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Human encounters: The core of everyday care practice

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Abstract

Although there is increasing recognition within health and social care policy that relationships are central within 'people work', little attention is given to exploring the nature and purpose of these within everyday care practice. Social pedagogues appreciate that human relationships, in all their complexity, are intrinsically valuable and, therefore, central to everyday care practice. This article explores human encounters as the foundation of relational practice, and we discuss how the space for true encounter incorporates spiritual care and a movement from dependence to interdependence. It proposes that everyday care practice is best understood as a series of human encounters that requires courage to embrace the complexity and uncertainty of encountering the essential humanity of those we care for. In order to do so, practitioners need to develop moral integrity, enabling them to navigate situations of care without fixed recipes. Drawing on perspectives from care ethics and the Nordic care tradition, this article contextualises the discussion within the authors' extensive care practice experience and, in focusing on human encounters as the basis of relational care, presents implications for practitioners in diverse everyday care contexts.

Keywords: social pedagogy; everyday care; spiritual care; relationship-based practice; encounter; love

Complete freedom is when I will not have to announce my plans to others.

Partial freedom is when I have to announce them a good time in advance.

Slavery is when others tell me in advance what I will do.

<div align="right">(Nadolny, 1983, p. 43, authors' translation)</div>

Introduction

Although there has been an upsurge in recognition in the professional literature and within UK health and social care policy that relationships are central within 'people work' (Ingram and Smith, 2018; Bryan, Hingley-Jones and Ruch, 2016; Ruch, Turney and Ward, 2010; Scottish Executive, 2006), little attention has been given to exploring the nature and purpose of these relationships within everyday care practice (Cameron, 2013; Steckley and Smith, 2011). In this article, we seek to add to the debate about the nature of relationship in the context of everyday care and propose that at the heart of caring relationships is human encounter, which constitutes the most basic, yet also the foundational pillar of relational practice. Here, everyday care practice can be understood as a series of meaningful encounters. Likewise, through our discussion of spiritual care, we aim to capture what is unearthed through the mystery of human encounters, connecting those who care with those who are cared for, independent of professional background.

In exploring the nature of encounter, we draw on perspectives from care ethics and the Nordic care tradition – a tradition rooted in the holistic and interconnectedness of human existence that adopts a hermeneutical, phenomenological and life-world approach (Arman, Ranheim, Rydenlund, Rytterström and Rehnsfeldt, 2015), contextualising this in everyday care practice through a social pedagogical lens. In'social pedagogy, care practitioners might be thought of as 'experts in the everyday' (Cameron, Reimer and Smith, 2015) and, often, find themselves in complex situations without fixed recipes. Although social pedagogues appreciate that human relationships, in all their complexity, are intrinsically valuable, they practise within 'the midst of country-specific multiplicity' (Hämäläinen, 2015, p. 1025). Through exploring encounters, we aim to overcome some of the contextual ambiguity that exists, not only within social pedagogy but also between discipline-specific knowledge and practice within everyday care contexts.

Throughout, we frame our discussion within our extensive direct care practice experience that, combined, spans over 70 years in overlapping disciplines such as mental health nursing, teaching, social care, residential child care, learning disability and higher education. In focusing on human encounters as the basis of relational care, we are particularly interested in presenting implications for practitioners in everyday care contexts.

The context of everyday care practice

Although the concept of 'care' is universally accepted as intrinsic to all fields of care practice, what is meant by care remains elusive and contested. Because care depends on contextual considerations and is framed by shifting, dominant discourses, it is notoriously difficult to define. The dominant professional and policy discourses framing care practice in the UK have tended to reduce care, regardless of field, to technical rationality underpinned by neoliberal ideology (Cheung, 2017; Lorenz, 2005). In child and youth work, direct care practice is dominated by risk-averse cultures of protection (Featherstone, Gupta, Morris and Warner, 2018), leading to what Barry (2007, p. 1) termed as the 'blaming society'. The present preoccupation with abuse, for instance, has led to what Jackson and Monteux (2003, p. 54) described as 'Hermetically sealing children in a protective cocoon', denying human responses in the form of touch, warmth and intimacy.

