

**THERAPEUTIC INTIMACY:
THE LIVED EXPERIENCE OF THE ONCOLOGY NURSE**

BY

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**A Thesis
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
for the Degree of**

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Therapeutic Intimacy: The Lived Experience of the Oncology Nurse

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Vivian G. Painter

**A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University
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ABSTRACT

Many nurses experience moments of deep and intimate connection with patients. This is particularly true in the oncology setting where illness is often sudden and perceived to be life threatening causing patients to seek support from nurses. Kadner (1994) defines therapeutic intimacy as “a confiding relationship between two people, a self-disclosure of personal information with the expectation of understanding and acceptance [consisting of] trust, closeness, self-disclosure and reciprocity.” The lived experience of oncology nurses who experience deep connected relationships with patients was explored in this study in an attempt to better describe the phenomenon, therapeutic intimacy.

Ten oncology nurses participated in the research. A semi-structured interview guided conversation between the researcher and participant. The participants were encouraged to tell a nursing story that involved an intimate relationship with a patient. The interview or conversation used an exercise in reflexivity: the participant had an opportunity to reflect on clinical practice situations in both detail and depth. The data gathered were found to be rich and full: a total of 58 nursing stories were related from which 370 significant statements were extracted. The data were analyzed using Colaizzi’s phenomenological method.

Significant statements created formulated meanings (sub-themes) which became organized around 15 themes. The themes formed several theme clusters. Finally, the theme clusters developed into a recognizable pattern of three categories, that helped to described the experience of therapeutic intimacy: The Ingredients of Intimacy, The Kinds of Intimacy and The Meaning of Intimacy. Findings of the research provided a detailed description of what was prerequisite to the intimate experience, the range of intimate experiences to be engaged in and the results of the intimate experience from the nurses’ perspectives.

The findings of the research were found to be consistent with the literature that describes nurse care and Watson's Model of Human Care. The result of the research supported the notion that therapeutic intimacy can be viewed as one kind of nursing intervention that makes up the larger constellation we refer to as care.

Based on the findings of the research, recommendations for nursing practice, nursing education, nursing administration and nursing research were made.

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CHAPTER ONE

BACKGROUND, PROBLEM AND PURPOSE

Introduction

The term therapeutic intimacy is uncommon in the clinical nursing world. Yet, nurses frequently describe occasions of deep and meaningful connection with patients and significant others so powerful that they sometimes surprise the nurse and perhaps surpass their personal experiences. While clinical nurses may be somewhat unfamiliar with an esoteric nomenclature such as therapeutic intimacy, the nursing literature is replete with scholarly discourses, philosophical treatises and qualitative and quantitative research studies that attempt to describe this phenomenon more fully. It is my contention, however, that these demonstrations have largely been done under the broad heading of nurse caring or caring behaviors. The purpose of this chapter, therefore, is to illuminate the concept of therapeutic intimacy in nursing practice. Background information, including my own personal experience, will be provided so that the problem and purpose of this research will be better understood.

Background

A Personal Testimony

I remember a patient who came to the unit with multiple myeloma, very ill and for his family suddenly ill. I never really knew the patient well because his renal failure was so severe and damaging that he was quite obtunded. I nursed this man. I provided all of the essential and important aspects of physical care: I monitored his physical state, maintained his fluid balance, kept his hygiene and observed for and treated any discomfort I perceived. As I nursed the man's body, I came to know his son. His son maintained a steady, unwavering vigil of grief at his father's bedside. He knew in his heart there was no turning back, there was no hope. I will never forget this young man's pain. I will never forget the hours of questions he had for me, night after night. Did his dad know he was there?... Was his dad in pain... How long could he live for... One night the son stood at the bedside gently massaging his father's limp feet. He rubbed them with great care and with obvious love. He watched for signs of response in his father. After a time, the son asked me if I thought that rubbing his father's feet might mean anything to his father, was this act that he was doing, was it of value? I remember being a bit taken aback by the profoundness of the question. I thought about it for a moment. Then I responded that I thought that whatever he could give to his father in words, in touch, in love, his father would take with him on his journey wherever that may be... that his father would hold fast to the gifts his son had given. After the man died, the son came to the unit to speak with me... to thank me for giving him the support and encouragement to be with his father however painful and difficult... I believe he thanked me for nursing his mind and spirit. That's when I knew what a nurse does. That's when I learned the privilege of being a nurse and being invited into human communion with another.

My personal experience with the intimate relationship in nursing practice has been one of significance and lasting memory. The story I related above is one of many experiences with this connectedness, this incredible privilege. These experiences have left me fascinated with the nature of the nurse-patient relationship; it was this and other experiences that have lead me to wanting to know more about this phenomenon.

The Landscape of Caring Nurse Practice

It is important to place the concept of caring and therapeutic intimacy within the framework of clinical practice. To do otherwise is to negate the essential element of nursing. While nursing research and education are critical elements of the profession, the clinical realm, the forum where the nurse and patient meet, needs to be the point or location from which the nursing world is viewed. Additionally, nursing work, clinical work needs to be analyzed in the context of how work is managed. Nurses practice in a system where they are parts of a whole activity. Therefore, the background to therapeutic intimacy in clinical practice needs to examine key elements: nursing work, the organization of nursing work, the economics of health care, definitions of care, the cancer experience and the relationship between care and therapeutic intimacy.

Nursing Work

Theorists and others have described nursing work in various ways. It consists of physical, psychosocial and spiritual dimensions. There is no difficulty in describing the physical aspects of nursing work. These are the tangible and visible aspects of nursing practice, the parts of practice that are referred to as traditional nursing skills. The other aspects, psychosocial and spiritual, are unseen or hidden. As a result, these less tangible aspects of practice go unnoticed and to some degree ill-described.

The seen or visible aspects of clinical nursing are well described in a multitude of nursing texts. (Kozier and Erb, 1990; Luckman and Sorenson, 1990). Both nurses, as providers, and patients as recipients of clinical nursing practice, can easily describe these nursing interventions: assessments, education sessions, medications, procedures, dressings, feedings and assistance with activities of daily living. Most agencies and

institutions utilize methodologies (PRN, GRASP and the like) that describe and statistically measure these activities. Measurement considers time and resource allocation and application intensity. As a result, physical activities are thoroughly accounted for and determination of the resource of the nurse is better understood.

This, however, is not the case with the less tangible, unseen aspects of nursing practice. These dimensions, described as behaviors and sometimes interventions, are not as well described. There are attempts in the same fundamental nursing texts (Kozier and Erb, 1990; Luckman and Sorenson, 1990) but these behaviors and interventions cannot be photographed or described in terms of a set discrete steps of a nursing procedure. Further, the unseen, intangible interventions have not been well documented and while there is a growing body of outcome-based nursing research, they remain largely unmeasured and not understood in a systematic way. Interestingly, it is strongly contended by nurses and nurse theorists alike that these elements are the essential and fundamental qualities of nursing. This quality is often referred to as care or caring behaviors.

Duke and Copp (1992) describe this unseen nursing, this concept of care as the “common thread that runs through all the activities that [nurses] do”. Further, they suggest that care is the synergistic element that allows the sum of the parts to be greater than the whole. Utilizing the image of a necklace, they insist that the physical activities of nursing are like the beads of a necklace and that the unseen attributes of care are the string that gathers the parts together into a thing of beauty and meaning.

While all this may be true, the inherent, underlying and historical problem remains if you cannot see it and name it, you cannot measure it and therefore you cannot claim it

exists or that you own it. This is one of the ongoing problems of professional nursing practice: how to describe, document and credit the unseen aspects of nursing, particularly that of caring. As Kitson (1987) maintains “we cannot run a health system on such notions as personal hunches and intuitions”. If we say that unseen activities, such as care, are part of clinical standards we must find ways of scientifically validating and authenticating them.

Organization of Nursing Work

Like any work activity, organization of work is key to effectiveness of result. This is true of nursing work. For the most part, nurse managers organize nursing work. Several methods are used. Team nursing divides nurse work based on task. That is, one nurse is assigned to provide medications, another nurse performs all dressing changes, and another may perform and document all vital signs and so on. The patients are seen as a group that requires a defined set of tasks. The nurses are assigned to patients based on the unique task they will perform. Using this method of work organization results in a multitude of nurse-patient relationships based on the service (task) provided.

Another method of organization of nurse work is total patient care. This approach does not divide the work according to task. Rather, it divides the patients into small groups assigned to individual nurses. The individual nurse is responsible for all aspects of nursing task and care for each individual patient. In this method of work organization, the number of nurse-patient relationships is more limited and based more on person to person.

Total patient care can be taken one step further to ensure that nurse-patient relationships are strengthened and flourish. Primary Nursing is a model of nursing where

total patient care occurs and the same nurse provides this care most of the time. Patients are assigned to one nurse (with an alternate available) with the expectation that the primary nurse will provide holistic, patient care which takes place over time allowing for a meaningful relationship to grow. This model of nursing care delivery (and philosophy of nursing) is most important when the disease process is intense and debilitating. It has been suggested that where a person's health status incurs change to the extent where illness is traumatic, life altering, requires long term intervention (increased length of stays or illness trajectory) and may leave the individual markedly changed and vulnerable a strong, dyadic relationship is important to the healing process (Kadner, 1994).

Primary Nursing has been defined as a “modality of care in which the nurse is assigned a...case load of patients so that care of an individual patient is the responsibility of one nurse, the primary nurse” (Ventura et al, 1982). The primary nurse is the coordinator of care, the navigator of care and, ultimately, a partner of care. When patients are in positions of traumatic, complex illness that require decisions and problem solving, a knowledgeable partner in care is essential (NCI, 1997).

Economics of Health Care

As alluded to earlier, there may be difficulties in the documentation and measurement of unseen nursing practice of which caring is a major element. The stresses and demands that have built over the last many years in the health care system compound this difficulty. As Valentine (1989) argues health care is an art and science with the healing *art* side not lending itself well to quantification. Further, decisions in health care are made on the basis of quantifiable data. This leaves caring practices, however, more valued by the caregivers, less valued by planners and funders. Most often it is the nurse

task, which equates to care for many, that is recognized and valued and not the nurse process.

The lack of description, recognition and valuing of nurse caring is compounded by a system whose resources have dwindled over the past decade. Kurtz and Wang (1991) report that a society which does not value caring expects nurses to provide service and to do more with fewer resources. A recent description of this phenomenon (Boon, 1998) identifies that economic pressures threaten nurses' abilities to provide caring practices. Cost containment of health care services has nurses providing professional service to ever-increasing numbers of patients. As a result, nurses are working harder, faster and with large numbers of patients while carrying the expectation that they will develop relationships with their patients, be attentive and provide expert care. The result is often a missed expectation leaving the patient and family perceiving they have not been cared for and blaming the nurse for an unsatisfactory health care experience.

The implications of this situation are clear. The invisible part of professional nursing practice must be fully described and the hidden components must be made tangible. If nurses who are currently compensated for the tangible, visible care they provide expect compensation for the hidden parts of professional practice, they must be able to clearly define and evidence this practice.

Definitions of Care

Is therapeutic intimacy a constituent of the intangible, unseen world of nursing? Little has been written or described about this phenomenon. Perhaps this is a result of more attention, both scholarly and research, having been paid to the overarching concept of care. Many nursing scholars and theorists have pursued the concept and theory of care.

The purpose of the following discussion is to demonstrate that insufficient definition and delineation has occurred in the study, conceptual development and ultimately the articulation of care. As a result, the parts or internal constituents of this phenomenon we call care have gone ill described. It is hoped that therapeutic intimacy will be understood and seen as a component of nurse caring.

Morse, Bottorff, Neader and Solberg (1991) used conceptual synthesis to establish five categories of nurse caring. Nurse theorists and their theories were then assigned to one of the five categories. Care was seen as a human trait, a moral imperative, an affect, an interpersonal interaction and a therapeutic intervention.

In the first category, caring is described as a human trait, necessary for survival and an essential component of Being Human. It is universal in its approach in that caring is not seen as exclusive to nursing. It is an essential way of being in the world. It is viewed as a constant force and long lasting in its duration.

The second category sees caring described as a moral imperative that maintains the dignity and respect of patients as people and emphasizes the mutual, reciprocal and interactive experiences that preserve humanness. Care in this category is seen as foundational to nursing and therefore, unique to nursing in some aspects. Care guides decision-making and defines the "oughts" and the "shoulds". Care in this case is constant for the patient.

The third category identifies caring as an affect, as an emotion, a feeling of compassion or empathy with the patient. These feelings motivate the nurse to care for the patient. Again, care is seen as unique to nursing. Care is seen as a motivator for action

rather than a decision making guide. The time frame of care as affect will depend on the patient, the relationship, type of patient and other demands.

The fourth category describes care as an interpersonal interaction where caring is mutual between patient and nurse and where communication, trust, respect and commitment occurs. This view of care brings the nurse and the patient together in relationship that is mutual. Care is seen as process and as the development of intimate relationship. The time frame of care as an interpersonal interaction will depend on the desire of the patient and situational demands on both the patient and the nurse.

Last and fifth, care is seen as a therapeutic intervention. A therapeutic interaction is seen as a nursing action that meets a patient's needs. Care is seen as delivery of tangible nursing actions. Care is focused on the patient as recipient. The nurse does not need to be engaged in care in an affective way to provide care in this instance. Care in this instance is dependent on the knowledge and skill of the nurse and on other situational demands.

The Cancer Experience

The cancer experience or oncology process for patients, officially, begins with receiving a cancer diagnosis. This serious and traumatic life event is described by survivors and others as a life altering experience that threatens and challenges every aspect of personhood: personal identity, life roles, belief systems and relationships (Howell, 1998). While this diagnosis causes the person to perceive an immediate threat to their life, cancer, most often, is a long term, chronic illness. The cancer illness trajectory, the journey the person with cancer takes provides a rich setting for meaningful, connected relationships to form between patient and nurse.

The cancer experience can be seen as having a life cycle of its own: From early detection, diagnosis, intervention, follow up, potential disease free status, through recurrence, additional treatment and palliation. Throughout the life cycle, multiple points of contact for patient and nurse occur. A decade ago, this contact occurred largely within hospitals where the patient received treatment as an inpatient. While patients are still admitted to hospital, the majority of treatment and care occurs in the ambulatory setting.

The ambulatory setting offers much to the continuity of nurse-patient relationship. Because there is no need to consider the 24-hour clock, and thus no altering shift patterns to contend with, patients can be reasonably sure that they will encounter the same nurse in the clinical setting they saw on the first visit. The inpatient setting, with its 24-hour clock, and altering shift patterns presents potential problems with continuity of care: depending when a patient is admitted and readmitted, they may not encounter the same nurse they saw on their first visit to hospital.

In both the ambulatory and inpatient setting, the consistent point of contact can be maximized and ensured by using a primary nurse model of care delivery. Mayer (1986) points out that primary nursing provides the structure necessary to develop therapeutic, caring relationships between patients and nurses.

The Relationship between Care and Therapeutic Intimacy

The concept of care, for the most part, is thought to be at the heart of nursing (Griffin, 1983). In all five categories of care theories presented above, the nurse-patient relationship is featured. It seems that care may be something that occurs as part of a relationship. Care, however, as a concept remains elusive. To clarify this problem, a

look at care relative to the relationship between patient and nurse may aid to see the concept of interest as a component of care.

Griffin (1983) analyzes the concept of care and examines the components as follows: the receiver (patient), the giver (nurse) and aspects of interaction between the two that constitute care. She identifies the receiver as vulnerable requiring an understanding of his wants, desires and priorities; the receiver of care may have profound questions that require answering and this act of relationship can have a lasting effect on the receiver. The giver of care must have an understanding of the situation, have experience to relate and be reflective. The giver must possess maturity and have a good relationship with the self. Care occurs as the giver pays attention and becomes attuned to the receiver's situation and reality. Griffin maintains that this attention and attunement has emotional aspects that she defines as compassion and through this relationship understanding is generated. Griffin says that a nurse sees patients (human beings) at their most vulnerable (there is nothing to hide behind and everything of value is at risk); she maintains that to see this, to be part of this, is a privilege that is not necessarily granted in other personal relationships. This description of deep connectedness seems to be a description of intimacy.

Care requires a giver and receiver: it requires a relationship. Is therapeutic intimacy a component of this relationship? Kadner (1994) maintains therapeutic intimacy is an essential element of the nurse-patient relationship. Based on her review of the concept as studied by others, she maintains that the "existence of intimacy within a dyadic relationship has been found to be a more important predictor of positive health outcomes during traumatic life changes than any other type of socially supportive relationship" (p.

215). Kadner defines intimacy as a confiding relationship between two people, a self-disclosure of personal information with the expectation of understanding and acceptance. Kadner cites Timmerman's (1991) analysis of the concept of therapeutic intimacy in the identification of its key components: trust, closeness, self-disclosure and reciprocity.

Kadner, like Griffin, presents the concept from a client-nurse interaction (receiver), a nurse-client interaction (giver) and places these interactions within the context of the nursing process. Again, we see the patient, the receiver, as vulnerable and requiring support as he faces his true feelings and thoughts about what troubles him most.

Utilizing intimacy, trusting the nurse, according to Kadner, allows the patient to enter into dialogue as opposed to remaining in a "lonely inner monologue of apprehension and despair" (p.216). The components of therapeutic intimacy, trust, closeness, and self-disclosure, are seen in this part of the interaction. The nurse, the giver, is required to be involved and concerned with the client. Kadner points to the limitation in the nurse's ability to participate fully in self-disclosure. She does not see this problem as damaging to the full utilization of the concept: the nurse self-discloses information that is of vital interest to the client, not to herself. The components of the concept are visible here: trust (as the nurse may be vulnerable), closeness (by involvement and concern) and self-disclosure (limited by professional relationship and to things vital to the client).

The gains (reciprocity) for the client are clear: acceptance, support, comfort are but a few. The gains (reciprocity) for the nurse are less clear. Kadner does not detail the reciprocity fully. Griffin (1983) identifies reciprocity for the giver as a sense of personal worth, gratitude and perhaps, love.

Statement of Problem

A clear description of the concept of therapeutic intimacy is not wholly available. While descriptions of care and nurse caring behaviors abound in the literature they do not articulate the whole experience of caring: they do not articulate therapeutic intimacy. It is my contention that care occurs as a result of relationship and that therapeutic intimacy is a component of the nurse-patient relationship. The lack of rich descriptions of care and relationships makes validation of therapeutic intimacy difficult. Without rich description, a full articulation of this concept cannot take place and therefore, negates its value as a phenomenon in nursing practice.

Statement of Purpose

The purpose, therefore, of this research is to describe as fully as possible the concept of therapeutic intimacy in oncology nursing practice. By engaging in exploration of the concept with oncology nurses who have experienced it, it is hoped that a detailed understanding will be gained. This new knowledge will allow the intangible, unseen practice of nursing to be better defined, more clearly visualized, articulated and valued in a meaningful way.

Research Questions

The research questions addressed were:

1. Is the experience of therapeutic intimacy known to oncology nurses and what is the nature of that experience?
2. How does therapeutic intimacy occur: what helps and what hinders its occurrence?
3. How is it used and to what end?

It was hoped that as the research questions were answered an understanding of the importance of the phenomenon would be achieved and the essence of therapeutic intimacy would be described.

Summary

This chapter provided a backdrop for the concept under examination, therapeutic intimacy, and identified the problem associated with its use in the clinical setting. A clear statement of purpose has been developed and several research questions have been generated.

CHAPTER TWO

A REVIEW OF THE LITERATURE

Introduction

The previous chapter raised a number of questions and identified areas where further information and description should occur. The purpose of this chapter is to describe and discuss the elements important to therapeutic intimacy. A description of the concept of nurse care, the dyadic nurse-patient relationship and use of self as instrument in nursing practice as found in the nursing literature will be provided. A sensitizing framework for the research will be described in order to place the problem and purpose of the research in a meaningful context.

From the Literature

Concept of Care

As described in Chapter One, the nursing literature does not suffer from lack of discussion of the concept of nurse care. Both philosophical analyses and qualitative and quantitative research have produced literature on the concept of care. A brief review of these contributions will occur so as to identify the gaps in both conceptualizations of care and therefore, the constituents or components of care and the methods of investigation used to date.

Philosophical Analyses

Three significant philosophical analyses were discovered in the nursing literature. Gaut (1983) utilized this “new approach” (p.313) to thinking and research ideas and phenomenon. Morse et al (1991) produced a comprehensive synthesis of care. Kyle (1995) did a thorough literature review and analysis of the concept of care.

A New Approach

Gaut (1983) used philosophical analysis to ask questions about concept clarity and justification as opposed to the more empirical stance of discovering explanation of cause and event. She engages in this process beginning with a semantic analysis of ordinary language, a surveying of the scholarly literature and the development of an action description that determines the “necessary conceptual features and properties” (p.314) of the concept.

Gaut begins with semantic descriptions of care. She concludes that care consists of attention to, concern for, providing for and regards, fondness or attachment to another person. This is followed by a review of literature produced by social scientists May, (1969), Maslow (1975) and Erikson to name a few. She identifies care here as a human need, a sense of concern and the essence of a helping relationship. Gaut investigates the nursing literature as a next step. She identifies Leininger (1978) as the theorist on care in nursing literature. Gaut concludes from all three sources of investigation that care comprises of “a disposition or feeling within the carer...the doing of certain activities regarded as caring activities...or a combination of both attitude and action...” (p.316).

Gaut moves to action description with the goal of developing an adequate theoretical description of care. She identifies components of care as consisting of four parts. First,

awareness of self and other; self and other is seen as distinguishable and separate and therefore, the ability to concentrate, focus and attend to another's needs is possible. The second component is respect. Respect is determined to be a necessary attitude of persons involved in caring. It is both respect of self and respect of other. A third part of care is knowledge. Gaut maintains to be aware and to have respect is not enough, it involves a kind of knowing. The carer must be aware of the caree's needs and possess the knowledge to act or provide for those needs. Last, awareness, respect and knowledge must provide for positive change. This could be growth, maturation, fulfillment or movement. Gaut ends her analysis having identified conceptually adequate description of care.

Categorization of Care

Another philosophical analysis by Morse et al (1991) provides a categorization of caring by theorist. This analysis proposed five categories: Caring as a human trait, caring as a moral imperative, caring as an affect, caring as an interpersonal interaction and caring as a therapeutic intervention.

As a human trait, caring, here, is described as essential to humanness. It is felt to be universal and not discreet to nursing practice. Caring is felt to be necessary for survival and an essential way of being.

Caring as a moral imperative is described as being the foundational basis of nursing where nursing is a virtue. While caring is universal, nurse caring is seen as special and unique. Caring maintains patient dignity, provides guidance for decision-making and identifies the duties and obligations of the profession.

Caring as an affect is described as empathy, feeling and concern for another. Again it is nurse-centered: the attributes of affect are not exclusive to nurses, but they are essential for nursing practice. Compassion is an essential ingredient and motivates nurses.

