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Oncology nurses' descriptions of intimacy with patients: mirroring Edith Stein's phenomenological conceptualisation of empathy.

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Introduction

This paper highlights the relevance of Edith Stein's philosophy on empathy in understanding oncology nurses' expressions of intimacy with their patients, as revealed from narratives in an interpretive phenomenological study.

The nurses interviewed in this study revealed identification and empathy essential to the process of developing intimacy with their patients. Empathy, in itself, is a complex concept and is used in various ways in the literature. Kristjansdottir (1992) traces the early work of German psychologist and philosopher Lipp, who in 1907 distinguished empathy from sympathy. Morse *et al.* (1992) identify four components of empathy: moral, emotive, cognitive and behavioural. Another conceptualisation of empathy is proposed by Kunyk and Olson (2001) who consider empathy as a human trait, as a professional state, as a communication process, as caring and as a special relationship. Rawnsley (1980) presents empathy, firstly, as a concept of characteristics and abilities and, secondly, as a construct including a developmental progress and/or a behavioural and cognitive process. The view of empathy as a special relationship requires a reciprocal relationship to build over time between the nurse and the patient (Kunyk & Olson, 2001). Moreover, the term 'friendship' is used in this view of empathy, which is in opposition to the view of empathy where a professional distance is presented (Kunyk & Olson, 2001). None of these aforementioned views provided adequate explanation for the process of empathy revealed in oncology nurses' narratives from this study. However, the view of Phenomenologist Edith Stein on empathy mirrors the description of empathy provided by nurses in this study.

The study

The aim of the study was to explore the meaning of nurse-patient intimacy in oncology care settings. An interpretive phenomenological (also known as philosophical hermeneutics) design was chosen, with insights from the philosophy of Phenomenologist, Gadamer (1975) utilised to guide the study process. Twenty-three nurses who volunteered to participate, were interviewed twice by the researcher, over a 10 month period (March-December 2005). All the interviews were audio-taped.

Ethical approval for the study was granted from three hospitals offering oncology services in one health service area. All oncology nurses working in the three hospitals were informed about the study and invited to participate. Each study participant was given written

information about the study before the first interview and signed an informed consent.Thirty oncology patients were also interviewed once, however, their narratives are not the focus of this paper.

Much deliberation went into how the opening question in the first interview with nurses would be phrased. Although it is argued that in the conversational interview the interview process "needs to be disciplined by the fundamental question that promoted the need for the interview in the first place" (van Manen, 1990, p.67), intimacy is not a word normally applied in descriptions of nurse-patient interactions. Indeed, Williams (2001) reports that some nurses she interviewed in her study, exploring their perceptions and experiences of intimacy in their relationships with patients, expressed the view that intimacy was an inappropriate term to describe closeness in the bonding or 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 their patients.   With an abstract concept, such as intimacy, by asking participants about their interactions with patients, it would identify for them a more "concrete, specific experience" (Kahn, 2000, p.63). In addition, Walsh (1996) reports that when he asked psychiatric nurses about their relationships with patients, they would look at him blankly or give a psychological treatise on the helping relationship. So instead, he asked about their 'encounters', similar to the approach taken in this study of asking about interactions.

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. This is a process also employed in a study reported by Lindseth *et al.* (1994).   The repeat interview then became a collaborative dialogue on the issues raised in the first interview, similar to that described in hermeneutic research by Street (1995). Repeat interviewing in hermeneutic research acknowledges that the understanding of researcher and participants changes over time (Fleming *et al*. 2003), and considers interviewees as collaborators of the research project (van Manen, 1990).   This allows reflection on the text (transcripts) of the previous interview in order to aim for as much interpretive insight as possible, and determine the deeper meanings or themes of these experiences (van Manen, 1990).

Data analysis
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. This combination of van Manen's work with others in the field of phenomenology is not unusual. For instance, Jongudomkarn and West (2004) utilise Colaizzi's and van Manen's work in their phenomenological study. Moreover, others have utilised van Manen's phenomenology with Benner's paradigm cases (Fielden 2003, Hassouneh-Phillips 2003).

