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Love as a Continuing Practice Theory

—A Pre-Empirical Middle-Range Theory of Relational Continuity through Illness, Caregiving, and Bereavement

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Abstract

Illness, caregiving, separation, and death can disrupt valued relationships without ending their influence. Existing theories of continuing bonds, meaning reconstruction, caregiver stress, and hope illuminate aspects of adaptation, but they do not specify how these processes may combine to transform love into sustained relational and ethical practice. This paper introduces Love as a Continuing Practice Theory (LCPT), a pre-empirical middle-range theory of relational continuity through serious illness, caregiving, and bereavement. LCPT proposes a recursive pathway in which disruption generates grief and uncertainty, while compassionate presence and emotional permission foster relational safety. Relational safety may enable reconstructed connection, restored capacity, and adaptive hope, which can develop in parallel, in varying orders, and through mutually reinforcing relationships. Their convergence is expected to strengthen enacted legacy, in which valued aspects of the relationship guide present conduct, and transmitted love, in which caring practices are taken up by others. Contextual conditions influence whether continued connection is adaptive, neutral, distressing, or unsafe. LCPT integrates established constructs into a falsifiable process model proposing conditions under which relational continuity may become adaptive and transmissible. The paper defines the constructs, advances testable propositions, identifies preliminary empirical referents, and outlines qualitative, measurement, and longitudinal research. Pending empirical evaluation, LCPT is offered as a critical heuristic rather than a prescriptive intervention.

Keywords

Bereavement, Caregiving, Continuing Bonds, Grief, Meaning Reconstruction, Middle-Range Theory

1. Introduction

Relational disruption changes what people can do with and for one another. A cure may become impossible, familiar roles may collapse, physical presence may end, and anticipated futures may no longer be attainable. Yet relationships may continue through memory, internalized values, ritual, storytelling, and action. Continuing-bonds scholarship challenged detachment-based accounts of grief by showing that an enduring relationship with the deceased may support adaptation, although the form and function of the bond matter [1] [2]. Meaning-reconstruction scholarship likewise positions sense-making, identity change, and benefit finding as central processes after loss [3]-[5]. The Dual Process Model adds oscillation between loss-oriented and restoration-oriented coping [6], while caregiving research identifies burden and support as determinants of sustained capacity [7] [8]. Hope theory contributes the distinction between valued goals, workable pathways, and agency [9]. LCPT integrates these domains into a single, testable account centred on love as continuing practice.

The purpose of this paper is to define LCPT, specify its assumptions and constructs, state directional relationships, distinguish its contribution from adjacent perspectives, and establish a research programme through which the theory can be refined, challenged, or rejected. In nursing, a useful middle-range theory should connect a bounded set of concepts and propositions to observable phenomena without claiming universal scope [10] [11]. LCPT is therefore broader than a single intervention but narrower than a grand theory, and it is intended to generate research across serious illness, active caregiving, separation, and bereavement.

2. Theoretical Foundations and Distinct Contribution

LCPT is a synthesis and extension rather than a claim that continuing relational influence is newly discovered. Continuing-bonds theory established that adaptive grieving need not require severing connection [1], but later integration showed that bonds vary in content, context, and consequences [2]. Meaning reconstruction explains how people rebuild identity and world assumptions after loss [3]-[5]. The Dual Process Model explains oscillation between confronting loss and engaging restoration [6]. Phenomenological nursing accounts position caring as a way of being involved in what matters [12], while stress-process research explains how demands and resources shape caregiver burden [7] [8]. Hope theory identifies pathways and agency as mechanisms connecting goals to action [9]. LCPT's distinct contribution is to configure these insights around *love as continuing practice* and to specify relational safety, reciprocal care, adaptive hope, enacted legacy, and social transmission as linked mechanisms. Conceptual work advances nursing knowledge only when it moves beyond definition toward explicit theoretical relationships and empirical consequences [11] [13].