Caring as an interpersonal intervention is described as a relationship based on trust and respect. This description of caring is based on mutual involvement. It is dependent on intimate relationship and is a process in itself.

Finally, caring is described as a therapeutic intervention. It is based on nurse action that attends to the patient's needs. It improves the patient's plight, is focused on the patient and relies not on the nurse's needs, goals or aspirations.

Therapeutic Intervention

Kyle (1995) makes precisely this case in describing the concerns of nursing theorists in her review of the literature related to the concept of care. Care is described as being poorly defined and an elusive and imprecise concept. She maintains that several theorists attempt to "uncover the ingredients in order to make the concept more precise in nursing practice" (p.507). Kyle outlines nursing theorists whose writings about caring provide the current foundation in the literature. She begins the discussion with Leininger's (1984) view of care as a universal phenomenon consisting of acts that assist, support or facilitate other individuals in improving their conditions. She lists the constructs Leininger maintains constitute care (comfort, concern, compassion, stress alleviation, support and trust).

Kyle identifies Watson's (1979) beliefs that caring in nursing practice is a therapeutic interpersonal process. She lists the components or constituents Watson theorizes are the "carative" factors. Kyle states that Watson identified two key types of activities around

care: establishing relationships based on trust, faith, hope, sensitivity, empathy, touch, warmth and genuineness and offering support including surveillance and comfort.

Kyle goes on to separate theorists by perspective or view. Caring, she reports, is viewed by some theorists, McFarlane (1976), Griffin (1980, 1983), Orem (1985) and Weiss, (1988), as an activity. Others, Benner (1984), Gaut (1986), Dunlop (1986) and Duke and Copp (1992), see it as a set of behaviors. Caring can be viewed as an ethic, as it is with Carper (1979), Kelly (1988), Harrison (1990), Kurtz and Wang (1991). Finally, caring is perceived as a moral value (Fry, 1988).

The three philosophical analyses provide definition and description of the concept of care and its constituents. From this work, a number of research studies were performed with the intention to fully illuminate the concept of care.

Research on Care

Research on care has taken both a qualitative and quantitative approach. As well, both the perspective and the perceptions of the givers (nurses) and the receivers (patients) have been considered.

There has been some exploratory, descriptive research performed on the concept of caring as it is found in the clinical realm. Oddly, for a concept that is touted to be of such significance to nursing practice as to claim that care is foundational and fundamental, there is a lack of study available. Description of qualitative and quantitative approaches will be presented.

Qualitative Studies

Drew (1986) used qualitative methodology to explore care as a phenomenon experienced by patients. Her sample (n=35) of hospitalized patients were interviewed to

examine depersonalizing and confirming actions. Drew postulated that exclusion was an occurrence in a nurse-patient interaction where another disregarded a person's feelings. From the philosophical analyses this could be seen as not caring. In this study, confirmation was determined to be the opposite of exclusion. Confirmation, therefore, can be seen as the acknowledgment of a person's feelings, confirmation of another's existence and being touched and heard by another who cares. Again, much of this description is found in the philosophical analyses of care.

Having defined the terms and variables of study, Drew set out to explore encounters of distress and nurturing in hospitalized (vulnerable) patients. She utilized an interview schedule that had been evaluated by a panel of experts to ensure content validity, clarity and simplicity. Interviews were conducted and tape-recorded in private. Transcripts of the interviews were made and themes and patterns were identified to guide subsequent interviews. Constant comparative method of data analysis was utilized to produce emerging themes.

Drew produced a composite portrait of excluding and confirming behaviors. Her findings identify ways of humanizing health care for both patients and nurses. She surmises that caregivers are subject to great stress and if caregiver needs are not met they in turn will be unable to meet the needs of patients. She concludes that as care is defined more and more technically, its essence will continue to be something that happens between people. Cultivation of relationship, says Drew in the end, is necessary if care is not to be diminished.

Forrest (1989) examined the phenomenon of caring from the perspective of the nurse. This inductive, descriptive research utilized hospital nurses (n=17) who were selected for

having experience with the topic under investigation and an ability to articulate their experiences. The researcher stimulated research subjects by asking an open-ended question about the meaning of care. Participants were encouraged to describe fully and deeply their experiences. All interviews were recorded and transcribed verbatim. Participants were asked to read their transcript and add, delete and otherwise make corrections and clarifications.

Data were analyzed using Colaizzi's method: getting a sense of the transcript as a whole, extraction of significant statements and phrases, formulation of meanings, organization of meanings into themes, integration of an exhaustive description of the phenomenon resulting in the essential structure of the phenomenon. Validation with participants occurred in order to compare the description with the lived experience. Caring was identified as involvement and interacting and consisted of presence, respect, empathy, closeness, physical contact, awareness and knowing them well. Caring was affected by oneself, the patient, the situation, coping and finding comfort and support.

Implications for nursing practice were suggested. Forrest maintains that caring becomes an emotional burden for nurses and support for taking this burden comes from other nurses. Other nurses either provided the support required to care or cause frustration, hurt and disappointment when they fail to provide this support. Drew concludes that nursing and healthcare administration must ensure support for nurses among nursing staff exists.

Forrest (1989) built on Drew's (1986) work by investigating the meaning and value of caring in nursing practice as perceived by student nurses. This qualitative research utilized a sample of student nurses (n=26). Participation in the study was voluntary. The

participants were asked to describe an incident in which they observed caring and noncaring behaviors. Interview data were compared and themes and categories emerged. The findings identified caring behaviors as giving of self, meeting needs in a timely way and providing comfort. Non-caring behaviors were identified as not giving of self, not meeting needs in a timely fashion and not providing comfort. Chipman embarked on the research to aid the change in program curriculum that proposed to utilize Watson's theory of care. Her findings concluded that caring and noncaring behaviors are present in the clinical environment. The significance of the findings are clear when it is recognized that student attitudes are socialized and that role models (nurses) are an important factor in communicating expectations, attitudes and values.

Clark and Wheeler (1992) produced a small study that sought to view the phenomenon of care in nursing practice. The stated intent of the study was to enhance future research into a focus of the important parts of nursing. A sample of nurses (n=6) was selected based on experience with caring and their ability to articulate these experiences. Participants were interviewed about the nature of the meaning of caring and to give examples of caring; a tape-recording was made and transcribed. Subjects had the opportunity to read their transcripts and add, delete and correct.

Data were analyzed using Colaizzi's method. The categories and themes that emerged were being supportive, communicating, pressure and caring ability. The essential structure of caring that emerged identified a process that is experienced by giving of oneself to another and that creates trust, love and value. Other essential constituents were active and passive communication, awareness, empathy and provision of comfort. Caring was found to be rewarding.

The findings of this study are similar to the other qualitative studies in that the participants identified the interpersonal aspects of caring as the most significant. The category identified as pressure indicated to the researcher that the cost constraints of recent years could affect the quality of care provided. Further studies were indicated that would examine both nurses and patients and their families.

Quantitative Studies

A number of quantitative studies focused on nurse caring have occurred. Several research instruments were used in studies that attempt to measure the phenomenon of interest. The studies are summarized below. It should be noted that each of the following studies reported that the research instruments used were reliable and valid but no detail of this was provided.

Larson (1984) used an earlier study on nurse caring behaviors to develop a research instrument designed to measure care. Instrument development used two groups of nurses (n=57 and n=112) to define caring behaviors nurses use to indicate to care to patients. The Caring Assessment Instrument (CARE-Q) was then used to measure care as perceived by cancer patients (n=57).

The findings of the study indicated that the sample group of patients perceive care in terms of tangible tasks such as monitoring, providing physical care (giving injections, medications) and providing comfort. The study concluded that it is important for nurses to validate the care they provide with the recipients. It was acknowledged that the study had limitations and was not generalizable. It was indicated that more study on the concept of caring was needed.

Larson (1986) replicated this early study choosing nurses as her research subjects (n=57). Her goal was identified as exploring whether patient and nurse perceptions of care were similar. Again she used the CARE-Q instrument with reported reliability as stated in her initial study. The top ranked indicators of care from the nurses' perspective were in contrast to the same listing of the patients' perceptions. Nurses identified listening, touching, expression of feelings (by patient) and talking as most important. All but one element (giving adequate physical care was at the bottom of the top ten list) had to do with communication and relationship.

Larson, again, states that the methodology, the instrument (reliability and validity) limit the generalizability of the findings. She wonders how realistic the nurses' perceptions are when their list of important qualities lies in the affective realm. Patients in the earlier study identified trust relationship and accessibility, within the ten top ranked ten behaviors. What is important is that there may be differences in the ways nurses and patients (the givers and receivers) perceive care. It is not possible to account for the differences between the groups without assessing the instrument thoroughly, although one could speculate that the early study's subjects were hospitalized patients whose focus may have been on their physical illness and response to treatment.

Mayer (1987) produced a replication study of Larson's work using a sample of both nurses (n=28) and patients (n=50). Mayer used the CARE-Q instrument to measure perceptions of care.

The results indicated that while there was agreement between the nurses and patients on the importance of individual items, like listening, the ranking of importance demonstrated marked difference. Again, a physical activity such as giving injections was

ranked as most important to patients whereas nurses ranked listening and knowing as most important. Mayer concludes that patients appear to value the instrumental, technical expression of care while the nurses continue to value the caring relationship. She acknowledges the limitations of both the methodology and the instrument; oddly, she claims that quantification is important to understanding the parts of the whole as a response to Benner's advice that nursing care is relational and therefore, should not be evaluated by instrumentation (p.51). I agree with Benner: while I agree knowing the parts better is most important, I think instrumentation may be used prematurely particularly when not enough is known about the parts of the concept to truly understand what is being measured.

Another, more recent study (von Essen & Sjoden, 1991) was performed in an attempt to replicate Larson's and Mayer's work. The study took place in Sweden and measured perceptions of patients (n=86) and nurses (n=73). It was stated that the instrument had been modified for use in Sweden but which elements were modified was not specified.

The results of the study were similar to the North American findings: patients value clinical expertise while nurses value components of relationship. There was, however, agreement in the least valued indicators of care between nurses and patients: professional appearance, volunteering to do "little" things and the like. These researchers identified that patients feel cared for when they feel safe and secure. This could account for the focus on task oriented, technical care. They also allude to the hospitalized patient's predominant focus on getting better and subsequently, physical, competent care.

The authors of the study identify limitations as arising from the vagueness of some questions that could lead to a number of interpretations by respondents. They identify,

interestingly, that there was stronger agreement between specific patient-staff dyads: one questions whether the instrument is measuring what it was intending to measure. The most important limitation identified was the instrument was not able to cover the measurement of the construct sufficiently. One conclusion they arrive at is the need to look more closely at the nurse-patient agreement and ways to build positive relationships between the two realms.

Another instrument, Caring Behaviors Inventory (CBI), was used by Wolf et al (1993) to measure perceptions of care by nurses (n=278) and patients (n=263). The instrument (CBI) was developed by Wolf in an early study, (1981). Reliability, both test-retest and internal Consistency, was rated high (.83 and .96, respectively). Content and construct validity was reportedly established but no details were provided. Patient and nurse responses were combined.

The findings indicated five important dimensions: respectful deference, assurance, conceitedness, professional knowledge and skill and attentiveness to the other's experience. It was identified that the findings of the CBI fit the dimensions of Watson's Transpersonal Caring Theory.

The authors identify limitations as being due to the preliminary nature of the study, the convenience sampling technique, the combining of the sample and the inability to replicate the sample for further validation of the findings. They also identify the need for more reliability and validity testing of the instrument.

Morrison (1989) frames her research by identifying the significance of caring to the nursing profession. She maintains that the gaps in the research literature present a serious problem for the profession. To address these gaps, Morrison used a survey to gather

nurses' perceptions of themselves as carers. Her purpose was to develop a conceptual framework based on two tools, the Personal Construct Theory (PCT) and the Kelly's Repertory Grid Technique to analyze the survey data.

A sample of nurses (n=25) was drawn from a variety of practice settings using a strategic informant sampling technique reportedly originating from an earlier study (Smith, 1981). The participants were asked to share their views and experience on caring and to rate a set of elements along some dimensions of caring. The procedure provided eight opposite or bipolar constructs for each participant. These pairs were placed on Likert-type scales and research subjects were asked to place themselves on this scale and where they would be ideally. The self-reporting, self-analysis bias was discussed as a potential problem and strategies to ensure protection from bias were employed. Scores were generated from the self-rating of the participants.

Simple scores were calculated that indicated how participants saw themselves as carers and how they saw the ideal carer. The difference between the scores was identified as discrepancies. These discrepancies were used to indicate three main areas. First, the participant-nurses set very high standards for themselves, perhaps unrealistic standards when identifying the ideal carer. Second, the participants may not have the skill and knowledge to perform caring to the level they set as the ideal. Finally, the system of values dominant in the organizational culture may be different than the ones held by the individual.

Morrison acknowledges that the sample size being small limits the findings' application. She identifies, however, that further empirical research needs to take place.

Dyson (1996) utilized the methodology of Morrison's study. She based her study on Morse et al's work on the conceptualization of care (care as a human trait, a moral imperative, an affect, an interpersonal interaction and a therapeutic intervention). Her sample (n=9) of qualified nurses responded to grids of caring attitudes and caring behaviors set in opposite, bipolar pairs referred to here as dyadic combinations.

Data were analyzed using Euclidean measures (measuring the distance between constructs and identifying those constructs that are closely related). Themes were identified from this analysis and supported the concept of caring as what the nurse does and who the nurse is (p.1266): consideration and sensitivity, giving of self, honesty and sincerity and general approach. The findings did not fall into the categories of care identified by Morse et al but Dyson believes they formed a synthesis of that work.

Limitations were identified as small sample size. Dyson concludes that the results emphasize the importance of the humanistic and psychosocial components of care. She believes that more empirical work needs to take place in order to produce theory relevant to professional practice.

Dyadic Relationship

Human relationship can be defined as the thread that ties one person to another: the common element or link between two people. People are brought together in relationship because of personal attraction, family links, common interests, mutual goals and the like. Relationships between patients and nurses, so called dyadic relationships, are not terribly different. While personal attraction and family link do not form the foundation of this

relationship, patients and nurses are brought into contact with one another because of common interest and mutual goals around the illness trajectory.

The purpose of this discussion is to identify the nature and importance of the dyadic nurse-patient relationship. The intention is to provide a concise philosophical analysis of the continuum of nurse-patient relationship from basic therapeutic communication (a tenant of nursing education) through concepts such as involvement and commitment, and knowing the patient. The latter conceptualizations are about deep and connected links: moments of meaning and ultimately intimacy. The goal of the discussion will be to logically link the nurse-patient relationship to the concept of care. It will be demonstrated that the intimate nurse-patient relationship is therapeutic and therefore, therapeutic intimacy is a critical component of care.

Nurse-Patient Communication

Both the literature and nursing education material are replete with descriptions of nurse-patient communication. This basic skill is taught early and developed in nurse education and practiced daily in clinical nursing. Nursing theorists, namely Peplau and King, have based models of nursing on interpersonal processes (Bradley & Edinberg, 1990).

These interpersonal processes are presented as fundamentals of communication. Communication is seen as foundational to nurse-patient relationship. It consists of transactions, or purposeful interactions, guided and directed by the individuals values, beliefs and feelings producing negotiated outcomes and goals (Bradley & Edinberg, 1990).

Nurse-patient communication and therefore relationship, is an imperative of nursing practice in every clinical setting. This is well demonstrated by a small study of Icelandic women which describes this imperative (Fridfinnsdottir, 1997). The purpose of the study was to explore the stressors women perceive during the diagnostic phase of their breast cancer experience and identify the sources of social support on which they rely. The sample (n=12) were interviewed and data were thematically analyzed. The findings identified the stressors (receiving information, waiting for results and uncertainty of the future) and the social support they sought out (husbands, family and friends). While health professionals were not defined as part of social support, the women articulated importance of access to and communication with the nurse. The researcher indicated the implications for nursing practice to be ensuring that nurses acquire therapeutic communication skills.

Involvement and Commitment

At one end of the continuum, the nurse-patient relationship consists of simple therapeutic communication. If we move a little further on that same continuum, the nurse-patient relationship consists of more than therapeutic communication: it requires involvement.

May (1991) produced a study with a small sample of staff nurses (n=22) that sought to understand the appropriate basis for the nurse-patient relationship. The question the study sought to answer was to what level ought a nurse to be involved with a patient. Using qualitative methods, the study found that involvement was constituted of knowledge, reciprocity and exchange, and investment. Three modes of relationship were discovered: primary, demonstrative and associational. The findings identified the.

primary relationship as one of equilibrium where personal recognition of each participant gains a beneficial effect (reciprocity). The other two modes of relationship, demonstrative and associational, were found to negative with an overemphasis on reciprocity in the demonstrative and a rejection of reciprocity in the associational. In both cases equilibrium is lost.

Morse (1991) attempted to describe the nurse-patient relationship in depth as the result of interplay or negotiations that culminates in mutual satisfaction. She begins her research with the premise that the fundamental principles of the relationship are "routine and compulsory in all undergraduate programmes" (p.455) and that there is ample research on nurse-patient relationship in the literature. She identifies that the literature tends to focus on therapeutic response techniques and the linear stimulus-response model of communication. Her research sought to explain the development of the nurse-patient relationship.

Using qualitative methods, participants (n=44) were interviewed by 8 research assistants across a variety of clinical settings. Four types of relationships were described by the findings: clinical, therapeutic, connected and over-involved. These relationships represent a continuum of intensity with the clinical relationship not at all intense, mild intensity within the therapeutic relationship, moderate to high levels of intensity in the connected relationship and a loss of perspective in the over-involved relationship. All the relationships had resulted from a negotiation between the patient and the nurse.

Morse found that movement from lower to higher intensity of relationship, and ultimately the nature of the relationship, was governed by the patient's perception of the seriousness of the health need (illness situation) and their vulnerability. Four factors

(controlled by both the patient and the nurse) could increase and decrease the rate and level of development of the relationship. The four factors were isolating techniques and strategies (depersonalization, withholding of information), inconsistent exposure of specific nurse to specific patient (nurses being seen as interchangeable caregivers), specialization (where new providers supercede an established relationship and role) and lack of time (patient transfers, days off, task orientation).

Morse concludes that commitment is perhaps a more appropriate term than caring when describing the nurse-patient relationship. Caring, she says, implies love and affection that may not be seen as truly professional attributes.

Knowing the Patient

Morse identifies the notion of interplay and negotiation with the ultimate goal of mutual satisfaction. The interplay and negotiation must be founded in knowing the patient. Mutual satisfaction cannot be attained if the nurse does not have knowledge and understanding of the patient.

A phenomenological approach to this question was made by Tanner, Benner, Chesla and Gordon (1993) where research was pursued to answer what knowing the patient means and what difference does this knowing make to practice. Informants (n=130) were interviewed in groups and data were analyzed. The method of the data analysis was not reported. Knowing the patient was found to mean knowing both their patterns of responses and knowing the patient as a person. More importantly, knowing the patient was found to be central to nursing practice: it is primary to caring practice limits vulnerability and is essential to the patient feeling cared about. (p.279).

Likewise, Howell (1998) identifies this knowing the patient as one of five dimensions of caring as identified by Swanson. She goes on to identify that knowing the patient requires "exhaustive" understanding of what makes a patient an individual. This knowing is essential to the notion of interplay; it is connectedness with another human being. She concludes that in "knowing the patient, the nurse is able to provide compassionate care" (p.15).

The significance of the above-mentioned research to this endeavor is that it clearly links the larger concept of care to nurse-patient relationship and pays attention to the different levels and degrees of intensity and essential elements found in the nurse-patient relationship. It follows that therapeutic intimacy could be seen as one type of relationship, one component of nurse care within the larger constellation of care.

Self as Instrument

Instruments of Practice

When a surgeon engages in her work, she opens a bundle and exposes the tools or instruments she needs to perform her work: scalpels, retractors, forceps, sutures, and so on. For most health providers, tangible tools exist that aid in the ability to provide service to patients. While nurses have some *tools* at their disposal, these instruments relate more readily to the task oriented parts of practice; in the delivery of care, the only instrument a nurse can avail herself of is the self. When nurse care is viewed as relationship, the use of self by nurses becomes clear. Examples of this utility are provided below.

Jenny and Logan (1992) produced a small study that analyzed the concept of knowing the patient. The study focused on a specific aspect of nursing (ventilator weaning) and what impact knowing the patient had on knowledge, judgments and actions performed by the participants (n=16). The findings were focused on the above-mentioned elements and not specifically on nurse-patient relationship but in the discussion it was concluded that "nurses'...knowing involved their therapeutic use of self, by which they actualized an authentic... relationship with the patient" (p.258).

Nursing Action as Instrument

Without explicitly identifying use of self as the concept of interest, Perry (1996) investigated the nature of exceptionally competent oncology nursing practice. Using peer nomination, the participants (n=8) were observed, conversed with and exchanged narratives. The analysis gave rise to three themes: dialogue in silence (presence), mutual touch (connectedness) and humour (sharing). Perry identifies these themes as actions implying their utility to practice; in doing so, she makes them tangible, visible and perhaps available tools or instruments to be used. She qualifies how she perceives these actions of practice being used:

These actions were not done to the other, they are shared experiences, done with another, nurse with patient, patient with nurse and in some cases, nurse with nurse. (P.6)

Further, the analysis identified the effects of these nursing actions: connecting, affirmation of the value of the nurse and patient and joint transcendence. Connecting appears to be linked to the concept of knowing the patient. Affirming the value of the

nurse and patient appears to be linked with the concept of involvement and commitment. Joint transcendence appears to be linked to intimate nurse-patient relationship.

Summary of the Literature

A thorough review of the literature about the concept of care has occurred. The discussion of the philosophical analyses demonstrated that the broad concept of care is made up of smaller constituents. The qualitative research discussed the attempts at describing how care is used as intervention in the clinical setting. Quantitative research, using various forms of instrumentation, attempted to measure care in the clinical world. The review of the literature identified that the concept of care is studied and measured in its broadest sense and that not enough is known about its components. The purpose of the discussion was to link the notion that the concept of nurse care, broad in nature, is made up of smaller elements, interventions and behaviors. One of these elements is the intervention called therapeutic intimacy.

Sensitizing Framework

Like a conceptual framework, a sensitizing framework provides the researcher with a perspective or view of the phenomenon under study. The sensitizing framework sets the study material and questions within the researcher's view of the world. Therefore, the fit of framework to researcher is essential to well guided research. The sensitizing framework is meant to guide the selection of method, the research process and the analysis of the findings. For these reasons due consideration should be given when selecting the elements integral to the framework.