Within this context, the biological sciences are 'culturally ascendant' (Wastell and White, 2017), steering an increasing trend towards early intervention underpinned by a model of cultural deficit. Care, in this context, is rarely explored for intrinsic value but, rather, it is seen as a means to an end; one that is technical, rational, devoid of moral purpose and meaning; furthermore its effect has been to subsume care practice beneath more privileged concepts of treatment, clinical therapy and social investment. Consequently, biomedical orientations have been resurgent in recent years in spite of a shift in policy discourse towards more socially inclusive rhetoric. A clear example of such an approach is within the

recent discourse surrounding Adverse Childhood Experiences (ACEs), which has led to a search for simplistic, positivist and ostensibly scientific solutions to complex social issues (Edwards et al., 2017).

Our vision of care is divergent from prevailing dominant discourses as it attempts to realise care practice within multiple and complex contexts, locating everyday care within a holistic, human-orientated and relational process. Everyday care, as opposed to treatment, therapy, or intervention, is not defined by specific expertise in a professional field but is, rather, found in the daily interactions between people within the arena of shared life-spaces. However, everyday care should not be confused with simple notions of 'common sense' but, rather, incorporates notions of 'practice wisdom', 'cultivated through the intersubjective encounter' (Cheung, 2017, p. 619) experienced between carer and cared-for.

Relationship-based practice and person-centred care

Across diverse professional fields that could adequately be called 'caring', practitioners are, on the one hand, encouraged to develop and utilise relationship-based practice (RBP) and, on the other, hampered by powerful shifting discourses on care that privilege best practice and professional distance. In similar developments, although the concept of person-centred care (PCC) has overseen an increasing recognition of the 'person' within health and social care policy and practice, this is set within wider competing and restrictive aims of delivering safe and effective care (Scottish Government, 2010). In social care, the shift in policy towards PCC enabling self-determination and empowerment, most notably in Scotland through 'self-directed support', rather than developing participatory and autonomous action, frames care practice in a 'doing to' that both individualises and pathologises (Lorenz, 2005). Under the weight of such a dominant care paradigm, care relationships become contractual rather than entered into for an intrinsically human calling. In mental health, through professional 'hijacking' (Slade et al., 2014) of the user-led recovery agenda, although relationships are championed, these are often secondary to instrumental forms of care practice. This has led to an individualisation of mental well-being where people are framed as self-responsible, passive consumers of care packages (McWade, 2016) and relationships are reduced to simplistic drivers of positive change.

Within these current movements, care practitioners are directed by a false search for certainty; instructed by regulatory codes and notions of best practice towards predetermined and professionally led outcomes. Within such an approach, where the human being is seen from a deficit perspective, the person is reduced to an object in need of 'cure' or protection and relationships imagined, defined and enacted by the professional as 'expert'.

Apart from a few notable exceptions, for example McCance and McCormack's (2016) person-centred framework, PCC and RBP remain, largely, capable only of enacting a rhetoric of empowerment and participation and, in our view, fail to capture the mutuality and complexity of authentic relational practice. In such a climate, the person who is 'carer' is only permitted to 'give' and the person who is 'cared for', simply enabled to receive. Within this context, relationships are treated as transactional commodities (Jackson and Monteux, 2003). We believe that it is necessary to explore relationships at a deeper level for, as Ingram and Smith (2018) pointed out, relationships are neither inherently good nor bad – they can be both.

The caring relation – From independence to interdependence

We draw a distinction between care seen as 'doing to' and an 'everyday' care that is more about 'being with' (Garfat, Freeman, Gharabaghi and Fulcher, 2018). This important separation distinguishes between a professionalisation (Noddings, 1996) of caring that seeks status, expertise and certainty; and a relational professionalism (Ingram and Smith, 2018) that seeks, rather, to reduce the distance between carer and cared-for through genuine and authentic RBP. In doing so, we imagine a radical shift away from professional as 'expert' towards professional as 'skilled facilitator' (Smith and Monteux, 2019), navigating and embracing the complexity and uncertainty of everyday care.

