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Abstract

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 twenty-three oncology nurses and thirty oncology patients, from three 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.

Key words. Oncology nursing; nurse-patient interaction; intimacy; empathy; phenomenology; social judgement.

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) 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" (p. 23). 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 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 & 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.

Data collection

All of the interviews were conducted by the researcher. Patients were asked if they wished to be interviewed in their homes, but all requested to be interviewed while in hospital for treatment. All nurses were interviewed in their work settings except one who volunteered to visit the researcher at a neutral venue.

Each nurse participant was interviewed twice by the researcher. The thirty oncology patients were interviewed once. Plans to repeat interview patients were abandoned early in the study due to deterioration in some patients' condition. All the interviews were conducted over a 10 month period (March-December 2005), and all were audio-

taped. Interviews lasted on average of 21 minutes with patients and 27 minutes with nurses.

An unstructured approach to interviewing was adopted. This entails the interviewer refraining from using a definitive framework that leads the questions asked, but follows the participant's direction through their narrative in response to the opening question posed (Moyle 2002). Much deliberation went into how the opening question for study participants would be phrased. Intimacy is not a word normally applied in descriptions of nurse-patient interactions. Indeed, Williams (2001a) reports that some nurses she interviewed in her study, expressed the view that intimacy was an inappropriate term to describe closeness in the nurse-patient relationship. Also, surrogate terms for intimacy have been identified as 'sexuality' and 'sex' (Dowling, 2003). Therefore, the opening question of the first interview asked nurses to describe their interactions with patients. Similarly, patients' opening question asked them to describe their interactions with nurses.

Repeat interviewing was adopted as a method of 'member checking' (Kahn 2000), and also assisted in providing credibility of the researcher's interpretation as is recommended in hermeneutic phenomenological studies (Fleming et al., 2003). The repeat interview for each nurse began with the researcher giving a short summary of the first interview and asking if the summary was correct. The repeat interview then became a collaborative dialogue (van Manen, 1990; Street 1995).

Ethical considerations

Ethical approval for the study was granted from three ethics committees responsible for each research site. Each study participant was given written information about the study before the interview and signed an informed consent. Protection for the participants is vital and consideration of how their identities remain anonymous is essential (Carpenter, 2007). In view of the large sample in the study, each participant was given a number rather than a pseudonym.

Data analysis

The researcher conducted all analysis of the data. Direction on data analysis was provided by the writings of van Manen (1990), and Colaizzi's (1978) framework. van Manen's activities of data analysis proposes describing the phenomenon through the

art of writing and re-writing, as was adopted in the study. However, a framework was required to reach the phase of describing the phenomenon, therefore, Colaizzi's procedural steps provided direction for this aspect of the process of analysis. Colaizzi's (1978) method is suitable for studies which employ a phenomenological method (e.g. Scannell-Desch, 2005), and for those similar to this study, which are interpretive in orientation (Hodges et al., 2001; Fleming et al., 2003).

Analysis of the nurse transcripts revealed fifty eight formulated meanings and analysis of the patient transcripts revealed forty two formulated meanings. These were then organised into eleven cluster themes, and exemplars were then identified from each coded cluster theme.

A nurse familiar with phenomenological research also undertook a member check of a sample of transcripts from both patients and nurses. Her feedback reflected a similar interpretation of the narratives as that of the researcher, but with the use of different words. This strategy of member checking was undertaken despite the view of Cutcliffe and McKenna (2004) who caution that use of an auditor is driven by positivist tenets and the view of de Witt and Ploeg (2006) that confirmability and credibility as explicated by Sandelowski (1986), are "inappropriate generic qualitative criteria for expressing rigour in interpretive phenomenological studies" (p. 222). The view taken here is that two individuals arriving at the same interpretation of a text does not mean that subjectivity is eliminated, as argued by Yardley (2000). The inclusion of a member check was to further demonstrate that "care, thoroughness and professionalism" (Chamberlain, 2000; p. 291) was adopted for this study.