The purpose of the following discussion is to identify the elements or conceptualizations integral to the sensitizing framework. As the lens is to the eye, the sensitizing framework is to the researcher; it will aid the researcher in focusing more clearly the concept under investigation within the clinical world's context. Two conceptual frameworks will come under discussion here: Watson's Model of Human Care and Carper's Fundamental Ways of Knowing as adapted by John's (1995) as a guide to reflection in practice.

Watson's Model of Human Care

It is my belief that Watson's Model of Human Care, in its fullest sense, provides a framework that allows for understanding of therapeutic intimacy in the practice setting. Discussion of Watson's view of the nature of nursing, the Model of Human Care and its viability and relative utility to the research on therapeutic intimacy follows.

Transcendence

It is important to explore at the outset Watson's view on the nature of nursing with respect to care. In doing so, her model can be placed within an appropriate context. Cohen (1991) does this nicely by describing three dimension or concepts that help describe Watson's view of nursing: focus, goal and uniqueness. Watson's focus of nursing in the context of care is on the individual and the interactional process between the individuals. Her goal of nursing (again, in the context of care) is to mediate by use of profession, personhood, aesthetic and ethics the health/illness experience of the patient. Watson views nursing with respect to care as unique because interactions result in transcendence:

Responsivity, mutuality, intersubjectivity and full engagement and expressivity of the nurse as appropriate to the caring needs of the other are paramount.

Watson, (1994), p. 5.

With this view of the nature of nursing with respect to care, Watson' Model of Human

Care can be described. To quote Watson, the model:

Orients the practicing nurse toward a covenant that remains at the heart of the nursing profession: to develop with the other a trusting, caring-healing relationship that potentates health and well being, physical comfort, symptom management, pain control, and promotes meaning, growth, and harmony between provider and other.

Watson, 1994, p.1

There are three main components to the model: nurse-patient interaction, human care and actual caring occasion. Two processes (overlap of the nurse and patient's phenomenal fields and transpersonal caring) provide linkage to the components.

Watson's Model of Human Care is depicted in Figure 1. The components of the model overlap. Both the processes that link the components and the actual overlap of the components provide opportunity for transcendence to occur.

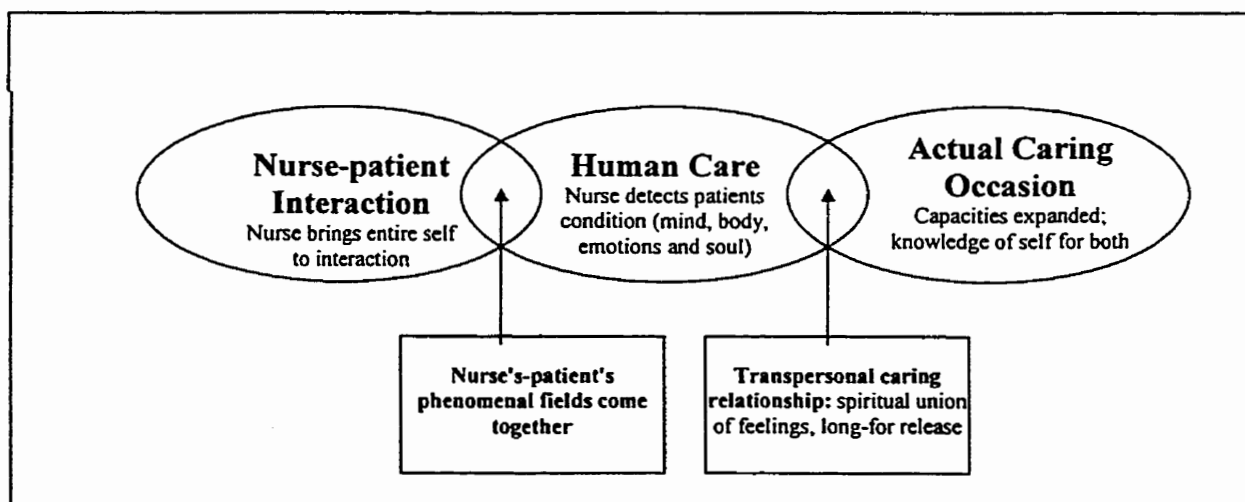


Figure 1 Watson's Model of Human Care (Adapted from Cohen, 1991)

When Perry (1996) speaks of joint transcendence she sites Watson as providing the richest and fullest description of this effect of nursing action. Kadner (1994) might argue that this joint transcendence has the essential components of therapeutic intimacy as identified by Timmerman (1991): trust, closeness, self-disclosure and reciprocity (p.216). The progression from the interpersonal sphere to the transpersonal sphere ultimately to full transcendence can be interpreted as therapeutic intimacy operationalized.

Therapeutic Intimacy as Transcendence

In Applying the Art and Science of Human Caring, Watson provides more cogent arguments for the operationalization of care, or as I stated it therapeutic intimacy. Watson makes the case that technical competencies are to the medical service paradigm what ontological caring competencies are to the modern nursing paradigm. Technical competencies can be seen as the use of tools and instruments in practice. Cohen (1991) refers to this as well. She refers to the technical competencies of nursing as the "trim of nursing (procedures, tasks, techniques)" and the ontological caring competencies as the "core of nursing (therapeutic nurse -patient relationship)"(p.908).

Watson's view of nursing as it relates to care, the Model of Human Care and her ontology of care competencies provide further opportunity to see self as instrument in clinical practice. It is in the use of self that the nurse moves through the linked components of the model to actualize in mutual transcendence with the patient; this is the action of therapeutic intimacy.

Reflexivity in Nursing Practice

In the tangible world of nursing practice, technical competencies, the tools and instruments of nursing practice, can be visualized, taught, monitored, inspected and

sharpened. When we perceive our technical competencies dull, to have lost their luster and effectiveness, we apply techniques and methods to sharpen and hone them. In the unseen world of nurse practice, the ontological care competencies, the other tools and instruments of clinical practice, are difficult if not impossible to visualize, to teach, to monitor, to inspect, scrutinize or sharpen. If we use self as instrument how do we visualize, inspect and sharpen the tool? How can a nurse scrutinize herself as instrument and make any necessary modifications?

If we argue that these competencies are integral to nursing practice and an imperative of nurse-patient relationship and ultimately care, we cannot continue to avoid employing techniques and methods to sharpen and hone these skills. It would appear that one technique to accomplish this might be the ability to reflect on practice.

Structured Framework

Johns (1995) describes the purpose of reflective practice is to allow the nurse to "access, understand and learn through his or her lived experiences and...to take...action towards developing increasing effectiveness...as desirable practice" (p.226). He maintains that through use of a structured framework, based on Carper's Fundamental Ways of Knowing (1978), the nurse has access to the unseen parts of her practice by using the framework to reflect upon everyday practice. Ultimately, according to Johns, reflexivity is learning through experience with the goal of developing self so as to use self more effectively in practice.

Johns' model of structured reflection is adapted from and uses all the elements of Carper's work. Carper identified four inter-related ways of knowing: empirical knowing,

aesthetic knowing, personal knowing and ethical knowing. Each way of knowing will be described below to better understand reflexivity.

Empirical Knowing

Empirical ways of knowing refer to laws, propositions and theories that describe, explain and predict phenomenon. Some see empirics as the only valid and reliable knowledge. Empirics can be likened to the tangible, explainable phenomenon in clinical practice; this is the world view of many in our society and if this one dimension is used to dictate reality it provides the opportunity to wholly discount aspects of reality that are less visible. It is, according to Carper, a way of knowing that should merely inform not dictate the other elements of knowing. Reflexivity, therefore, does not place empirics first; rather, it is placed within the framework as informing the aesthetic ways of knowing.

Aesthetic Knowing

Aesthetics, as a way of knowing, is described as the core process consisting of grasping, interpreting, and envisioning the clinical situation resulting in a response with appropriate skilled action. Johns describes it as in direct contrast to empirics in that it never seeks to predict. Aesthetics knowing seeks to perceive (grasp), understand meaning (interpret) and achieve outcomes (envision). The grasping and interpreting, the perceiving, is perhaps the art of nursing. For Johns it is intuition; it is the nurse understanding what is *going on here*. The envisioning and responding, setting the goal

and enacting the plan is knowing where to go and how to get there. Johns provides a tangible, straightforward example of aesthetic knowing in "responding to...redness on the sacrum of an unconscious patient" (p.228). Where the envisioned outcome is less tangible, let us say, a patient's broken spirit, the appropriate skilled response is more difficult to determine.

Personal Knowing

The personal way of knowing does not refer to personal knowledge but knowing the self. Johns identifies three components of personal knowing: awareness of the self's feelings and prejudices, management of these feelings and prejudices and managing anxiety to sustain the self. Personal knowing is necessary for connectedness between nurse and patient to occur. The nurse must have awareness of her feelings and prejudices; without this awareness she cannot manage them. Managing the potential anxiety that can result here is essential to sustaining self. When unable to sustain self, the nurse will retreat and limit engagement in order to survive. Where the empirical informs the aesthetic way of knowing, the personal influences. The degree of influence that personal ways of knowing place on the aesthetic is based on the level of engagement between the nurse and the patient.

Ethical Knowing

Ethics as a way of knowing is simply knowing what is right and wrong and being able to commit action based on this determination. Ethics is the process of deliberation characterized by conflicts. Ethical ways of knowing can place the values of the nurse in conflict with others (patients, colleagues and institutions). Ethics, as empirics, informs the aesthetic ways of knowing.

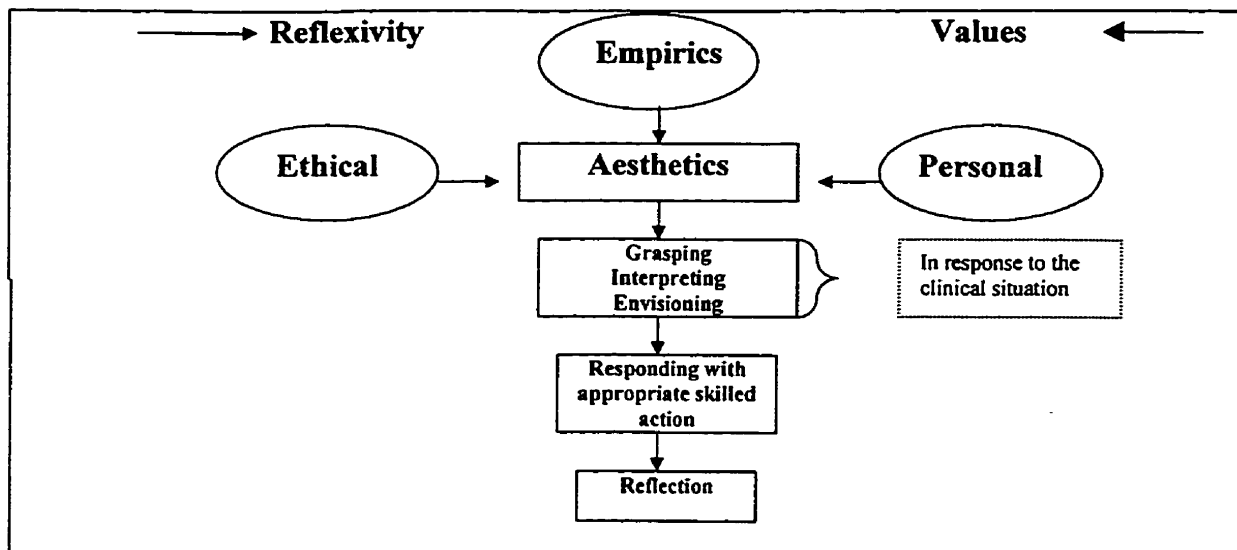


Figure 2 The inter-relatedness of Carper's ways of knowing (Johns, 1995)

The elements of Carper's ways of knowing are not static and freestanding; rather they inter-relate by informing and influencing one to another. Figure 2 provides further explanation of the inter-relatedness of the elements and the process of reflection.

Summary

The concepts of care, dyadic relationships and use of self as instrument have been presented and discussed with specific attention to therapeutic intimacy. A sensitizing framework consisting of Watson's Model of Human Care and John's Framework for Reflexivity have been presented and discussed. Watson's model provides a clear conceptualization of the nurse-patient interaction and the development towards transcendence. The act of transcendence has been compared to therapeutic intimacy. Johns' framework suggests a method by which the researcher might uncover the act of transcendence or therapeutic intimacy in the clinical setting.

CHAPTER THREE

RESEARCH METHODS

Introduction

The purpose of this chapter is to identify the method of study of the research problem. A justification of the qualitative research method will be presented. A research plan consisting of sample, including selection, and setting, data collection methods including demographic collection, the interview guide, procedures and data analysis, verification of findings and ethical considerations will be provided.

The Research Approach

The study of therapeutic intimacy is important to clinical nursing practice. The nurses critical skill set has many well understood technical competencies but few, if any, ontological caring competencies. These ontological caring competencies can be seen as the core of professional nurse services; they represent the essence of nursing practice. The study of therapeutic intimacy in the clinical setting provides an opportunity to make visible a core process employed invisibly by the nurse. Without this clear definition, the difficulties experienced in being recognized for being responsible and accountable for this kind of work will only increase: nursing work will be relegated to a task oriented and

skill set. The literature review demonstrated a gap in the research on care as ontological caring competencies. One of these ontological caring competencies is therapeutic intimacy.

Much of the research on care was quantitative in approach seeking to measure the concept of interest. Having now given due consideration to the unseen elements of nursing practice and the difficulties in articulating these ontological caring competencies, one does not get a sense that the quantitative measures employed measured the essence of the concept. For this reason, perhaps we have attempted, prematurely, to measure these elusive parts of care using the quantitative method. I would suggest that we have little knowledge of the unique, powerful and unseen components of care.

While some aspects of the empiric, scientific world has the advantage of microscopic evaluation, we have only the lens of phenomenology to view the hidden world of nurse caring: the essence of nursing. For these reasons, I have used a qualitative method to better define, describe and make tangible therapeutic intimacy, an ontological caring competency and a critical component of nurse care.

Phenomenology

Qualitative research emphasizes “nursing’s concern with human responses to actual or potential health problems” (Ploeg, 1999, p.36). The purpose of qualitative research is to describe, explain or explore nursing phenomena. Phenomenology is one qualitative method.

Phenomenology, as a philosophical point of view, was developed as a response to the use of the empirical, scientific approach originally taken towards the social sciences (Anderson, In Morse, 1989). The empirical approach seeks to know objective data, to

“see social facts as located in the social structure independent of interpretative schemes...” (Anderson, In Morse, 1989, p.19). Phenomenology holds that the objective, the facts, is inextricably intertwined with the subjective.

The Role of the Researcher

The phenomenologist views the facts of the empiricist as meanings, meanings that are created by human interaction. The purpose of phenomenology is to describe this human interaction, the lived experience of individuals. The individual or actor embodies understanding of their social world. Individuals relate to one another by resembling or typifying each other and in this process create meaning. The method is not interested in relation of subject-object; rather its interest lies in the relations of subject-subject. It is in this way that phenomenology concerns itself with intersubjectivity.

The role of the researcher in the phenomenological inquiry is first to understand one's own position or relation to the question. In this way, preconceived notions may be put aside (bracketed out) as they are recognized and description of the phenomenon rather than definition will be obtained (Oiler in Munhall & Oiler, 1986).

Phenomenological Process

The action, known as phenomenological reduction, allows for the peeling away of conscious or unconscious interpretations of the researcher so that the “meaning of the phenomenon to the individual” may be known (Valle & King in Knack, 1984, p.10). The activity is in some ways akin to the controlling of variables in empirically based work. The researcher attempts to suspend her beliefs and values, so that preconceived notions or assumptions about the data do not interfere with emergence of the phenomenon. By

doing this she exposes the general essences of the “common patterns shared by particular phenomenon” (Oiler in Munhall & Oiler, 1986).

The final act of the researcher is the halting or “apprehending of essential relationships” (Oiler in Munhall & Oiler, 1986) so as to allow the patterns and interconnections to be revealed. In doing so, the meaning of the lived experience may be known. The process utilizes imagination and interoperation of the general essences and thereby adds to the richness of description.

Research Instrument

The researcher becomes the research instrument. She interviews participants and makes notes of observations during the interview process. Questions are developed to bring out the individual’s experience; clarification of descriptions is sought to ensure that their experience was described accurately (member check).

Nursing has been influenced by the rationalist tradition perhaps as an attempt to legitimize itself as a discipline (Tanner, et al, 1993). Utilizing rational traditions as research methods to investigate aesthetic human phenomenon has led to missing the mark in an attempt to create explicit and propositional formal knowledge and the respect of other disciplines. Bishop and Scudder (1991) argue this has led to nursing practice as being seen as merely "a methodology learned by repetition" (p.5). They propose, however, that phenomenological interpretation can mitigate this situation by:

...giving nursing a way of articulating itself as a caring practice that reveals it to be much more sophisticated and intelligible than either the "traditionalists" or the advocated of science could have imagined.

Bishop and Scudder, 1991, p.5

Sample

The study sample is a critical element of any research. Because phenomenology attempts to reveal the essence of the concept under study solely through the lived experience of the participants, selection of the participants is of utmost importance.

Purposive Sample

A volunteer, purposive sample of oncology nurses (n=10) was constructed. The sample was procured from local oncology practice settings. Purposive sampling was believed to be the best strategy available to this research. A convenience sample, if used, may not provide participants interested in taking part in the reflective activities required by the data collection method. Purposive sampling required knowledge of the participants and judgment on their suitability (Polit and Hungler, 1991). My knowledge of the oncology practice setting and collegial relationships provided the appropriate sample in both number and quality of participants.

Purposive sampling is not without criticism. Polit and Hungler (1991), while concerned mainly with quantitative methods, say it is not a recommended approach but they concede that where research instruments are immature or where there is need to sample experts, a purposive sample is acceptable. This notion applies to the qualitative realm in so far as the accuracy and representativeness of a sample provide the ability to make theoretical generalizability. As a result, the purposive sample has not been seen as

indicative of all oncology nurses; it can only speak for the oncology nurses who participated and who have experienced therapeutic intimacy.

Inclusion Criteria

Participants had to meet inclusion criteria:

1. Five years of oncology nursing experience.
2. Must be providing direct patient care in an oncology setting.
3. Demonstrate understanding of the nurse-patient relationship (responded to “Research Participation Opportunity”, Appendix E or “Invitation to Participate”, Appendix A).

The rationale for the inclusion criteria is as follows. First, nursing knowledge and expertise develops on the continuum from novice to expert (Benner, 1989). On this continuum, the nurse develops technical competencies both general and those specific to their specialty. As previously discussed, the ontological caring competencies are very difficult to perceive and consequently require nursing experience well beyond the novice-end of the continuum. Therefore, a minimum of five years of oncology nursing experience was required. Second, nurses currently providing direct patient care had more potential points of reference than a nurse who must rely on distant experience. Because participants were required to relate a nursing story this criterion was important. Third, the participants related moments or experiences in their practice that they felt were exemplar: it is through their stories that the lived-experience and the essence of the phenomenon was developed. They needed to respond to the research invitation with something to say about the nurse-patient relationship.

Sample Acquisition

I sought permission to access participants from three settings: a tertiary ambulatory cancer center, an inpatient oncology unit and an inpatient medical unit at a tertiary facility and voluntary, local oncology nurse association. This was accomplished by gaining institutional permission to access participants (Appendix D) and presenting to a nurse audience at staff meetings. I provided preliminary information to the nurses using an information poster (Appendix E). A written description of and invitation to participate in the research was provided to the audience to supplement the in-person, verbal presentation.

Potential participants were asked to identify themselves by submitting the response form that consisted of a tear-off portion of the Invitation to Participate (Appendix A). The tear-off portions were placed in envelopes at predetermined locations on the nursing units and later collected by the researcher. The responses remained confidential.

Interview Setting

Once I obtained a response from a potential participant, I made contact by telephone. The potential participant was contacted at home and once she agreed to participate in the research, an interview was scheduled at the participant's convenience. Interviews took place in a private location that was comfortable to the participant. Because the interview guide was developed to encourage reflexivity, a comfortable, relaxed atmosphere was necessary. The participant was offered three choices of setting: their residence, my residence or at a private meeting space within the home institution.

Data Collection Methods

Demographic Information

Minimal demographic information was collected from the participants (see Interview Guide, Appendix C). I documented the following data at the outset of each interview: gender, age, years of nursing practice, and years of oncology nurse practice. The demographics provided summary information about the sample.

Interview Guide

The interview was developed with consideration of the use of narrative and Johns' adapted framework of ways of knowing. As a result, the interview guide consisted of two parts (see Interview Guide, Appendix C).

Using the Narrative Form

The first part of the interview guide asked the participant to relate a story or narrative of her clinical experience. Boykin and Schoenhofer (1991) identify story as a way of communicating and organizing nursing knowledge. They define story as a nursing situation. Participants were asked to remember and tell of a nurse-patient interaction, relationship or experience that represented a caring moment or a moment of intimacy. Each participant was encouraged to bring stories regardless of their presupposing the value of the story. The participant was asked to bring as many stories as they wished.

Reflective Exercise

The second part of the interview guide used reflexive technique. The participant, guided by my probing, reflected on the nursing situation described in her story. Questions and probes were made to help identify the empirical, personal and ethical informing and influencing of the aesthetic way of knowing of the nurse.

Interview Procedure

Once the participant indicated a preference for date, time and location of the interview, I made all necessary arrangements. The interviews took approximately one hour. A semi-structured tool (Appendix C) guided the interview. The participant was asked for demographic information at the beginning of the interview. All interviews were tape-recorded; I made supplementary notes during the interview: observations of the participant's emotional response, gestures and general demeanor were made. This was done to ensure fullness to the audiotapes. All taped interviews were transcribed verbatim. Through the process of in-depth interviews, data about caring, intimate experiences was gathered.

Data Analysis

Colaizzi's Technique

Colaizzi's technique was used to analyze the data. Each transcript was read in its entirety to acquire a sense of the whole. Significant statements and phrases were extracted from the transcript and meanings were formulated (moving from what informants said to what they meant). The formulated meanings were gathered into themes and themes into clusters. Clusters were reduced into categories. The results of the inquiry provided an exhaustive description of the phenomenon of interest. The essential structure of the phenomenon was revealed (Colaizzi in Clarke & Wheeler, 1992, p. 1285).

The findings of the research are presented in Chapter Four. In Chapter Five, the findings, the categories and themes, are compared with the sample, the research questions, the nursing literature and two sensitizing frameworks.

Methodological Rigor

Reliability and Validity

The purpose of this section is to examine methodological rigor of the research design. Methodological rigor ensures that findings of the research are reliable and valid; in other words, the findings need to be trustworthy. Methodological rigor in qualitative research is achieved by evaluating truth value, applicability, Consistency and neutrality (Guba & Lincoln in Munhall, 1994).