We, like others, understand the practice of everyday care, across multiple care settings, as a relationship-based *moral* practice (Delmar, 2013; Gastmans, Schotsmans and Dierckx de Casterle, 1998). In the context of nursing, for example, according to Bishop, Scudder and Scudder (1990, p. 104), nursing

can be defined as a 'moral practice based on the moral requirement to promote the well-being of the patient by caring for them through a personal relationship'. From a care ethics perspective, everyday care as a moral practice is rooted in an understanding of a relational view of human beings (Delmar, 2013; Noddings, 2012; Tronto, 1993; Buber, 1970). It was the Scottish philosopher John Macmurray (1961, p. 17) who said that 'the Self is constituted by its relation to the other'. Such an image of the human being, as existing only by virtue of their relationships with others, runs contra to the prevailing image of human beings as rational, independent and self-managing. Care cannot be reduced to its instrumental context, no matter how important technical expertise is. Good care outweighs this and is 'morally loaded' (Gastmans et al., 1998, p. 46). Here, the neutrality of everyday care practice, typically constructed within prevailing models of PCC and RBP, is radically called into question. In our experience, we have often confronted situations where practitioners have been reluctant to demonstrate personal feelings or show affection towards cared-for individuals. Time and time again we have had to battle to allow expressions of care that demonstrated 'going the extra mile' or that seemingly privileged one child/adult over another. In our view, honest expressions of having particularly meaningful connections with a certain person in our care was usually met with suspicion or the old slogan, 'you can't treat people differently'. Of course, though, you can, and we have to because people are different and should not all be treated the same way. Likewise, although always aspiring to 'good care', we have experienced forming 'special' or particularly meaningful relationships and to suggest that these are not congruent with best practice ignores the emotionally laden and intrinsically close nature of authentic relationships in everyday care.

Drawing on the Nordic care tradition, moral practice is based on caring and care is the basis of all human relations. Kari Martinsen, inspired by the philosophers Heidegger, Foucault and Logstrup, stated that 'moral practice consists of caring, which is also a foundation for our lives' (cited in Arman et al., 2015, p. 289). She saw caring as ontological and, as human beings are dependent, this requires a human response in the form of care. However, the fact that people depend on each other is challenging because people strive for independence and self-management in a context overshadowed by individualism and professional distance. However, as Delmar et al. (2006) rightly pointed out, 'It is important to think that what could seem unbearable without the help of others, can with the care of others become bearable. In Martinsen's philosophy of care, dependence is a positive word' (p. 22).

From a relational perspective, dependence and self-management can complement each other if one-sided giving and receiving are replaced by a mutual exchange. However, this does not mean that what is given or received is equal per se but, rather, that it is a practice that embodies the value of interaction and shared understanding (Jackson, 2006). This is the expression of everyday care seen as a movement from dependence to interdependence.

'Good' care relations are based on the interdependence of human beings. Within this context, concrete relationships are developed through everyday activities and everyday care is understood and shown in practice. Care is not simply a conceptualisation because care becomes alive and present only when it is 'unfolded' (Delmar, 2013). The task of everyday care is directed towards the realisation of human goals and this demands a form of care that seeks a more subjective and dynamic experience; one in which people understand and live their lives in view of their sense of ultimate meaning and value.

Spiritual care – Enabling encounter

Currently, spirituality is marginalised in discussions of care. Through incorporating spiritual care as part of a coherent 'whole person' approach, and not as rhetoric or a supplementary add-on, the everyday care practitioner seeks to enable the realisation of human goals such as meaning, purpose, connection, hope, love and identity. As a sum total, we see this as defining a generalised sense of well-being. This enabling of human goals transcends all specific disciplines associated with professional caring. In social pedagogy, the starting point, despite cultural ambiguity, is to ask fundamental questions about human 'being' and 'becoming'. Our understanding of care is based on an image of the human being as a complex and dynamic system of physical, mental, emotional, moral, social and spiritual elements that need to be in harmonious balance. However, it is inconsistent to speak about the parts of a human being for humans are an integrated unity – human beings are an indivisible entity. The task of care can then be

seen as either an ongoing engagement, supporting the maintenance of this often tender and vulnerable balance, or of supporting an individual(s) in accepting their specific situation and learning to create the best possible quality of life according to their unique circumstance and values: 'It is the spirit of human beings which enables and motivates us to search for meaning and purpose in life, to seek the supernatural or some meaning which transcends us' (Swinton, 2001, p. 16).

