thinking about mutuality and social capital can make health care more effective.

Conclusions. Mutuality and social capital can be enhanced in a variety of ways and may improve client and practitioner outcomes via training, educational and organisational design, and initiatives involving patients and service users, as well as practitioners and service leaders.

Relevance to clinical practice. The sociologically nuanced account of mutuality advanced here sensitises us to questions of power and domination, as well as enabling us to see mutuality in terms of networks of relationships instead of merely an interpersonal phenomenon. This enables practitioners to enhance clients’ and their own capacity for mutuality and develop effective resources to increase resilience and recovery.
Aims

In this paper I intend to discuss the notion of mutuality in nursing care. The idea of practitioners and clients being brought into a reciprocal, productive relationship can be found in a variety of nursing theories, and has been the subject of a growing literature, yet we still know relatively little in a systematic or consolidated way about mutuality in nursing as a concept. Accordingly it is valuable to examine what the term involves and how it has been deployed in the field of health care work.

Further to this, in an effort to place the idea of mutuality in a more sociologically systematic framework, I will examine the relationship between the idea of mutuality and that of social capital, a notion which has been gaining ground in the health sciences as a way of making sense of the value of social relationships, especially where well-being and recovery are concerned.

Finally, I will consider how an enhanced understanding of the relationship between mutuality and social capital can yield more practical solutions for those seeking to make effective changes for the benefit of clients and practitioners themselves.

Background

The idea that some kind of mutual exchange is valuable in therapeutic processes is widespread in nursing, and has informed many attempts to make care more compassionate and egalitarian. It dates back at least to the work of Hildegard Peplau (1952) and has underlain numerous attempts to investigate nursing as a relational process. The value of practitioners and clients entering into a reciprocal, productive relationship is also foregrounded in a variety of service user involvement initiatives, patient-public involvement projects and schemes for the co-production of services and solutions. In mental health nursing, which is apt to undertake a great deal of reflection on interpersonal aspects of nurse-client relationships, some of the field’s key thinkers value the construct even more highly. For example Barker and Buchanan-Barker (2004, p. 32) complain that the mutuality inherent in nursing’s nurturing process has often been overlooked. Mutuality underlies their well-known ‘Tidal Model’ in that they underscore the value of collaborative working, especially where this incorporates the person’s story, and the conjoint exploration of the person’s ‘world of experience’.

In connection with mutuality, the related construct of reciprocity describes a state of affairs where people respond to each other in similar ways; for example, by responding to kindness from others with similar benevolence. Following Aristotle, reciprocity has often been taken to refer to a relationship between equals. Mutuality represents a particular case of reciprocity. Mutuality and mutual benevolence come out of the face-to-face relations envisaged by Emmanuel Levinas (1985) or the I-Thou relationships described by Martin Buber whom we shall discuss shortly. Here, however, I want to stress the common foundations of reciprocity and mutuality as the terms are often found together in both health care literature and social theory.

There is now a growing literature featuring mutuality in nursing, yet we still lack a systematic or comprehensive way of thinking about the concept, and of translating this into effective action. Accordingly, it is valuable and timely to examine what the concept of mutuality involves and how it has been deployed in the field of health care work. To address this more fully, and understand the relationship between mutual 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.

This latter construct of social capital, I will argue, facilitates out making sense of how power relationships can influence the likelihood of mutuality being achieved, and allows us to see how mutuality is shaped by the broader social frameworks within which it is embedded. A critical exploration of the construct of mutuality as it is used in nursing literature is important if we are to explore how more egalitarian modes of care may be cultivated, and if we wish to more fully empower people to help one another in relation to their health, self-care and well-being.

