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### **Abstract**

'New' nursing ideology has promoted the concept of 'intimacy' between the nurse and the patient as a realistic concept. This paper examines intimacy from a sociological perspective. It reveals that 'over-involved' or 'intimate' nurse-patient relationships do not tend to be welcomed by nurses. The work of certain theorists is explored to provide a sociological explanation of intimate nurse-patient relationships and to illuminate the problems of nurses developing intimate relationships with patients in the workplace.

Nursing is essentially a social construct, that is, a mode of social organisation for the delivery of key nursing caring, comforting and technical skills (Johnson 1999). However, these skills are not exclusive to the nursing profession alone. Nursing continues to search for its own unique body of knowledge and this has probably had a big influence on nurse theorists adopting the nurse-patient relationship as the core of nursing practice. Nursing has followed the path of sociology in specific ways, with Mulholland (1997) arguing that sociology is invaluable to nursing.

### **'New' nursing**

Humanistic philosophy of the 1960s penetrated nursing theory and promoted the concept of a relationship between the nurse and the patient as being achievable (Aranda 2001). This 'new' nursing ideology argues that a one-to-one relationship between the nurse and patient is the foundation of nursing practice (Salvage 1990), and has been a catalyst in the drive for the professionalisation of nursing (Morrall 2001).

Evidence of the influence of sociology is evident here as 'new' nursing aimed to 'humanise' nursing care by its attention to a "bio-psycho-social" model in which a humanistic concern with communication prevails (Mulholland 1997). However, expression of the nurse-patient relationship as central to nursing practice pre-dates 'new' nursing ideology. This is illustrated by the work of Menzies in 1960 who documented that nurses showed 'excitement' and 'pleasure' when chosen to 'special' a patient (i.e. provision of one-to-one intensive nursing care to an ill patient) (Menzies-Lyth 1988). Moreover, Peplau's Interpersonal Relations Model of Nursing, first published in the USA in 1952, suggests a mutual nurse-patient relationship where both parties strive to become comfortable with each other and work together to understand their reciprocal reactions.

More recently, Barker has proposed the Tidal Model, based on a series of studies exploring various views of nursing (Barker 2001). His model incorporates tenets of Peplau's work as well as the therapeutic use of self (i.e. how the nurse uses his/her personal qualities in her/his relationships with patients they are caring for) as proposed by Travelbee (1969). This would suggest that early views of the nurse-patient relationship have changed little over the past three decades.

### **What is intimacy?**

The term “intimacy” as it applies to nurse–patient relationships is difficult to define, but there is agreement that it requires reciprocity, self-disclosure (Timmerman, 1991, Kadner 1994) and self-awareness (Dowling 2003), which suggests a closeness coupled with a high degree of intersubjectivity. Reciprocity and self-disclosure, according to May (1993) involves: “*Getting to know the patient, and allowing them to get to know you as well*” (p.184), and self-awareness is the need to “...*keep looking at yourself*” (Henderson 2001, p. 134).

Intimacy is also a term not used freely in nursing. Other terms such as ‘involvement’ or ‘engagement’ are instead adopted to describe close nurse–patient relationships (Dowling 2003). This is not surprising as a surrogate term for intimacy is ‘sex’ or ‘sexuality’ (Dowling 2003), and intimacy is often narrowly equated with ‘images of blissful heterosexual pairings’ (Learner 1989). There is consequently a silence that shrouds the use of the term ‘intimacy’ in nursing.

Nevertheless, the nurse–patient relationship is central to nursing, and intimacy is a concept that appears to fit in the centre of theoretical approaches to ‘care’ (Savage 1995). Nurse researchers have reported some tentative indicators of the rewards and satisfaction experienced by nurses associated with intimacy in nurse–patient relationships (Henderson 2001, Williams 2001a). Also, health is an integral concept in the metaparadigm of nursing, that is, the domain concepts of concern to nursing (the other three being person, nursing and environment). Moreover, the intimacy that results in supportive relationships has been found to play an important role in attaining positive health outcomes during traumatic life events such as long-term distress among the bereaved (Wortman and Conway 1985).