According to this, spirit is something greater than our normal, everyday self, yet also an energy that motivates us to ask questions and search for answers. This activity is what Swinton (2001) called spirituality. It is not important what we as individuals call this 'spirit' – God, Allah, cosmic energy, love and so on – what is important, though, is our relationship to it and how we express it in our daily lives. Taken from the NHS Education for Scotland (NES, 2009), the following quotation is, we believe, an insightful and bold depiction of 'integrated wisdom' in the context of spiritual care:

> Spirituality provides the higher-level intelligence and wisdom which integrates the emotional with the moral. It acts as a guide in integrating different aspects of personality and ways of being and living. It is found in the integration of several deep connections: the connection with one's true and higher self; the connection with society and especially with the poor, the deprived and the underprivileged; the connection with the world of nature and other life forms; and for some, a connectedness with the transcendent. (p. 19)

Here, we see similarities with the social pedagogical task of bonding with the concept of practical wisdom (Eriksson, 2014), which makes it possible for pedagogues to do the right thing at the right time. This practical – or integrated – wisdom is enabled through a process of authentic dialogue in which mutual recognition, respect and meaningful connection with the other is developed and maintained. Jackson (2006) went further and stated that it is the 'very essence of spiritual care' (p. 71) when a relationship of trust and mutuality is developed between carer and cared-for. Just as care becomes concrete through the activity of relationship formation, spirituality is also an activity – the work of our 'I', linking spirit and matter, finding meaning and purpose and awakening our knowledge of who we are and to our aims and potential. More importantly, though, it allows us to see the same in others – because if it is present in me it is also there living in others.

True encounter, in this light, is the moment when the 'real' person can be found; a mutual recognition of two or more individuals can come about. This is, however, not a static moment once achieved but, rather, it needs to be actively created in different situations like a journey of discovery into unknown territory. This type of encounter can come about unexpectedly as a fleeting moment, but can also be prepared by creating a space of simply being – as in being together (Garfat et al., 2018); sharing a space filled with everyday meaningful activities and experiences without the need to record, measure success, or apply a care plan. This way of caring addresses the whole person by taking into account not only their physical, emotional and mental needs, but also their spiritual reality and can be adequately termed spiritual care.

The caring encounter

The concept of encounter occurs often in the caring literature as a synonym for dialogue and/or forming relationships (Holopainen, Kasén and Nyström, 2014) and, often, describes deeper levels of interaction than typical of the contractual relationships we described as evident in much of current care practice. In Martinsen's philosophy of caring, these encounters are an abstract place created in the distance and closeness between individuals (Holopainen, Nyström and Kasén, 2019). This is reminiscent of what Garfat et al. (2018) called the 'in between' spaces and, according to Buber (1970), it is through encounter, not learning, that the other is able to experience a sense of that which is, and that which is becoming. These accounts of caring encounters all share something important in common. Within the encounter, or mutual connectedness, persons involved are exposed to an in-between space where strangeness needs to be tolerated and embraced in order to reach a renewed and transformed sense of sameness. Here, we understand strangeness as an experience incorporating alterity (Moss and Petrie, 2002), moving beyond intellectual uncertainty to what Kreber (2014) termed super-complexity. From this engagement, in the

uncertain space that inhabits encounter, recognition, reciprocity and authenticity are enabled to enter the practice of everyday care.

There are, however, two very different ways of approaching this task, or two different sets of tools which can be used. Schwen (2019) suggested that these two fundamentally different approaches can be described as (a) the *economic* and (b) the *dialogue* approach.

In the first approach, or set of tools, the everyday care practitioner utilises care plans, policies, risk assessments, standards, record keeping, measured outcomes and so on. These may be important – even essential – tools but need to be used carefully and with discretion as they hold an inherent danger of limiting the space of action (Delmar, 2013) and preventing authentic relationships from developing. Such tools, while important at a certain level, are rooted in previous behaviour and experiences and, in utilising these to manage practitioners' actions, have the inherent danger of trapping the cared-for person in a future decided by the past. This approach leads to seeing human beings as objects; as human capital that can be controlled and moulded according to preconceived 'expert' opinion. We believe that this attitude can hardly lead to meaningful, dynamic and trusting relationships. Neither can this approach overcome isolation, separation, nor create a space for the mystery of human encounter (Westerholm, 2009).