Truth Value

Truth value, as a criterion of rigor, is the first test of validity. It is sometimes termed as credibility. Munhall (1994) calls it resonancy or the degree to which the data "rings true" to the participant. Truth value was achieved by seeking verification of the findings with the participants. Validation was sought by having participants read the findings of the research. The analyzed data (findings) was presented to participants as part of the validation process. All participants were mailed a letter (Appendix G) and copy of Chapter Four, The Findings. The letter invited the participant to respond directly to me as to whether the material truly reflected their experience. Seven responses were received: three written and four verbal. The responses included statements such as "the findings are like a shaft or clear line into my inner world, my experience with patients" and "This explains what I really do; I want my family to read this so they will understand". There were no comments received, written or other wise, which did not validate the findings.

Applicability

This second test of validity refers mainly to the fittingness of the findings to the world outside the research (Munhall, 1994). Fittingness, and therefore applicability, was achieved by ensuring the fullest descriptions of the phenomenon under study were achieved. Rich and complete descriptions were sought. Munhall likens recognizability to this measure of rigor: does the reader of the findings recognize the experience and can they apply the experience within their own contexts?

Consistency

Consistency refers largely to the auditability of the research process. Rigor, and subsequent trustworthiness, was achieved in two ways. First, the thesis has been organized and written in such a way as to clearly define the goals of the research, the data collection methods, the data analysis employed and the findings of the research. Logical links have ensured that the research process is clear to the reader. Second, all data will be stored for a period of ten years; this will allow for review of the data vis a vis the findings at any time.

Neutrality

Neutrality is achieved by virtue of ensuring the other elements of methodological rigor have been employed. The achievement of truth value, applicability and Consistency, as described, has occurred and therefore neutrality has been accomplished.

Ethical Considerations

The purpose of this section is to examine the ethical considerations when conducting research with persons. It is essential that informed consent occurs and participation in the research is completely voluntary. As well, confidentiality of subjects, protection of data and vulnerability of subjects must be considered.

Informed Consent

Obtaining Consent

Informed consent was obtained from all participating nurses prior to proceeding with the interview. Each participant was verbally asked about their understanding of the study and their willingness to participate. Each participant was asked to read and sign a consent form (Appendix B). The researcher ensured that each participant understood that they were free to withdraw at any time during the research process. Consent was thereby both informed and continuous.

Voluntary Participation

I took care that no form of coercion (real or perceived) occurred. It was essential that the participants did not perceive me within my administrative role. I ensured that no discussions occurred that related to the workplace. I reiterated my role as student researcher and articulated the confidential nature of participation in the research. The protection of participant identity was explained. Each participant was assured that the administrative personnel to whom they report would not know of their participation. With each articulation of disclaimer, the participant was asked if their participation was

voluntary and whether they wished to proceed. As identified above, the participants were made aware of their right to withdraw from the research at any time.

Maintenance of Confidentiality

Coding and Pseudonyms

Each participant was assigned a numeric code and a pseudonym; the real names of the participants were not used in any way. The original tear-off information slip returned to me to indicate interest in participation was collated with the signed consent and supplied a numeric code. All data gathered were marked with the numeric code and pseudonym. The collated, numerically coded consent forms will be kept under lock and key in a location distinctly separate from the coded data. This will ensure that there can be no connection made between the named participants and the information they provided.

Access to Gathered Data

Access to the gathered data (audiotapes, transcribed interviews and supplemental notes) will be limited to my thesis chairperson, the transcriptionist and me. There may be need to expose other thesis committee members to the data. The participants are aware of this, as the consent clearly states these facts.

Storage of Data

Transcribed interviews have been stored in separate and distinct paper files as well as on computer diskette. Supplemental notes taken were collated with the interview to which they pertain. The consent forms have been stored in a secure location. The data (audiotapes, transcripts and notes) will be stored in a secure location separate and distinct from the consent forms. All of this material will be retained for 10 years. After this

period of time, all elements of the research will be shredded and destroyed as confidential waste.

Vulnerability of Research Subjects

Therapeutic intimacy is not a well-documented phenomenon. It is hoped that the phenomenon will become better known and made more tangible as a result of the research. Much attention is paid to technical competencies in clinical settings and nurses participate in numerous monitoring and certification procedures to ensure their skills remain well honed. It is hoped that with better understanding of ontological caring competencies, such as therapeutic intimacy, methods to monitor and mentor these core nursing competencies may be developed (Cohen, 1995).

The participants had the opportunity to engage in reflection on their practice and thereby, they stood to learn about themselves as care providers as well as learning about the technique of reflexivity. Through the validation process, the participants saw their practice within the context of a nursing model and come to understand the importance of ontological caring competencies. The participants made comment of this at the end of the conversation: all stated that the experience had been valuable and that they had learned something about their practice. One participant, who claimed at the beginning of the discussion that she had no control over the use of intimacy (“it just happens”) concluded at the end, after the reflexive exercise that she did indeed have control of her application of intimacy and used intimacy as intervention.

Cost to Participants

While there have been no direct costs to the participants, there were some burdens. First, some participants had to travel when they chose to participate in the research at a

place other than their own home. Second, each participant had to invest approximately 1 hour of time for an interview and a period of time to participate in validation of the findings. There was potential for inconvenience to the participants, but every effort was made to ameliorate these factors. No one reported feeling inconvenienced in any way during or after the interview.

Emotional Risk

There was mild to moderate risk to the research participants in that the nature of the research probed for information about private information held between the nurse and patient. The participant could have disclosed nursing situations that were perceived and remembered to have not gone well. There could have been elements of guilt and/or remorse with regards to these situations. Whether the nurse's story or reflection on clinical situations was recollected as positive or negative, the telling and reflecting had the potential to give rise to stored emotions. The participant could have been embarrassed at her emotional response (stored emotions) to the clinical situation. No episodes of embarrassment occurred.

Three main actions were identified and used to ameliorate the above mentioned risks to participants. First, in keeping with earlier points, the participant was given continuous opportunity to withdraw from the research. Second, the participant, having experienced stored emotions, was given an opportunity to compose herself; if desired, the interview could have been rescheduled. Third, I assured all participants that their nursing story and the clinical situation was not being judged; rather, it was providing information, data, to understand better the phenomenon under study. It was essential that the participants

knew that no negative information (real or perceived) would be communicated to parties outside the research setting. In relation to this last measure, if the nature of the negative and remorseful feelings being experienced by the participant were of such an intense nature, it would have been incumbent on me to assist the participant to seek a form of support. In the course of the research, no incidences of this nature occurred and no interventions were required.

Summary

In this chapter, the research method was discussed. A rationale for the phenomenological approach was made. Discussion of sample and sample selection, data collection methods and analysis was provided. Methodological rigor and ethical considerations were examined. In the next chapter, Chapter Four, the findings of the research will be presented.

CHAPTER FOUR

FINDINGS

Introduction

The purpose of the fourth chapter is to present the findings of the research. The chapter, therefore, consists of a detailed description of the sample and a reporting of the findings that emerged from the data collected. A chapter summary is provided.

All names of participants are protected by pseudonym. Further, there has been some slight alteration of detail, both event and circumstance, in an attempt to provide anonymity to the study participants.

Sample

This section describes the sample. The sample consisted of 10 participants. Information on interview setting, gender, age, practice experience and number of stories related are presented as qualities of the sample. A summary of this information is contained in Table I, (p.63).

Sample Qualities

Interview Setting

As indicated in Chapter Three, each of the participants chose the setting of the interview. Four nurses chose to be interviewed in a private room at their workplace; five asked to have the interview conducted in their homes; one chose to come to my home. Interviews were conducted using the semi-structured interview guide (Appendix D) and were perceived to be relaxed in nature. Each participant was interviewed for .

approximately one hour. All interviews were concluded when the participant felt they had completed the task.

Gender and Age

Of the 10 participants in the study, nine were female. This appears reflective of oncology practice settings in general with less than 10% of nurses being male.

The approximate age of each participant was noted at the beginning of each interview. Age of participants ranged from 30 to 50 years. There were three nurses less than 40 years. There were four nurses between 40 and 50 years. Three nurses were older than 50 years. The average age of the participants was 43.5 years.

The sample appears to be reflective of the practice setting in terms of gender and of age: predominantly women with the majority of nurses being middle aged.

Practice Experience

There was much diversity in the sample in terms of both the number of years in nursing, the number of years in oncology nursing and the practice setting of each participant. The majority of participants had spent all their working lives in nursing (60%). There was a group of participants (40%) who entered nursing as a later career choice. This accounts for those participants whose age is significantly greater than the total number of years in practice.

Years in Nursing Practice

In terms of total number of years in nursing, the range consisted of as few as five years to as many as 32 years. There were five participants with less than 10 years experience, three participants with more than 10 years but less than 15 years and two participants

with greater than 15 years of experience as a nurse. The group's total number of years of practice was 177 years. The average number of years practicing as a nurse was 17.7 years.

Years in Oncology Nursing Practice

Participants were asked specifically about their years in oncology nursing practice. All participants met the inclusion criteria of five years of oncology nursing experience as described in the Invitation to Participate (Appendix A). It should be noted that the participant was responsible for determining what was considered to be an oncology practice setting. Three participants had practiced in areas not specifically oncology (adult medicine and community nursing) but determined that there was enough focus on oncology patients to meet the inclusion criteria.

The total number of years of oncology nursing practice was 125 years. The range of years in oncology nursing practice was five years to 25 years. Some nurses (40%) had only oncology nursing experience; some (30%) had less oncology experience compared with their other nursing practice experience (less than 50%); others (30%) had more oncology experience than other nursing practice experience (greater than 60%). The average number of years in oncology nursing practice was 12.5 years.

Practice Setting

There was a good range of practice settings. Participants came from the inpatient, ambulatory and community settings. This diversity is noted in Table I, (p. 63): the setting of major experience is seen in bold while the setting of lesser experience is seen in parenthesis. Some participants (3 or 30%) had oncology experience in both inpatient and ambulatory settings. Four participants (40%) had oncology experience only in the

inpatient setting. Two (20%) participants had oncology experience only in the ambulatory setting. One participant (10%) had oncology experience only in the community setting. The inpatient setting was the predominant location (60%) of the experiences that gave rise to the nursing stories provided by the participants.

The Stories

Participants were contacted by telephone to arrange for an interview. Each participant was asked to think of a significant experience or relationship with a patient, one about which they had strong memory of and to come to the interview prepared to tell the story. Each interview began with a singular nursing story and all but one interview, gave rise to more than one story. There was always one story of great significance, but one story lead to another and another. The interviews ended when the participants felt they had shared all the stories they considered as relevant to the concept under review, therapeutic intimacy.

The stories shared by participants ranged in number from one to 11 in number. The total number of stories shared was 58 and the average number shared per interview six. The stories were of varying intensity: some recalled the participants back to the actual event so clearly that both teller and researcher were brought to tears; others were clear and concise reminiscences of events.

Summary of Sample Information

In summary, the study sample was small but reflective of a range in gender, age, years of nursing and oncology nursing experience. The participants were able to relate many nursing stories from which the researcher gleaned the experience of therapeutic intimacy.

Participant	Gender	Age	Number of years in nursing	Number of years in oncology nursing	Practice setting *	Number of stories
Nurse #1 – Holly	F	45	25 years	10 year	(Inpatient) Ambulatory	3
Nurse #2 – Rachel	F	30	9 years	9 years	Inpatient	11
Nurse #3 – Chris	F	50	14 years	14 years	(Ambulatory) Inpatient	10
Nurse #4 – Rita	F	50	32 years	14 years	(Ambulatory) Inpatient	7
Nurse #5 – Beth	F	50	30 years	25 years	Ambulatory	6
Nurse #6 – Mel	M	35	5 years	5 years	Inpatient	5
Nurse #7 – Gail	F	35	13 years	8 years	Inpatient	1
Nurse #8 – Ruth	F	45	9 years	9 years	Community	5
Nurse #9 – Mary	F	45	29 years	20 years	Ambulatory	8
Nurse #10 – Wendy	F	50	11 years	11 years	Inpatient	2

Table 1 – Sample Summary

*Bold denotes majority practice setting; parenthesis denotes some practice experience

The Findings from the Data

Introduction

As mentioned in the last section, there were a total of 58 stories related through the interview process. Each participant was asked to relate a nursing story. Generally, one story would lead to another. The semi-structured interview schedule asked a series of questions related to the experience of therapeutic intimacy, including the opportunity to define the concept. As a result, much detail was provided about the nature of the intimate nurse-patient relationship.

This section of the chapter will present what was found in the interview transcripts. A brief description of the technique used will be made. The findings will be presented as categories that consist of clustering of themes. A collapsing of the themes will be attempted in order to render the essential structure of the phenomenon under study.

The Analysis

Technique

The taped interviews were transcribed verbatim. Using Colaizzi's technique, I listened to individual interview tapes and read and reread each transcript. I began organizing the data using three strategies. First, I made notes on the thoughts that occurred to me during the reading of the transcripts. Second, a catalogue of all nursing stories was constructed: some stories were detailed, clear and linear; other stories were clear visualizations of moments in a participant's experience; others, still, were vague

references to a patient or clinical experience that did not develop entirely. Third, I identified significant statements.

Significant Statements

There were 370 significant statements; the majority of the statements were used in the analysis. Both the notes on thoughts and the nursing stories were contained in these significant statements. Each significant statement was treated as an independent data element. Data elements were reconsidered and sorted into a series of themes: the themes were not predetermined but rather occurred as a result of the consideration given to the statement's true nature. A sample of significant statements and their reformulated meanings can be found in Appendix F. Themes developed as clusters and clusters became organized into three headings or categories.

I will present discrete elements of data or quotations where necessary. However, where possible, the data are amalgamated and paraphrased. Some of the nursing stories shared by participants revealed themselves to be either succinct examples or exemplar cases of a certain theme or cluster. As much as possible I have tried to present these vignettes or snap shots of moments of intimacy. Their poignancy and beauty will hopefully touch you. The vignettes are actual individual contributions of participants as related during interviews. There has been a purposeful attempt made not to link the vignette with the participant in many places. Some vignettes are highly personal and for this reason the participant's anonymity should be maintained.

Categories

The Research Questions Revisited

The questions this research sought to address were threefold:

1. Is the experience of therapeutic intimacy known to oncology nurses and what is the nature of that experience?
2. How does therapeutic intimacy occur: what helps and what hinders its occurrence?
3. How is it used and to what end?

Introduction of the Categories

In response to the questions three major categories emerged from the data: Ingredients of Intimacy, Kinds of Intimacy and Meaning of Intimacy. Each of these categories was constructed from clusters of themes derived from the significant statements. Each major category will be developed through identification and discussion of the clusters and themes. The major categories relate with each other in a dynamic process and evidence of this will be provided. Please note that capitalization of words is meant to denote a category, cluster, theme or formulated meaning.

Category: Ingredients of Intimacy

The first category that emerged from the clusters and themes seemed to tell about the prerequisites of the intimate experience. The actual themes or ingredients were disclosed in variety of ways: some were within stories, some were actual statements of insight and others were conclusions drawn by participants during interviews.

The themes developed into two clusters: external considerations or the nurse's abilities to *set the stage* and internal considerations or the nurse's *use of self*. These ingredients of therapeutic intimacy, (clusters and their themes) are contained on a *recipe card* in Figure 3 below. Each cluster and corresponding theme element will be presented in detail in this section.

RECIPE: INTIMATE RELATIONSHIP	
Category One: Ingredients of Intimacy	
Cluster –Setting the Stage (External Control)	Cluster -Using Self (Internal Control)
Theme –Space: <ul style="list-style-type: none"> • Creating Space • Controlling Space 	Theme - I Bring Myself: <ul style="list-style-type: none"> • Myself as a Person • Myself as a Nurse
Theme – Time: <ul style="list-style-type: none"> • Finding Time • Nights • Making Time 	Theme – Approach: <ul style="list-style-type: none"> • Openness • Sensing and Touching • Silence
Theme – Contact: <ul style="list-style-type: none"> • Amount • Consistency 	Theme – Directing the Flow: <ul style="list-style-type: none"> • Intent • Boundaries

Figure 3 – Recipe Card: Ingredients of Intimacy

It should be noted that the notion of a recipe is not to be interpreted as a simplistic or trite approach. Neither should recipe indicate a singular or only this-way approach. I would make two claims about *recipe*. First, recipes are used in many instances to support and guide complex activity (i.e. breaking down the larger whole into understandable and manageable parts). Second, recipes are most helpful to the novice practitioner (of any profession) in that they guide and support during that beginning time a learning and growing. The more expert a practitioner becomes, the less they will need to refer to a

recipe. However, it is always advisable, even when expert, to check back occasionally just to be sure that you have included all the ingredients, or components, required.

Cluster: Setting the Stage

The participants spoke of the necessary environment for the intimate interaction to take place. Three themes were identified as important in Setting the Stage for an intimate interaction: Space, Time and Contact.

Space

He had a colostomy...one night I was cleaning it or emptying it or changing the bag or whatever. So we had the curtain closed, which gives you a nice little setting to be intimate. So he asked me about sexuality and would he and his wife still be able to enjoy their sexual relations. We talked back and forth about this...it just happened so naturally. We had our little intimate space and there was a person in the next bed, but when you draw that curtain, you have your little space. It just happened. Started talking.

Creating Space

The participants spoke of either creating or controlling the physical space. The nurse above told of how she created the space she needed. She would say “you need a quiet place and by drawing the curtain the space could be created.” In doing this, you might still hear the “goings” on of the ward but you would have created a world to be shared by only the nurse and the patient.

Controlling Space

Wendy recognized that sometimes the hospital atmosphere presented difficulties in achieving this (creating space) as sometimes it is the setting itself: “four-bed room, two bed rooms seemed easier to manage.” As well, there are other actors on the stage of the hospital ward: Chris said it was “noise, just hustle and bustle. If you can’t even close the

door, it just detracts from the attempt to create and control the atmosphere.” That quiet moment the nurse creates can be destroyed by someone barging in and ripping the curtain back, saying: “Here’s your meal tray.”

Where ever possible, the nurse attempts to create the necessary atmosphere.

Time

Once I had a patient who was just scared to death of dying...he needed me to be with him and I had three really slow times. I sat up watching stupid old TV shows with him all night long. I had the time to do it. And it was so important to him because he was so afraid. He did die. But the next week he wasn't so afraid of dying by himself. It was so important to him. When patients tell me those kind of things, I might not always be able to spend three nights sitting up and watching stupid old TV shows with people but if they identify the things that make a difference in their lives I try.

Finding Time

Participants talked about needing Time in order to develop intimate relationships with patients. Sometimes it was a matter of recognizing what was important and using Time. In the previous story , the nurse found time for her patient on a night shift.

Nights

Many participants noted that certain time periods, like Nights, were more conducive to achieving intimacy. Those were seen as the times when “you would have your closest times with patients. They couldn't sleep, they had to talk to someone, and you had time to sit with them and talk.” This nurse spoke further of Nights:

A lot of times, patients who are going through these terminal diseases...they wake up at night and all they do is think about it. It's a quiet time. There is nobody around. That's when they need some one to come in and speak to them...you check your patient every so often, and if he was awake, we would always exchange a few words and gradually he would start to open up a bit...

Another nurse said that the beginning of the night shift or the end of day shift presented opportunity to take time with patients. She said that it was a more relaxed time with fewer people around and your task work as a nurse was finished.

Making Time

One nurse was adamant that time was a big factor, perhaps the only factor. Then Wendy stopped for a moment and realized that it was not so much the time available but your ability to make time. The ability to make time was contingent on two things: the number of other things that the nurse had to do and the ability to reorganize and reset priorities. For Mel, that was the thing about being an experienced nurse “your whole day is organized enough and you’re not so busy that you have to leave the patient because you have so many other things to do (you may not actually say, I have to go and get Mr. M his medications, or I have his dressings to do, but it’s always in the back of your mind.)” The nurse knows what and how other patient care can be reorganized and prioritized to make this time. He remembered a time when he was less experienced. “A patient or a family member, they could sense that I had to go... It's like I was turning to go out the door... And that’s not good. I don’t do that anymore.”

Contact

Contact with and exposure to the patient was felt to be very important. There were two dimensions to contact and exposure that the participants noted: the Amount of time spent with the patient and the opportunity to look after the patient over the illness trajectory.

Amount

Some participants realized that they spent large Amounts of time with patients. Two participants said the following:

I think, that people are there with you for that long period of time, I mean I spend more time with them than I do with my husband, twelve hours in a shot, three days in a row, one day off, and three nights. It is very intense and I think just that being together, that you do develop a certain level of closeness...

... You really find that you bond with that person...you are there with them so many hours, more than any friend. I think of how many hours I spend talking with this person and dealing with problems and explaining things...if you look at how many hours you spend in a year, because that person was in hospital for over a year, you realize that you almost can't help but become intimate.

Sometimes the nurse was made aware of the Amount of time spent with a patient by the patient saying they missed them on their days off or vacation. The patient might "tell you nicely that it wasn't the same when you were gone or just say 'Gee, I'm glad you are back' or something that."

Consistency

The other dimension that pertains to contact with the patient was being matched with the same patient over time. In the ambulatory setting this was not a problem as the hours of work negate the need for shift work and nurses and patients remain in their pairs. Holly practiced in this setting and noted the ability to make contact on a continuous basis, "Gee, they call everyday, everyday, everyday. All they want is for you, even if it is a small problem, to know; some patients will call me everyday just to connect."

In the inpatient setting, continuous contact was maintained over the various shifts using primary nursing. Gail noted that "primary nursing really allowed you to develop

relationships with your patients...because of the consistent contact.” She recognized the continuity for “...not only getting to know the patient, physically and mentally, you know the patient well, you know what is going on. You know how they would normally react.” Participants were often told by their patients that this was important. Wendy said it was the way they greeted you on your return, “They would say, ‘I like you, I’m so glad you’re here tonight’; like that kind of thing.”

The nurse is responsible for Setting the Stage for the intimate relationship. She creates and controls the Space and the Time. She ensures that favorable conditions exist. With continued contact and exposure to the patient, the intimate relationship can begin to develop. These are things that are external to the nurse. The other ingredient is the nurse herself.

Using Self

Something I think is really important is your role in a therapeutically intimate relationship...the nature of the self and who the self of the nurse is in relationship...the important part is...how I will use myself in order to allow them to have this experience...It’s definitely a conscious using of the self... It is to use myself as a way to help with the other person or people to reach whatever potential they can.

The nurse here speaks of the role of the self in the development of intimacy: what she brings. She implies that the nature of who you are and how you use who you are in relating is key to helping people achieve their potential. What ingredients does the nurse contribute to the intimate experience with a patient? The participants provided a great deal of information pertaining to this area. There were three themes that emerged in this cluster: who the nurse is, which arises from personal experience and nursing experience; the nurse’s approach to her work, that being openness, the ability to sense and touch, and

understanding of Silence; and the nurse's ability to direct the flow of the relationship, that is understanding Intent and recognizing Boundaries.