As mentioned earlier, involvement is a related concept of intimacy. The term “involvement” suggests an emotional investment on the part of the nurse in her/his relationships with patients, but may occur without reciprocity and self-awareness as experienced in intimacy. This issue is raised by Williams (2001b) who 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 “care” in this context suggests an emotional investment by the patient in their relationship with the nurse. This description of ‘over-involvement’ is interesting in light of the theoretical views proposed by ‘new nursing’. Perhaps the issue is not with mutual trust and respect between the nurse and patient, but with the inclusion of caring for each other. Such mutual caring may be perceived as the antithesis to the expected ‘professional’ relationship between nurses and patients. The use of the term ‘over-involvement’ suggests a nurse who is not in control. Indeed, balancing engagement with detachment is reported by many nurses as a way of coping with the realities of a close nurse–patient relationship (Carmack 1997).

### **Associations with identity**

Identity is the set of behavioural or personal characteristics by which an individual is recognisable as a member of a group, and difference is an important related concept. The idea of nurses becoming 'over-involved' and consequently being different from their colleagues can be related to identity, as identities are constituted in and through 'difference' (du Gay *et al* 2000).

Handy (1991) provides evidence to suggest that subtle actions were taken against mental health nurses who were perceived by colleagues "...to be deviating from socially acceptable norms" (p.824) by over-involving themselves with patients. Although a study conducted almost fifteen ago, Handy's research is worthy of closer examination. She utilised a variety of data collection methods in her "comparative study" of stress among nurses in mental health community and hospital settings, such as interviewing, participant observation, analysis of nursing notes and in-depth interviewing. She found that one of the key strategies for "...controlling nurses who seemed to be deviating from socially acceptable norms" (p.824) was to label them as having psychiatric problems themselves. This is summed up succinctly by one nurse participant who expressed the view that over-involvement with patients usually occurred with nurses described as "*vulnerable...with problems of their own who identify with patients- and it's usually the neurotic or manipulative patients they get involved with- if I ever see that happening I usually have a word with them for their own good...*" (Handy 1991, p.825). This labelling of a fellow nurse as 'deviant' can be examined from a symbolic interactionist standpoint.(see glossary of terms for explanation]. George H Mead, an American Philosopher (1863-1931) is the acknowledged father of symbolic interactionism, and he proposed that persons adapt to, and survive, in their environment by sharing common symbols (both verbal and non-verbal) (Bielkiewicz 2002). According to Mead, a significant symbol is a kind of gesture, one that only humans can make, and becomes significant when it arouses in the individual who is making it the same kind of response as it was intended to elicit from whom the gesture was addressed (Mead 134/1962) (cited in Ritzer 2000). Becker (1963) regarded deviance from social norms as being a result of the interpretations that members of society use with regard to certain individuals. Therefore, nurses may consider other nurses' intimacy as one of "over-involvement" as described by Morse (1991) above, and possibly deviant because they have been socialised to believe that this is the case.

Discussions on identity are also relevant to this discussion. An approach to identity has been developed within social psychology and provides specific reference to the location of identities within the social structure. For example, McCall (1987) argues that society is composed of roles and describes the processes by which individuals assume the roles that they believe are expected by them as they act out and attempt to live up to expected identities.

Student nurses are exposed to the theoretical concepts of relating to patients, such as those proposed by Peplau (1952), who argues that nursing is essentially an interpersonal process in which the nurse and patient respect each other as individuals and both learn and grow as a result of their relationship.

However, in practice, their experiences may socialise them to behave differently in their relationships with patients than they intended. For instance, Peplau (1952) argues that both nurse and patient play equally important roles in their therapeutic relationship. However, in practice, the experience of illness renders many patients vulnerable and dependent on nurses for much support, which alters any attempts of equality in the therapeutic relationship with nurses considerably.

