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The meaning of nurse–patient intimacy in oncology care settings: From the nurse and patient perspective

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Oncology nursing;
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Intimacy;
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Phenomenology;
Social judgement

Summary
This paper reports the findings of a study exploring the meaning of nurse–patient intimacy in oncology care settings. An interpretive phenomenological design was adopted. A total of 23 oncology nurses and 30 oncology patients, from 3 hospitals, were interviewed between March 2005 and December 2005.
Three main themes emerged from the data: developing intimacy, experiencing intimacy and outcome of intimacy. Nurse–patient intimacy is revealed as a process, which begins when the nurse and patient first meet, with nurse empathy for the patient developing following the nurse's identification with the patient. This identification is influenced by the patient's characteristics and response to their cancer and its treatment. Reciprocal self-disclosure characterises the intimacy that develops in the context of the nurse assuming a 'professional friend' role in a homely atmosphere where care is delivered. The outcome of intimacy is satisfaction for the nurse, but also emotional effects. Peer support among nurses in sustaining intimacy with patients is also revealed.
Close relationships with patients appear central for oncology nurses in their caring role. Intimacy with patients follows identification. However, nurses' identification with patients is dependent on nurses' views of patients' characteristics, which reveal judgemental labelling of oncology patients, and suggests the role of patients in influencing the relationship that develops with nurses.

Introduction

The rationale for this study was a need to explore the experience of nurse–patient intimacy in oncology care settings. Discussions on nurse–patient intimacy are inextricably linked with the nurse–patient relationship. It is argued that oncology nurses become 'hooked' on nursing due to the connected relationships they have with patients (Fall-Dickson and Rose, 1999). There is, however, a lack of conceptual clarity of intimacy from a nursing perspective (Williams, 2001a). Timmerman (1991, p. 23) defined intimacy as, "a quality of a relationship in which the individuals must have reciprocal feelings of trust and emotional closeness toward each other and are able to openly communicate thoughts and feelings to each other". Reciprocity of trust, emotional closeness and self-disclosure are revealed as antecedents of intimacy (Timmerman, 1991). Self-disclosure of personal information is viewed as confirmation of the acknowledgement of interdependence and given with the expectation of understanding and acceptance (Kadner, 1994). The literature unremittingly implies that self-disclosure occurs with self-awareness. Dowrick (1991) suggests that intimacy begins with

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the self and links intimacy to self-expression. Henderson (2001) reports that the more self-reflexive the nurse, the more likely they are to appreciate emotional connection with their patients.

Dowling (2003) identified the attributes of intimacy to be self-disclosure, reciprocity and passivity, with related concepts identified as involvement, closeness and engagement. Williams (2001b) however, questions whether theoretical writings regarding intimacy in practice actually represent over-involvement. Morse (1991) describes the over-involved relationship as one where the patient and nurse mutually respect, trust and care for each other. The use of the term 'over-involvement', however, suggests a nurse who is not in control (Dowling, 2006).

Intimacy is also related to discussion on love and caring in nursing (Dowling, 2004). This viewpoint revolves around it being a mutual attempt of caring between the nurse and the patient. For caring to occur, both the nurse and patient must communicate openly with trust and respect for each other (Morse et al., 1990), and the nurse must engage with the patient (Morse et al., 1992). However, Dowling (2006) argues that nurses are encouraged to find what could be termed as a safe equilibrium and are expected to care with empathy and kindness but, at the same time, maintain a degree of emotional detachment. Dowling (2006) also argues that it is perhaps only nurses who are truly self-aware that can really engage in intimate relationships with their patients. However, self-awareness and knowledge of the self develops over time with experience. Moreover, the risks of self-disclosure appear greater if the nurse has not developed self-awareness. This issue is also closely related to how the nurse communicates with patients, which in turn affects the development of intimacy.

Purpose

The aim of the study was to explore the meaning of nurse–patient intimacy in oncology care settings.

Method

An interpretive phenomenological (also known as philosophical hermeneutics) design was chosen, with insights from the philosophy of the Phenomenologist, Gadamer (1975) utilised to guide the study process. Gadamer (1975) views the research interview as a dialogue between researcher and participant (Haggman-Laitila, 1999). Moreover, repeat interviewing of each nurse participant was adopted, which is espoused with Gadamerian phenomenology (Fleming et al., 2003). Finally, Gadamer asserts that pre-judgements or prejudices have a special importance in interpretation and strongly affect one's understanding. This resulted in an identification of the researcher's own personal pre-understandings on the topic of nurse–patient intimacy prior to interviewing the study participants.

Participants

The informants for this study were recruited from three centres offering oncology care in one Irish Health Service Executive area. Two centres were nurse-led and offered an outpatient day service to patients. The third was a Supra-Oncology regional centre, and both inpatients and outpatients study participants were included from this centre.

The sampling strategy employed with the recruitment of patients required the involvement of oncology nurse managers at the three sites. The study was discussed with each nurse manager and information leaflets were made available to be given to patients who met the study's inclusion criteria (those being, receiving treatment/completed treatment for cancer, aware of their diagnosis and possible prognosis, no evidence of serious cognitive impairment and able to give informed consent that they were willing to be tape-recorded and share their experiences). Thirty patients volunteered to be interviewed by the researcher (Table 1).

All oncology nurses in the three sites were provided written information on the study. In the early part of the study, nurses volunteered to be interviewed. However, theoretical sampling with nurses became evident about mid-way through the study, where the researcher actively sought to interview nurses in Clinical Nurse Specialist (CNS) roles. Earlier interviews with nurses in the outpatient day oncology units suggested that these CNSs might have had greater opportunities for intimacy with patients. Moreover, these nurse specialists play a central role in offering emotional and psychological support to cancer patients (Corner, 2002; Skilbeck and Payne, 2003). Twenty-three oncology nurses were interviewed (Table 2).

The voices of women feature strongly in the study, since the sample consisted of mainly women. It was not the intention of this study to focus mostly on the experience of women; however, all of the nurses interviewed were women. Eighteen of the patients interviewed were women, reflecting the number of breast cancer patients attending the day care services.

Table 1 Patient participants ($n = 30$).

Age range	42–80 years
Gender	Female ($n = 19$); male ($n = 11$)
Diagnoses	Breast cancer ($n = 18$); bowel cancer ($n = 5$); non-Hodgkin's lymphoma ($n = 3$); myeloma ($n = 2$); chronic lymphocytic leukaemia ($n = 1$); ovarian cancer ($n = 1$)

Table 2 Nurse participants ($n = 23$).

Gender	Female ($n = 23$)
Length of time qualified	6–27 years
Length of time in oncology nursing	2–15 years
Postgraduate qualification in oncology nursing	Higher diploma in oncology nursing ($n = 17$)
Designation	Staff nurse ($n = 10$); clinical nurse manager ($n = 2$); clinical nurse specialist ($n = 11$)