Design and methods

This position paper is based on searches of Scopus, Web of Knowledge, PubMed, Science Direct and the CINAHL database, seeking literature which made use of the terms
Defining mutuality

In attempting to come to an understanding of mutuality, it is noteworthy that while the term is frequently used it is not usually defined explicitly, but rather by implication. Among the few explicit attempts are Briant and Freshwater (1998), Hedelin and Jonsson (2003) and Jeon (2004). In their study of mutuality in the lives of depressed older women. Hedelin and Jonsson (2003, p. 318) define mutuality ‘as interdependence and influence in the relationships with others and the view of self’. They argue that for their participants, having one’s existence and value confirmed through one’s relationships with others was a major constituent of mental health. Its absence was associated with depression. For depressed participants, their interactions with others were interpreted as reinforcing their sense of worthlessness, whereas those who were not depressed saw their relationships with others as confirming their worth. In Jeon’s (2004, p. 128) study of nurses and depressed clients, mutuality is defined as involving ‘high levels of empathy, collaboration, equality and interdependency’. For Briant and Freshwater (1998, p. 211), the significant element is a ‘mutual alliance [which] relies on individuals relating to both themselves and others as whole persons’. In Speirs and Wood’s (2010) study of nursing psychotherapy, establishing mutuality was said to be essential to the early stages of the therapeutic process. In the case of voluntary groups, Love (2007) says that mutuality is based on reciprocal relationships that people enter into with one another to pursue a common purpose.

The concept of mutuality therefore links a number of different domains of activity with some common themes. Chief among these is a sense that beneficial mutuality involves reciprocal transactions and exchanges, mutual influence and responsiveness and a sense of common purpose. While conceptualised and implemented differently in particular situations, 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, which takes place in an egalitarian fashion.

Mutuality and power – when relationships are unequal

This emphasis on equity in so many accounts of mutuality invites the question of how likely it is that this degree of equality is likely to be found in health care relationships. There are clearly many favourable accounts of mutuality in nursing’s literature and a number of authors clearly have high hopes for what it can achieve in caring and therapeutic relationships. However, there are some indications that mutuality in the full sense of the term may be hard to achieve in many health care settings.

To illustrate this problem, concerning the way that in many practical health care contexts apparent mutuality may be weighted in favour of more powerful interests, let us turn to the work of Martin Buber. As a theologian and philosopher, Buber (1970) is well known for his focus on what he called the so-called ‘I-thou’ relationship. At its best, Buber believed, the human condition as one of dialogue or encounter with others. The mutual, holistic exis-
tence of two beings in the ‘I-thou’ encounter was fundamentally different from the contrasting ‘I-it’ relationship where the other – be it a person or an inanimate object – is seen as something to be used and experienced. This has parallels with much that has been written in existential and client centred psychotherapy, and Buber, along with Ludwig Binswanger and Paul Tillich, is often cited as providing the philosophical undergirding of these approaches. Indeed, it is readily apparent that there are parallels between this and core 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’. In his later writings Buber makes the case that these principles are vital in psychotherapy (Buber 1974, p. 93–97). Yet Buber was critical of the assumption that therapy could be an equitable relationship. There would be differences in power from the very outset. Buber said of the client: ‘He comes for help to you. You don’t come for help to him’ (Buber 1965, p. 171). In a debate with Carl Rogers Buber maintained that a therapeutic relationship cannot be equal because it is the client’s experience that is under scrutiny rather than the therapist’s. The details of the therapist’s life are not picked over (Buber 1965). This inequality was referred to by Buber as the ‘normative limits of mutuality’. As he explained:

[An] example of the normative limits of mutuality may be found in the relationship between a genuine psychotherapist and his patient…. He [the therapist] cannot absolve his true task, which is… regeneration…. That can be brought off only… if he enters as a partner into a person–person relationship…. Again the specific “healing” relationship would end as soon as the patient decided to practice the art of embracing and actually succeed in experiencing events also from the doctor’s point of view. (pp. 178–179)

By implication, once the relationship becomes mutual and the participants fully embrace one another’s points of view, it is no longer recognisable as a therapeutic relationship. Here, Buber was talking about the situation in Rogers’s client-centred therapy, but the same could be said of many other therapeutic encounters. Nurses could well be the same position. Thus, the potential for mutuality is limited by the structure of social relationships, professional and institutional expectations and possible boundaries, as well as the relative powers of the people involved in the health care setting.