This theory-practice fissure may affect nurses' identity and those of the patients for whom they care. This is evident in the observations of Jourard (1971) who documents the rigid interpersonal behaviour of nurses distancing themselves from patients by employing closed communication in situations of anxiety. He argues that this rigidity and fear of disclosure by nurses results in the denial of patients' individuality. From a sociological perspective, Parsons (1951) would argue that institutionalised roles result in a stable social system. However, it is important to note that despite the assertion by Porter (1991) that nurse education is often characterised by discipline and the inculcation of uniformity and subservience, the widespread inclusion of communication skills and development of self-awareness among nurses through strategies such as reflective practice, has at least made nurses more aware of the way they communicate with **patients**.

Jourard (1971) suggested that the rigid interpersonal skills among nurses he observed had "sameness" in their nature. "Sameness" implies a type of uniformity, and is closely related to how identities are formed. Individuals can find or lose identity in social groups (Williams 1995). Menzies-Lyth's (1988) seminal work illustrates how the method of organising nursing work results in nurses losing their identity. Menzies-Lyth concluded that the hospital nurse managers viewed nurses in her study as a homogenous group, who were fulfilling a service need (the nursing personnel in the hospital studied numbered 700 with only 150 being fully trained and the rest students), and through the organisation of care by task allocation were prevented from developing any type of relationship with patients. She also concluded that the defense mechanisms she observed among nurses developed as a result of "...collusive interaction and agreement, often unconscious, between members of the organisation as to what form it shall take" (Menzies-Lyth 1988, p.51). The group made decisions and there was minimal reliance on personal responsibility. This relinquishing of personal responsibility probably resulted in nurses losing some of their own personal identity as it did not promote self-awareness of their personal impact on patient care (my opinion). This also had a consequence for patients who were not viewed as individuals, echoing the findings of Jourard (1971).

### **Parsons' status role**

The work of Parsons (1951), a structural functionalist, is relevant to any discussion of how nurses are socialised into what is considered 'appropriate' interpersonal involvement and intimacy with patients. Functionalists speculate about needs that must be met for a social system to exist, as well as the ways in which social institutions satisfy those needs. Parsons argued that social expectations are converted into action through the learning of social roles. Roles involve expectations of how we should interact with others (Porter 1998).

Student nurses are socialised in nursing mainly in the acute hospital setting. Jourard (1971) argues that such institutions are public and deprive their occupants (nurses and patients alike) of privacy, concluding that where there is no privacy, there is maximum opportunity to control behaviour and produce conformity. Nurses often undergo an official socialisation process into a system where it is considered 'unprofessional' to become too close to patients. "Too close" in this case being similar in nature to the "over involved" relationship as described by Morse (1991) earlier.

This is reflected in the study findings of Handy (1991), discussed earlier, who found that younger psychiatric nurses often expressed concern about the control-orientated ethos of their activities and spoke of their desire to develop more effective therapeutic relationships with patients. This indicates a theory-practice gap. Nursing theories such as those of Peplau (1952) encourage a close nurse-patient relationship, but the reality of practice is often quite different. However, the context of the care setting is important to this discussion. Froggatt (1995) argues that in hospice care (where the duration of the nurse-patient relationship is limited), intimacy in nurse-patient relationships is facilitated. Moreover, intimacy with terminally ill patients has "...a moral value beyond the extent to which it might offer relief from the routines of nursing work" (May 1993, p.184). This suggests that perhaps intimacy is not encouraged in mental health settings where the time limit of the nurse-patient relationships are often lengthy.

### **Parsons' view of social systems as interactive relationships among individuals**

Parsons presents a multidimensional scheme for classifying relationships containing five dichotomous pattern variables, which he argued structured all social action (Lidz 2000). These patterns reflect the reality of intimacy in nursing practice. The first of these patterns is the dichotomy between affectivity and affective neutrality, with neutrality referring to the amount of emotion (affect) that is appropriate in an interaction. Nurses are encouraged to find what could be termed a 'safe equilibrium' between these two extremes. They are expected to care with empathy and kindness but at the same time maintain a degree of emotional detachment. Indeed, Davies (1995), in a feminist analysis of role formation, proposes that nurses should be neither distant nor involved, but engaged. "Engaged" in this context suggests the presence of reciprocity, where the nurse would self-disclose some personal details that she/he considered appropriate, such as if they had experienced death of a parent when asked of such information by a bereaved patient.