Management of the interview transcripts was helped by the utilisation of the qualitative package, ATLAS. Ti. ATLAS.ti is an example of a code-based theory builder (Lindlof & Taylor 2002). Its strength lies in its ability to store the inputted memos and creation of codes, and offer transparency in how the analysis process proceeded.

An exhaustive description of the phenomenon of nurse-patient intimacy was then formulated, based upon the eleven theme clusters. The activity of writing and re-

writing revealed a process of nurse-patient intimacy, with cluster themes being grouped into three main themes (See Table 3).

Findings

In keeping with the art of writing in the phenomenological tradition, the findings presented here are in interconnecting themes to assist in maintaining context.

Developing intimacy

First meeting with subsequent identification and empathy

Many nurses talked about their first meeting with patients and how it strongly determined the relationship that would develop. This is evident in the nurses' expressions of patients' personal characteristics in their narratives. Many nurses talked about 'clicking' with some patients, and not 'clicking' with others, with this 'clicking' sealing the identification process. The term 'identification', in this context, is the process revealed in the nurses' narratives, whereby the nurse identifies something in the patient that triggers the encounter to move to another level, prompting empathy on the part of the nurse:

Nurse 4 "...there was a girl [patient] in recently and I kind of clicked with her as she's the same age as myself, has young kids as well... I think you'll always meet up with some patients that are you'll click with, and a lot of the time it's probably similar lifestyles to yourself".

Nurse 15 "I suppose it's human relations really that...just...I suppose there are just patients that you just click with...I feel myself I'm pretty much not bad at clicking with a large number of patients, but there's always people that you will really identify with, I guess some of it must be identification, you know...you're identifying...".

Baillie (1996) argues that nurses identify with patients' age and life events that are comparable, therefore empathy is personalised by the infringement of nurses' values and beliefs. Similarly, Crigger (2001) reports that student nurses identified "similarities between themselves and the client" (p. 619), which was categorised as an antecedent to what Noddings (1984) terms 'engrossment', which results in the carer investing full attention in the one being cared for and is characterised by a "move away from the self" (Noddings, 1984, p. 16). Moreover, identification is also a feature of nurses' "special relationships with [cancer] patients" in a study of psychosocial care reported by Roberts and Snowball (1999).

Patient characteristics

Most of the nurses interviewed expressed their admiration for patients who displayed a positive outlook regarding their illness and its treatment, and were attracted to engage with such patients. However, patients displaying what nurses perceived as a negative outlook were described as difficult to develop an intimate relationship with:

Nurse 10 “I find it frustrating if a patient won’t, won’t open up..., puts a barrier against you...”

Nurse 1 “You mightn’t ask the questions or you mightn’t kind of be, leave yourself open to get into a kind of a two-way long heavy conversation with them, you know, when they’d be kinda looking at things in a negative way. ... Well I suppose you learn, I suppose you learn to side-step too.”

Similarly, patients who assume a detached position were also described by the nurses as difficult to engage with:

Nurse 5 “He just likes to get in here, get his treatment on time...and really he just wants to get on with it, and move on, and move out”.

Nurse 8 “They shut down. They put up this wall against you, and they just don’t want to let you in, and you don’t want to push yourself on them...”.

Despite the majority of nurses interviewed expressing difficulties in their relationships with patients perceived as negative or detached, some nurses relayed an acceptance of patients described as detached:

Nurse 20 “that’s the way they are, it’s our issue as well, that we kind of have to remember that; they were this type of personality before they came into the unit”.

Nurse 21 “If somebody is quiet, then maybe that’s just the way that they are...I just feel we can probe too much. Some people are just quiet...”.