A second, radically different, approach is underpinned by dialogue. Referring to Martin Buber's (1970) ideas on meaningful relationships made possible through dialogue with a living 'other', Schwen (2019) detailed that this approach places significant emphasis on the everyday care practitioner's individual responsibility for their own actions and attitudes towards the other – the cared-for, and for their own ongoing learning and development. In social pedagogy, this attitude is captured by the concept of *haltung*, which incorporates a practitioner's orientation to 'the other' (Smith, 2012) and must be an authentic reflection of one's own values and ethical orientation (Eichsteller and Holthoff, 2011). This has already been expressed in 1965 by Dr Karl König, the founder of the international Camphill Movement, albeit in a somewhat old-fashioned language but relevant here:

> Only the help from man to man – the encounter of ego with ego – the becoming aware of the other man's individuality without inquiring into his creed, world conception or political affiliation, but simply the meeting eye to eye of two persons, creates that Curative Education (Spiritual Care) which counters, in a healing way, the threat to our innermost humanity. (Cited in Jackson, 2006, p. 22)

Such an approach, based on ethical individualism (Steiner, 1995) – expressing moral content in action, asks for open give and take, based on trust and intuition. This genuine human encounter comes about only when there is the will to decide again and again to not terminate the understanding of the other person, but to perceive them again and again as a unique and developing individual.

We do not doubt that each caring profession needs tools specific to the task at hand. Each professional needs to decide how to use his/her tools and when to look for new ones. In order to perform practical tasks, the individual using these tools needs to have a plan or design – an aim. However, in the context of everyday care, it is important to ask where the inspiration for the design or plans originates. Is it informed by a search for certainty that employs linear methods to reach predetermined outcomes; or by an attitude to support the other person in discovering and/or recovering the uniqueness of their personality in the search for meaning and wholeness in their lives? Is the caring relationship ruled and limited by a certain prescribed set of tools; is the carer even turned into a tool of given care standards rather than given the freedom to decide each time according to the given situation? Shifting from the former to the latter is what we believe constitutes the necessary move from expert to skilled facilitator (Smith and Monteux, 2019).

Human encounters of the type we describe are defined by being conscious in the present and, in deciding on particular caring actions, the practitioner needs to navigate contextual ambiguity that does not limit the person cared for but, rather, opens up the possibility for the unfolding of the person's unique and essential humanity.

Perceiving the other we encounter

Just as the tools, or approach, we utilise will enable or inhibit a true encounter, how we bring about caring encounters will depend very much on who or what we look for. For Emmanuel Levinas, encounter

with the face of another is an appeal; an ethical imperative and a responsibility to and for the other that begins with the everyday, yet reaches beyond it (cited in Morgan, 2007). The quality of this human encounter depends again on how we perceive the person who we believe needs to be cared for. In a nursing context, Martinsen (2003) formulated the following question that we believe is fundamental in the search for overcoming perceived tension between strangeness and sameness – self and other: 'How do we (as nurses) take care of the person's eternal meaning, the individual's unending worth – independent of what the individual is capable of, can be useful for or can achieve? Can I bear to see the other as other, and yet not as fundamentally different from myself?' (p. 3).

In Martin Buber's (1970) seminal exploration of how human beings relate to and experience the world, he argued that the oscillation between self and other enables absolute relation – the experience of overcoming strangeness and otherness; towards an experience of sameness, 'you'. Likewise, Noddings (2012) differentiated between assumed needs and the expressed needs of the cared-for. Depending on which of these is looked for, the carer is either drawn towards the person and, however brief, moved to act on their behalf or, with an emphasis on assumed needs, withdrawn from meaningful connection by the prescribed requirements of the institution or governing rules. Of course, those who have experience of the realities of everyday care will appreciate that we, as practitioners, are often placed within this tension field of competing demands (Rothuizen and Harbo, 2017). Here, it is a matter of maintaining the caring relationship and, often through conflict, balancing the needs of the person and those of the organisations and regulatory bodies we operate in. It is, we believe, precisely this ability to enter into conflict between competing demands and, through the medium of authentic encounter, act as skilled facilitator between the assumed and expressed needs of the person in need of care that empowerment is transformed from rhetoric into reality.