Integration-Specific Prediction

Love as a Continuing Practice Theory (LCPT) predicts that a comforting, meaningfully reconstructed bond will most strongly foster values-congruent action and social transmission when relational safety enables reconstructive work, reciprocal care preserves capacity, and adaptive hope directs energy toward attainable goals. These processes may develop in parallel, at different rates, or in varying orders; the prediction concerns their coordinated operation rather than a required sequence. Accordingly, their combined and mutually reinforcing configuration should predict future change in enacted legacy and social transmission more strongly than continuing-bond quality, meaning coherence, caregiver resources, or hope considered separately. Because this prediction depends on relationships among LCPT's components, it follows from the theory's integration rather than from any single component theory. It also provides a direct test of proposition P10: LCPT demonstrates incremental value only if the integrated pathway explains additional variance beyond established measures of grief severity, social support, caregiver burden, hope, and continuing-bond frequency. If it does not, the claim that LCPT constitutes a distinct theory is weakened.

3. Theory-Development Approach

LCPT's earliest conceptual roots emerged more than 20 years ago through the author's children's book *Daddy's Smile*. The author's nursing experience at The Hospital for Sick Children early in her career and her mother's example of expressing love through care, generosity, and service informed the book's concepts. Themes first explored in that work—and later developed in reflective books addressing caregiving and loss—included enduring connection, remembrance, compassionate presence, hope, and the ways love continues to shape action after illness, separation, or death. These books remain unpublished and are currently being prepared for publication. Their recurring themes provided the initial experiential and narrative foundation for the theory. Theory development then proceeded through a focused examination of established scholarship to identify concepts that could clarify, qualify, and test these early insights. Source theories were selected purposively for their relevance to LCPT's scope, the conceptual clarity and empirical tractability of their constructs, and their complementary treatment of relational continuity, interpretation, coping, caregiving capacity, and future-directed action. Continuing bonds and meaning reconstruction informed reconstructed connection; the Dual Process Model informed the theory's recursive, non-stage-bound pattern of adaptation; phenomenological caring and stress-process perspectives informed compassionate presence, reciprocal care, and restored capacity; and hope theory informed the movement from disrupted expectations toward attainable goals, pathways, and agency. LCPT links these constructs as provisional relationships rather than established causal sequences, with relational safety proposed as an enabling condition and enacted legacy and social transmission proposed as downstream expressions of continuing practice.

4. Scope, Assumptions, and Boundary Conditions

LCPT applies when a valued relationship is altered by serious illness, progressive decline, caregiving strain, separation, or death. It assumes that bonds shape identity and action; that love can be expressed behaviourally as well as emotionally; that adaptation is dynamic rather than stage-bound; and that receiving care can be necessary for sustainable caring [6] [12]. Cultural, spiritual, relational, and material contexts shape what counts as meaningful continuity. The theory does not presume that every bond should be maintained, that intense bonds are intrinsically beneficial, or that reconciliation is always possible. In disenfranchised or ambiguous loss, social recognition and certainty may be constrained [14] [15]. Where a relationship was harmful, coercive, or unsafe, adaptive practice may require distance, boundary setting, or a legacy defined by protection and change.

Central Theoretical Claim

Love may persist adaptively when people can acknowledge disruption and experience sufficient relational safety. From this foundation, reconstructed connection, restored capacity, and adaptive hope may develop in parallel, at different rates, or in varying orders. Each process may support the enactment and transmission of the relationship's sustaining values in present life, and their convergence is expected to strengthen these outcomes. These processes may recur as circumstances and meanings change.

5. Conceptual Model

The proposed pathway is: relational disruption → relational safety → reconstructed connection, restored capacity, and adaptive hope → enacted legacy and transmitted love. The arrows represent relationships to be tested rather than demonstrated clinical effects or a required stage sequence. Compassionate presence and emotional permission are hypothesized to foster relational safety, which may facilitate access to the three intermediate processes. Reconstructed connection, supported by continuing bonds and meaning-making practices; restored capacity, supported by reciprocal care; and adaptive hope, directed toward attainable forms of comfort, purpose, belonging, reconciliation, or contribution, may emerge in parallel, at different rates, or in varying orders. The theory further proposes that they may reinforce one another: reconstructed connection may clarify valued goals, restored capacity may make goal pursuit feasible, and adaptive hope may motivate continued meaning-making and help-seeking. No single intermediate process is assumed to be universally necessary, although their convergence is hypothesized to strengthen enactment. Enacted legacy refers to the translation of internalized values into observable action, and transmitted love refers to the uptake of those practices by others. The model also proposes recursive feedback: enacted legacy and transmitted love may contribute to renewed relational safety, meaning, belonging, and hope, while later stressors may reactivate grief.