Baillie (1996) reports that empathic feelings are difficult for nurses to generate when the patient is difficult to know or communicate with, or displays lack of trust. Similarly, Aranda and Street (1999) cite the experience of a nurse Jane, who believed her relationship with a patient was “ineffective and nontherapeutic because it was not the kind of helping relationship she valued” (p. 81). The patient actively refused to be a “good patient” because her attitude was: “just do it [treatment] and don’t talk to me”

(Aranda and Street, 1999, p. 81). Shattell (2005) concludes that patients have a far greater role in developing nurse-patient relationships than the nursing literature suggests, and asserts that patients are active participants in the building of nurse-patient relationships.

The nurses' narratives presented above suggest the judgemental labelling of oncology patients. Johnson (1997) considers judgemental labelling from an interactionist perspective, and views it as "a process through which care is managed and which provides nurses with a strategy for coping with the emotional labour of care" (p. 1). Johnson's (1997) view could also suggest that oncology nurses' need for fulfilment and reciprocity in their caring role is deprived when they encounter 'detached' patients. The 'detached' patient may be labelled 'bad' by virtue of their lack of need for support from nurses, or assuming independence. This latter point is relevant and fits with the view of labelling patients negatively when such patients' behaviour confronts the nurse's role in using his/her skills in a therapeutic way (Kelly and May, 1982).

Nurses' technical skills

Another theme identified in the development of nurse-patient intimacy, is the patient's appraisal of the oncology nurse's technical skills. Most of the patients interviewed were receiving treatments in nurse-led oncology day units, therefore, the cannulating skills of nurses featured strongly. Nurses' technical skills was alluded to by both nurses and patients interviewed as a contributing factor to the closeness of their relationship. When the patient trusted the nurse's competence with regard to their technical skills, they wanted that nurse to care for them:

Pt 3 "There's one particular nurse in oncology, I would have great time for. She's not actually one of the more senior ones...Just even when I was going in for the chemo. I just liked to see her come to put in the needle. I just always seemed to have huge faith in her you know. ...She seemed to have the most success".

Pt 13 "Well I suppose the ones that found it easier to put the needle in my arm were the ones that I [laughs] identified with. I suppose the best was *** [Nurse]. I would look for *** [Nurse] to be here".

Some nurses interviewed also acknowledged that patients considered nurses' technical skills important to the development of their relationship with them.

Oncology patients report their three most important concerns related to satisfaction, to care, and to technical competence (Wiggers et al., 1990). In addition, it is also reported that cancer patients perceive caring behaviours dealing with information and competent clinical expertise as more important than expressive/affective caring behaviours (Larson, 1984; Mayer, 1987; Larson, 1995). Nevertheless, connection between caring for (physical care) and caring about (relationship and commitment) are considered intimately connected (de Raeve, 2002).

Experiencing intimacy

Reciprocity in self-disclosure

The experience of intimacy revealed itself as reciprocity in self disclosure, in the context of a professional friendship in a 'homely' care setting. Some disclosure of personal information was viewed as important to the quality of the nurse-patient relationship by all the nurses interviewed:

Nurse 4 "I think it's important to share a bit with them, because they share an awful lot with us, I mean we know everything about them in some ways, so it's nice to kind of give back a little to them as well.....it shows the patients you've a certain kind of trust in them as well, if you can talk about family things, and it makes it all a bit more on a personal level."

Nurse 8 "I mean here are the patients here and they are telling you all their problems, and they don't know anything about you... You can always open up a little to them as well, and I think that's good too as well, because they get to know you as well, on a personal basis, without getting to know everything about you, but you do have to open up to them as well like you know".

Patients clearly play a role in initiating the process whereby nurses disclose personal details about themselves. This is suggested in the following patient narratives:

Pt 12 "If they were in here now they'd be, now I might ask them if they worked full-time and they'd say no, that they had children at home. And one of the girls [Nurse] was on holidays and she was telling me, and another girl [Nurse] was engaged and all this. But I would be very interested. And it's nothing to do with nosiness. I would be genuinely interested".