The unequal nature of relationships in this kind of social field, highlighted by Buber is also highlighted by many thinkers on the sociology of health (Foucault 1973, Turner 1995). In this broader critical literature on health care, there have been a great many attempts to think about power in nursing and within the nursing encounter. For example, Wilkinson and Miers (1998) discuss the power exercised by nurses over their clients, and Davidson (2015) explores power in organisational contexts. What is striking in this case, however, is that where mutuality is discussed, this kind of politically aware consideration of power is virtually absent.

Borrowing from Springer and Clinton’s (2015) advocacy of the value of critical reflection on the discourse of nursing, we might well ask why this has happened. For many years, thinking about interpersonal activities in nursing has been dominated by an interpersonal focus rather than a social or political one. Perhaps most famously, Hildegard Peplau (1952), who coined the term ‘psychodynamic nursing’ and who developed what she called a model of ‘interpersonal relations in nursing’, was inspired by interpersonal psychiatry (Sullivan 1953). In addition, she drew on symbolic interactionism, but this was the inwardly focused work of Mead (1934) rather than the more socially focused work of Blumer or Goffman. This has perhaps encouraged subsequent scholars of mental health nursing to understand the mutuality in terms of the microstructure of interpersonal relationships and their presumed psychodynamic underpinnings, rather than in terms of broader sociological concerns about power.

Despite a number of attempts to explore the inequality in relationships in health care then, within the material that addresses mutuality we have relatively few conceptual tools to tease out how social relationships may be contoured by patterns of power and inequality or how mutual relationships may add to the stock of mental well-being. Clearly, thinkers from Buber to Foucault have laid out significant challenges to the egalitarian ideas about mutuality in much of the literature on the subject so far. Some new ways of thinking are needed about how the relative powers of clients and health care providers can be reconciled with notions of mutuality.

**Further limits to mutuality: institutions, professionalism and boundaries**

Although claims have been made about the benefits of mutuality in health care, these ideas have not always been welcome in health care institutions or among health practitioners. Institutional rules and professional concerns can limit the prospects for mutuality even further. Often, concerns about professionalism or boundaries take precedence over the desire for mutuality, and thus shape the kind of relationship achievable. For example, in Alexander and Charles’s (2009) study, their participants were aware that the practice of mutuality could be at odds with the teaching they had received concerning practitioner–client relationships. As one put it:
I remember that ethics course, right – you do not take anything from anybody. But that you know, in accepting [a gift from a client]… I am conceding to the fact that I had this relationship with a client… Because again, you were taught that you don’t do this, and mind you I don’t necessarily believe that my client should go and buy me a something… but in doing the context of this interview, you know, you do it with the understanding that you are working against what you have been taught to a large extent, right? (Alexander & Charles 2009, p. 17)

Thus, constraints on the extent to which professionals can enjoy mutual relationships with clients can arise from training and notions of professional practice. If we see what is going on here in terms of social capital it is possible to consider these limitations and restrictions as more than just accidental failures of personal capacity or training programmes. Rather, it reflects the way that relationships incorporate power relations and established ways of doing things, so as to privilege some groups at the expense of others. What is apparently mutual may mask mutually contradictory material interests.

This ambivalence about mutuality and the extent that it is valuable to practice it can also be seen in the tensions within governmental attitudes and policies. Certainly, a participatory view has been foregrounded in a variety of policy documents (NHS England 2013). To take an example from mental health in the UK, there has now been over a decade and a half of such policy, ever since the 1999 National Service Framework for Mental Health (Department of Health, 1999) spoke so warmly about service user involvement. Yet at the same time, policy tends to reflect also a more paternalistic view, seeing people with mental health needs as requiring treatment and management, and as a risk to be addressed via hospitalisation or other custody, as well as a variety of means to ensure treatment compliance. This latter position seems to reflect aspects of public opinion rooted in fears of ‘the insane’, and manifested in shifts in mental health legislation towards increasing compulsion (Collier & Stickley 2010). In this respect, then, mutuality is overridden by concerns of risk management, containment and coercion. In addition, mental health, like much of the health care system as a whole, is informed by Government policy which defines patients and service users as consumers or customers. This tendency to regard service users as customers is fundamentally different from thinking of them as partners, so is also arguably a barrier to mutuality. As Collier and Stickley (2010) point out, absorbing service users as customers in this way means that often their role is to monitor, comment upon and assess the services provided by the health care organisations, rather than being active agents in either therapy or the process of change. While this level of involvement may look like progress, some have argued that it may merely reinforce an existing power/knowledge base (Campbell 2006) rather than provide a platform for constructing mutuality.