> The relationship between carer and child (or person) is characterised by mutuality, defined here as the respectful give and take between and among persons. Mutuality is not merely a technique or attitude; it is a practice that embodies the value of interaction and understanding as opposed to isolation and alienation. (Jackson, 2019, p. 177)

Solomon (2012) spoke of two distinct ways of understanding identity and perceiving the other we encounter. The first, *vertical identity*, is informed by the circumstance of birth, heredity, race, religion, traditions, expectations of family and friends. This identity gives a feeling of belonging, security, stability and certainty. However, this identity can also become a stifling habit of conforming to expectations and can be a role or a mask that covers up one's own truth and individuality. The second, *horizontal identity*, is informed by everything that makes us different, standing out, not fitting in; be it disability, mental health disorder, or simply rebelling against the perceived norms of society. If we, as everyday care practitioners, only encounter someone in their vertical identity, we will not be able to move beyond an outer appearance of illness, deficit and strangeness. In the horizontal identity we encounter that which is unique to the individual but also that which connects us. Contemporary life is characterised by the disintegration of traditional structures of outer authority that informed and gave stability to social relations and is accompanied by increasing moral uncertainty. Therefore, it makes sense that those working across complex domains of care practice would reach for external guidance to inform decisions. However, in order to meet the unexpected beauty or pain – the challenge of the other, we need to have the willingness, even courage, to be open to uncertainty and reach beyond the safety of vertical identities into a realm where it is possible to meet the actual needs of the other.

Returning to the Nordic care tradition, in the essay *Seeing with the heart's eye*, Martinsen (2011, p. 18) distinguished between perceiving and recording as pivotal to *who* we encounter. When we record, we differentiate within narrow margins of existing frameworks. The recording eye, on the one hand, reduces the person to deficits, clinical signs, victim or villain, and fails to capture the living, subjective human entity that lives in interdependence with us. From this standpoint, the danger of such a reductionist approach is that we, as carer, become vulnerable to indifference, take on the mantle of disinterested observer and fail to recognise the expressed needs described earlier. The perceiving eye, on the other hand, enables an openness to the world and the other; one in which sensations and emotions work together in harmony. In this light, the practitioner is transformed from the neutral stance to one in

which they are emotionally active, engaged and able to grasp the expressed needs of the person requiring care. These thoughts are remarkably similar to those formulated by Schwen (2019) as the *economic* and *dialogue* approaches referred to earlier.

Broadly speaking, these two approaches can be described as either a deficit- or a strength-based approach. In the former, we only see the person in the light of deficiency, difference and in need of treatment or protection. In the latter, we see the person first, the true spiritual self in their unique manifestation as whole person; not lacking something or ill but having additional challenges and needs that make them different but not inferior. In this context, we can take care of the person's unending worth – independent of what the person is capable of and, though other, not as fundamentally different. It is of course initially important to experience the 'otherness' of the person we encounter or there is the danger of reducing the person to simply an extension of our self; of our own self-development. However, the capacity for self-development does not arise from an act of the other but, rather, from the caring encounter itself. This is an important point because if we were only to see the other as similar to us, a narcissistic extension of our caring, the danger of sentimental emotional attachment will override the more necessary requirement of 'altruistic care virtue' (Gastmans et al., 1998, p. 53). However, once the other is *seen*, the experience of strangeness, of otherness, is overcome and we are called to meet the other in mutual recognition of our shared humanity.

In the context of everyday care, this could mean putting an emphasis on the well-being of the other person, rather than on having to achieve expected outcomes. Is it, for example, more important to support a person with anxiety and a learning disability to complete a set task as quickly as possible, or to accept that this person needs to feel relaxed and to act without pressure in their own time, which can lead to a sense of achievement and pride? In order to be able to shape this space of action in collaboration with each other it is imperative to ask oneself what motivates *my* action and *my* attitude? Is it the fear of missing a target, professional pride and ambition, or the loving concern for the well-being of and respect for the other individual?

Facilitating encounters through 'difficult love'

The literature identifies many ingredients of meaningful encounters in everyday care, such as trust, compassion, power, presence and freedom, that are often explored as sources for human encounters. Although we readily recognise all of these as viable foundations, we have chosen to focus on *love* as an important source for human encounter. We do so to some extent because it interests us and, in large part because from our experience of everyday care we value this as an essential support for enabling true encounter.

