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Nurses' perceptions of facilitating genuineness in a nurse–patient relationship

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ABSTRACT

Background: Genuineness was highlighted as an important concept when nurses' perceptions of facilitating a therapeutic relationship were assessed in a study conducted in private general hospital wards. Training courses are mainly professionally orientated and little attention is given to genuineness, which is underpinned by values and influenced by culture and self-awareness. Reflection on patients' feelings enables mindfulness in the nurse–patient relationship, but nurses often act on instinct or rely on learned knowledge and skills. Despite the increased emphasis on virtue ethics and honest disclosure, hope is offered but nurses are often not honest with themselves or in their response to patients. This poses a challenge when genuineness is facilitated. In this article, nurses' perceptions of facilitating genuineness will be discussed.

Method: To assess nurses' genuineness, a quantitative, contextual, deductive and descriptive study was conducted. A purposive sample of nurses was taken from private general hospitals in Gauteng, South Africa. Nurses' (n = 181) perceptions of facilitating genuineness in a nurse–patient relationship were self-assessed on a five-point scale in a questionnaire.

Data analysis: Descriptive statistics and non-parametric statistical techniques were used. Specific hypotheses were tested to identify whether statistically significant differences in perceptions of facilitating genuineness existed between two or more groups.

Results: When groups were compared, statistically significant differences were identified in nurses' perceptions of facilitating genuineness with respect to age, years' experience as a nurse and qualifications. It is recommended that nurses' awareness of genuineness and its facilitation should involve learning through socialisation and self-awareness.

1. Background

The purpose of this article is to highlight the importance of nurses' awareness of and reflection on genuineness in the nurse–patient relationship, which was explored in an overarching research project (Van den Heever, 2012; Van den Heever, Poggenpoel, & Myburgh, 2013). As a theoretical framework, Carl Rogers' person-centred concepts of a therapeutic relationship and a systematic approach to the evaluation of interpersonal relationships (Aiken & Aiken, 1973, p. 865; Rogers, 1957, p. 100) were used. Psychological

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interventions tend to take the forms of facilitating, supporting and nurturing instead of teaching or controlling. During interactions with patients, nurses present themselves as being able to offer help, but they should also promote genuine interest in and respect for the patient; in other words, show that they genuinely care.

The reality today is that nurses are not always caring and genuine with themselves or with their patients in the nurse–patient relationship (Van den Heever, 2012, p. 67). Little attention is given to genuineness, and training courses are mainly professionally orientated (Torres-Rivera, Phan, Maddux, Wilbur, & Arredondo, 2006, p. 2). Knowledge is necessary, but not always sufficient to facilitate understanding and promote awareness of other people. The term "nurse" will thus be used inclusively in this paper to refer to all categories of staff (professional, enrolled, auxiliary nurses and care workers) who interacted with patients in private general hospitals at the time of the research study.

There are various conditions and contexts that can facilitate nurturing. One of the conditions in a hospital is relating to vulnerable patients. Within the theoretical context of genuine empathetic understanding and caring, patients' basic psychological needs of relatedness can either be nurtured or inhibited by what others say or how they respond to each other.

Nurses are expected to have knowledge and skills, but they also become aware of feelings and emotions when engaged in real interactions with patients. In a relationship, nurses facilitate, integrate and reflect on what patients say; however, Sidney Jourard in the 1960s and 1970s proclaimed that we camouflage our true being before others to protect ourselves against criticism or rejection. Nurses, according to Menzies-Lyth (1988, p. 90), would then, instead of letting anyone know how they really feel, use various coping mechanisms or avoid answering a question to protect and defend themselves from anxiety or to hide uncertainty (Scanlon, 2006, p. 325). Uncertainty can thus unfortunately inhibit facilitation and expression of feelings.

Although it is expected of them, it is not always possible for health care professionals to have all the answers, and nurses have often expressed their fear of not knowing what to say (Reed & Fitzgerald, 2005, p. 215). In most nurses' minds there seems to be a strong connection between being a good nurse and doing the "right thing" which supports the recent popularity of virtue ethics (Begley, 2008, p. 337). Rather than focussing only on the moral actions themselves, virtue ethics looks to the person's character as the foundation and source of ethical action (Smith & Godfrey, 2002, p. 301).

Professional, ethical and therapeutic boundaries are often blurred when nurses have to come physically close enough to the patient to offer care, but at the same time also have to maintain emotional distance. Patients and their families often express hopelessness. Vague and abstract responses from nurses then may offer some hope when a patient is in despair, but also hinder self-exploration and a trusting nurse–patient relationship (Frisch & Frisch, 2011, p. 102; Arnold & Boggs, 2011, p. 19; Gilbert, 2009, p. 45). Over-involvement on the other hand, with routine and administrative tasks or sarcastic humour for example, may be used by nurses to either avoid discussing the patient's fears or maintain the nurse–patient relationship at a superficial level (Van den Heever, 2012, p. 62; Poggenpoel, 1997, p. 29).

Awareness, reflection and genuineness seem to be interrelated and therefore, being reflective of patients' verbal and non-verbal messages nurses are also being mindful of their feelings. Mindfulness is an open and undivided awareness of current experiences both internally and externally in the here and now, rather than a cognitive approach to stimuli (Brown & Ryan, 2003, p. 822). Mindlessness, on the other hand, is when a person refuses to acknowledge or attend to a thought, emotion, motive or object of perception (Brown & Ryan, 2003, p. 823).

At times during the nurse–patient interaction, nurses act on instinct when they pick up non-verbal cues, as opposed to acting according to any learned methods. Awareness or intuition therefore is an application of self-awareness and human skills by a knowledgeable person who draws on experience and insight gained from maturity (Begley, 2008, p. 338; Scanlon, 2006, p. 328).

Most health professionals are taught to be polite, kind, pleasing, socially and professionally appropriate rather than to be genuine and congruent in their relationships with themselves and their patients. Facilitating genuineness involves learning through socialisation or experiential learning (Scanlon, 2006, p. 328) and is founded in the awareness and perception of each other in an open and trusting relationship (Bozarth, 2001, p. 1; Rogers, 1957, p. 95).

Honesty is often perceived as truth-telling. Practises among nurses and doctors have moved to more honest and truthful disclosure to patients, but truth-telling practises and preferences are to a certain extent a cultural artefact (Tuckett, 2004, p. 500). Then there is also the argument for or against telling the truth, which is mostly grounded in the ethical principles of the patient's autonomy and prevention of physical or psychological harm. Truth-telling and genuineness in the nurse–patient relationship is intrinsically good, and doing "good" is an ethical principle. An integral part of "doing good" in nursing, is to offer hope, yet the question still arises whether withholding the truth for the sake of having hope is detrimental or not to a trusting relationship.

According to Tuckett (2004), one ought to ask patients and their families what information they require, and to explore the cultural nature of the patient and the healthcare setting. In China, many families object to telling the truth therefore doctors and nurses seem to follow the wishes of what the family of their patients want to know (Tse, Chong, & Fok, 2003, p. 339). However, the majority of patients indicate that they want truthfulness and information about their illness which will enable them to manage their own uncertainty and allow them to make decisions for themselves (Epstein & Street, 2007; Tse et al., 2003, p. 339). Genuineness and truthfulness are virtues and characteristics which have long been perceived as being real and transparent, while honesty has been defined as truthfulness, authenticity, morality, integrity and trustworthiness (Begley, 2008, p. 337; Ashton, Lee, & Son, 2000, p. 360; Rogers, 1957). Genuineness and honesty are therefore consistent with constructive relationships.