Mutuality may be limited by these kinds of institutional, legislative and policy barriers (Briant & Freshwater 1998). There are powerful forces at work to impede mutuality in health care. In a sense, mutuality has to find a way of existing despite the limitations often placed upon it by political, professional and institutional life.

This is why it is important to consider a more sociologically nuanced way of conceiving of mutuality which is sensitive to the relative powers of the actors involved. This is especially useful if nurses are to make relationships with patients more equitable, and fully realise the interpersonal potential alluded to in many of the classic theories of nursing. In the next section, therefore I shall explore a way of thinking about the social field which enables critical thinking about power relations, deeply embedded institutional and professional ways of doing business and which enables interpersonal activities to be seen in their wider social context.

Mutuality as social capital

To resolve the theoretical and practical puzzles mentioned above, let us consider about how our awareness and practice of mutuality can be made more systematic by understanding 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 (Read 2014). In his generative work on social capital Pierre Bourdieu (1986) emphasised the role of social networks and relationships in enabling mutuality. Variables like norms, trust, obligations, reciprocity and sanctions represent different facets of social capital. Winter (2000, p. 24) argues that this is because ‘social capital is a social product demanding social interaction’. Schneider (2009, p. 647) also draws attention to the ‘mutual, reciprocal relationships’ from which social capital is generated. Social capital is based in connections with others and involves participants gaining mutual benefit from these relationships. Bourdieu originated a well-known definition of the concept in which 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)
The parallels between these definitions and the ideas on mutuality in nursing discussed above are noticeable. Benjamin (1988) writes that the desire for recognition implied in the notion of mutuality creates interesting dilemmas: 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, recognise as a person in his or her own right. (p. 12). The consonance between mutuality and social capital, such that the one implies the other, is also noted by Glover and Hemingway (2005, p. 6):

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.

Therefore, mutuality has an important relationship with social capital. Both constructs involve mutual recognition between participants in the social field. In social capital theory, mutuality is often defined in terms of what it does and what its consequences are; for example, strengthening social networks or making resources available. As Barth (1969, p. 15) puts it, social capital can be thought of a ‘bounded condition of mutuality’ that enables social activity to happen in a way that is consistent with the overall ‘rules of the game’. In this respect mutuality is closely related to what Bourdieu (1977) called ‘practice’. Practice is a term which attempts to capture the way in which human actors, complete with their different histories, motives and intentions, actively produce and shape the social world in which they reside. In Bourdieu’s theory, practice is an interplay between social structure and human agency mutually influencing one another in a dynamic relationship.

In a health care or therapeutic context, this idea of practice also includes the way that the actors manifest and deploy their personal traits, characteristics and idiosyncrasies so as to give form to 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 writings on therapy and in social capital theory, mutuality is said to be shaped by this process of interaction. It is about doing something – acting with others and reciprocating their actions, shaping the trajectory of social activities, configuring and reconfiguring experience to make it more inviting and inclusive.

For nursing, a focus on mutuality is important and distinctive because it represents a strong contrast with much of what has been done and a great deal of what has been written about health care. As Cushing and Lewis (2002, p. 174) say, the ‘philosophy of relational mutuality stands in contrast to the popular conception of the one-way flow of benefits in care relations rooted in medical and charitable paradigms’. Instead, mutuality describes a relationship which foregrounds dialogue and reciprocity in a ‘mode of communication that builds mutuality through awareness of others and as an instance of unfolding interaction. In this way then, the focus on mutuality serves to delineate a distinctive contribution for nursing.