6. Visual Model of the Framework

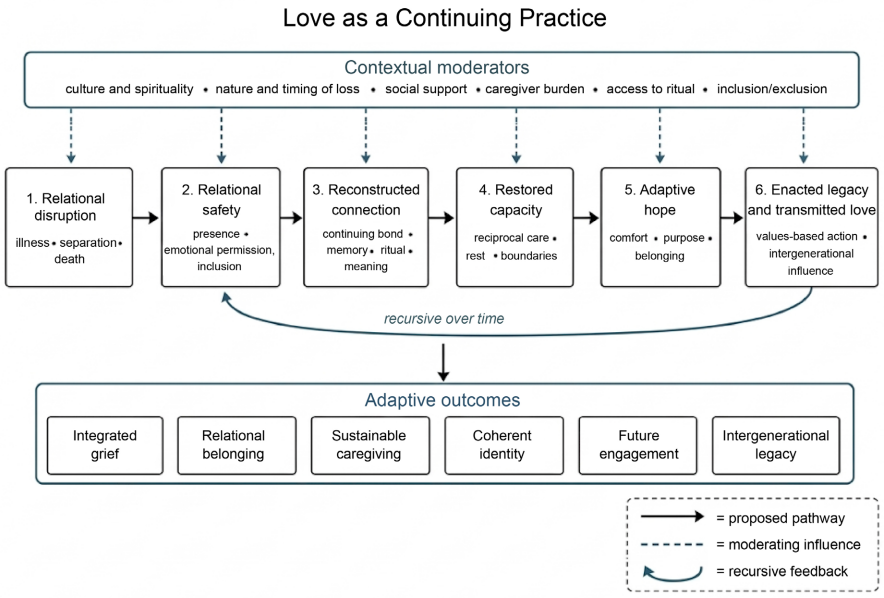


Figure 1. Love as a continuing practice: proposed pathways, contextual moderators, recursive feedback, and adaptive outcomes. Note. Solid arrows represent the proposed pathway; dashed arrows represent moderating influences; and the curved arrow represents recursive feedback over time. The model is conceptual and does not imply that adaptation is linear or uniform across individuals or contexts.

7. Core Constructs

To better understand **Figure 1**, these definitions provide additional context. Relational disruption is a change that threatens an established bond, role, identity, or expected future. Compassionate presence is attentive, accepting companionship that privileges reliable presence over perfect performance. Emotional permission is freedom to experience and express mixed emotions without shame or externally imposed timetables. Relational safety is the resulting perception that connection, disclosure, and emotional expression can occur without judgment, abandonment, coercion, or pressure to adapt on a prescribed schedule. Continuing bond is an enduring inner or social relationship maintained through memory, story, symbol, value, ritual, or choice. Meaning-making comprises practices that place disruption within a personally and culturally intelligible account. Reconstructed connection is the reorganization of the bond into a form compatible with changed reality. Reciprocal care is a pattern in which caregiving is accompanied by receiving help, rest, recognition, and protection from self-erasure. Restored capacity is the retained or regained ability to participate in caregiving and valued life activities without unsustainable depletion. Adaptive hope is a truthful, flexible orientation toward attainable goods when original outcomes are no longer possible. Enacted legacy is the embodiment of a loved person's sustaining values in present conduct. Transmitted love is the uptake or repetition of those caring practices by others.

8. Preliminary Operationalization

Table 1 translates selected LCPT constructs into provisional indicators and potential data sources. Relational safety, reconstructed connection, and restored capacity are not yet represented as separate rows; early construct refinement should determine whether they require distinct measures or can be validly derived from indicators of compassionate presence, emotional permission, continuing bonds, meaning-making, reciprocal care, and functioning. The entries are intended to guide feasibility testing rather than prescribe a finalized measurement instrument. Indicators are provisional empirical referents, not a validated scale; early studies should combine interviews, behavioural descriptions, care-network maps, and self-report, distinguish bond frequency, bond quality, and bond-related distress, and test whether the proposed constructs show discriminant validity.

Table 1. Preliminary operationalization of love as a continuing practice theory constructs.