Utilisation of the qualitative package, ATLAS. ti assisted in managing the large amount of data collected. Such a package cannot automatically result in interpretation of the text (Muhr, 2004). Its strength lies in its ability to store the inputted memos and creation of codes, and offer transparency in how the analysis process proceeded. Moreover, the package facilitated smooth movement between the narratives, assigned codes, highlighted quotations, and memos, during the analysis process.

Three major themes were revealed following data analysis, i.e. Developing intimacy, experiencing intimacy, and the outcome of intimacy. Identification and empathy for patients was revealed as a central sub-theme to developing intimacy. In addition, the need to balance intimacy with detachment was revealed as a major sub-theme in the outcome of intimacy. Both these sub-themes are relevant to Edith Stein's descriptions of empathy.

Trustworthiness
Narrative studies, such as this one, do not have formal methods of reliability (Polkinghorne, 1988). However, the views of Eberhart and Pieper (1994) on the procurement of reliable information in a hermeneutic study was adhered to in the study. This included, selection of an appropriate sample, a preliminary research question, information to be relayed to participants before the interview, and repeat interviewing with participants. Moreover, Eberhart and Pieper (1994) suggest that the transcription of the audiotaped interviews into a written text should be carefully checked against the audiotape to ensure the language in the text accurately reflects the verbal description of the experience. Consistent attention to reflexivity was also adopted by the author throughout the study, and a diary was kept during data collection and analysis. Finally, similar to the method outlined by Lindseth *et al.* (1994), each nurse was given a short summary of their first interview at the beginning of their second interview, as well as the researcher's interpretation of the narrative, with the second interview probing the issues raised in the first interview further.

Findings

Nurses revealed in their narratives that their first meeting with the patient was critical to the relationship that developed. Nurses described a process of identification with certain patients occurring during that first meeting. 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.

The nurses' narratives reveal that they 'click' with certain patients, and this 'clicking' seals the identification process. This is evident in the following nurses' narratives, where the use of the terms 'clicking' and 'identify with' are used.

> 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, and there's …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…"*.

The nurses' narratives also suggest that the process of identification is actively pursued by nurses, in an attempt to find something in common with patients.

> Nurse 5 "*I might identify a certain trait in a patient and say 'oh gosh, I know how that could feel'…I suppose in your forties, you meet so many people in their forties with cancer, who would be married, who would have teenage children, whose parents would still be alive, and that you have a lot in common, and then you interact with that…We'll just have a small chat really, but it may build into finding out that we have this in common."*.

> Nurse 12 "*If you relate to them, the first thing would be like you'd say 'have you children?' or 'are they at home?' or 'where are they?' or whatever. Or for a younger person 'are you in college, what are you doing?' and all that… I think it makes them realise that yes, on a personal level she has the same things I have. I know what it is like to have 3 teenagers, so obviously she's going through the same thing as me with hers"*.

Nurse 15 "*If I meet say, a seventy year old lady and she's from way out the countryside or something, right, and really, I, I straight away, will try and sort of find something that puts us on a balance, on par*".

Being a Mother, and caring for oncology patients with children, was expressed by some nurses as a common trait that propelled the identification process. This is evident in the narrative of Nurse 6 below.

Nurse 6 "*I think it's when they're really young as well, because you identify with that. Or if they have really young kids, I think it's just…I really, I'm always looking at how they're coping, or how the kids are, or who's minding the kids, or…I'd nearly be asking them who's doing their washing...you know*".

Other nurses with children also talked about their identification with patients who had children and expressed a heightened empathy. This is evident in the three narratives below.

Nurse 13 "*I know that we've one young patient who is similar age to my own age. She has a daughter that's 8. And she's a single mother…she'd be someone that I would have kind of a strong link with because I suppose, in a sense, maybe because she has a child, I maybe identify with that as well*".