This conception of mutuality owes something also to developments in early 20th century anthropology. In 1922, Malinowski proposed that reciprocity was the basis of social cohesion and was ‘part and parcel of the whole system of mutuality’ (Malinowski 1966, p. 26). Anticipating Bourdieu and later notions of social capital, Malinowski also pointed out that the reciprocity and mutuality he observed was not indiscriminate. It followed patterns of existing kinship and friendship networks, and was also oriented to the participants’ expectation of future relationships and exchange opportunities. Mutuality then contains both a representation of existing relationships and the participants’ image of what they might look like in the future.

As a result of the strong interpersonal tradition in nursing, many accounts of mutuality have stressed interpersonal and intra-personal aspects. Hostick and McClelland (2002, p. 114) said that like any other successful relationship, a nurse–client relationship is mutually beneficial for both nurse and client. It involves ‘mutual trust, feeling comfortable with, testing out, respecting and being sensitive to each other’. From this perspective nursing is an interhuman process involving nurturing, being nurtured and, as an important part of this, a relationship, ‘the between’. This aspect of mutuality may be experienced in the nurse–patient relationship, where each participant sees the other as a distinctive and unique individual.

This focus on the interior, intra-psychic aspects of mutuality and reciprocity, has led to some authors thinking of them as developmental processes. Hence, Rogoff (1995) proposes that mutual relationships act rather like a process
of apprenticeship. As Rogoff puts it, this learning process involves:

active individuals participating with others in culturally organized activity that has as part of its purpose the development of mature participation in the activity by the less experienced people. (Rogoff 1995, p. 142)

And this has implications for the future:

through engagement in an activity, individuals change and handle a later situation in ways prepared by their own participation in the previous situation. This is a process of becoming, rather than acquisition. (Rogoff 1995, p. 142)

Therefore, mutuality can represent a way of sharing knowledge, developing or disseminating expertise for a group or community as a whole. Thus, as well as formal patterns of interrelationship and formal exchanges, it is important to note how less tangible aspects, such as knowledge, skills and coping resources can be accumulated and circulated via mutual relationships. It is within these networks, through the acquisition and deployment of economic and social resources that mutuality occurs. In the next section then, let us consider how mutuality can best be seen in its wider social context.

Broadening the construct: mutuality in context

Interpersonal and mutual aspects of nursing are clearly attractive ideas when any discussion of the nursing role and its key activities is undertaken. We have seen how this notion has a particular kind of history in thinking about the profession, with contributions from interpersonal psychiatry informing Peplau’s generative account of nursing work. These ideas have become sedimented into the everyday thinking surrounding nursing. Bourdieu (1998) wrote about what he called ‘practical reason’, often commonsensical and relatively unquestioned, which condenses social actors’ sense of the rules of the game in which they are engaged. Importantly, practical reason enables us to do things. Having a sense that one is expert in interpersonal relationships facilitates continued engagement with health care tasks which might sometimes seem to be exhausting and never-ending, and where hope of recovery can seem remote. The focus on mutuality is a kind of practical work on the self of a kind which some commentators have seen as central to nursing (Crawford & Brown 2008). Framing the work of one’s professional group in these interpersonal terms establishes one’s value in the wider field of health care activity. The focus on mutuality is perhaps part of a moral project of creating an identity as a good actor in the health care field, an ideal dispenser of care that may enable further helpful advancement, additional resources or enhanced status.

At the same time as all this focus on interpersonal and learning processes, there are hints that some authors are keen to expand the concept of mutuality to include a wider set of social processes and determinants. As an example of this, Forsman et al. (2013) point to the contribution to health of shared social activities, common life events, social support, mutual appreciation and trust, and a sense of belonging among older adults. However, in contrast to some theories of social capital which emphasise formal contacts and memberships, Forsman et al. found that informal social contact between family and friends was the most crucial aspect for mental well-being among their participants. This highlights the way that social capital may exist just as significantly in people’s lives in informal and familial relationships as it does in formal group memberships.