Research evidence has also found that nurses balance their engagement with detachment by not getting too involved or feeling responsible for the outcome (Carmack 1997). Feminist theory also informs views of intimacy related to the nurse researcher and study participants. According to feminists, there is reciprocal sharing of knowing, with the researcher and those being researched becoming collaborators

and partners in the research endeavour (Schutz 1994). Such reciprocity between researcher and study participants is also espoused by critical theorists in participatory action research.

The second dichotomy outlined by Parsons is between collective orientation and self-orientation (Lidz 2000), and defines whether an individual pursues his or her personal goals or the goals of a collectivity (e.g. the nursing team). With regard to intimacy in nursing, the nurse is expected to consider the social order and 'not stand out from the crowd' (collective orientation). [my own opinion]. Menzies-Lyth's study highlighted that nurses were considered interchangeable and all the same, as were patients (Menzies-Lyth 1988). The nurse who does follow a more self-orientation pattern, by for instance, approaching their care of patients in a manner that may deviate from their colleagues, may be considered different and even threatening. This was evident in the work of Handy (1991), discussed earlier, which found that nurses caring for psychiatric patients were 'controlled' by the organisation by being labelled as having psychiatric problems themselves if they appeared to be deviating from the socially acceptable norm by singling out specific patients for 'special attention', by spending more time with them and befriending them.

In clinical practice nurses have learnt informally that articulating their feelings to a particular patient is criticised (Muetzel 1988, Handy 1991, May 1991, Morse 1991) and results in restrictions against them (Aranda 2001). Institutional structures control the relations of persons to one another through 'locating' them in the structure and defining acceptable expectations of their behaviour (Parsons 1951).

This collective orientation, however, may have less to do with nurses being threatened by self-orientation, than with the consequences for social order. May (1991), in his qualitative interview study of 22 qualified nurses, reported that for the respondents the most significant effect of other nurses' demonstrative involvements was the potential for the disorganisation of nursing work and the unequal distribution of care; if one nurse decided to spend time with one particular patient his/her colleagues would be left with an uneven distribution of work to accomplish. In addition, Henderson (2001) asserts that nurses need to be aware of the implications for quality care when some nurses feel the need to expose themselves to a high degree of emotional openness with patients, while others avoid emotional contact. This latter viewpoint is important as effective nurse-patient relationships have been found to be central to quality nursing care (Irurita 1999). Moreover, Glen (1998) suggests that quality of care is reflected in the nurse-patient relationship.

It could be argued that collective orientation fits with a task-orientation model of nursing care delivery where each nurse performs a task or number of tasks for each patient on the ward. The dominance of collective orientation is evident in Menzies-Lyth's work, which was first published in 1960 at a time when task-orientated care was the predominant method of organising the delivery of nursing care. She clearly illustrated how nurses in the organisational structure of the hospital developed socially structured defence mechanisms against anxiety. By employing task allocation, the nurses were prevented from developing relationships with their patients and therefore were considered "protected"

from their feelings. (Menzies-Lyth 1988). Her work also demonstrated how nursing management attempted to protect student nurses from anxiety by moving them frequently from within and between units, thus preventing close relationships with patients from developing. This practice resulted in reduced satisfaction for the nurse and Menzies-Lyth argued that it also contributed to the large number of student nurses who failed to complete their training (Menzies-Lyth 1988).

A third dichotomy outlined by Parsons is particularism versus universalism and refers to how people respond to others. In particularism, a nurse will respond differently towards different people, depending on how much they have in common. Having some similarities with a patient may accelerate the nurse-patient relationship. Kadner (1994) argues that nurses should assess 'who are most needful of an intimate relationship'. Particularism fits with research evidence that states that nurses only become intimate with certain patients depending on a subtle blend of their personalities and the context of their interactions. For instance, it has been reported by Baer and Lowery (1987) that student nurses liked best to care for cheerful and communicative patients who were accepting of their illness and the nursing care offered, and they conclude therefore that the characteristics of patient communication are essential variables in the nurse-patient relationship. Fosbinder (1994) also, is in agreement; arguing that the patient's interpersonal competence has an important influence on nurse-patient communication. Moreover, Pettegrew and Turkat (1986, p. 391) argue that "... patients may have a far greater impact on and responsibility to the health-care relationship" than has been revealed in previous research.