Nurse 22 "*I suppose there are people* [patients] *I get a bond with because I suppose I have kids, and I suppose I just feel that if I was in the same situation, how I'd cope*".

Nurse 4 "*I mean I empathised with her* [patient] *at the time, when she had a child, but I think the fact that I have a child now as well, that I think I'd find it even harder, because you know definitely ...you know what it feels like for her then to be leaving something behind*".

Identification, therefore, reveals itself as a critical antecedent to nurse-patient intimacy, and results in nurses' empathy for patients. The central role of empathy in the development of nurse-patient intimacy is described eloquently by nurse 15 in the following narrative.

Nurse 15 "*The presence and the response and the people around them* [patients] *at that time is huge as well, in so far as my empathy towards that person... I can't change the fact that*

this person has a diagnosis...if I'm sympathising with somebody, then really I'm taking on their stuff, whereas I can be empathetic and step back and be completely empathetic with somebody…".

Other nurses too, described empathy for the patient as a feeling of being at their 'level' and an awareness of how they are feeling. Suggestions of 'clicking' and identification are also evident in the following narrative.

Nurse 2 "*Well I think you have to be at the one level with them* [patients]. *That you're not thinking, not a step above that you're like you're talking with them, you know as if you were. Like empathy maybe like you were…as if picture yourself in their shoes. How you'd like to be treated… ".*

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. Many nurses described the need to maintain a professional distance in their relationship with patients, as revealed in the following narratives:

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 or. I just try not to get just too involved. I suppose it's something you can't ….it's just sometimes hard to …but there are sometimes ways 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".*

The need to maintain professional distance was viewed by some nurses as a way of avoiding the risks of identifying too much with patients, which they equated as over-involvement. The following narrative from Nurse 12 illustrates how she manages this risk.

Nurse 12 "*I make myself stand remote from it...when I'm talking to them, I'd be talking about the children, talking about*

whatever, but I suppose I'm never really...I probably don't let myself get totally into it. I don't...I mean how into it do you get? I just...I talk about it, I feel that I put it out of my mind then, but I can relate to them because if I thought about it, I'd get very upset. If I kept thinking about it, I'd get very upset".

Nurse 15 expressed an interesting view of what she believed over-involvement to be. She considered it to arise out of a nurse's sympathy, as opposed to empathy, for the patient, illustrated in the following narrative.

Nurse 15 "*…if I'm sympathising with somebody, then really I'm taking on their stuff, whereas I can be empathetic and step back and be completely empathetic with somebody, and I just think that that's why self-awareness is so important …but I think that it's the fine line and the knowing, you know, because at that point you become no good to the patient, and that's huge".*

Discussion
The study narratives reveal that the first nurse-patient encounter begins a process of identification that results in empathy for the patient.   Identification is described as, "to involve a growing sensitivity to the 'movement' within" another person (Smyth, 1996, p. 935), and is highlighted as a characteristic of empathy (Rogers, 1975; Rawnsley, 1980; Smyth, 1996).   In a similar vein, Scott (1995) discusses empathy in the context of constructive caring as imaginatively identifying with the patient that requires working of the imagination, "which are unbounded by rules or laws, because beginning with preconceptions is likely to be damaging" (p.1199).

In an analysis of the writings of Scheler, Campbell (1984) discusses empathy and identification in the context of caring in the helping professions. Scheler (1992) describes emotional identification as an "infection" to illustrate its limiting capacity and argues that identification is something that is not rational or deliberate but a letting-go of self, and childlike in nature (p. 50). The reference to childlike is important to this discussion. The nurse's empathy for the patient must be naïve in nature so that the patient is viewed as a unique being and his/her experience of illness is also viewed as unique to them.   Moreover, this view would suggest that identification fits with the description of the 'lifeworld' *(Lebenswelt)* proposed by Husserl (1970), where individuals experience pre-reflexively, without resorting to interpretations.