Game and Metcalfe (2010) describe how a worker at a shelter for destitute individuals held herself to very exacting standards and eventually had a breakdown. When this happened, some of the people for whom she had formerly been caring began providing her with gifts. This mutuality, and her role as a wounded healer has, say Game and Metcalfe, enhanced her ability to do the job. ‘She has gained the capacity to heal through her own experience of woundedness’ (Game & Metcalfe 2010, p. 26). For Martin Buber, the difficulties faced by the care provider (or as he put it ‘the doctor’, but it could equally well be the nurse) involve something profound or fundamental about him or her. The ‘wound’ calls on the therapist to face the shared ‘abyss’:

The abyss does not call to his confidently functioning security of action, but to the abyss, that is to the self of the doctor, that self-hood that is hidden under the structures erected through training and practice, that is itself encompassed by chaos, itself familiar with demons. (Buber 1999, p. 19)

Thus, there is an exhortation in Buber’s work to get beyond or behind the training that practitioners have undergone and to confront something that is more basic to the human condition. In his view it is the latter that affords a full measure of mutuality, rather than the professionalised, rule-following intervention that is often found instead.

Despite these impediments that Buber found in training and professional practice, there have been a number of recent attempts to foreground the importance of mutual support in enhancing health and well-being, and offer pathways that will enable it to flourish.
Moreover, the constructs of mutuality and social capital can often be found underlying other activities and interventions in health care practice. For example, the idea of mutuality as arising from a body of common experiences and shared interests informs a great many attempts to facilitate peer support activities. This may range from informal contact between clients, through to consumer-run initiatives to more formal arrangements where peer support workers are recruited and paid by health care organisations so as to provide ‘a system of giving and receiving help founded on key principles of respect, shared responsibility and mutual agreement of what is helpful’ (Repper & Carter 2011, p. 394). This has clear parallels to the ideas we have considered above.

The central role of mutuality in many of these kinds of programmes becomes especially clear when it is remembered that the key element in such activities is reciprocity. Both mutual support groups and consumer-run programmes seek to foster relationships between participants that facilitate and value reciprocity (Repper & Carter 2011). Through the facilitation process, relationships between participants are cultivated so as to provide opportunities for sharing experiences, as well as giving and receiving support and for developing a mutual and synergistic understanding to benefit all parties.

Peer support, and the mutuality that it entails, has been noted to have value among those who suffer from health problems, but it also has a good deal to offer informal carers too. Hyde (2013) describes an initiative involving mutual aid groups for carers of people with long term mental health problems. The carers particularly appreciated the collaborative supportive quality of the groups. Equally, these interactions require some care in facilitation, says Hyde, such that the optimism of those embarking on the caring role is not entirely crushed by the experiences of those who have been long-term carers. A focus on mutuality, then, represents a persuasive and readily understood way of getting the job done, in the face of circumstances that might seem austere and unpromising, and health problems that might appear intractable. It enables people to cope, whether they are patients themselves, informal carers or practitioners, or, as is often the case, have elements of all these roles in their life story.

Information sharing has been highlighted as a key component of mutuality, and this has found its way into the model of working in the newly developing ‘recovery colleges’ in the field of mental health in the UK. In a study by Meddings et al. (2014) recovery colleges’ activities were particularly welcomed when combined with mutual respect. This combination of information giving and experience combined with a mutualistic relationship was also found in a study by Shattell et al. (2007) attempting to discover what participants found to be genuinely therapeutic about their relationships with professionals. From a client’s perspective, the best relationships were those which involved in-depth personal knowledge, of the kind that could be acquired only over a long period of time, as well as understanding, and skill. Participants also highlighted the value of the professional knowing the whole person, rather than the participant merely in terms of symptoms or as a patient.