Construct	Provisional indicators and example item	Potential data source
Relational disruption	Type, timing, severity, role or routine change, uncertainty, and functional interference. Example: "This change has disrupted my sense of who I am and what I expected for the future."	Event profile; severity rating; functioning log; interview.
Continuing bond	Remembering, inner dialogue, storytelling, ritual, guidance, preserved values, and whether the bond is comforting, distressing, or mixed. Example: "My connection with this person continues to guide my choices."	Self-report subscale; ritual or memory log; qualitative interview; multidimensional continuing-bonds measure.
Compassionate presence	Availability, attentive listening, nonjudgment, reliability, supportive contact, and reduced loneliness. Example: "Someone stays present with me without trying to fix or rush my experience."	Recipient and supporter ratings; contact frequency; structured observation.
Emotional permission	Ability to name mixed emotions, express grief, experience acceptance, and reduce shame or suppression. Example: "I can express sadness, anger, relief, doubt, or hope without feeling that I am grieving incorrectly."	Self-report; emotion diary; interview coding.
Meaning-making practices	Storytelling, reflection, ritual, forgiveness, spiritual exploration, benefit finding, sense-making, and narrative coherence. Example: "I can place this loss or change within a story that has personal meaning, even if some questions remain."	Self-report; narrative interview; ritual log; coherence coding.
Reciprocal care	Help requested and received, respite, boundaries, fairness of support, unmet needs, strain, and capacity over time. Example: "I can receive care and rest without believing that I am failing the person I love."	Self-report; respite records; care-network map; caregiver-burden measure.
Adaptive hope	Realistic goal adjustment, attainable goods, future orientation, pathways, agency, and flexibility. Example: "Even when the original outcome is no longer possible, I can identify meaningful possibilities ahead."	Self-report; goal inventory; interview; agency and pathways measure.
Enacted legacy	Values-based actions, helping, mentoring, hospitality, service, traditions, and alignment between inherited values and behaviour. Example: "I honour this person by putting what they taught me into practice."	Self-report; behavioural log; family or community reports; value-domain coding.
Transmitted love	People reached, repetition of caring practices, intergenerational storytelling, continued traditions, and perceived ripple effects. Example: "The care I received influences how people in my family or community now care for others."	Social-network mapping; family interview; observation; participation records.

Candidate outcomes for empirical testing include integrated grief, relational belonging, sustainable caregiving, coherent identity, future engagement, and intergenerational legacy. Measurement should be longitudinal and interpreted relative to personal baseline rather than a universal timetable. Cultural and spiritual context, relationship quality, anticipated or sudden disruption, time since disruption, caregiving intensity, social support, inclusion, and access to ritual should be examined as potential moderators.

9. Theoretical Propositions

9.1. P1—Relational-Safety Mechanism

At comparable levels of disruption severity, compassionate presence and emotional permission will prospectively predict lower perceived isolation. This association will be partially mediated by greater relational safety, such that compassionate presence and emotional permission increase the perception that connection and emotional expression can occur without judgment, abandonment, coercion, or externally imposed timetables, which in turn reduces perceived isolation.

9.2. P2—Access to Reconstructive Work

Relational safety at an earlier time point will predict subsequent engagement in meaning-making and the formation of a continuing bond experienced as more comforting or integrated, after accounting for baseline distress and social support.

9.3. P3—Conditional Effect of Continuing Bonds

Continuing-bond intensity alone will not predict adaptation. Its association with identity coherence, functioning, and grief-related distress will depend on bond quality and meaning-making: comforting or integrated bonds accompanied by greater meaning coherence will predict better outcomes, whereas conflictual, compulsive, or fear-based bonds will predict neutral or adverse outcomes.

9.4. P4—Reciprocal-Care Moderation

Caregiving demands will predict declining capacity and increasing burden. Reciprocal care—reflected in respite, practical assistance, recognition, and permission to set boundaries—will moderate these associations, such that the effects of high objective demand on capacity and burden will be weaker at higher levels of reciprocal care. Reciprocal care is therefore expected to buffer, rather than erase, the effects of high objective demand [7] [8].

9.5. P5—Adaptive-Hope Mediation and Conditionality

Acceptance that an original outcome is unattainable will predict subsequent renewed engagement in valued activity indirectly through greater adaptive hope, defined as a flexible orientation toward attainable goals, workable pathways, and sufficient agency. The indirect effect will be stronger when this adaptive-hope configuration is more fully developed and weaker when goals, pathways, or agency

are constrained. Adaptive hope is therefore the mediator linking acceptance to renewed engagement, while contextual barriers to goal identification, pathway generation, or agency are expected to weaken that indirect effect. The mediated relationship will be stronger for adaptive hope than for undifferentiated optimism [9].