Edith Stein's conceptualisation of empathy
The view of empathy proposed by the German philosopher Edith Stein (1917/1970) is helpful in understanding the nurses' narratives described in this study. Her work is one that combines the philosophical, psychological, aesthetic and the interpersonal (Davis, 2003), and is described in a three-level model of empathy where a field of tension between views on closeness and distancing in relationships is evident, and sympathy is considered part of empathy (Maatta, 2006).

Moreover, Stein's view of empathy appears 'active' in contrast to that of another phenomenologist, Emmanuel Levinas (1905-1995), in that Stein suggests that I go out of myself and encounter the other, through "the emergence of the experience" (Stein 1917/1970, p.11), whereas Levinas suggests that the other initiates the relationship (Moran, 2000). Stein's conceptualisation of empathy is, therefore, useful in explaining the active nature of nurses' pursuit of identification with patients described is this study.

Level one of empathy
Davis (2003), drawing on Stein's view of empathy, describes level 1 as a cognitive process whereby there is an attempt to enter into another's feelings and to put ourselves in their place. This first level of empathy requires the ability to use imagination and reflects the art of empathy (Davis, 2003). By reading the facial expressions or other signals, we attempt to obtain an idea of the person's emotional and mental state. This represents a determined aspiration to enter into the feelings of another and an attempt to position ourselves in another's place (Davis, 1990). Stein (1917/1970), describes this as, "When it [empathy] arises before me all at once, it faces me as an object (such as the sadness I "read in another's face"), but when I enquire into its implied tendencies (try to bring another's mood to clear givenness to myself), the content, having pulled me into it, is no longer really an object"(p.10). Davis (2003) uses the term *self-transposal*, one proposed by Speigelberg (1982), to describe this first level. This description is also similar to that of caring by Noddings (1984) who argues that "all caring involves engrossment" (p.17) which results in the carer investing full attention in the one being cared for and is characterised by a "move away from the self" (p.16), and suggests the primacy of ethical comportment in relationships with the other. However, it is important to note that the counselling literature rejects the view of empathy proposed by Stein is favour on one that only involves the first of the three stages (Davis, 2003).

Level two
Level 2 of empathy is one that follows closely after the first and is a gut feeling of identification following a shift from intellect to emotion. Davis (2003) calls this second phase a "crossing over" (p.269), a term derived from the work of Buber (1955/2002). It is argued that nursing empathy "may or may not involve emotion" (Lemonidou, *et al*. 2004, p.132). However, it is difficult to imagine empathy being mobilised in the absence of emotion. Level 2 involves an attempt to clarify the person's emotional state and a sudden feeling of being in the person's place (Davis, 1990). The empathiser feels that s/he is identifying with the other, but it occurs as "a parallel experience" (Maatta 2006, p.6).

Travelbee (1971) too, like Stein, differentiates between identification and empathy. She describes identification as: "an unconscious process and a mental mechanism wherein an individual strives to be like another…it is an unconscious imitation process" (Travelbee 1971, p.132), and argues that the person is unaware of identification when it occurs. Moreover, Travelbee (1971) similar to Stein (1917/1970) suggests that empathy is an antecedent to sympathy, and "the sympathetic person takes action to relieve the distress of another" (p.144). Travelbee's view of empathy is, therefore, curiously similar in orientation to that of Stein. However it is not evident if her work has been influenced by the writings of Stein, since she makes no explicit reference to such influence in her book (Travelbee, 1971).

Davis (2003) reveals that 'crossing over' (the second phase of empathy) is the most powerful of the three stages. She reached this view following her study with physical therapists who could not describe this second phase completely, but did reveal that it seemed to happen without them doing anything, but just listening. This 'crossing over' appears similar to the 'clicking' referred to by many nurses in the study described here.