I Bring Myself

The nurse as an entity is developed from her personal experiences (as both a child and an adult) as well as from her professional experiences (as a student, novice and mature nurse). Participants said they bring themselves to their practice. All commented on the components that seemed to make up who they are as individuals. They all said, "I Bring Myself as a Person; I Bring Myself as a Nurse."

Myself as a Person

Many participants spoke of their personal experiences. One participant recalled a memory from childhood.

I remember when I was a kid, going to the store. There was this old man who was trying to buy a jar of pickles. He didn't have any money to buy the pickles. I remember feeling horrible. So, I gave him my milk money. That's part of me and that's how I nurse people. If you think about it...I can't go and be a nurse and not do that because then I am not doing my job...Like the man with the pickles. That was just me. That's been my life. My whole life has been experiences similar to that. That has obviously shaped me, how I think and how I deal with people.

Another participant related her experience with other kinds of work and identified how this experience had shaped her as a person.

I was a waitress...and I tell you I learned, you know that book *Everything I Needed To Know I Learned In Kindergarten*, everything I needed to know about nursing I learned in a restaurant because it's the same kind of thing, just a different setting. Instead of lights going off, you have tables full. Everybody wants something, needs something. They're not life and death things but to a smoker who doesn't have a cup of coffee or an ashtray it is life and death because you better get me that quick like the way a patient needs a warm blanket for chills and

rigors. I learned how to talk to people, to communicate with people. You also really get insight into the human condition, different kinds of people and learning to connect.

Some participants spoke of personal work they had done as opposed to other occupational experience. For Ruth, it comes from “personal work I’ve done on myself ...we can’t be effective if we haven’t done personal work on ...our issues.” She continues on to identify that we face difficult questions and situations as nurses and while she does not “have any of those answers...I’ve had a 25 year practice of trying to figure out what I’m all about. I don’t think I would have been able to connect with people if it weren’t for that work.”

Some participants had personal experience with illness. They said they draw on this experience and bring it to their work as a nurse.

The mother was dying and ...the daughter was just absolutely distraught. She sat by the bedside and her Mom told her to go away and you know, so I just moved and sat beside her. I think I probably just put my arm on her shoulder and then all of a sudden she just turned to me and she would bawl her eyes out on my shoulder...I think some of it, the intimacy of that moment, may have been [because] I was about 23 or 24, my Mom died, and I wasn’t with my Mom when she died, so I think maybe that part of it was there for me too.

Another participant spoke of a personal experience that contributed to who she was in her practice. She recounted that her mother had died of cancer and that “that kind of stuff helps as well because you have the other side of the story. You know how hard it is. It’s tough to just sit back and watch...you know what the patient’s family is going through...You have the bigger picture.” Mel talked about a recent experience as a family member as a negative case.

I learned first hand what it feels like with my own personal experience of having a family member go to the ICU. Now I

know ...I tried to explain it to somebody. I said, "It's sheer panic." And it's beyond that. It's so far out there that you have no idea. The loss of control that you feel is. . You can not describe it or you can't even fathom what a person goes through until you have walked that mile...I remember a nurse sat with me and gave me some Kleenex and then she was gone. And I sat alone. It was terrible.

This experience helped him grow as a person and has ultimately contributed to his nursing practice.

Rachel, Chris and Ruth talked about how being a nurse had caused them to stretch: all claimed to be introverts by nature. Rachel stated "I am an introvert. I have lived most of my life inside my head. I forced myself to look at the root of the problem. Is it because you are too shy to be with all these people? I disciplined myself to be analytical and take these things and I apply the same thing to nursing." Chris said, "I have always been a person who has been a bit reserved, but I find when I come to work that I am not that way. And I guess it's just because I have always wanted to be a nurse and there is something inside of me, a caring part of me." Rachel told me that it is not easy for her to meet people, "I'm not a real outgoing kind of person but when I think about working in nursing, it's a challenging thing for me to have tried to do because it's not a part of my natural way." Through the challenges of the profession, these nurses experienced personal growth.

Myself as a Nurse

Many participants remarked on their development as a nurse from novice to expert and how this growth is an important ingredient when attempting to achieve closeness with patients. Just as the nurse brings her experience as a person to the intimate experience, she brings the part of her that is about nursing. An individual's life as a nurse

begins in nursing school, develops through the novice stage, and arrives at expert nurse stage.

From what I remember about school, they talked about your impact on the patient but nothing prepared me for the kind of intimacy, the profound relationships I have with people you encounter. I can remember one time when I was still in school, somebody I knew who had been nursing for years said, ‘Don’t ever let the head nurse see you crying or sad about a patient. They will think you are weak.’ And I remember thinking, ‘Am I in trouble’ now because I know I will cry and be sad. I could never be that kind of person and if that were the accepted standard of nursing, I would have ignored it or I might have just stopped nursing.

I was trained in an area where you weren’t even supposed to – it was more important to have the bed straight, this nonsense – there was no emotional support given to patients at all – when I trained.

Participants remarked on their abilities to engage with patients as expert nurses. They recognized that this ability was not where they started as a nurse. Ruth points out as she grew and understood what she was doing in nursing, so too grew her understanding of how she used herself. She recalls “less so as a new practitioner...” Mel said “that’s something where, you look at it, the nurse that is coming onto the ward is a novice nurse, you can’t explain that to them. They have to experience it for themselves and they have to learn for themselves. It’s something very hard to teach somebody. You can explain it to somebody, but that doesn’t necessarily mean that that person would be able to do it”

One participant recalled her time as a novice nurse vividly. She identified clearly what she was unable to bring to her patients at that time.

When I first started nursing, I was so focused on clinical skills, on technical aspects of nursing. You don’t have time to think about or let yourself take time to even talk to people because you are so busy running around trying to stay organized. That first

year, I would say, was more spent on honing my skills, on becoming organized, on learning to become a basic nurse. Later you become much more comfortable with the technical aspects of nursing and it felt like I was able to focus on other aspects of care like developing relationships with patients.

All the participants related the things they brought to their practice of developing intimate relationships. The bringing of self as nurse was identified as an ingredient that only the individual nurse controls and uses.

Approach

Having brought herself, both person and nurse, to the clinical setting there needs to be a certain posture or stance the nurse must take towards the development of the intimate relationship with a patient. Participants identified a kind of positioning or approach that is essential. This theme, Approach, was found to be made up of themes consisting of the nurse's openness, her ability to sense and touch and her use and comfort with silence.

Openness

Openness is a posture, a way of positioning oneself as being open. It is a way of making the nurse herself available to her patient. One participant related the following story:

I went to her door and knocked on it and as soon as she opened the door there was this powerful interchange...there was just this connection. I allowed myself to be totally open and vulnerable in this situation with her... and I just knew I would be with this person through her whole process. It happened like in 5 seconds...there was an intellectual part...and there was an emotional response and I had a sense that she was connecting in some way ... Then I just said her name, 'Mariam' and I knew that I was in it with her to the end, whatever that meant. So that's where we began.

Many participants spoke of how they make themselves open and available. Mary indicated that she saw it as part of her role as a nurse. It was important for her that she was open to the “patient need or a family need.” She gives the patient an open invitation to call her; to get questions and concerns answered. The nurse, according to Mary, has the choice to “embrace it or run away from it.” Mel identified that he postures himself to the patient with an openness as if to say “Look. I am ready to listen”. These are examples of Openness that are verbal and almost physical.

The story demonstrated a less tangible form of Openness. Some participants talked about this less palpable openness. Ruth said “It’s hard to talk about because it’s not an intellectual thing, it’s allowing the heart to deal with it. I’m open, there is an openness of the heart.” She went on to describe how she would “always take a moment before I rang the bell. I just stood there and tried to center within myself. I would take a deep breath and then I would just open myself to whatever was going to be in there, because that was my job. As a nurse, that’s what I need to do, to make myself available.” Mel, too, described this phenomenon but in a little different way. He said “I’ve always had a soft heart or whatever, for people that were in trouble or had problems or whatever. My heart went out to them.”

The ingredient of Openness was found to be about sharing your personal sphere. Mel said it best:

When you share anguish what you do is you step into the sphere of that other person and share with them. It has nothing to do with yourself. You are just there...You are just open. You let them come to you. The nurse opens his realm and the patient opens their realm. You wonder if the same thing isn’t happening both ways. The person starts opening to you. They tell you their fears and you’re there for them when they cry and you’re there for

them when they are happy. You know when you click with a person. It just happens. You are on the same wavelength. It's like you know that you are tuned on the same frequency and boom, it's there.

Sensing and Touching

The nurse needs to use all of herself as a person and as a professional, be open and available and she needs to be able to sense what the patient may need to create an intimate relationship. Mariam's story continues:

I am not even sure why I offered her Reiki to be honest, because it's not something I offer to everybody, but she had no experience with those things. I guess it was just, it was an intuitive thing, I just sensed that was appropriate healing for her and she healed on many levels and as I said, she did die - but there was a lot of spiritual work she did through that connecting with me and connecting to her own essence.

The nurse in the story sensed the patient's need to engage at a deep level. Participants demonstrated sensing on many levels.

Wendy spoke of "reading the situation", trying to figure out what the patient may need. Sometimes, if she felt her sensing wasn't clear, she would check with the family and ask "is this person really like that" just to be sure. Chris was careful to do the sensing and not have the patient sensing things like "even times when things were really hairy, you certainly don't need to transmit your tension to the patient." Mel, again, spoke of how you grow in your ability to sense and respond to what you have sensed: "You have to learn how to sense it and I think that's the thing about being an experienced nurse."

The nurse, having sensed the patient need, can employ touch. Rita used touch with patients after surgery; they are at their lowest point then and "it just seemed natural to sit

down and give them a hug.” Ruth said, “I think one of the ways that nurses can connect and share is with touch because nurses have permission to touch and patients expect us to touch.” Sometimes touch was used when there was nothing to say. Beth recounted an experience when “I gave him a hug, I didn’t need to say anything, just gave him a hug and just said good bye – he was a special person.”

Silence

The ingredients of Approach consist of an Openness of posture and heart, the ability to sense the patient’s need and finally the ability to work in Silence. The participants indicated that a great deal of the intimate relationship occurs in silence. The following story is about Silence.

I understood that she just wanted me to do my work: to be quiet and do my work. That was most important to her and that created the connection even though we never really talked a lot, she valued what I could give her in my silence taking care of her life. I am OK with silence and we would spend days where I would look after her for the whole day and we wouldn’t say two words to each other. And I was OK with that and she was OK with that and she actually in the end, I realized, she really appreciated that. I think part of it was there was a lot of buzz going and she just wanted some peace and quiet. That was her home, that was her room, keep the chatter out.

This was not an uncommon experience among the participants. Chris described one patient as a very quiet man. Her response and comfort with silence was that she is “not terribly noisy at the best of times, and when I go in to see patients I always try to approach with a very quiet, calm manner.” Ruth identified her comfort with use of silence. She described it by saying “a lot of times actually nothing needs to be said and a lot is going on and I suppose the most important thing that I bring to my nursing practice is my ability to be comfortable in silence with my patients. Within that silence, there is a

connection that can happen that doesn't happen if there is – if you always have to be talking, filling it with the weather or whatever.” Mel described this phenomenon as well when he said “That’s the very interesting thing about being human, is that you could say a lot of things without saying anything.” Of a close patient relationship he experienced he said, “I know that we didn’t come to that moment for a length of time and it wasn’t a verbal agreement, it’s more emotional agreement. It’s a feeling agreement that both of you know that it’s there but you both don’t talk about it.”

Directing the Flow

I had an experience that lasted one morning where I cared for a woman who was dying at home – that was all I spent with this family. The family felt very comfortable with the care that they were giving but this last bit on the journey, they needed a guide, that’s all they needed. The woman was comfortable and what I needed to do was just to let them know what a wonderful job they had done and not to step in and take over this woman’s care but to suggest things that they might do to help her in this last part. I made it very clear that I would take a back seat, like I would sort of stay to the back of the room. I insisted that the family stay at her bedside so they would have that final experience with her. When I knew that she was going to die I gathered the family together. I was standing at the back of the room. It had been really cloudy all week and it was very grey that morning. All of the family was in the room and there was an incredible amount of love. They were a very connected family. When this woman took her last breath and the sun came out and the room was radiant, it was absolutely, absolutely blinding, brilliant and everybody in that room felt complete. I felt really good about what I did because I was able to allow that family to have that experience. I was aware that I could have been selfish and have gotten right in front. That was probably where it became very clear to me that it would be easy to sort of allow ourselves to be the center of things.

Just as the nurse is responsible for Setting the Stage of Time, Space and Contact, the nurse directs the play: she directs the flow. Directing the Flow emerged from two

elements: understanding the Intent and recognizing Boundaries. When the nurse employs these two elements she is able to direct the intimate exchange in a therapeutic way.

The story related above is an exemplar of this theme. The nurse in the story is cognizant of the incredible beauty of the experience, but she knows the intent of the experience is for the woman and her family; it is not about herself. She recognizes the boundaries: she is not a part of the family. Her role is to support and facilitate the woman's death and her family's part in the experience. She must direct the flow.

Intent

The participants understood their role with Intent as being able to discern whom the relationship, the intervention was for: "Is this for me or is it for them?" Ruth spoke of it as containing your ego and guarding against the buildup of the self-importance, "because I am not that important- it's about the person, the patient." She went on to say "I have noticed that not all nurses remove themselves because it is such a wonderful experience to have yourself. And it's not just nurses but chaplaincy, social workers, other people in the care giving profession. I have seen people push themselves to the forefront and want to be the most important caregiver out of our own needs. It's not about you... You need to be aware of that."

Chris spoke of understanding intent and identified this well:

Patients, they need you emotionally, they will talk about their fears, their concerns ...knowing whose need is paramount is important. Comparing experiences: that's not what is important. What's important is what the patient is feeling and what they need to talk about, what they need to discuss. My own personal fears and concerns aren't relevant to what they were talking about. I am not the one lying in the bed suffering; they are.

Rachel talked about being conscious of the intent. She said that when the focus of intent becomes the nurse and not the patient you are no longer helping because then it would be for the nurse and not the patient. “And that’s sort of how I assess it, ‘Is this for me or is it for them?’” she said. “The flow or the intention of the flow, should always be in that direction, giving to the patient. It shouldn’t ever be the one wanting to take for yourself. The balance should be more going away then coming back in terms of who's getting what out of the relationship.”

The nurse must direct the Intent of the relationship. Rachel related she has become self-aware. She checks herself to make sure that the intent is on a professional level: that she is meeting the patient’s needs, not meeting her own. She called it being a “maybe not a shield but a filter because with a shield nothing gets through. The filter you can let the good stuff get through, but the things that get too overwhelming, the pieces that get too big get stuck and they don’t come through.” The filter she uses helps her direct the flow toward the patient while protecting her from harm. While the filter helps direct the flow, the shield represents a boundary.

Boundaries

The participants spoke about Boundaries. Boundaries were seen as essential to therapeutic intimacy. Boundaries were used to protect the patients and the nurses. Sometimes, the boundaries were not employed as they should have been and the nurse got hurt. This is one story.

I really bonded with the patient. We had lots in common. I shared a lot of myself with the patient and his family. I shared my home, my life...it seemed like I shared everything. We really clicked. I did more than what you do just as a nurse – I did more as a friend. You know he died, so of course it was very sad. He was on the ward for a long time. It was difficult but you can

predict it. And that doesn't say that it makes it easier when you know they are going to do poorly but it's easier if you're not there. It's been along time and it is still sad. But um.... That's why you do it though. It is so hard, you know, when you have made a bond with somebody. That's all part of it and if you didn't want that, you know you wouldn't allow it (crying). You don't have to. You know you build on your relationship and [then] have it gone. I think that you have to remember what I have to remember now, is you are really only a small part of their life, you know. ...and that... I think, that when I think of now, it's that.... You are there for like two months, three times, and that's really all there is, you know. I think that is what I think now...if you think about it...they lived forty years and we are involved in their care for such a short.

Many participants identified that recognizing boundaries was an important ingredient of therapeutic intimacy. Rachel disciplined herself to be analytical: In connecting with patients, did she go over the line? Was it therapeutic? Without boundaries, nurses could get hurt and patients could get hurt as well: the nurse's role could be misconstrued, the patient could be used. With boundaries, nurses were able to direct the flow of the therapy and patients were able to maintain themselves. Boundaries were used to direct the flow of the relationship when the nurse felt the relationship was moving in a less than professional direction or where the nurse felt emotionally unsafe.

Beth identified that "you have to know, we have only a small portion of their lives here, they have got another life and it's part of our job to help them get to that life" and not maintain ourselves in their life. Ruth had similar thoughts "remember this isn't your story, you are a bit player in this story. It's not that your role is not important – it is...but you are a tiny bit player. Somebody whose lived 30 years, 40 years, 50 years, you're coming in for this little tiny part at the end...I'm not trying to belittle that but you must

remember you're a bit player, it's not your story." The nurse in the vignette realized this as well, but after being deeply hurt.

Rachel identified that patients can be hurt as well when the nurse goes too far, gets over involved because "they may actually feel your need and help you to fill that need by what they are doing. If you are too involved you are sucking on a patient and they may not have the strength or the energy or even the ability to see that."

The participants identified how they used boundaries successfully. Beth said "you do have to weigh just how intimate and how much information you give for the protection of yourself and your family. You have to draw boundaries because there are limits. Rachel said there was an optimal distance where you can help while maintaining logic and objectivity but you are not emotionally detached. She called it a magic line. Rachel judged whether she was on the right side of the magic line from her response to a death: "I don't react the same way as I would if a friend of mine would die. It is a whole different reaction. So that tells me that although I am feeling a closeness, but I have maintained the right distance so that I am separate."

Sometimes boundaries were used by the nurse to prevent involvement. Sometimes the relationship with the patient was "almost de-personalized to make it easier to cope with. Half of the people who walk on to that ward will not walk off. It's a fact and some people cope with it I think, by the distance."

Boundaries were used by nurses to direct the flow of the relationship away from places that were not of the therapeutic, professional realm.

So I probably unconsciously drew a line at a certain point about myself and I can't recall anyone asking something that I felt really uncomfortable with. If they started to approach that subject,

or approach that line that I had drawn, I would have probably kind of veered them away. Back to themselves.

Another participant recounted the story of a lonely man.

I think there is that possibility if we are not really self-aware, things can be misconstrued. It was something that I especially worried about with him, because he was single and I was not yet married at the time, although I was seeing somebody. There were a couple of times that he made comments that sort of made me wonder. And I just carefully directed around them and didn't really address them. I just went around them and kept it professional because he was really feeling quite poorly at the time and I think he was reaching out for more emotionally than I was comfortable then I was giving. So yeah, we had to kind of put that line there. I must have been successful because he gave me a card that said *"Thinking of you especially when the holidays are here and wishing you happiness always. My way to say thanks to someone special like you. To someone so special as you, who has a heart of gold. It feels good to have someone like you to talk to when we feel a little down."*

Another participant told of instances where she used boundaries to close herself down to protect herself. She would give competent care but she would not open herself to the patient's very unhealthy ways.

Rachel provides the best conclusion to the discussion on boundaries: "if you get too close, then you can't help any longer, because you are not thinking straight. And if you are too far, you're not helping as much either."

Summary of Ingredients of Intimacy

The Ingredients of Intimacy have been shown to consist of two themes: Setting the Stage and Using Self. Both of these themes are made up of clusters. A baker or a chef knows that most of her repertoire of pastries or menus are made up of ingredients. It is the amount, the handling and the quality of the ingredients that creates the result or kind of pastry or meal. So too it is with therapeutic intimacy. The ingredients, the elements

are more or less the same in every relationship the nurse forms: one to another may contain a little more of this, like time, or a little less than that, like the nurse's self as a person.

Category Two: Kinds of Intimacy

You gradually get to see all different kinds and you realize that not all people communicate on the same level.

A second major category was found through careful consideration of the data. This category emerged from a series of clusters that when brought together demonstrated the types or Kinds of Intimacy. The participants told of a range of intimate relationships they experienced. They explained, through their stories, that in their relationships they were either Seeking Connection or Finding Connection. Specific Kinds of Intimacy or themes were clustered under the main headings of Finding Connection and Seeking Connection.

The specifics of this framework can be found in Figure 4, The Intimacy Grid (p.88). Just as the earlier participant's words indicated patients are found on many different levels: there is a range of intimate relationships. None of the Kinds of Intimacy are better or worse than the other; patients and nurses meet on the grid where fit to the need is right. Each nurse is responsible for determining the need of the patient and the kind of relationship required. The place on the grid is not static: rather, things can change and the relationship between patient and nurse can move to another part of the grid, again, as need is demonstrated. The authenticity of the relationship increases with the deepening connection developing from merely Meeting Needs to being a Trusted Partner.

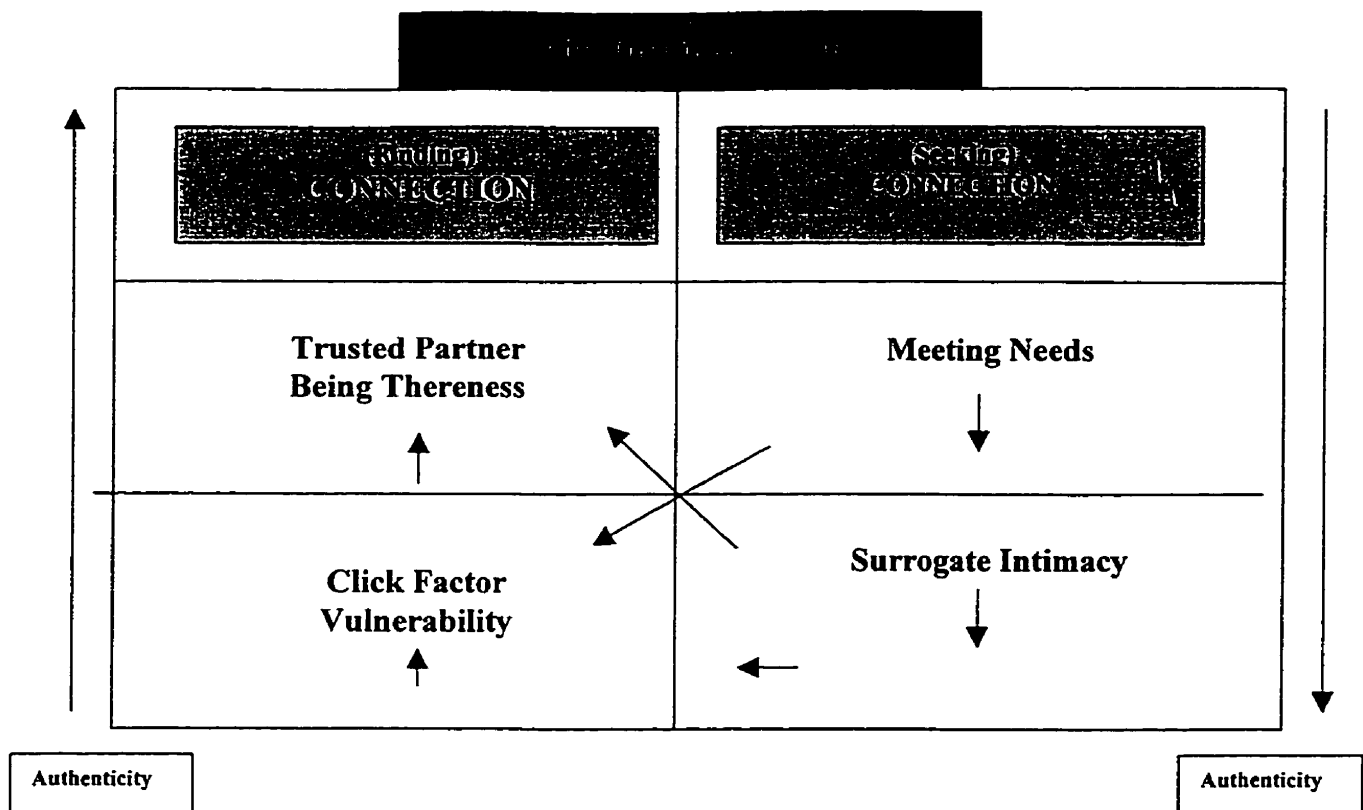


Figure 4: The Intimacy Grid

The themes, or types of relationship, will be discussed in an order that mirrors building authenticity of relationship: beginning with Seeking Connection by meeting the patient's needs and ending with Finding Connection as a Trusted Partner. Where ever possible, the participants' stories will be used as an example of the elements.