9.6. P5a—Parallel and Mutually Reinforcing Development

Following relational safety, reconstructed connection, restored capacity, and adaptive hope may develop concurrently or in different orders rather than as required stages. Across time, reconstructed connection will predict greater adaptive hope by clarifying valued and attainable goals; restored capacity will predict greater adaptive hope and valued action by making goal pursuit feasible; and adaptive hope will predict further reconstructed connection and restored capacity by motivating meaning-making, help-seeking, and engagement in valued activity. Each process will also retain an independent association with later valued action.

9.7. P6—Enacted-Legacy Pathway

Meaning coherence and adaptive hope will independently and jointly predict later values-congruent action inspired by the relationship, beyond time since disruption, relationship closeness, baseline religiosity or spirituality, and general prosocial orientation.

9.8. P7—Social-Transmission Pathway

Enacted legacy will predict subsequent uptake of specific caring practices by members of the person's relational network. This association will be mediated by the visibility, narration, and repeatability of the practice rather than by private remembrance alone.

9.9. P8—Recursive Adaptation

Enacted legacy and social transmission will feed back into belonging, identity coherence, and adaptive hope over time; later anniversaries, health changes, or relational stressors may reactivate disruption and restart parts of the pathway. A reciprocal longitudinal model should fit the data better than a strictly linear stage model.

9.10. P9—Contextual Moderation

Social exclusion, shame, unsupported burden, material insecurity, unsafe relationships, and restricted access to culturally meaningful practices will attenuate the proposed pathways. Social recognition, resource access, and culturally congruent ritual will strengthen them [14] [15].

9.11. P10—Discriminant Prediction

If LCPT adds explanatory value, its pathway constructs will account for variance

in identity coherence, sustainable caregiving, valued action, and relational transmission beyond established measures of grief severity, social support, caregiver burden, hope, and continuing-bond frequency. Failure to show incremental validity would count against the theory's distinctiveness.

10. Research Agenda

10.1. Phase 1: Conceptual Refinement

Conduct qualitative interviews and focus groups with bereaved people, caregivers, clinicians, spiritual-care providers, and community members across diverse cultural contexts. Use findings to refine definitions, identify omitted pathways, and examine whether reconstructed connection, restored capacity, and adaptive hope are experienced as parallel, variably ordered, mutually reinforcing, or context dependent.

10.2. Phase 2: Measurement Development

Generate item pools for each construct, establish content validity, conduct cognitive testing, and examine factor structure, reliability, convergent validity, discriminant validity, and measurement invariance. Existing measures may be used where conceptually aligned; new measures should be developed only when current instruments cannot represent LCPT's constructs.

10.3. Phase 3: Proposition Testing

Use prospective longitudinal designs and multilevel or structural models to examine mediation, moderation, reciprocal effects, and change over time. Compare a fixed-sequence model, a parallel-process model, a reciprocal cross-lagged model, and models based on the component theories alone. Test whether LCPT's integrated configuration explains additional variance in reconstructed connection, restored capacity, adaptive hope, enacted legacy, and transmitted love beyond baseline distress, social support, caregiver burden, hope, and continuing-bond frequency. Compare illness, active caregiving, recent bereavement, and longer-term adaptation cohorts. Intervention studies should follow only after construct validity, temporal ordering, and incremental explanatory value are established.

11. Implications for Practice and Education

Before empirical validation, LCPT should function as a reflective heuristic rather than a prescriptive protocol. It invites practitioners to assess whether people have safe companionship, permission for mixed emotions, opportunities for culturally meaningful remembrance, practical support for reciprocal care, and room to redefine hope. It also cautions against equating adaptation with forgetting, self-sacrifice, forced forgiveness, or premature positivity. Education may use the model to connect relational care, caregiver support, grief literacy, and legacy-oriented practice while maintaining clear distinctions between conceptual guidance and evidence-based intervention.