Elstad and Kristiansen (2009) explore the possibilities for mutual support in a network of mental health centres in Norway called ‘meeting places’. They argue that ‘flexible community mental health services can be helpful by offering support and challenges as well as possibilities for mutual relationships’ (Elstad & Kristiansen 2009, p. 195). The kinds of relationships which participants were able to establish with one another and with staff were perceived to offer benefits. ‘Relationships of mutual recognition provide opportunities for experiencing solidarity, social inclusion and increased self-worth’ (p. 203). Yet at the same time, some participants expressed the view that some direction by the staff was desirable lest the situation descend into chaos. In other words, the mutuality achieved was seen as precarious and needed structure in order for the social interaction to be ‘normalising’ and ‘identity-forming’ (p. 203).

Thus, there is a need for a practice based mutuality that is attentive to the difficulties faced by people with anomalous experiences of the body or mind in a society which is sometimes ill-equipped to respond to illness or disability.

**Why social capital theory and mutuality are better together: creating practice based mutuality**

An important yet somewhat neglected element in discussions of mutuality so far is how these ideas might be carried through into nursing practice. In the majority of papers in which mutuality in nursing is considered, the enhancements brought about through improve mutuality are rather abstract. To take some examples, awareness of mutuality has been said to be a way of increasing empathic reach, raising awareness of common benefits and social justice (Dreverdahl et al. 2001), enabling the nurse to give of him or herself. It is said to yield gains in the ability of nurses to ‘be with’ patients (Holpainen et al.) as well as promoting ‘connection’ in the relationship (Lane & Serafinia 2013). The benefits are claimed to include quality of life (Hsiao et al. 2012), as well as vocation and altruism.
Rather than imposing their own personal knowledge and truths, nurses can use connected knowing to learn about the patient's beliefs (Lane & Serafica 2013) and appreciating mutuality can help in the provision of better holistic and community-based support (Balnaam 2015). These abstract benefits correspond to the interpersonal and relational focus in many theories of nursing, but in themselves they lack direction for concrete or practical actions.

Much of the existing writing on mutuality then focuses on personal or interpersonal processes, rather than what may be taking place around the social actors. Therefore, to take action and achieve a genuinely practice based mutuality, an awareness of social capital may be helpful, because ‘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 mutuality of the 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 towards increased well-being, nurses need a way of thinking about social relations and their impact upon health. Sieger et al. (2012) claim that the interaction between nurse and client can succeed only if the social sense of the action becomes intelligible for both parties and the goals are made explicit. She agrees that Bourdieu’s approach provides a theoretical foundation for this critical dialogue. Similarly, those who write about mutuality in exclusively interpersonal terms might be well advised to expand their horizons to the social and political context in which mutuality takes place, as critical scholars of nursing have been attempting for some time.

In an attempt to do this, the approach advocated in this paper conceptualises human agency as taking place in a wider social context or field of practice. This field of practice emerges from culture and accumulated knowledge, earlier socialisation and broader patterns of power relations between competing interest groups. It is, in Bourdieu’s sense, a field. At the same time it is open to the possibility of co-creation and novel action via an intentional conversational engagement between the acting agents.

As a number of critics of health care have pointed out, the therapeutic process is apt to shape the client’s knowledge, consciousness and awareness. While the manifest position of many therapies and models of health care is that the patient or client is in the driving seat, and the focus is on the client’s concerns, as Barton (1971) pointed out many years ago, the practitioners’ value systems and socialisation enable them to attend to those aspects of the client’s story that they regard as ‘truly deep’ or representing ‘real feelings’ or authenticity. Thus, the susceptible client comes to really believe these aspects are features of his or her psychic life rather than having been derived from the professionals’ world view. While Barton was an early proponent of this position in the English speaking world, these arguments about the nature of therapy became more familiar through the work of Foucault (1973). Building on these insights, Rose (1990, p. 222) described how the helping professions have been involved making citizens ‘internally literate’ in ‘the minute arts of self-scrutiny, self-evaluation and self-regulation’.