Within the last decade, particularly in the fields of social care and residential child care, there has been a renewed interest in exploring love in care. Explorations around love have highlighted a renewed confidence to challenge professional mistrust in this area (Thrana, 2016), and Little (2016) pointed to love as enabling the practitioner to model risk and embrace vulnerability in ways that move critical self-awareness beyond mere rhetoric. However, talking about love in professional caring contexts can create unease (Vincent, 2016). In our experience, in other health, education and social care contexts, unlike the concept of hope which is increasingly recognised as central to mental health care, love is rarely spoken about. When love is part of the professional discourse it tends to be in relation to when nurses or teachers are struck off the register for forming inappropriate sexual relations with patients and pupils, or highlighted in connection with good parenting and infant brain development (Gerhardt, 2014).

If we retreat a little to a time before our recent collective inability to champion love in care, we can of course see that love has always been front and centre of caring theory and constructs. Macmurray (1961), for example, said that the caring relationship was not simply a sense of duty but was an ethic of love. Likewise, Martinsen (2003) detailed love as an ethical demand and Herman Nohl, a pivotal early figure in the development of social pedagogy, emphasised the role of love in relationships that nurture self-efficacy (Hämäläinen, 2003). There are, of course, many forms of love. Here, we do not mean sentimental notions of emotional attachment, nor sexual love, nor do we equate the type of love we explore with parental or sisterly love.

In contrast to sentimental love, or what Solomon (2012) called easy love – love based upon the vertical identity of someone who fits nicely into our expectations, our shared interests and values – 'difficult love' is something that needs to be developed over a series of often challenging encounters. This is similar to what (Garfat et al., 2018) termed 'hanging in', referring to the need to still be there when things seem too difficult or intolerable. In relation to physical restraint, Steckley and Kendrick (2008) also highlighted the image of 'holding on' while 'hanging in' resonating with ideas linked to the need for difficult love to overcome moments of extreme challenge. From experience, we have both had to engage in moments of physical restraint and, while we do not at all advocate a pervasive positive image of such practice, we have on occasion experienced those in our care who have benefited from human containment and the perception, on behalf of the cared-for person, that we did not shy away from difficulty or the need to 'hang in'. We have in fact been told on occasion years after the individual had left our care that they had appreciated our physical engagement and could respect and trust us for it. In contrast, our more recent experience of rapid tranquilisation or ongoing use of psychopharmacology (of course in certain scenarios unavoidable), although seemingly more sanitised, has not led to the same human experience of engaging in difficult love. These forms of clinical encounters run the risk of moving away from our image of everyday care and straying further into territories of treatment and sterilised control. Furthermore, in our experience, it is rare that those in our care display challenging behaviour, and instead we have understood this as relationship seeking requiring a response that is intimate, not distanced. It is incredibly challenging to meet those who kick, spit at, or call us names with love. However, it is not so much a question of maintaining human engagement in these situations with 'liking' someone, rather, it is to maintain the image of that person's inimitable humanity. Here, having experienced a prior mutual recognition through meaningful encounters can support this task.

Linked to perceiving the horizontal identity, difficult love involves entering into uncertainty and strangeness. Courage on behalf of the care practitioner is central and, often, includes the ability to let go of care plans and external directions that seek to achieve best practice. Difficult love enables encounters that are based upon mutual exchange of, not what is outwardly similar but, rather, allows for difference that strengthens the unfolding of both carer's and cared-for's space of action.

Jan Göschel (2019), referring to Solomon (2012), captured the essence of this difficult love and its support of encounter in the following statement:

> Through this deep acceptance which must be developed when the easy love, which is based on unproblematic, shared vertical identity is not possible, although the relationship is still maintained, a new form of love – difficult love is developed. This process demands a transformation – not of the loved person, but of the one who loves. Not – you must change so that I can love you; but I change because I love you although you are a stranger to me. The process which begins when the strange is tolerated, held in relationship and, more and more deeply accepted, is a process of spiritual development akin to an initiation. It leads to a sacramental, holy encounter of I to I. This holy space remains unattainable to easy love if it is not transformed. (p. 31, authors' translation)