Pt 10 “I like to get to know them [Nurses] and them to get to know me. And I do try and get their names...I mean that you can have this contact and form a trust with them to know, and they will tell you things about themselves and you in turn will tell them things about yourself. And you form a relationship with them”.

The sharing of personal information has been found to help develop a trusting relationship between the nurse and patient. Davis (2005) found the sharing of self by nurses to indicate their acceptance of patients as individuals and promoted the development of a trusting relationship.

Nurses in this study revealed that their disclosure to patients was mostly related to social conversation. Kleiman (2004) reports such communication to involve a naïve attitude and a welcoming demeanour and labels this ‘chitchat’ (superficial talk). This finding of superficial conversations between oncology nurses and patients is also evident in a study of nurse-patient communication whilst chemotherapy is being administered, reported by Dennison (1995), and in a study involving both in and out-patient radiotherapy and chemotherapy patients (Jarrett and Payne, 2000). The use of social conversation by patients is reported by Shattell (2005) as a method of getting nurses to like them. Moreover, Hunt (1991) reports that much of the verbal conversation between terminally ill patients and nurses is social in nature. Similarly, Shattell (2005) reports that patients want relationships similar to friendships with nurses, where the use of social, everyday conversations is a means of connecting with nurses.

Different levels of disclosure in nurse-patient intimacy is reported by Williams (2001a), with the building relationship level being the exchange of superficial information, such as family (Williams, 2001a). Similar to the findings presented here, Williams (2001a) also reports that superficial disclosure opens the door for disclosure on a deeper level.

Professional friend

Many of the nurses interviewed alluded to a type of professional friendship with patients. This permits the development of intimacy, but at a distance; somewhat like the ‘disinterested love’ described by Meehan (2003), which is a love of a neutral and detached nature.

Nurse 16 “But she’s [patient] very positive and we have a very special relationship. Now it doesn’t go beyond professional, but there’s a very close relationship there”.

Nurse 3 “I think in oncology because you get to know people so much better you develop more a friendly...it’s professional but you do develop this friendly interaction as well”.

Nurses in this study also revealed that they measure their disclosure by not disclosing too much and being selective in what they feel is appropriate to disclose. Such expressions of disclosure by nurses reflects the description of engagement/detachment continuum suggested by Henderson (2001) to explain the process of nurses’ relationships with patients, depending on the response to different patients or circumstances. Campbell (1984) refers to the “delicately balanced relationship” of personal involvement in helping relationships and argues that “either an absence or an excess of professional detachment” affects the companionship (p. 50). Similar to this, is the description of “being a chameleon” as described by Aranda and Street (1999) where nurses use ways to “reveal or conceal aspects of themselves depending on the situation” (pp. 76-76). Turner (1999) reports similarly, and highlights that experienced nurses divulge a certain amount of personal information, but not enough to risk over-involvement.

One of the first references to the nurse as a professional friend to patients is made by Campbell (1984), who argues that such a type of friendship requires a form of love to exist, which he labels “skilled companionship” (p. 935). The term was subsequently adopted by Trygstad (1986) to describe oncology nurse-patient relationships. Use of the term ‘friendship’ to describe nurses’ caring relationships with cancer patients is also revealed elsewhere (Roberts and Snowball, 1999; Turner, 1999). Interestingly, others suggest that the nurse-patient relationship cannot be described as one of friendship (Caroline, 1993; Bignold et al., 1995). This is argued based on the view that such a relationship lacks reciprocity and personal exchange, and that use of the term ‘befriending’ is suggested as more appropriate (Bignold et al., 1995).

Homely atmosphere

Patients interviewed also talked about how humour was common-place in their interactions with nurses. All three oncology sites sampled in this study, were viewed

by patients as warm and friendly environments, where humour was an aspect of the experience of care.