It has been suggested that only a few relationships between nurses and patients would ever become close or intimate (Savage 1995). Boyle (2000) argues that nurses encounter 'special' patients and families who 'become more to [them] than others'. However, the findings of Allan (2001) suggest that intimate relationships occur as a result of patient action rather than being initiated by nurses, in so far as Allan (2001) reports that patients did not always demand an emotional response from nurses caring for them but were aware that they could receive such a response if needed. Nevertheless, May (1993) argues that the extent to which the nurse invests in interpersonal relationships with patients is a choice the nurse makes.

Schubert (1989) asserts that a blending of 'nurse readiness' and 'client comfort' is required for intimacy to occur, which is achieved by the 'nurse communicating caring' through the use of caring behaviours such as touch, and the 'client negotiating for comfort', through their decision to trust the nurse. This matches the view of Kadner (1994) who argues that intimacy is difficult to plan for in advance as opportunities for intimacy occur by chance: 'Instead of pursuing or forcing intimacy, the nurse maintains a psychological readiness for its occurrence'. Conversely, according to Parsons, in universalism, which is guided by a standard set of criteria (Lidz 2000), each patient would be cared for similarly and a nurse's interaction with patients would not be influenced by the nurse's view of the patient as an individual.



It is also relevant to note that Parsons regarded expressive variables, as used in the act of communicating, as being associated with women (Porter 1998). This point is noteworthy as nursing is synonymously associated with women despite the increasing number of men entering the profession.

Social differentiation is achieved through norms that set dominant and subordinate groups apart in their behaviour. Generally, when nurses are promoted and enter the realms of the dominant groups, such as nursing management, they also move further away from the patient's bedside. Thus, they may be removed from direct patient care and therefore their opportunities for intimate relationships with patients are limited (Muetzel 1988). Therefore, the less dominant groups, such as student nurses, are most likely to be in a position to develop intimate relationships with patients, but often have less developed personal skills to do so effectively, due to lack of both personal and professional experience. [I have no reference to this. This is my personal experience) Indeed, it is felt that as nurses progress up the professional ladder, they discard some of their involvement in basic nursing care interventions (Morrall 2001). However, it is precisely such basic nursing practices, like bed bathing and toileting that facilitates intimacy with patients as it requires time, privacy and space, and these are the essential elements required for intimacy (Allan 2001). Nevertheless, roles positioned prominently in the nursing hierarchy, such as that of clinical nurse specialist facilitate expert nurses remaining at the bedside.

### **Self-awareness**

Perhaps only nurses who are truly self-aware can really engage in intimate relationships with their patients. Self-disclosure is considered essential for intimacy (Cline 1989, Howell and Conway 1990, Timmerman 1991), but can vary greatly in nature depending on the circumstance. For instance, nurses often self-disclose that they have children if asked by patients. Where self-disclosure requires an acute degree of self-awareness is when a distressed patient may probe the nurse with questions in order to ascertain the nurse's personal experience of coping with stressful events. In such a case, the nurse must measure their self-disclosure carefully as the outcome of their sharing may have a positive or negative effect on the patient (this is my personal opinion based on what oncology nurses have told me in interviews in a study I am currently conducting on this topic). However, self-awareness and knowledge of the self develops over time with experience. Menzies-Lyth's (1988) seminal work was carried out with student nurses who, as a result of their youth (organisational constraints aside), found it difficult to develop and manage intimate relationships with patients. Menzies-Lyth documents that some nurses resorted to what she termed 'irresponsible action', which manifests in them becoming emotionally attached to patients (Menzies-Lyth 1988). This appears to suggest again that an 'appropriate' intimate relationship requires the ability to balance the relationship. With experience, nurses have been found to still care intimately, but do not feel such an intense reaction to the experience (Aranda 2001).