Others, too, describe emotions in the identification stage of the empathic process. One of the nurses in a study by Henderson (2001) talked about identification and how the patient's characteristics promotes this: "*So I think it's a characteristic that somehow touches you, and whether it comes from within you or reminds you of someone else, that you care about, that's probably where a lot of it comes from*" (Henderson, 2001, p.134). Moreover, she reports that nurses' responses to specific patients are possibly mediated by previous personal or professional experiences (Henderson, 2001). This can be explained by the words of Stein (1917/1970) who describes "reflexive sympathy" as one "where my original experience returns to me as an empathized one" (p.18).

It is also reported how student nurses described, in their journals of clinical practice experience, that "the act of identifying and empathizing with patients appeared natural and immediate" (Lemonidou *et al.* 2004, p.125), and that the students' "thoughts and actions were driven by their emotions and by compassion" (Lemonidou *et al.* 2004, p.131). Moreover, it also suggests the impulsiveness of empathy, and its ability to 'just happen'*.* The work of Scheler (1992) on identification supports this notion. He argues that irrespective of the type of identification, it is "always automatic, never a choice or of mechanical association" (p.66). Furthermore, the "unconscious dimensions" of identification influence the development of interactions with others "beyond our conscious awareness" (Bondi, 2003, p.68).

Many raise the role of imaginative identification in relation to empathy. Lemonidou *et al.* (2004) discuss empathy as requiring "imaginative identification" (p.133). Similarly, Patistea (1999) relates "imaginative identification" with "pseudo-engagement" (p.89), while Smyth (1996) discusses empathy as an art and argues that it is "the most critical dimension of the caring relationship…and demands imagination and creativity" (p.934). This view is supported by the writings of Scheler (1992) on identification, who presents a useful perspective on this topic. He suggests that to attain identification with the other, the one identifying must be "at least unmindful, of all spiritual individuality; he must abandon his spiritual dignity and allow his instinctive life to look after itself" (p.66).

Returning to the description of 'clicking' with patients described by nurses in this study, Stein's theory argues that empathy is given "after the fact" in that it cannot be made happen but "catches us in its process" (White, 1997, p.254). This is termed the "Z factor, an unspecified relational quality" (van Manen, 2002, p.279) that cannot be described. The writings of Buber (1955/2002) are also relevant to the interpretations gleaned in the study. He proposed that dialogue between 'you' and 'I' can lead to a special moment where empathy erupts suddenly and spontaneously. He further proposes that this flash of empathy cannot be manufactured. Maatta (2006) argues, however, that Buber's view of empathy is perhaps a bit simplistic in comparison to the complexity of the empathic process outlined by Edith Stein. Nevertheless, Buber's view adds clarity to the process of empathy and further suggests its naïve quality.

Level three

Davis (2003) cautions that the crossing over to level 2 is "true identification" (p.270), but cannot be sustained. The final stage of empathy therefore, is a movement described as a "reaching out to the other" in an effort to reinforce the reality that this is happening to the other person and not themselves, resolving into "a deep fellow feeling for the other person, or sympathy" (Davis, 2003, p.269). Level 3, a form of self-recovery, is represented by a cessation of this feeling of affinity, and the empathiser becomes himself or herself again. "Sympathizing with the sense of affinity that just arose, we stand side by side with the person again" (Maatta, 2006, p.6). Travelbee (1971) also views sympathy as "a step beyond empathy" (p.141). However, Travelbee considers sympathy as active in orientation, with a "*desire to alleviate distress, absent in empathy*" (Travelbee's emphasis, p.142), as opposed to the "neutral process" of empathy (Travelbee 1971, p.143). Moreover Baillie (1996) reports that nurses in her study viewed sympathy as "feeling sorry for" (p.1302), whereas empathy required a closer relationship as it needed an understanding of the other's experience. However, the use of empathy and sympathy is often muddled. Related cases for empathy include sympathy and pity (White, 1997). Nevertheless, Davis (2003) argues that empathy can be distinguished from other similar interactive exchanges such as sympathy, pity, identification and projection because of its three overlapping stages and the fact that it is "given to us after the fact, or *nonpriordially*" (p.270). Davis (2003) therefore concludes that empathy is transcendent in nature and "introduces the spiritual aspect of experience" (p.271).