Pt 29 “Just as soon as you go in there’s a great sense of “Hiya.” “Hi, how are you today?” “Any news?”...we have the fun with them [Nurses], and it’s as jolly a place as you could spend a few hours... No dwelling on how you are, or are you well... they’ll ask you if you’re well all right, how you feel, but there’s no sense of you know, all day long, as long as you are there. You know, cancer isn’t mentioned and I like that. We know we have it. That’s enough. Just, you know, have a bit of jolliness and a bit of fun. And try and divert away from that altogether...We want normality. It is **hard** enough to come in, and spend the day here without listening to this all day long. And we don’t hear it here. And we don’t, we could be in a beauty salon for all we know.”

Pt 28 “Well, I like the way that they’re [Nurses] always jolly about things. You know, it’s not doom and gloom when you come in, you know. [laughter] Because you might feel a bit down, odd times when you’re at home on your own, but when you come in it’s all light-hearted...”

Pt 19 “Well they [Nurses] make you feel at ease, you know. You just feel you’re among friends... family, actually... when you walk in you just feel as if you’ve come into a friend’s house”.

The employment of humour in oncology has also been revealed elsewhere (Jarrett and Payne 2000). Bolton (2000) also reports the use of humour by gynaecology nurses to ease tension or lighten the situation, and suggests that the nurses offer humour as a gift in the context of Hochschild’s (1983) conception of ‘emotion work’ as a gift. Savage (1995) reports that humour between staff and patients is used as “a way of building or even accelerating the development of relationships towards intimacy or ‘closeness”” (p. 78). Furthermore, she reports that nurses liked when patients began to tease them, as they interpreted this as a “positive comment on the patient’s morale and on the nurse-patient relationship” (Savage 1995, p. 79).

Outcome of intimacy

Satisfaction for the nurse

The consequence of nurse-patient intimacy in oncology care is like a two-sided coin for nurses. They feel a sense of satisfaction, which sustains their caring efforts. However, simultaneously, they make efforts to maintain a comfortable emotional distance from patients for fear of over-involvement:

Nurse 10 “I mean it’s what can make it very rewarding for you. I mean that you can have this contact and form a trust with them to know, and they will tell you things about themselves and you in turn will tell them things about yourself. And you form a relationship with them. I mean obviously you have to be careful, how deep a relationship you form. But it is, well it makes you feel that sometimes that what you do is worthwhile if you’re able to make contact with someone... I think sometimes they don’t realise that we get something from it too...”.

Nurse 21 “I think that sometimes patients maybe don’t realise that they are giving you sort of so much back, and for like, for every one bad day, you have ten or twenty good days”.

Emotional effects of intimacy

Most nurses interviewed also revealed to that they needed to be careful about getting too intimate with patients because of the possible emotional effects on them:

Nurse 6 “You do just have to hold back a little bit...you have to maintain some kind of professional level”.

Nurse 23 “I think it’s trusting, I think it’s good to be open, but not too open. Like you have to be careful as well”.

Nurse 10 “I mean obviously you have to be careful how, how deep a relationship you form or what have you... Well, obviously sometimes you can get too, too emotionally involved with, and you find yourself getting upset with a patient that you become particularly fond of, dying or getting very ill. I just try not to get just too involved...You can I suppose prevent yourself getting too involved in the whole thing, by not getting too knowledgeable about the whole family dynamics, and not getting too involved in taking on what is their journey at the end of the day”.

Satisfaction for nurses from emotional engagement with patients is also reported elsewhere (Tippl, 1995; Turner, 1999; Henderson, 2001; Williams, 2001a). Moreover, although nurses admit that their emotional involvement with patients causes them the most anxiety, they also regard the emotional stresses as bringing the greatest potential for job satisfaction (Bolton, 2000). The positive outcome for nurses, as a result of experiencing involved relationships with cancer patients, is reported by Turner (1999) to result in job satisfaction and feeling valued. Cancer nurses’ relationships with their patients provides for them a “deeply meaningful experience” (Bertero, 1999; p. 417). Moreover, nurses state that they develop their sense of self-esteem and satisfaction from the patient in seeing the value of their presence for their patients (Bertero, 1999).