Not Connecting

All the participants had the experience of not connecting with the patient. They told of the variety of relationships they used to attempt to meet the patient's needs. They did this in two ways: by attempting to meet the perceived needs of the patient even if that were only what they considered to be basic and by developing Surrogate Intimacy with a family member.

Meeting Needs

There are just some people that aren't able to get past that barrier that they have put up there. And they might not be able to get past that barrier with a spouse or a significant other. It's just there. You let the patient know that you are there and you try to get them to open up without having them feel like you are probing...it doesn't work on everybody. Some people are not able to open up to you, to get past that barrier. And they are probably like that with everybody in their lives. You try and I know that I have met a few people that I can't get past the more formal aspects of dealing with them as patients, you know, you just can't get past that. And I think those ones hurt the most because you know if it is something really significant that's happening to them, you know that they are suffering. And they do really need a closer connection and you can't get to it.

This participant recalled an experience where she was unable to get past the barrier the patient placed around himself. All participants found this to be a difficult and frustrating relationship to be in with someone. The nurse uses herself to sense the patient need, as identified earlier. Now sensing the need, she is prevented from engaging by the patient.

Having sensed the need though, the nurse will seek intimacy, attempt to find a way to break through. Mel said, "But if you don't have it, you can't force it to happen. It doesn't work. It's like leading a horse to water but you can't make them drink, right? You bring him there, you bring him to that point and if they do, they do, and if they don't, they don't." He went further, again talking about the frustration of being in this kind of relationship: "I found sometimes it's really frustrating with certain patients that they never allow themselves to tell you how they are feeling even though you might ask them. You can tell they're just always skirting issues and they don't want to deal with their emotions. That, I think is harder, because then this person will never be able to deal with their frustrations or to express themselves and how they feel. They will never be able to let it out."

Rita, too experienced this, “Some people you don’t go past – some people just have that barrier there and you don’t pass by that and that’s it” This, however, does not alleviate the nurse of her responsibilities to care for the patient. Ruth explained that the patient might not want to connect with the nurse. Maybe they just want the nurse to come in and give them medications or do whatever needs doing; they were not interested in connecting. She tried to find out if this tangible care was the patient’s only need or whether they had support in other places.

The nurse in this part of the grid has three choices of relationship: To respect the barrier and provide competent, basic care, continue to push against the barrier hoping to find a weak spot or use Surrogate Intimacy.

Ruth related how she accomplished accepting the barrier:

I think I am less judgmental as time goes on. I really believe that people, they die as they live and they don’t make dramatic changes about what their lives are about in the last weeks or months. If some one was not open to that kind of connectedness in their life and I don’t mean it in a judgmental way –so as long as ...their needs are being met, that’s fine.

For her, if the patient truly was not interested, that was acceptable. She still provided what she needed to as the nurse, but the patient did not desire the relationship.

The second choice for the nurse, the participants said, was to keep trying. Rachel pointed out “Some people aren’t as open to connecting. Sometimes you can intuitively sense that maybe there is a way to get past that crust or that maybe I could get past this crust and realized, ‘No, it’s not happening. There is a wall and no one is penetrating it.’ So I think you have to try but not everyone is open to that. And maybe if you had five years you could get through to them.” If she had the five years, she might be successful.

Holly experienced times when the patient seemed so distant. She had to work up slowly and try to find out why. Sometimes, she assessed that that was just that kind of person. She might leave them alone, “kind of just leave it” in the hopes that eventually the relationship might change. Rita spoke about recognizing the barrier, and not knowing how to reach through. She would kind of take “baby steps along” with the patient and then all of a sudden it would change. Chris related an experience where after trying to cross the barrier the patient placed between the two of them, she made a breakthrough: “After I got to know him, that initial wall he put up slowly crumbled down.” The nurses who are successful in crossing the barrier are free to move into another part of the Intimacy Grid: as the walls come tumbling down the journey towards more authentic relationship proceeds.

The last choice the nurse can make when trying to achieve relationship with the patient who is not connecting is by working through others. All participants spoke of this phenomenon: Surrogate Intimacy.

Surrogate Intimacy

Nancy was an amazing woman: a wife, a mother, a dynamic businesswoman, and a great dresser. She would breeze into the clinic when, it seemed, she could fit it into her busy schedule. The nurse tried and tried to find the place where they could be together, where they could begin to develop a close relationship. In the nurse’s experience this almost always happened when the patient started chemo treatments. Nancy came for her treatments sporadically, only when she felt she needed them. She maintained herself for a long time but then she became very ill. The nurse had never been successful in penetrating the wall around Nancy: she continued to act as if nothing had change but she was dying. That’s really when it started: daily, some times twice daily interactions with Nancy” family. It started with her husband but included her sisters and brothers. They loved her very much and could sense they were losing her. The nurse spent hours with them, in fact she worked through them: they were her

line to Nancy. Nancy died. The family was grieving very hard: Nancy never opened to any of them. The nurse joined the family at the bedside; she was there when Nancy died. She was there because of her relationship with the family.

This is an exemplar story of Surrogate Intimacy. There was not one intimate moment between the patient and the nurse, there didn't even seem to be much intimacy between the patient and her family. But the family needed that kind of relationship to stay with Nancy on her illness journey and through to her death. The nurse knew that there would be needs; but she anticipated the needs to be demonstrated by the patient. The family ended up demonstrating this need instead. The nurse responded to the family's need: the nurse sought intimacy with the patient through the family.

The participants all noted this phenomenon. Beth said that the nurse sometimes has a stronger relationship with the family member than with the patient. If the patient is not available to engage in relationship, whether emotional, physical, intentional or involuntary unavailability, the nurse reaches out to meet the family's needs.

There have been instances where a patient is very sick and you can't really ...they're too sick to communicate and that's when you really link up with the family members. Oh, I do remember one, where a lady came in and she had metastatic disease and it was not good. There were a lot of family dynamics that were going on from the past. The dynamics were coming to a head because this patient was sick and all the family was together and you could just feel the tension in the room when certain individuals were in the room. The patient's husband was really contributing negatively to these dynamics. I remember talking to his sister and having her pour herself out to me...It was just like, you just didn't expect it but you knew that this person needed to do this and I guess, for whatever reason, I guess she trusted me. That's the only thing you can think of, is that people don't do that unless they have some trust...

Again, the story is an exemplar of how the nurse develops Surrogate Intimacy; the relationship consists of the same ingredients as the intimate relationship with the patient, but it is the needs of the family that are served. Mel talked about “the patient’s dying or crashing, or in trouble, the shift goes to the family member. I make sure that someone is with them. Just being there. Like a hand around the shoulder. Giving them Kleenex...” Sometimes, those needs are being met so that the family can serve the patient. Ruth told of how some of the close connections have been with the family member instead of the patient themselves. That, she said, would allow that caregiver to have the strength to survive the process, to care for someone who is dying.

Cluster: Finding Connection

It is at this point that we cross over to the connecting side of the Intimacy Grid. Here, on this side of the line between seeking connection and finding it, examples of more integral connection between nurse and patient are encountered. The relationships build from working through vulnerabilities of both patient and nurse and simply clicking with the patient to being there as a trusted partner. Again, as we move through this part of the intimate relationship range the authenticity of the relationship continues to become stronger.

Vulnerability

Being vulnerable is a kind of intimate relationship. The vulnerability can be seen in the patient as they physically expose themselves to their caregiver, the nurse. Part of the nurse is vulnerable in this physical exposure and contact. The story below tells of this relationship:

I became a nurse when I was older. I had been working not even a year when I had this man who was about my age and I took him

into the shower room to give him a shower. And I thought here I am with this strange man, I am showering him and he is sitting here with nothing on. Whoa! You know! And this is all part of it, I mean, he is a human being. He had just wanted this shower so badly, so I said, "Not a problem I will get you in a wheel chair and I will take you in there and give you a good shower and he just loved it. And I thought, you know, a couple years ago I would have been just shocked to bathe a strange man. It's a growing process.

Physical intimacy is usually reserved for the most personal relationships: between parents and children, husbands and wives, connected partners. The participants told of being allowed into this realm with their patients. Another story demonstrates this phenomenon. The nurse, now visitor in the patient's home, maintains that intimate connection:

I had gone to his home after his surgery. He was now paralyzed and needed a lot of physical help. His paralysis had rendered him incontinent and he obviously had to wear a diaper. He wanted to go to bed so he needed to have his diaper changed. And his wife said, "How can we do this?" And he said, "You can have my nurse help you. She knows what do." So I went and we boosted him into the bed together. We changed him. So he felt comfortable with that.

The nurse and the spouse entered into that Vulnerability with the patient.

The nurse does not expose herself physically, so her vulnerability of relationship is expressed differently. For the nurse, being vulnerable has to do with who you are as a person. Mel identified that his gender made him vulnerable sometimes: "When I first met her, and was going to be her primary nurse, I had in the back of my mind being a male nurse, I had some fears with dealing with a woman of a similar age. He had had the experience of having cared for people that pushed away from him because of the gender issue of having a man look after a women in a nursing situation.

For other participants, it was not their gender that made them vulnerable: it was their values and beliefs. They told of situations where they might disagree with how a patient, a person lived their life. Rachel said “I can disagree with how somebody chooses to live their life but still connect with and make them feel valued and cared for. And that to me was a really neat lesson: She learned how to accept her vulnerability of relationship. “I can believe what I believe but still interact with people who have a completely different view and care for them. I can separate that and live what I was taught.” Chris spoke of this as well. Some situations challenged her, “Being brought up in a fairly straight Christian tradition, I found that looking after AIDS patients very difficult. When I had them as patients, I always did my best, because I didn’t want to compromise their care because of how I was raised.” Again, she worked past herself, suspending her bias and “got to know a number of the patients very well. I was able to get past the issue of their gayness and recognized they were human beings who needed to be looked after, and that was why I was there. They were people who were ill and they needed someone to look after them. And that was part of my job.” Rita summed it up by saying, “I guess I feel that people have a right to experience whatever they want. We can help them no matter what.”

Click Factor

The relationships mentioned above describe people being brought together because of need and working past vulnerabilities. Many participants described relationships that developed not out of the patient’s need but because they had things or found things in common; in short, they clicked together. Mel said, “you know when you click with a person. It just happens. You are on the same wavelength. It’s like you know that you are

tuned on the same frequency and boom, it's there." Gail described a relationship with a patient whereupon meeting him she said, "I think we really clicked ...but we had a lot of things in common." Mary described a place where she and the patient shared a special bond, a kind of click: "sharing laughter...it makes people feel good and puts me as the nurse on an entirely different plane; it's like we are just now like two people sharing something special, something funny probably just for us." These are examples of relationships where the people have that instant connection.

This was not always the case. The participants all spoke of having to look for that connection; they would set out to find that thing that would help them click with the patient. Rachel talked about looking for that "connect point. But not everybody either has that, or wants to tell you that, or whatever. To me, I think the people that I have connected with, the reason I've connected, is because there has been some level that we could relate. I was able to find something that was important to them that I could somehow either talk about or listen about." To many it was a matter of sounding out where people were at and meeting them there. The participants felt that they were able to find the Click Factor despite how different or even how similar they were to the patient. Again Rachel says "You have to have some sort of a level of connection and in thinking about this I think I try to sort of sound out patients, sort of figure out where that connecting point is: listening to the patient, getting their perspective and knowing how to communicate with them. Finding the things that are important to them."

Being There

Whereas relationships that were a result of the Click Factor were perceived as close by participants, they did not have the same intensity as relationships that had being there at

their core. Participants spoke of a certain Being There-ness that occurred. These relationships represented further movement on the range or continuum of relationship with growing authenticity.

I admitted her in February on a Friday; I forget what the date was. I think it might have been the 14th and then she died in June on a Friday and I was there with her when she died and it was like there was real closure, like I was there with her and they said that. The family noticed that too. 'You were there when we came in and you're here at the end'; and that was really important to them. It was like bookends.

The nurse in this story was there, occupying the same Space and Time as the patient and family. The family felt the Being There-ness of the relationship. Rita talked about this kind of intimacy: the nurse needs to "Just be there...you don't have to necessarily say anything." She remembers being there for a family member "...she looked so lonely sitting there and so sad and so full of despair because...her mom was not like this. Her mom was a very loving person and now, because of illness she was acting so differently. It really hurt the daughter to see her mom this way ...that memory of her mom talking like that to her, when she was dying". Rita's response was to be there in relationship with the daughter to support her through this difficult time. She helped the daughter maintain the memory of her mother as a very loving person. She did this with Being There-ness.

One participant talked of a Being There-ness relationship she had with a patient. It is a brief account of what that relationship is like:

And there is often nothing you can say that will make this person feel any better, but you are there. I think it's just sometimes the physical presence of being there that is important. We didn't talk that much; sometimes I was just there for this person when they are crying about ah, you know all bad news and when things weren't looking great. And you were just there for that person. Sometimes I would just walk into a situation where this person was at a critical moment and let's say she had a tear in her eye

and I could see that she was frustrated. I would just go up to her and say, "Look if you want to talk, I am here to listen, or whatever". And then if she didn't invite me in, then I would let her in. Then you bridge that gap. It's not something that I threw myself at them. I was just there for them.

She talks about physical presence and sharing Space and Time with a person. She speaks of sharing pain and frustration; one can only do this if you have achieved a relationship that is one of Being There-ness.

Another story about Being There-ness was told as follows:

He was a young man. He was 36 years old. He was a very proud man. He was admitted to the ward for a work-up. His family physician hold told him he probably had arthritis in his back, but they discovered that he had a tumor on his spine. I got him prepared for a laminectomy; I went in there and did what I needed to do pre-operatively and sent him down. He came back and he was paralyzed from the waist down. I went through his chemo with him and just tried to help him as much as possible. I did a lot talking to him and letting him vent. His own mother had died when she was 37; he wanted to at least reach that age. When he came back after his back surgery and he was paralyzed, I was there but I just let him do as much as he could. I wouldn't insist on my helping him. And I guess because we had developed this trust, he knew that if he told me "Yes I can do that", I wouldn't be there hovering. I would stand back and let him do it. But I was there and he knew that I was there and he could call on me if he needed me. If he was awake, when I was on nights, we would always exchange a few words and gradually he started to open. After he came back from his surgery, it was probably a day and a half later and the doctor had given him the bad news and his wife wasn't there with him at the time, and I happened to be on shift so I went to him, he told me what the doctor had told him. So I held his hand and he cried. And I think that was probably the biggest step because he had been such a proud man and when I saw him crying I couldn't help it, my eyes watered up right away. And I think that's OK too. At least the patients know that you're human too. You have feelings. This just isn't a job, you know. I think that really kind of cemented our relationship.

Clearly, the nurse in this story was there when she needed to be. As with the story of the bookends, the nurse is there for all the significant moments with the patient. Her being there allows for the full human communion to be shared: she cries with him. This nurse uses the Being There-ness of relationship to move to the next quadrant and the ultimate authentic relationship: Trusted Partner.

Trusted Partner

At the upper left quadrant of the Intimacy Grid, at the point of greatest authenticity, the nurse finds herself in relationship with the patient as a Trusted Partner. The participants all spoke of this relationship based on authentic interpersonal respect, trust and ultimately love. The following story is exemplar of this relationship:

I once had a patient, a young woman in her late 30s, just diagnosed with a lung cancer looking like somebody had told her that her life had just ended, even though she was still walking, talking, breathing. My first look at her was, 'I wish I could tell you, that as bad as it is, we can help you deal with it, to whatever the end might be and neither of us knows what that is'. Without being able to say that, I just introduced myself, took her and her husband into an examining room to begin with her, what I felt was one more long journey dealing with this very difficult disease; and not being able to say to them, "really, yes it's bad, but it is not the end, not yet. There is a lot that I hope we can do for you. She asked me if she would die from it. I told her I didn't know that. I didn't know what would happen. She was the one that was really wanting to know what would happen and I think she wanted me to tell her that it wasn't true. This was the beginning of a relationship. She was very, very, overwhelmed. I wanted her to call me with whatever concerned her I said to her "if it is a concern to you, you call me and together we will decide. She initiated the contact, she did call me. Like, she wanted that kind of contact, she wanted the recognition that there would be somebody there who was committed to help her through this, whatever she needed, whatever step she needed to take. That's just the way the process occurred. What happened was we developed a special relationship, not a dependent relationship, but shared. She would learn where I was and if she needed me she could call. Once she started on treatment, she would still want to

come and see me and just touch base with me. I was never very far whether it was by telephone or by physically being in her presence. She was in the treatment room undergoing chemo and having um, a rather difficult day because she was having problems with nausea and feeling very unhappy about her response to the treatment itself and what was happening with her disease. I was asking her how she was, we went to how she physically was to how she was emotionally and how she felt about her daughter getting married. Her daughter was very young and the patient felt that she might be getting married so that her mom would be alive for her wedding. But she didn't think it was ok. Bev, herself, had married her husband very young. I think it just happened to be the timing and the fact that I physically came and sat with her in the treatment room for a few minutes and to sit down with her meant, 'I have time for you', like 'I want you to really tell me how you are', not the kind of 'hello how are you', passing someone in the hallway where you expect them to say 'fine' so you can keep on walking; it wasn't that at all. And I think by that time we had developed a relationship where I not only...I felt she knew that I not only cared about what was happening to her as a person with lung cancer, but what was happening with her as a young woman facing the end of her life at some time that would be much earlier than she had ever imagined. She wasn't sure that that would happen, but she wanted to, which I didn't know at the time, she wanted me to be there for her daughter. She felt that her daughter needed another woman to talk to, another woman who could share some life experience with her, or listen to her. I'm not sure exactly what it was; that was unusual for me, but that's what made that relationship with the patient special. I ended up developing a relationship with her daughter. I still see her daughter; her daughter comes to see me. Although I didn't develop a relationship with her daughter until after she died. That was very unusual. I've never been in a situation before where I felt a patient wanted me to participate not only in their care, but also in their life and by extension to the life of their family. Like they don't teach you that in nursing school. They don't teach you that anywhere.

Over the years and the illness trajectory this nurse worked with the patient. Their relationship likely moved through the Intimacy Grid coming to completion when the nurse became the trusted partner of the patient. The nurse was respected, trusted and loved enough that the patient bequeathed her mother-daughter relationship to the nurse.

“I mean, we get privileged with a lot of information, with a lot of feelings that patients are going through that they don’t even tell their families” said Beth. She recounted many instances where she as a nurse learned intimate detail of a person’s because she was their

Trusted Partner:

When you see an elderly couple and you know, they admit to you that they know that they are not going to be able to have sex for a couple of weeks because of her chemotherapy. They trust you enough that they tell you about their little ritual where they would have a shower together every night before she started her next course of treatment. Or another time when a patient admitted that she hadn't taken the pre-meds and I said “Well, we will work around that” and she said “Oh, thank you, thank you, I was so frightened, not to have my treatment, but last night we reached for each other and things just happened ... She was comfortable telling me about this experience and how wonderful it felt for her and her husband to have sex, to love each other for that short time but in the course of it she hadn’t taken her medications.

Beth said they tell you because you are a safe haven, a trusted partner. Chris had a similar experience where the intimate information was shared by the patient with her.

She became the repository of a deep secret:

I looked after a gentleman who had married a second time. I looked after him fairly frequently. Once when I was working nights, he told me that he didn't really love his second wife. He had married her out of a need for companionship. He told me when his first wife died, he was so lost, really lost. So it came to the point where he was actually dying. I thought I better call his wife, because he wasn't going to last that long. You know you have that intuition, so I phoned her and her answering machine was on, so I left a message. I stayed with him. I stayed with him and held his hand. I don't think I even talked to him. I just held his hand. We would reposition him every once in a while and then he died. His wife came up about half an hour after he died. I thought about what the patient had told me about his marriage. Initially I felt a little uncomfortable because I thought, I really don't need this information, and I didn't request it. But then I thought he needed to tell somebody. Obviously it wouldn't go any further and it didn't. I never told anybody. And he was so sad, so sad and when it came closer to his dying he probably

really felt that connection he had with his first wife, the love they shared. And he wanted to talk about it. So that was very sad. I can still see him lying in his bed.

Mel recounted a relationship where a deep bonding took place. He experienced a relationship with a patient where he became the trusted partner.

First it was just general conversation and then it kind of developed into more talking about our own lives and what we did in our families. You realize that as you go along you start talking, getting to know that person and them getting to know you because it has to be a two-way street. They let you into their life, and that's where you find that you get that bond. They allow you to know who they are and you allow them to know who you are. You know what I mean. That's what I found was the biggest thing. And you can't force that. To me, that's where that connection comes in because then it's more of a friendship than a professional relationship of just looking after needs, physical needs. We would talk about our families and slowly drift into this thing, this situation where you are discussing, really, our lives. I was sharing my experiences with her and she was sharing her experiences with me. After a period of time there was a trust and bond that developed between us. You develop a very deep, long-term understanding of how this person ticks and you have deep conversations about their frustrations, their fears, everything. This person allowed me to enter or invited me into a realm that is normally the privilege of a husband to a wife, a parent to a child. It's something that is a very deep connection.

The story, the exemplar speaks for itself. The nurse became the trusted partner over time.