According to Davis (2003) empathy is not achieved unless level 2 is breached. Maatta (2006) suggests that Stein's (1917/1970) description of level 2 helps explain how nurses manage closeness and distance in their relationships with patients. The third step described by Stein is reflected in the view of Holden (1990) who describes empathy as emotional knowing where the nurse "projects herself into the physical being of the patient while simultaneously retaining her detached objectivity" (p.72).

Stein explains that because level 2 is of a temporary nature, it is not a "danger nor a threat to the ego" (Maatta, 2006, p.9). This is similar to the view of Travelbee (1971), who places the phase of empathy before sympathy in her theory of nursing as a process. Moreover, the movement from the second to the third level of the empathic response, as described by Stein, also helps explain nurses' views in the study, that an approach similar to a 'disinterested love' (Meehan, 2003) is the most appropriate response to patients in

order to offer the nurse some emotional protection from being overwhelmed by their empathic response.

Conclusion
The findings presented here highlight a philosophical explanation of the process of nurse empathy evident in nurse-patient intimacy. Moreover, the significant role of the first meeting between the oncology nurse and patient in the initiation of identification has been identified.

Identification and empathy represent reflections of the quality of relationships that nurses can offer to patients they care for. However, Campbell (1984), in his proposal of a moderated love assumed by professionals, differentiates between empathy and identification, which, he argues, may prevent the professional helper giving effective help. This view is in opposition to the findings reported here, where identification is necessary before empathy. However, Campbell (1984) does clarify that identification is ineffective if it is prominent over empathy. Such a view is also reflected in the work of Stein (1917/1970) who argues that the one empathising must move through the three levels for empathy to occur.

The narratives presented here and the supporting discussion, strongly suggest that empathy "just happens" (Baillie, 1996, p.1303). Moreover, Stein's conceptualisation of empathy, describes empathy as one given *primordially* or after the fact, because it happens only after you realise it, as it happens so quickly (Davis, 2003). The dominant aesthetic aspect of empathy is therefore evident, and illustrates the importance for the nurse to develop self-understanding into his/her own values and beliefs in order to raise awareness and mediate cultural biases and maximise the potential for cultural sensitivity (Kleiman, 2006).

The unconscious nature of empathy and its importance to developing intimacy with patients poses a question mark regarding the teaching of empathy to student nurses. One nurse participant in the study reported by Turner (1999) questioned if it was possible to teach nurses about involvement since the experience happened almost unaware to them: " I think [being involved] is something that you can't be taught. Because nobody knows how they're going to react to a situation until they're in it; nobody knows how close they can become to a patient until they're actually in that situation" (Turner, 1999, p.159). This suggests that raising nurses' awareness of their emotions is the first step in the approach to the teaching of empathy, and also highlights the central role of intuition in the emphatic process. Of relevance also, is the view of Roth

(1972), who argues that the nurse who admits a patient has a major role to play in applying a judgemental label on patients, which can influence their subsequent care. The possible lack of nurse identification with patients at this first meeting, therefore, has potential significance for the caring experience of both nurses and patients.

Scheler (1992), writing on emotional identification argues that it is "the act of identifying one's own self with that of another" (p.59). This view is supported in the descriptions of identification and empathy provided by nurses in this study, and highlights the centrality to self-awareness to nurses' empathy and subsequent intimacy with patients.

Finally, it could be argued that empathy and intimacy are closely related concepts. Empathy is intimately associated with the concept of 'closeness', and simultaneously requires closeness (Baillie 1996). Yegdich (1999), however, questions this conclusion and asks: "Can 'closeness' be sustained as the key defining feature of empathy? …closeness could reduce objectivity, affect commitment to other patients and cause personal stress to the nurse when their feelings were aroused." (p.90). Yegdich (1999), however, in this argument appears to be focusing on the possible consequences of over-identification, rather than on closeness, which further illustrates the difficulties in untangling the concept of empathy from intimacy.

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