However, the nurses' narratives presented above illustrate their attempts to balance their intimacy with patients. The work of sociologist, Hochschild (1983), on 'emotional labour', is one that has been applied to nursing (Smith, 1992; Froggatt, 1998), and also applies to this study. Maher (2003) reports that for some nurses in her study, the intimacy associated with knowing patients was charged with a sense of emotional overload and was experienced as a type of powerlessness related to a feeling of loss of control over one's professional self. However, Savage (1995) reports that nurses in her study were clearly skilled in facilitating close relationships with patients, but they were "not *necessarily* emotionally intense" (p. 124).

Although no nurses interviewed used the term 'over-involved' explicitly, it was implied as a concern through their narratives in their descriptions of balancing distance and closeness with patients. Similarly, Hess (2003) asserts that engagement between the nurse and patient is not synonymous with "becoming enmeshed in experiencing the patient's perspective", as such an entanglement can only result in the loss of the nurse's self (voice) in the shared relational narrative with the patient (p. 145). This concern for nurses who work with oncology patients is also revealed in an ethnographic study reported by Roberts and Snowball (1999), where "emotional closeness was referred to as over-involvement" (p. 44).

Over-involvement is described by Morse (1991) as a relationship in which the patient and nurse mutually respect, trust and care for each other. However, use of the term 'over-involved' in describing such nurse-patient relationships is problematic and "it raises the question of who can or should decide whether or not a nurse is too involved" (Turner, 1999; p. 155). Turner (1999), reporting on her findings in a grounded theory study with cancer nurses (n=40), provides a quote from one participant which expresses this very point: "*It's difficult to know when somebody is over involved because what for one nurse is a relationship that they can cope with may be over-involved for another nurse*" (p.155).

Over-involvement clearly can result in negative consequences for nurses and may result in "emotional pain" for cancer nurses (Turner, 1999; p.157). Similar to the findings reported here, Turner (1999) reports that cancer nurses can find themselves

feeling extremely upset when a patient, known for some time, dies. One of the nurses in Turner's study reported wanting to leave oncology nursing following the death of a patient: "*at the time when I became too involved with a patient, when she died I felt like I never wanted to nurse another cancer patient again. It's that painful really*" (Turner, 1999; p.157). Over-involved relationships in oncology care also have possible negative consequences for patients. Turner (1999) reports that patients may become dependent on nurses and this can lead to problems when the nurse is off duty.

Peer support

All of the nurses interviewed talked about the support they valued from their nursing colleagues when they experienced emotional effects of intimacy with their patients.

Nurse 10 "We support each other really. I think amongst ourselves, we do a lot of talking together, you can go and have a half an hour away, and that you're not embarrassed to show your feelings and we don't like to bring it home to our husbands, or partners, or your parents or whatever, because it's a separate world, and they don't need to be hearing all of it anyways. It's good if you can keep it here I think."

Forrest (1989) highlights the role of support in caring work. In order to manage emotions in their caring relationships, nurses need to support each other. Moreover, nurses' willingness to engage in intimate relationships with patients often depends on the opportunities and encouragement within particular work settings to develop methods for coping with emotional situations (Henderson, 2001). Smith (1992) concurs with the view that it is the climate of the ward that determines the emotional tone for the staff; where staff feel supported, they have the freedom to care for each other and their patients.

Patient comfort in feeling known

For patients, the consequences of intimacy are less clear. Many patients interviewed talked about feeling known by certain nurses and they implied a sense of comfort in this knowledge:

Pt 10 "If I want to talk to her [Nurse] she'll talk to me. Now, they won't push themselves on you, you know. They won't. No, they're good. You know, and if you want to be left alone, they'll leave you alone. If you want to talk, they'll talk. And sometimes I might go that little bit further and make it better talk that

you just need. Teardrops fall and then that's it. That kind of thing... If I was down now and if there was one that would come in there [pointing to the door], I'd know right away whether she'd be able to cope with me or not".