It is also important to highlight that the act of engaging in intimate disclosure involves relational and personal risks, as the discloser risks betrayal of personal information while also risking rejection (Cline

1989), and increases vulnerability, as some “letting go” results (Schubert 1989). However, these risks appear greater if the nurse has not developed self-awareness. Jourard (1971) argues that if nurses are afraid or ignorant of their own self, they consequently feel threatened by any self-expressions of patients, and if a patient sends “...out a ‘trial balloon’ concerning what really is on his mind”, he will encounter “...a response from the nurse which effectively squelches him” (p.184). Furthermore, it is believed that a positive correlation exists between the nurse’s level of understanding of self and his/her openness and honesty in interactions with others (Burnard 2002). There is some evidence to support these views. For example, Henderson (2001) found that the more self-reflexive the nurse, the more likely he or she was able to appreciate emotional connection with patients.

### **Conclusion**

Intimacy is central to caring in nursing, and nurses appear to gain personal and work satisfaction from their intimate relationships with patients. However, reduced hospital stays and the increase in day services as a result of health service rationalisation has placed limitations on opportunities for the development of intimacy in nurse-patient relationships. Moreover, staff shortages often result in care management being organised around a model of task allocation, which also limits opportunities for intimacy.

This paper has attempted to address intimacy in nursing from a sociological perspective. Such a perspective sheds light on the organisational and personal issues that affect intimacy in nursing. The literature suggests that although patients and nurses do engage in close and intimate relationships with each other, the organisation plays a role in facilitating or hindering such relationships. Nurses may consider that other nurses’ intimacy with patients has the potential to disorganise nursing work and distribute care unequally. Therefore, normative sanctions against over-involvement with patients can develop.

Discussions on identify highlight that the nurse who engages in what is termed an ‘over-involved’ relationship with a patient may be viewed as deviant. Nurses strive for a safe equilibrium along the affective to affective neutrality continuum. This avoids individual nurses standing out from the crowd and possibly disrupting the social order in the organisation and delivery of care. It would appear therefore, that the need for even distribution and orderly organisation of care, plays a central role in nurses’ intimate relationships with their patients. Moreover, in nursing roles such as clinical nurse specialism, where a high level of autonomy within individual practice exists, constraints on intimacy such as organisation and delivery of care are less evident.

It would appear that a theory–practice gap exists on this issue. The literature indicates that intimacy in nursing is somewhat of a theoretical aspiration that nursing wants to embrace it but is simultaneously cautious of the possible chaotic consequences to its social order. This disparity between theory and

practice is particularly troublesome for student nurses as they often rely on their theoretical knowledge to help them make sense of their experiences on clinical placement.

Perhaps nurses need to engage in intimate relationships with some patients in order to be fulfilled in their role. Indeed, from the author's experience, many student nurses cite the attraction of engaging in close relationships with patients as one of their principal reasons for entering the nursing profession. However, educators promoting the theoretical work of Peplau and others must also make students aware of the research evidence suggesting the need for nurses to balance their relationships with patients.

Consideration of the socialisation of students in clinical practice is also vital. Clinical staff play an essential role in supporting students as they negotiate the complexities of their relationships with patients and find a comfortable balance on the engagement/detachment continuum.

More evidence on the experiences of the intimate relationships of nurses and patients as they are lived daily is required. This will illuminate the costs and benefits of engaging intimately with patients and help nurses negotiate the complexities of nurse–patient relationships in 'new' nursing.

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### Glossary to terms

Sociology	Sociology is the study of human social relations or group life. Sociologists examine the ways in which social structures and institutions (such as hospitals) influence society.
Symbolic interactionism	Symbolic interactionism emphasises the subjective meaning of human behaviour, the social processes and common-sense meanings. For interactionists, humans are practical and continually must adjust their behaviour to the actions of other actors. There are a number of versions of interactionist thought some deriving from phenomenological writings by philosophers