Sharing the life-space

From a social pedagogical perspective, the arena in which everyday care is concretely realised is in the everyday interactions within the life-space that carer and cared-for inhabit. Facilitating moments of encounter and then being able to perceive the person in all their otherness, yet sameness, requires skill, motivation and courage. This very subtle process needs the right environment and space to unfold and lead to positive experiences for all concerned. As highlighted previously, true human encounter – the moment when individuals can perceive and meet each other on the level of shared humanity – can be seen as such a space where being together, without set agenda or expectation of outcome, can create an atmosphere of trust and simply enjoying each other's company. This can include a cup of tea, watching TV, or sharing an activity such as baking, walking, observing nature, greeting each other, or engaging in arts and crafts. Fulcher (2003) described how *rituals of encounter* – the notion that encounters occur over rituals of everyday life, are powerful symbols ascribed to the experience of giving and receiving care. In the language of social pedagogy this is called the 'common third'. Through such an approach, social

pedagogues vacate the 'expert' space and inhabit, as skilled facilitators, the *life-world* of those who need everyday care (Grunwald and Thiersch, 2009).

In such moments, *having a relationship*: carer and cared-for, teacher and pupil, nurse and patient; changes into *being in relation* within a shared life-space of everyday events. This allows for the nurse, teacher, therapist or social worker to step out of their role and to enable rather than to direct what is happening. Within the life-space, rhythms and rituals supersede interventions and care plans, enabling greater meaningful participation and belonging (Eichsteller and Holthoff, 2011). This, again, calls for presence of mind, creativity and courage to deal with the unexpected and enter realms of uncertainty and strangeness as the process and outcome might be very different to what was expected or planned. In the context of everyday care, the ability to let go and be present in the moment becomes key.

Engaging with people through a common activity in the life-space enables us to experience spirituality and encounter as actively integrated and manifest in moments of everyday care practice. Such encounters are created in which each individual has the opportunity to contribute in their own unique way: motivated by the needs of others; united and supported by social and shared cultural activities and cooperation: 'Being in relationship means we have what it takes to remain open and responsive in conditions where most mortals, and professionals, quickly distance themselves and become objective and look for the external fix' (Fewster, 2004, p. 3).

Although we have focused our attention on the person-to-person encounter, all of this can be even more powerful if done together with others – if people can come together in community. This common aim of creating meaningful activity within shared life-spaces can facilitate a coming-together of individuals who want to work with and encounter each other to bring ideas into practical life; into everyday care practice. Here, the potential to celebrate such activity in a group care context would be a welcome challenge to the current individualising context of care that tends to avoid notions of shared community experience.

Conclusion

In everyday care, the caring relation is developed through a series of encounters that begins as asymmetric (care directed to the other, for the other) but, over time, sees an oscillation between 'self' and 'other' that uncovers both 'sameness' and 'strangeness' in equal measure. This interplay, if facilitated and nurtured, can lead to a mutual spiritual experience of growth, meaning and purpose. The everyday care practitioner requires great awareness of the quality of these encounters in order to utilise these moments and carry the mutual recognition of this experience of the spiritual essence and positive potential of the other into other situations which might include conflict, aggression and/or frustration. The memory of these positive encounters can be a source of strength and confidence in the ability for conflict resolution. We believe that the avoidance of conflict and attempts to have recipes to keep life safe and predictable, avoiding pain and difficulty, actually negate the respect for the individual and their ability to deal with challenges in their lives. Everyday care is, by nature, intuitive and spontaneous, requiring complex navigation across situations of care without fixed recipes, and is cultivated through a series of true, human encounters.

Nadolny's words, used at the beginning of this article, can be understood as summing up the complexity of everyday care and the role of human encounter; a journey into the unknown where freedom to act according to the moment is needed, as well as the 'slavery' of prearranged plans. The success of this journey depends on the ability to strike a balance between the two and on the courage to take the right action at the right time.

Author biographies

Sebastian Monteux is a registered mental health nurse and lecturer in mental health nursing at Abertay University. He was born and grew up in the Camphill Schools, Aberdeen, and has previously worked in Scotland and the Netherlands in the NHS, in the fields of local authority residential child care, adult social care and learning disability, and trained as a Steiner Waldorf School class-teacher.

Angelika Monteux – now retired – came to the Camphill Schools in Aberdeen in 1973 after having completed a degree in education in Germany. She has extensive experience of teaching children with

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Declarations and conflict of interests

The authors declare no conflict of interests with this work.

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