Pt 28 "She [Nurse] mostly deals with me, and I think she's an exceptionally good girl. ...she seems to understand me better, maybe, than the others and know more about me, like, or whatever do you know? She knows everything about me, She keeps an eye on me, you know. Because you feel she's interested in you."

Turner (1999) reports that involved relationships between cancer nurses and their patients has positive consequences for patients in continuity of care, security/safety and trust, and nurses strive to know patients in order to care for them better (de Raeve, 1996). Williams and Irurita (2004) similarly report that patients "perceived that they received a higher quality of care from hospital staff who knew them" and the outcome was "feeling secure" (p.810). Moreover, Shattell (2005) reports that patients who felt they knew and trusted their nurses "felt more comfortable about their care" (p.214).

The benefits for the oncology nurse of knowing their patient is significant. When cancer nurses know their patients, they can help them understand their cancer (Bertero, 1999). Furthermore, knowing patients gives nurses a basis for effective planning of care (Billeter-Koponen and Freden, 2005).

Study limitations

The sample for this study is large in comparison to most qualitative studies. However, this strength does not render the study findings generalisable. Utilisation of repeat interviewing with nurse participants is a strength of the study. However, the failure to also re-interview patient participants, has resulted in nurse participants' voices featuring predominately in this study.

Conclusion

This study highlights the personal, emotional investment by nurses in their intimate relationships with cancer patients. Moreover, this emotional investment appears to be accepted as a key feature of oncology nursing. However, intimacy is not a term that nurses or patients used in this study, with other related terms used instead, such as 'bonding', 'linking' and 'closeness'.

The finding in this study that intimacy follows identification has important clinical relevance because it has been revealed that identification is dependent on nurses' views of patients' characteristics, exposing judgemental labelling of oncology patients. It is argued that the social judgment of patients by health care professionals may depend on the how much effort patients are prepared to undertake (Strauss et al., 1982). The importance of promoting oncology nurses' exploration of their judgments of patients is therefore paramount, as this has far reaching consequences for oncology patients and the relationship that nurses chose to develop with them.

This study also reveals the 'emotion work' undertaken by oncology nurses in attempts to achieve a balance on the intimacy continuum with patients. The most appropriate term to use in describing this is that of 'moderated love': "the subtle balance between involvement and detachment" (Campbell, 1984; p.126), which requires the self-awareness to 'switch off'. Oncology nurses therefore, require sufficient self-awareness to recognise their emotional reactions to patients. Self-awareness is also necessary to equip oncology nurses with the required skills to recognise their role in persisting gently with patients who may be perceived as "detached" and engage with them for their cancer journey.

This study also suggests that peer support is essential for oncology nurses in helping them maintain close relationships with patients. Such support, however, is informal, and formal support in the form of clinical supervision is required. The argument for clinical supervision to assist nurses manage their intimate relationships with patients is long standing (Smith 1992, Turner 1999, Jones 2001, Teasdale et al., 2001). The importance of clinical support is highlighted even further when one considers that many view the uniqueness of nursing to be based "upon the health enhancing use of

personality and personal knowledge base, through the medium of nurse-patient relationships” (Antrobus 1997, 834).

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Table 1: Patient Participants (n=30)

Age Range	42 yrs – 80 yrs
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 years – 27 years
Length of time in oncology nursing	2 years – 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)

Table 3: Cluster themes

<u>Cluster Theme 1:</u> Developing intimacy	First meeting Identification and empathy Patient characteristics Nurses' technical skills
<u>Cluster Theme 2:</u> Experiencing intimacy	Reciprocity in self-disclosure Professional friend Homely atmosphere
<u>Cluster Theme 3:</u> Outcome of intimacy	Satisfaction for the nurse Emotional effects of intimacy Peer support Patient comfort in feeling known