Where mutuality occurs between nurse and client then, it is achievable because they speak much the same language, about experiences, feelings, hopes and fears, and this in turn has been informed by the past century’s fascination with inner psychic life, which has sedimented into both popular consciousness and professional training. Therefore, it is valuable to understand the interpersonal processes of mutuality in terms of social capital, because the acquisition and deployment of this vocabulary about the self is a social process, taking place through a set of relationships, media of communication and educational activities. The concept of mutuality is more than merely a term, it is an idea in action: it enables practitioners to do their everyday work with clients, to recognise and value the moments of connection with clients, and to frame their work as a valuable asset in the health care field. The concept of social capital also sensitises us to the overall contours of this field, enabling us to ask questions such as who has the most legitimate knowledge, expertise and power in any setting. Bourdieu’s account of social capital incorporates the notion of dominant interests and practices in a given field or context. By accessing and using the kinds of capital associated with more powerful groups, individuals or collectives can advance their social status. Forming relationships with others may lead to changes in social status or position. So-called 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 notes, through relationships with one another, 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 enables people to get ahead, make progress and enhance their own prospects for recovery.
By taking the insights of social capital theory seriously we can recast mutuality as a genuinely social, collective construct. Rostila (2010, p. 316) notes that social capital ‘brings a comprehensive view [and] contributes to a greater understanding of how various dimensions and levels of social relationships are related’. 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, limitations to mutuality can be seen and tackled as systemic problems relating to the positions in the social field of the people involved.

Understanding mutuality in terms of social capital highlights the mutual nature of all relationships, and if this is acknowledged in nursing it enables practitioners to foster ‘an awareness of the care their clients have and express towards them’ (Alexander & Charles 2009, p. 20). Making mutuality central to nursing care involves creating the kind of relationships where reciprocity and growth are possible and not truncated by overly precious concerns with expertise or professional boundaries. Building the capacity for mutuality takes time – most participants in Alexander and Charles’s (2009) study identified their openness to mutuality as stemming from a learning process over a long period. In a sense, it means unlearning a good deal of training and policy which we imbibe as practitioners, so as to connect with people in the equitable manner envisaged by Martin Buber.

An understanding of the role and value of mutuality can help us optimise the relationships (and hence the social capital) cultivated by practitioners and clients. It is also possible in this way to appreciate how mutuality might be encouraged or discouraged by policy and training, how they are shaped by power relations, by custom and practice and how mutuality can be liberating and life enhancing for clients and practitioners.

**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, powerful economic or political interests, 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. In this way the critical and political dimensions of health care practice, which have been underdeveloped in accounts of mutuality so far can be more fully embraced. The professional purposes served by the concept and the growing body of writing on it can be more effectively pursued. Through judicious use of Bourdieu’s concepts, which are becoming more wisely used in the literature on health care, mutuality can be seen as a genuinely relational yet politically situated activity that yields benefits for clients and practitioners.

Within health care organisations, strong workplace social capital and mutually supportive relationships among nurses potentially benefits nurses themselves, patients and organisations 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 and Seraficia (2013) 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 organisational components that involve trust, cooperation and strong social ties (Sheingold & Sheingold 2013). Yet social capital is not a panacea for gaps in theory or practice. A useful future direction in thinking about this construct is to reflect critically on its applicability and value for nursing theory, despite the initial enthusiasm with which its use has been promoted. Likewise, Bourdieu’s concepts cannot be applied unhesitatingly, because Bourdieu himself conceived of his ideas as thinking tools or as ‘open concepts designed to guide empirical work’ (Bourdieu 1990, p. 107) rather than to be taken as literally true.

An understanding of the role and value of mutuality in nursing can help us appreciate and optimise 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, and to challenge the ways in which it is discouraged by policy and training. Once we understand how opportunities for mutuality are shaped by power relations, by culture, custom and practice it becomes possible to engage in a genuinely practice based mutuality that can be liberating and life enhancing for clients and practitioners.

**Contributions**

Study design: BB; Data collection and analysis: BB; Manuscript preparation: BB.
References