12. Clinical Relevance

Love as a Continuing Practice Theory conceptualizes love not solely as an emotion or an isolated caring act, but as a continuing relational practice through which compassionate presence and emotional permission may foster relational safety. Within clinical relationships, this safety may enable reconstructed connection, restored capacity, and adaptive hope as patients, families, and caregivers respond to serious illness, caregiving strain, separation, and bereavement. The theory therefore offers nurses a structured language for recognizing and reflecting on relational processes that may support values-congruent action without assuming that all relationships should be maintained or that adaptation follows a uniform pathway.

In healthcare environments shaped by high patient acuity, workforce pressures, and technological demands, LCPT can orient reflection toward the relational conditions of nursing practice. Its constructs may help nurses examine whether patients, families, and caregivers experience safe companionship, permission for mixed emotions, practical support, culturally meaningful continuity, and realistic possibilities for hope. These questions may be relevant across acute care, community health, long-term care, mental health, palliative care, and rural and remote settings. Application in Indigenous health and other culturally distinct contexts requires partnership, cultural safety, and local interpretation rather than assuming that LCPT's constructs have equivalent meanings or relationships across communities.

At its current stage, LCPT may support clinical reflection, grief- and caregiver-informed assessment, education, and the development of research questions rather than direct clinical intervention. Its use may help clinicians identify candidate relational conditions and processes for further assessment while avoiding prescriptive expectations about remembrance, reconciliation, hope, legacy, or continued connection. Intervention development should proceed only after the constructs show cultural relevance, discriminant validity, temporal ordering, and incremental explanatory value. Research is also required before concluding that LCPT improves patient and family experiences or enhances professional meaning and resilience among nurses.

13. Limitations

LCPT has several substantive and methodological limitations. First, it is pre-empirical: the sequencing, mediation, moderation, and feedback claims have not been tested, and the apparent coherence of the model may reflect conceptual arrangement rather than causal structure. Second, most constructs overlap with established theories. Unless LCPT demonstrates discriminant and incremental validity beyond continuing bonds, meaning reconstruction, the Dual Process Model, caregiver stress models, and hope theory, it risks redescribing rather than explaining adaptation [2] [5] [6] [9].

Third, *love* is morally and culturally saturated. Its meanings may not translate

cleanly across languages, kinship systems, spiritual traditions, or relationships in which duty, obligation, interdependence, or collective identity are more salient than individual affection. Treating love as universally benevolent could obscure ambivalence, exploitation, coercive control, estrangement, or justified refusal of connection. The theory therefore requires participatory, cross-cultural concept refinement and explicit testing of measurement invariance; it should not make distance, forgiveness, ritual, or legacy into normative expectations [14] [15].

Fourth, reverse causality and omitted-variable bias are serious threats. People with lower baseline distress, stronger social support, greater resources, secure attachment, better health, or higher dispositional hope may be more able to engage every proposed process. Self-report and shared-method variance could inflate associations, while selective recall may make enacted legacy appear more coherent than it was prospectively. Longitudinal, multi-informant, behavioural, and network data are therefore needed, with temporally separated measures and preregistered rival models.

Fifth, the pathway may not be invariant across anticipatory grief, sudden death, ambiguous loss, non-death separation, collective bereavement, dementia-related change, or active end-of-life caregiving. Material insecurity, racism, colonial disruption, migration, inaccessible services, and survival demands may limit opportunities for reflective meaning-making or ritual. Sampling only people willing to discuss love or legacy would create selection bias and underrepresent those whose adaptation involves silence or disengagement. Finally, positive outcomes such as benefit finding or transmission must not be used to romanticize suffering or imply that adversity is necessary for growth. Null, mixed, adverse, and ethically resistant cases are theoretically informative and should be retained rather than classified as failures to adapt.

14. Conclusion

Love as a Continuing Practice Theory proposes that relational adaptation may occur not by erasing attachment, but by reorganizing it through relational safety, meaning, reciprocal care, adaptive hope, and enacted legacy. Its potential contribution lies in making this configuration explicit, conditional, and falsifiable. The theory will be supported only if its constructs can be distinguished, its temporal and contextual predictions are replicated, and the full model explains outcomes beyond established alternatives. The next task is therefore not affirmation but disciplined inquiry: determining where LCPT fits, where it fails, whom it excludes, and whether it adds explanatory or practical value to nursing and bereavement scholarship.

Declaration of Generative AI Use

The author used a generative AI tool solely as an editorial aid for formatting and grammar review and for improving readability.

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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