All the participants shared at least one experience where they had become the trusted partners in a patient relationship. Nurses hold a position of remarkable trust. Ruth spoke of working with people at a most privileged time in their lives: at the deaths. She said, "I've worked with the dying. It is a very powerful experience and ...I felt very privileged to be allowed to offer help and provide care to the dying and their families ...it is a very powerful experience when you are with someone when they take their last breath. Your life is not the same you know, there is something very profound about that." She said

she is very respectful of the privilege of being there and very respectful of being a nurse.

To help in a person's death is an honour and a privilege; to help a family member say their good byes and let go is a role afforded to someone who is a trusted partner. The following story is evidence of this:

When people are dying, the nurse tries to keep them as comfortable as possible. The nurse is also teaching their family, helping them to learn to let go. We had a young male on the ward. He was just 18 years old. He and his mother were very close and his treatment had failed and he was dying. A few days before he died I asked his mom "He's just so restless. Do you think we could give him something to relax him a bit?" "No!" she refused. I said that's fine, you know him best. The day that he actually died, he was so restless; he was in so much pain. So when I went to look in on him, I realized he was dying and he was struggling not to die. I called the mom and dad out into the hall and I said, "We should give him something to relax him." The mother agreed to allow me to do this for her son. So I gave him something and I said to the mom, "Now you are going to have to tell him that it is OK; tell him he can go". And sure enough, within the hour he had died. And I just hugged her and I said, "You know, he is so peaceful. He is not struggling anymore". I know at the moment she was really hurting and she probably will hurt for the rest of her life. But I thought that was good the way he died. She had agreed to it, because she probably knew this is what he needed. But I was able to say to her "Tell him it's OK to go." And I found that very rewarding and it sounds kind of foolish when I say it out loud but it felt really good. She didn't see him struggle right until the very end. He died peacefully and that's what she needed.

One story demonstrated that the nurse, as Trusted Partner, might hold the balance of power. She may have more influence than any other human being. It is a great responsibility and demonstrates the ultimate in trust. To put your life in her hands:

It is so traumatic being in the hospital. You come in and people take over your life. They tell you when to eat, when to sleep, you have no control, none. So one of the things about developing that kind of a relationship with the patient is that they see you as

someone who is familiar, somebody they can trust, somebody they can hang on to. I develop a relationship with some patients where I try to take their mind and my mind, spiritually out of the context of the hospital and say "Let's go somewhere else, so that I am not a nurse, you are not a patient; we are people". I had such a relationship with a patient, Ted. We had so many times when we would be alone and he would relate details about his early life and one of the things he talked about was his relationship with his kids and how important his sons were. All he ever wanted to do was marry and have children and have a family life that was so different from what he knew. I got to know him and his wife so well. I just felt such warmth from both of them. He was really sick. He went home and I was working one evening and his wife called and said he was having problems. So I said to her you need to get him to the hospital. He came in and they found he had a huge lesion in his head. They needed more information about the lesion so they wanted to do a brain biopsy. The neurosurgeon wanted to do the procedure and didn't want to wait for Ted to make up his mind. I came on shift and was told that he was refusing the procedure. I remember going into his room; it was a private room. He was there with his wife and his kids and by this time he was so emaciated and he was really embarrassed about losing his hair; he used to wear a polka-dot scarf around his head. And I remember walking into the room and he was sort of standing by the window. He turned to me and just opened his arms toward me that he needed to be held. And that's what I did and he was just a little man. I held him to my chest and gave him comfort. I tried to tell him that I knew how afraid he was, that he may never come out of that OR alive, but unless we found out what was growing in his head we couldn't treat him. You know, underneath it all I thought, he probably isn't going to make it, but he had to try because he had a loving wife and two kids who just worshipped him and in the end he agreed to have the procedure. He did survive the surgery but he died a week and a half later. I often think of him. It's funny on that night when I came on shift and they told me what was going on, that he was refusing the procedure I thought "I can get him to do this, I know that I can; he will trust me, he will listen to me" But I was also very frightened about that the whole time, thinking "okay, is this what Ted really wants? I mean I know the team wants it, his wife wants it, and I know I can make him do it or get him to do it. It was a really hard thing. It's been a long time since I've cried about it and he did touch my life.

So trusted a partner was the nurse, she contributed in an important way in the decision the patient needed to make.

Summary of the Kinds of Intimacy

Through the participants' stories, the exemplar descriptions of the relationships they have shared with patients, the range of intimate relationship has been presented. All the participants use the same ingredients but each relationship is different from the other. The nurse meets the patient where their needs are. What are the results of this intimate relationship? What do these relationships mean in the end?

Category Three: The Meaning of Intimacy

The last category, the Meaning of Intimacy, emerged after consideration of *so what*; what does all this mean? The analysis has considered the ingredients, the range of intimate relationships but in the end what are the results and what is their value? The participants said much of this in the interviews. The results were not spoken of in succinct, specific statements: Only one participant said, "This is the result". Rather, I found small but beautiful jewels left in quiet corners of the transcripts where a participant would say what the intimate relationship, what therapeutic intimacy really means. This last category will be presented as a series of clusters where the actual themes will take the form of vignettes. In this way each jewel, each gem may be experienced. This category brings together several clusters that illuminate that the experience known as therapeutic intimacy means having in the Ties That Bind, Being Human and being A Better Nurse.

Cluster: The Ties That Bind

Three stories follow that exemplify what it means to have created Ties That Bind from the nurse-patient relationship. There is little that needs to be said of them; they speak for themselves.

The Exhibit

Two years after he died, his mother showed up on the ward looking for me. "Where is my son's nurse?" They were having an exhibition of their son's art. And she had to invite me. When I went there, they introduced me to people as their son's nurse. Like I was the only nurse he had ever had. I know I wasn't the only nurse that looked after him. They couldn't stand to see him die. They could not lose him; it was very tragic. I think that's part of where his art exhibit came from. They were trying to keep his memory alive. They seemed to need me there. I did not have time to go to this reception. But, I just thought this is for them. If they cared enough to find me two years later, to invite me to this, I need to go. I went to that reception, and I was really glad that I had gone. His dad just grabbed on to my hand and just held on to me for I don't know how long and just sort of dragged me around the room and wouldn't let go. It was like I was that connection. That thread, the tie that binds.

The Dream

After he died I started to dream about him. I could never see him but I could hear his voice. He was always asking me to do something that I had failed him at. Like he wanted his slippers, and I couldn't find his slippers. I would wake up feeling really so down hearted. I guess the dreams were telling me that I was feeling like I had failed him through the whole process of working with him. I talked to a colleague who pointed out that we developed a close relationship and it was grief that has to come out somehow. After that conversation I never dreamed about him anymore...I had really good feelings about him...I thought about him. I helped as much as I could, and...getting over that bit about not being able to help him... it helped. So that was a good experience. Sad, but a good experience for me.

Christmas

She had a daughter Ester who was 10 when her mom was sick. At Christmas, I got a phone call from Ester. I didn't get who was calling me so I asked her again and she said Ester. It was this 10-year-old who was now 16. Basically, we just talked for a while and then I sort of felt she sounded like she had something else she needed to say. I just kind of said, "it's been five years since your mom died" and it was obvious she just wanted to talk to someone about her mom. I was the person she connected with her mother and obviously she felt safe to call me five years later. She never said a word to me when her mother was in the hospital. She was this shy little kid. She is 15, 16 years old now and she needed someone who had a connection to her mom and she called me at Christmas time when she was missing her mom. She didn't really ask me anything; she just stayed on the phone in quiet, just silence. So I was kind of carrying the conversation and I just asked her about her life and I asked her.... Her mom was very concerned about her and the other youngest ones. This woman had ten children, but the youngest two were nine and 11 and she was most concerned about them. She figured the children would be OK. But the mom needed to know that the young girls were going to learn how to sew, because Hutterite women need to know how to sew. And so it was strange but I needed to know that she had learned how to sew, because it was important to her mom. So we talked about that and yes, she had learned how to sew, but her sister was still a little too young, and she hadn't learned how to sew yet. But they were fulfilling their mother's wishes. We just sort of talked about nothing, and then I said "you know" because she sounded kind of quiet "it sounds like you're missing your mom" and she said "Yeah" and then she started to cry and I said "you know she was a very special person and I'm sure you do miss her very much and she loved you very much and she left a big hole in your life." It was something along those lines and just sort of tried to voice what I thought might be what she was feeling and she just kept agreeing and kept crying. Obviously I had hit a nerve and then she said thank you and she said good-bye. She sort of got what she wanted but to me it was so neat because I had a really deep connection with those people.

These three stories tell of the deep and lasting connection between the nurse and the patient. Even after the patients had gone, the nurse remained linked to their worlds, the worlds and lives of those remaining. Sometimes the link allowed the family remaining to

re-experience their loved one: an almost reaching from here to the beyond. They are jewels of lasting beauty. The experience of therapeutic intimacy means having Ties That Bind.

Cluster: Being Human

A second cluster of themes was found as the jewel or gem of Being Human. The participants gave many examples of how they evidenced Being Human: by taking risks, feeling pain, shedding tears and seeking closure. Again, the vignettes need no commentary, no interpretation. Their message is clear.

Risk

When I offer myself in relationship and I'm rejected it's not a personal rejection. I separate that and even if it was, so what? How many people have I missed offering something that would be very healing in some way, offer that connectedness, because there is an intimate connection that goes on, a touch? How many people did I miss because I was afraid of rejection? There is a risk that you'll be rejected if you are open and that you will not be wanted. I think I did accept that that might happen. ... The whole notion of rejection and how personal it is needs to be placed in the context of who you are in that relationship and why you even would take it personally if you were truly aware of who you are and what your role is. Because it isn't about who you are personally. Intimacy is a therapeutic nursing intervention. Therapeutic intimacy is a nursing intervention. From a personal gains point of view you don't engage in it because you're going to get something out of it personally. It's about the directing of the benefit back to the patient.

Pain

When you engage in a relationship...if it becomes fairly close, there could be a potential for...hurt feelings...some kind of raw feelings because you are exposing yourself emotionally and so are they...there is that potential. Anytime you open yourself up emotionally there is always that potential. But it comes with the territory...when you're close. It's there. But the difficult part was when I knew we would lose him. It hurt very, very much and it was like losing part of me because there was not a thing I could

do about it and I could not control what was going to happen and I don't like that feeling. I don't like not being in control. But you can imagine, how the mother or the patient would feel – they have no control and it's happening to them; and then I would feel bad because how.... I can't even probably begin to feel as out of control as a lot of them must be and I feel bad about it so how can I even compare how I am feeling to what they are – it was very, very difficult. But, in the end, I learned from that, that it doesn't mean forever; because if it hurts too much you run away and protect yourself, and that's not good because what you get back very much outweighs the hurt.

Tears

And I said, "Talk to him. Just let him know it's OK." It brought tears to my eyes and still does. And she said, "You know, we had a good life. We raised beautiful children. You were a good husband and a loving father". As she was talking you could just see him... almost leave. I was standing at the foot of the bed and the tears were just rolling down my cheeks... When she spoke to him she wasn't crying, but she was so positive. It was really moving, being able to interact and to show your human side to a person who is suffering, to me that's really important you realize that this is a person with feeling. They're a person and you're a person. So you interact on a person to person level.

Closure

I went to her funeral, which is something I don't do very often. I could count the number of patient funerals I have been to. But hers I felt I needed to go to. And also, I felt, it would have been a social faux pas not to go to that funeral. They actually called me and had me write the like the funeral thing that they handed out. They phoned me and said, "You were the person that was closest to her at the end of her life. We need you to write this because we're all too upset right now but we know you can do this." I was really awed by that because on the surface, if you would have looked at things, like I know I connected with them but just the manner of the connection, I don't know if people had necessarily seen that. I don't know that I saw that. It was totally quiet but it was something that she valued and they valued.

The experience of therapeutic intimacy means Being Human. By being human, the participants contributed to who they are as persons and thereby completed the circle. They are able to replenish the ingredients they bring to the intimate relationship.

Cluster: A Better Nurse

The participants all spoke of what they gained from the intimate relationship with patients. The result for them was being a better nurse; the experience of therapeutic intimacy made each a better nurse. They learned important lessons, created repertoires and felt beauty in their lives as nurses. There are three stories remaining.

Lessons

You learn something; you take something away from every relationship you are in, whether it be a good one or a bad one. We help people through the hardest times of their lives and their deaths and they gave us more in terms of the way they feel about us. Sometimes it is just the way they make you feel –it does wonders for your heart, you know – it makes you feel good, You learn patience, you learn how to share: you can share a little bit of yourself and in turn what they share with you. It is even more bountiful than you imagine. You learn how to feel for others and the patients; you take them with you throughout your life. You learn love.

Repertoire

So although I helped them, they helped me more because of what they taught me about nursing. I justify all the losses I feel by being determined to make it a point to learn from the patients. I take what I learn to the future so that when I then deal with other patients I am sort of bringing the collective knowledge of what I have been taught by other patients. I think they give me the gift of knowing how to be a better nurse by sharing themselves and sharing what's important. I hang on to what I've learned and put in my file, my repertoire, so that when I am dealing with other people I can think "Is this going to work, is that going to work. I keep a list, a mental list, and you refine that over time. Patients have given me these lessons and I treasure them. And those lessons are valuable because even though the patient may die, the lessons can benefit hundreds or thousands more people before I

die. Nursing is what I have decided to do with my life. This is why. This is who for. The patients that you connect with, they just make you a better nurse.

A Beautiful Experience

Being a nurse...helps it to come out. To blossom, is the best way to put it. I wanted to be a nurse but I didn't really understand when I was younger. I really didn't understand actually until I became a nurse, why I really wanted to be a nurse. And I think it's the fact that in some small way you are helping people, you're helping people to get better, or you're helping people at the other end of the journey. You have helped and hopefully have made a difference to them on this journey. When I think back on all the lives that you have encountered, the lives that you have been touched by and hopefully those that you have touched as well, the patients, the families, the significant others, the children, it feels good to know that you did make a difference some place in their life, on that journey. It just feels good. A sense of satisfaction. I am finding the longer that I am in this profession, the more I do open up. I am able to listen to people. It's something that's always inside of you and coming into this profession just brings it out more. I get back just as much as I give, if not more. It's just a beautiful experience

Once more, the circle is complete. With each intimate relationship, each meaningful encounter, they fill themselves up as nurses. In this way, they return to the bedside with fresh ingredients, the right elements to achieve intimacy with those they serve.

Summary

In this chapter, findings of the research were presented. A synopsis of the sample was provided and the three significant categories were presented. Each of the three major categories was presented in detail: the clusters and the themes that make them up.

As I wrote about the themes and their internal elements, the formulated meanings, I found myself thinking more and more about the participants' narratives, their stories as

jewels of great beauty. Duke and Copp (1992) used the necklace image to describe how nursing actions could be strung together to make up a necklace of beauty, a necklace of care. I have arrived at a similar conclusion in my summary of these findings: A necklace of intimacy.

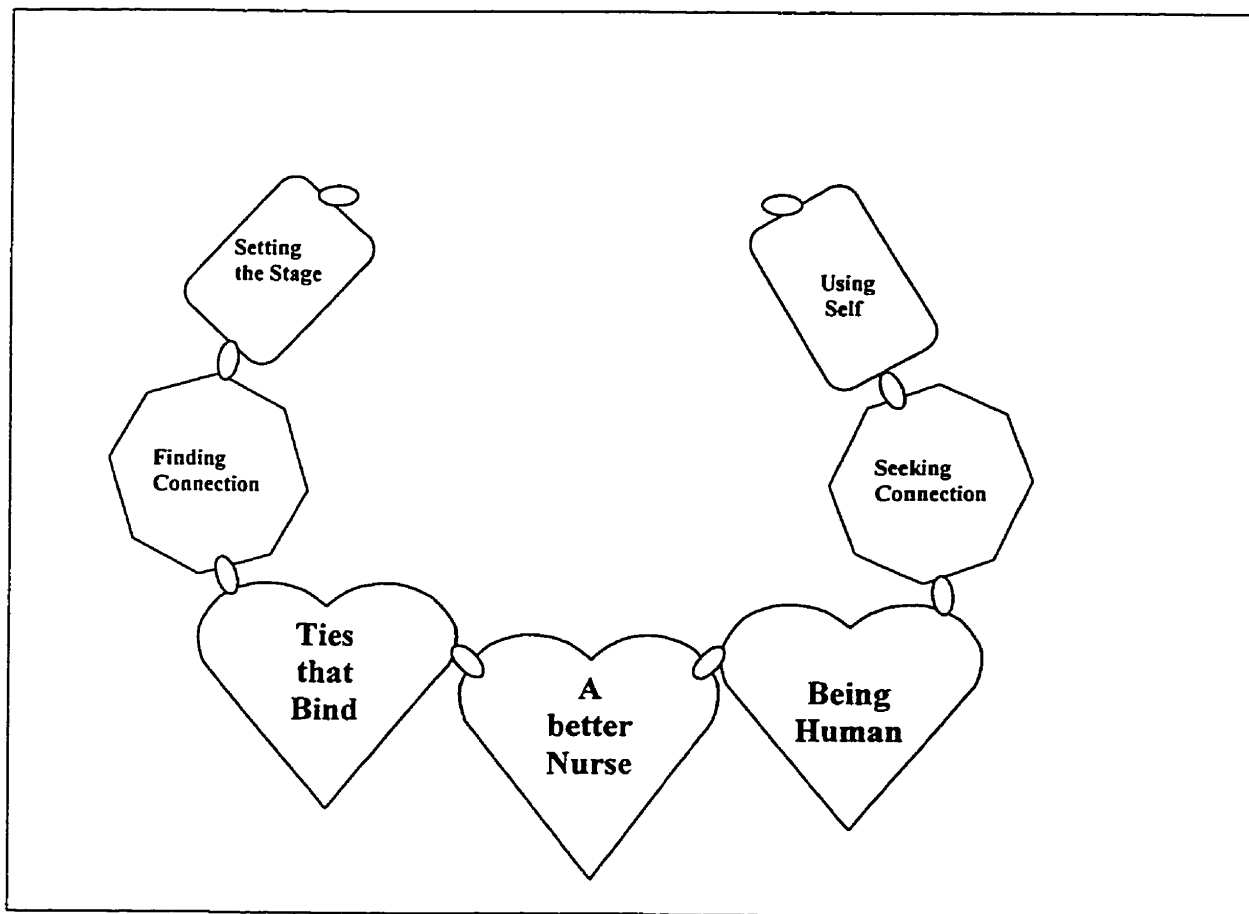


Figure 5: A Necklace of Intimacy

CHAPTER FIVE

DISCUSSION, RECOMMENDATIONS AND CONCLUSION

Introduction

The final chapter of the thesis has three purposes: to offer full discussion of the findings presented in Chapter Four, to make recommendations for the nursing profession as indicated by the results and to draw some conclusions from the research.

Discussion

The discussion section of the chapter focuses on the relationship of the findings to four key areas: the research sample, the research questions, the nursing literature as presented in Chapter Two, and the sensitizing frameworks, Watson's Model of Human Care and Carper's Ways of Knowing. By comparing and contrasting the findings with key areas, a clearer understanding of the meaning of the findings and what is known about the phenomenon will result. The aim of the discussion is to further illuminate the meaning of therapeutic intimacy while identifying any conceptual gaps. The discussion should ultimately make clear any recommendations pertaining to the research.

Relationship of the Findings to the Sample

The sample summary was presented in detail and a table was constructed to organize these data. In review of the qualities previously described two aspects of the relationship between the findings and the sample are worth discussion: gender and maturity.

Gender

Assumptions are sometimes made about how gender affects caring behaviors in nursing practice. Kadner (1994) suggests women do not fear intimacy while men might. This research probed for information on the nature of deep connectedness between nurse and patient: moments of intimacy. If gender does affect caring behaviors between nurses and patients, this may have been demonstrated in the findings: one such finding might have been the difference in the number and/or quality of the nursing stories recalled during the interview.

The sample consisted of 9 female nurses and one male nurse (9:1). The male participant recounted 5 significant patient experiences; the average was 5.8 stories related per participant. There was no difference between the number of stories told by the male and female participants.

Length of interview and my perception of the overall depth or superficiality of the interview determined the quality of the interview. In the case of the male participant, the interview transcript was within the range of the average transcript length (600 lines). As well, I could discern no difference in depth or superficiality in comparison to other interviews: had I been blinded from gender by pseudonym and pronoun I do not believe I would have perceived any difference.

Maturity

Maturity is seen here as the combination of years of age and years of experience. On the whole the sample consisted of older nurses with considerable practice experience.

Age

With regards to the participants' older age, the inclusion criteria required that each participant have at least five years of oncology nursing experience. This criterion would have ensured that all participants were in their mid 20's at minimum. The average age of the participant was 43.5 years. This is considerably older than what could have been the lower age range. In fact, there were no participants under 30 years.

Experience

There was an average of 17.6 years of nursing experience. Further, four participants identified that they became nurses later in their lives and that they brought considerable life experience.

What can be made of this? First, I think that the average age of the participant (43.5) is indicative of the older nurse practice environment of today. MARN reports the average age of the Manitoban nurse to be 48 years (personal conversation with the registrar). A second interpretation can be made based on the findings themselves. Many of the participants commented on how maturity, both personally and professionally, influence the nurse's ability to engage in connected and intimate relationships. The tools (Appendix A and E) used to attract participants listed the inclusion criterion, understanding of the nurse-patient relationship, may have spoken to the more mature and ultimately more experienced oncology nurse.

In both the cases of gender and maturity, data were merely recorded as part of the sample demographics and no probes were made about the relationship of these qualities to the intimate experience between nurse and patient. For this reason, the comments offered above must be seen only as observations of interest and not interpretations of the data.

Relationship of the Findings to the Research Questions

While the research questions were revisited in Chapter Four, the revisiting exercise had as its purpose to orientate the researcher as she submerged herself into the data. The exercise did not permit me to consider whether the research questions were answered in any way. The purpose of this section is to ask about the relationship of the findings to the research questions. Put simply, were the questions answered?

Again, there were three questions asked:

1. Is the experience of therapeutic intimacy known to oncology nurses and what is the nature of that experience?
2. How does therapeutic intimacy occur: what helps and what hinders its occurrence?
3. How is it used and to what end?

I will consider each question separately below in relation to the findings as reported in Chapter Four.

The Nature of the Experience

The first research question explored whether the phenomenon of study, therapeutic intimacy, was known to oncology nurses and second, the nature of the experience. The

findings answered both parts of the first question adequately in terms of all three of the categories that emerged from the data.

With regard to the first part of question one, whether therapeutic intimacy is known to the oncology nurse, the data informed me that the concept, the phenomenon, is well known to the group of nurses interviewed. I used my perception of the interview or conversation process, the number of nursing stories and the perceived clarity of the participants in the transcripts to make this judgement.

Interview Process

I reviewed supplementary research material (journal of comments, notes on the individual interview guides, and my recollection of each individual interaction with the participants) to evaluate whether I perceived any degree of uncertainty about the concept under study, therapeutic intimacy. I found no evidence to suggest that the participants did not understand the concept and therefore reported experiences that were perhaps something other than therapeutic intimacy.

Each participant was contacted by telephone prior to the interview and asked to think of a story that exemplified a deep and connected relationship, one that would be considered intimate, to share with me. At the onset of the interview, the participants were asked to tell the story they came prepared with in an unhurried, thorough way. No participant was unable to recall an intimate experience with a patient.

Stories

Further, while I asked for one story, all but one participant provided many. A total of 58 stories were told. The way in which the stories were generated was interesting. Participants would start with their exemplar story. As we proceeded with discussion

(reflection) of the first story, the participant would sometimes say “Can I tell you another story?” or “I just thought of another time.” This iterative process of story and reflection proceeded until the participant felt satisfied. Through the story telling process, the participants were able to demonstrate and describe the range of intimate relationships experienced. The large number of stories leads me to believe that the experience of intimacy with patients is well known to oncology nurses. Had the phenomenon been one of little or only occasional experience, there may have been greater difficulty in the stimulation of exemplar cases.

Clarity

In attempting to discover if the first research question was answered, consideration of clarity of participants’ responses should be considered. The request for an exemplar story, with the corresponding reflective exercise and the direct questions of conceptual understanding contained in the interview guide produced over 300 pages of transcripts. On review of the transcripts, I identified 370 significant statements. Examples of the significant statements and their formulated meanings can be found in Appendix F, p. 168. I extracted only data elements that were clear, succinct and ultimately, meaningful. During the analysis phase of the research, those statements were determined to be formulated meanings from which the themes, clusters and categories that describe therapeutic intimacy emerged.

The Intimacy Grid

The findings demonstrated the experience with and understanding of the nature of intimacy by these oncology nurses as well through the category called Kinds of Intimacy. This category, The Kinds of Intimacy, is summarized in Figure 4, The Intimacy Grid.

The Intimacy Grid is an expression of the range of intimate relationships these oncology nurses experienced.

The Intimacy Grid was developed out of consideration of the formulated meanings, themes and clusters that described the types of relationships in the intimate range and the detailed nature of these relationships. The placement of the nurse-patient relationship on the Grid is based on patient need and is not static to one quadrant only: all relationships are subject to change and as the patient demonstrates different needs, the relationship can move from one quadrant to another. And while the grid demonstrates a building of authenticity of relationship, from less authentic to more authentic, the movement through the quadrants of the Grid is not necessarily progressive in nature. Rather, the degree of authenticity is relative to the quadrant. This allows for dramatic shifts in the nurse-patient relationship, again as indicated by the patient need. This finding, *Kinds of Intimacy*, indeed answers the first question the research posed.

Prerequisites of Intimacy

The second research question asked how therapeutic intimacy occurs: what helps and what hinders its occurrence. In considering the relationship between the data that make up the findings, this research question appears to have been sufficiently addressed by the category called the Ingredients of Intimacy. A summary of this category is depicted in Figure 3 Recipe Card: Ingredients of Intimacy, (p.67).

This category was made up of two theme clusters: Setting the Stage and Using Self. Setting the Stage was determined to consist of elements (themes) that the nurse externally controls in order to move towards an intimate interaction or relationship. Using Self was determined to consist of elements that the nurse controls within her. The nurse's success

or lack of success in controlling the external and internal elements of the clusters (themes) can be perceived as the answer to the research question, what helps and what hinders its occurrence?

Helps

There were seven themes in each of the clusters, Setting the Stage and Using Self. All of the themes and the elements, formulated meanings, were identified by the participants as ways of helping intimacy to occur between themselves and a patient. The participants attempted to control the Space, Time and Contact with patients. Likewise, they had control of those parts they brought of themselves(I Bring Myself), their Approach and ultimately, their competence in Directing the Flow of the intimate relationship. With differing amounts or emphases of the elements or ingredients, the nurse was found to be able to help the intimate relationship develop.

Hindrances

Hindrances occur as a result of the nurse's inability to successfully use the elements or ingredients. Again, those elements are Space, Time and Contact with patients and who the nurses were (as people and professionals), their Approach and competence in Directing the Flow.

Elements external to the nurse were subject to two kinds of variation that could render the ingredient not of value to the recipe. First, the nurse may not have full control of the element, for instance a patient's room or the patient assignment and the resultant lack of contact. Second, the nurse may not have enough of one ingredient, for example Time.

Elements internal to the nurse were subject, again, to two kinds of variation that could render the ingredients of little value. First, who the nurse was as a person and

professional was identified as subject to wide variation by the participants. They all spoke of being novice nurses with greater concern, initially, with developing technical competencies as opposed to caring competencies. This was an element that was better controlled with experience. But sometimes, even experience over time did not resolve this hindrance.

The participants spoke of experiences where the nurse, herself, was the hindrance to the successful use of the elements or prerequisites of intimacy. Either as a result of fear and wanting to protect oneself from potential risk and pain or because of a kind of obliviousness to the Intent, some nurses were seen to use Boundaries as an element ineffectively. The result was the missed opportunity of intimate relationship.

Recipe Card

The answer to research question two in the final analysis is the Recipe Card (Figure 3, p.67) for the intimate relationship. All of the necessary ingredients are listed. The nurse decides on a cup of this, a spoon of that or a pinch of another. Mix them up and you have all of the Kinds of Intimacy the participants spoke about.

The Results of Intimacy

The third and final research question posed was how is intimacy used and to what end? The first part of this question has been sufficiently answered in the discussion pertaining to the first two questions and the categories that delineate the Ingredients of Intimacy and Kinds of Intimacy. As to the second part of this third research question, to what end, the findings, specifically, the category, The Meaning of Intimacy, serves as answer.

To what end? What is the end the question seeks to find? Is the end the reason why a nurse engages in intimacy with a patient? Is the end the ultimate goal of her practice and if so, what is the reward for achieving this goal. The results of intimacy can be seen as the gifts the nurse receives as a result of her practice using intimacy. From the category, the Meaning of Intimacy, the participants alluded to three kinds of gifts they received: satisfaction, privilege and rejuvenation. Interestingly, just as therapeutic intimacy is not a tangible nursing intervention in the conventional sense, neither were the gifts the nurses were given.

Satisfaction

The participants, having engaged in intimacy, received the gift of satisfaction. First, they had satisfaction from the deep connections with patients and ties with family long after a patient's death. Second, they received satisfaction from the lessons they learned while engaging in the intimate relationship. Finally, they received the satisfaction of being a better nurse. The vignettes that support this relationship of the findings to the research question are found under the theme headings of The Ties That Bind and A Better Nurse.

Privilege

The participants acknowledged having been the recipients of privilege of Being Human. The privilege took many forms: risking (even if scary), feeling (even when it hurt), crying (even when you may not want to) and seeking closure (even if you felt awkward). The nurses accepted and were willing to engage in Being Human. Likewise, the patients accepted and allowed this showing of the human face. So the smaller privileges can be seen as one gift, the gift of Being Human. The vignettes that support

this relationship between the findings and the research question can be found under the heading, Being Human.

Rejuvenation

The last end achieved or gift received by the nurses who engaged in intimate relationships was the ability to rejuvenate themselves. Through the stories that populate the landscape of the findings, one cannot help but be in awe of the human communion the nurse and patient share. The question raises itself: how can the nurse go from one tragedy to another without succumbing to the burden of care? One participant spoke of ten significant relationships in ten years; a remarkable burden. I will argue that this last question the research asks, to what end or why do they do it over and over again, is answered by looking at the findings in relationship to the question.

While the participants did not speak of directly receiving of the gift of rejuvenation, they intimated to it in the vignettes. They spoke of the lessons they learned, of building their repertoires, of learning love, of being better nurses. The same was said of being human: the more the nurse engaged in being human, the more humanness she took to the next intimate experience. The participants acknowledged that they bring to every relationship the ingredients of self, both person and nurse and that it is through the gift, the ultimate gift, of rejuvenation that the nurse is never short ingredients of the recipe for intimacy. I believe it is through this rejuvenation that they complete the circle, they join the clasp of the necklace of intimacy, and they feed their nurses' souls.

Relationship of the Findings to the Nursing Literature

It should be recalled that there was virtually no information available in the nursing literature that described therapeutic intimacy, save for Kadner's (1994) discussion that

spoke of the concept. In the first chapter of this thesis, I made the argument that therapeutic intimacy could be seen as, perhaps, a new term that provides for better articulation of one specific intervention that is part of the broader constellation of nurse care; the argument was that therapeutic intimacy should be categorized as a kind of nurse care. As a result of this argument, the literature reviewed for the purposes of this research concentrated on nurse caring.

This section of the discussion will consider the findings of this research in relation to the nursing literature presented in the background information and the literature review. The findings will be compared and contrasted to Gaut's (1983) description of caring, Griffin's (1983) analysis of caring and to Kadner's (1994) discussion of therapeutic intimacy. The purpose of this exercise is threefold. First, it will determine whether the findings of this research fit with descriptions and analyses of care from the literature. Second, this research asked direct questions of participants about therapeutic intimacy and therefore the findings need to be compared and contrasted with the one description of the concept available in the scholarly literature. Third and last, the discussion in this section should consider whether the concept be considered as a constituent of nurse care interventions as the earlier argument proposes.

Descriptions and Analysis of Care

Both Gaut's (1983) and Griffin's (1983) efforts to describe and analyze nurse care are compared with the findings of this research. Each is considered separately paying attention to where the findings fit and where they do not fit.

Gaut's Description of Care

Gaut (1983) developed an action description that determined the “necessary conceptual features and properties” (p.314) of the concept of care. Care consists of four parts: awareness, respect, knowledge and positive change condition. Each of these components will be compared with the findings of this research. This measure will be used to determine whether the findings fit Gaut's description of care.

When Gaut talks about the first component of care, awareness, she is speaking of conscious focussing of attention on self and other. When this component of care is compared to the findings about intimacy, it would seem that awareness of self and other was addressed under the category, Ingredients of Intimacy and specifically the themes, I Bring Myself, Sensing and Touching and Intent. The participants spoke of having to be aware (awareness) of who you were as a person and as a nurse. As well, they identified having to Sense (focus and be aware) the patient's need or Openness. Lastly, the participants were very clear that the nurse must be clear about the Intent (focus) of the interaction.

The second component of care in Gaut's description is respect. Respect is seen here as part of the attitude necessary for caring and makes a link back to awareness by maintaining that respecting oneself, a result of self awareness, is key. Having already made the case for the findings fitting with Gaut's component of care, awareness, discussion here focuses on respect. While there were no themes that emerged from the findings called 'respect', the importance of respect in the intimate relationship was articulated by the participants. The participants spoke of this component in the context of the second category, Kinds of Intimacy. The relationship, the theme, called Trusted

Partner was described by participants as consisting of authentic interpersonal respect, trust and ultimately, love. Participants called their approach to this relationship 'respectful'.

The third caring component as suggested by Gaut is knowledge. Knowledge, as a component of care, just as with the component respect, is an amalgam of both awareness and respect. The person who cares must use informed awareness to perceive (sense) the need and respect the dignity of the other. In doing so, care takes place. The component of care Gaut calls knowledge can be seen in the findings as the nurse's responsibility to enter into relationship at a certain point on the Intimacy Grid. The nurse determines which quadrant the relationship will be situated. The nurse decides when and if the relationship moves to another quadrant: it is based on need of the patient as perceived (sensed) by the nurse.

The last component in Gaut's description of care is positive change condition. As with the other components, Gaut sees positive change or action as the outcome of the three other components of care. I think the discussion in the paragraph above delineates the positive action Gaut speaks of here. It is the nurse's movement with the patient through the Intimacy Grid that can be seen as positive action.

It would seem that the findings of this research that attempt to describe the phenomenon, therapeutic intimacy, fit with the components Gaut's sees as part of the description of care. What of the other attempts to describe nurse care?

Griffin's Analysis of Care

Griffin (1983) analyzed the concept of care and determined that care was constituted of a receiver (patient), a giver (nurse) and an interaction between the two. Because this

research focussed on the nurse's knowledge of the concept of intimacy, the discussion of the relationship of the findings to this analysis of care will focus on the latter two elements of care: the giver of care or the nurse and the notion of attention and attunement or the nature of the interaction.

The giver of care, in Griffin's analysis, must have an understanding of the situation, have experience to relate and be reflective. The giver must possess maturity and have a good relationship with the self. Having paraphrased Griffin, can these components of care be located in the findings of this research? All of the above components of care as they relate to the giver can be found in the category, Ingredients of Intimacy. The giver must have understanding, be able to relate and be reflective. These components of care can be found in the cluster, Setting the Stage (understanding) and the themes of Approach (ability to relate) and I Bring Myself (being reflective). Specifically, with regards to maturity and a good relationship with self, the themes of I Bring Myself (as person and nurse) and Directing the Flow are indicative of the components that guide the giver of care.

Care occurs as the giver pays attention and becomes attuned to the receiver's situation and reality, according to Griffin. She maintains that this attention and attunement has emotional aspects that she defines as compassion and through this relationship understanding is generated. The category, Ingredients of Intimacy is made up of themes that focus on things akin to attention and attunement: Openness, Sensing and Touching and Intent. Can the sum of these attributes, these themes, be seen as Griffin sees attention and attunement, or compassion? Compassion can be defined as feeling for another; I would maintain you cannot achieve compassion without being open to, sensing the

distress in and understanding the intention of the other. Attention and Attunement is perhaps a different way of saying Using Self. In this way, the findings appear to fit well with Griffin's analysis.

Kadner's Description of Therapeutic Intimacy

Kadner (1994) maintains therapeutic intimacy is an essential element of the nurse-patient relationship. Kadner defines intimacy as a confiding relationship between two people, a self-disclosure of personal information with the expectation of understanding and acceptance. Kadner describes a receiver, the patient and a giver, the nurse and places their interactions within the context of the nursing process. She makes the components of the concept clear: trust, closeness, self-disclosure and reciprocity. Of greater importance, Kadner details the action of the nurse-patient interaction as it develops into one of intimacy. The discussion that follows will consist of two parts. First, as with Gaut's description and Griffin's analysis, a comparison of the findings to the components as described by Kadner needs to be provided. This discussion is relatively brief, as the components of intimacy are similar to the components of care as stated by Gaut and Griffin. Previous discussion has borne out that the theoretical components of care are evident in the findings of this research on intimacy. Therefore, the contrasting of the findings with components of intimacy with the findings has occurred. More emphasis is placed on nurse-patient interaction. The second part of this discussion describes Kadner's conceptual definition of therapeutic intimacy as it relates to the nurse-patient interaction and compare this process with the findings of the research.

Components of Intimacy

Trust, closeness, self-disclosure and reciprocity are the resident components of therapeutic intimacy according to Kadner. She further defines trust as the reliance on the integrity of another. Closeness is not fully defined, but appears to consist of presence and attachment or feeling of being bound to another. Of these first two components, clear links to the findings of this research can be made. As in Gaut and Griffin, trust as a component is best seen in the theme of Trusted Partner in the findings. The component closeness, while being linked to the themes of Openness and Intent, appears to have similarities to the cluster of themes called Setting the Stage. Aspects of physical presence, in Space, Time and Contact, are situated in the themes Time, Space and Contact.

Self-disclosure

Kadner takes the concept of intimacy one step past the Gaut and Griffin description and analysis of care, when she speaks of the component called self-disclosure. She identifies that in a personal relationship that is intimate in nature the element of self-disclosure ought to be equitable; that is, one party ought not to be disclosing more than the other. She asks the question whether self-disclosure can be as truly mutual in the intimate relationship between nurse and patient. She concludes that the professional is limited in self-disclosure, but rightly so, as the patient does not have the energies to expend on the nurse's problems.

This component was most definitely identified by the participants in the research under review. The theme Directing the Flow is made up of two formulated meanings

called Intent and Boundaries. At the heart of Intent was the question ‘who is it for, for me or for him?’ Participants were acutely aware that directing the flow towards one self would do a disservice and potentially harm the patient. I would see mutual disclosure where the nurse shares her personal problems with the patient as directing the flow towards herself and burdening the patient as a result. The formulated meaning, Boundaries, speaks to the component of self-disclosure in that positive boundaries were identified by the participants as being helpful in the appropriate directing of the flow of the intimate relationship. Again, if boundaries were lacking, the potential risk to patients occurred.

The findings of this research appear to fit with this aspect of Kadner’s notion of the component of self-disclosure.

Reciprocity

Reciprocity, like self-disclosure, in a personal intimate relationship would assume that the give and take between, the gains of the relationship are equal in nature; again, that one party is not getting more than the other is. In the nurse-patient intimate relationship, this appears to be problematic. The nurse, in this relationship, appears as the giver. This is the case by way of semantics (both in Gaut and Griffin) and in description of activity (process). How then can the relationship be truly intimate if the patient is the only party who benefits and why, then, would the nurse continue to engage in this way? Kadner says “this arrangement may provide relief and satisfaction for both.” (p.216)

While Kadner is somewhat tentative about the reciprocity on the nurse’s account, the findings demonstrated this relief and satisfaction quite clearly. The category Meaning of Intimacy articulated the participants’ feelings of satisfaction of enduring ties and being a

better nurse. They spoke of the 'relief' within the theme of Being Human: risking, feeling, crying and ending. In the earlier discussion of the finding's relationship to the research question, the gift of rejuvenation was seen to have been alluded to by the participants. I would argue that this gift is the reciprocity that the nurse derives from the intimate relationship with the patient.

The Process of Intimacy

In Gaut, the process of care is seen as the abstraction, positive change condition. Griffin does not operationalize the concept, but rather focuses on the internal constituents of care. Kadner describes the engagement of nurse and patient in intimacy in very tangible ways. As a result intimacy can be viewed as a process, the process of intimacy.

Kadner says the nurse is perfectly situated to have an intimate experience. She notes that the nurse is seen more frequently and constantly than any other health professional. As well, nurses are in contact with patients during their most vulnerable times. Kadner states that therapeutic intimacy does not *just happen* as a result of these two factors though. She believes that there needs to be active encouragement through the levels of intimacy by the nurse. Once intimacy is accomplished, it enables the nurse to understand or know the patient; intimacy allows the patient, by trusting the nurse, according to Kadner, to enter into dialogue as opposed to remaining in a "lonely inner monologue of apprehension and despair" (p.216). Kadner talks about the clinical use of intimacy and specifically that knowing the patient in this way makes the perceptions gathered, verbal and otherwise, more accurate than those gathered by the nurse who knows the patient only superficially. Of planning for intimacy in the clinical realm, Kadner concedes

difficulties, but challenges the nurse by saying opportunities may simply arise and the nurse needs to maintain ‘psychological readiness’ for the possibility.

Germane to the discussion here is whether these aspects of process, frequent and constant contact with the patient, perceiving and understanding the patient, active encouragement by the nurse to engage in intimacy and clinical use of intimacy, where the communion of the two people occurs were expressed in the findings. The following discussion examines the process of intimacy, as defined by Kadner in relation to the categories, clusters and themes in the findings.

The category, Ingredients of Intimacy and the cluster Setting the Stage clearly identified the themes of using Space, Time and Contact. The participants told of how they created and maintained the opportunity, with frequent and constant contact, for intimacy.

The participants spoke of their ability to manipulate the environment. Nurses were seen to actively Create and Control Space by using different types of rooms and simply drawing curtains around the patient and them. The nurses talked about Finding Time and Making Time by taking advantage of a slow night or being skilled at organizing the nursing tasks and reprioritizing these tasks to make time for a patient with an immediate need. The participants came upon their patients experiencing the lonely inner monologue on the shift that developed as the theme, Nights. Space, Time and Nights demonstrate how constant and frequent contact allows the development of intimate relationship.

The participants spoke of the need to have exposure to their patients in the theme Contact. Contact was developed as a theme from the formulated meanings of Amount and Consistency. The nurses identified that there were periods in their practice when

they spend more time with a patient than they do with their spouse; in other words, large amounts of time. Additionally, the participants talked about being matched with the same patient, as is the case in primary nursing. It would appear that Kadner's recognition of frequent and consistent contact as being part of the intimate relationship finds a fit with the category, Ingredients of Intimacy and cluster Setting the Stage in the findings.

The category, Ingredients of Intimacy and specifically the cluster, Using Self appears to be related to perceiving and understanding the patient. The ability to perceive and understand in the findings was articulated through the specific theme, Approach. Approach is the posture, the stance the nurse assumes toward the patient. Approach consists of Openness. The participants identified this openness as key to being able to attune oneself to the patient's needs and sense his willingness to engage in intimacy. What the participants spoke of, was found to fit. Kadner states this can be verbal or non-verbal by patient or nurse. The participants spoke loudly about Silence; they told of how much is said in Silence. The findings appear to relate congruently with Kadner's operationalization of the concept.

The category, The Kinds of Intimacy appears to articulate Kadner's notion of active encouragement and as a result clinical use of intimacy. With regards to the findings, this was one area of the findings where the nurse's activity can be perceived, almost *felt*, in the operational sense. At the heart of this category is the Intimacy Grid. The Grid is constructed from two clusters: Seeking Connection and Finding Connection. Interestingly, the cluster names are built from active verbs, seeking and finding, again denoting activity. One can almost feel the nurse bringing the patient, leading the patient with her to the quadrant of the Grid that best meets the needs of the patient. The nurse

has used her approach, her ability to perceive and understand the patient: she came to the patient with Kadner's psychological readiness. Together, they locate themselves and partake of the intimate relationship at the level that is appropriate, or authentic, for them at that point in time. The relationship between the category, Kinds of Intimacy, and the findings appears to be one of congruence with Kadner's active conceptualization of therapeutic intimacy.

Over all, Kadner's conceptualization of therapeutic intimacy and the findings of this research appear to have a high degree of congruence. Kadner provided the best fit between findings and the literature. The analysis made by Griffin fit well with the findings, had congruence for the most part but lacked any description of operationalization of the concept of care. The description of care provided by Gaut was adequate, allowed fit without being incongruent but the attempt to operationalize the concept, perhaps, did not go far enough. Kadner manages to see care or therapeutic intimacy as a tangible, usable, active intervention.

Therapeutic Intimacy as Care

Having reviewed the literature on care and the literature on therapeutic intimacy it appears that the argument made earlier, that therapeutic intimacy is a kind of care, may be one of substance. Care, nurse care, consists of many aspects and dimensions. In fact, care is such a broad term that it perhaps overshadows the smaller, but important discrete elements of care. By naming those smaller discrete elements, we may give better, clearer voice to our nursing practice. Seeing therapeutic intimacy as a kind of care intervention or competency and using its name is a step in that direction, having voice.

Relationship of the Findings to the Sensitizing Frameworks

A sensitizing framework provides the researcher with a perspective or view of the phenomenon under study and is meant to guide the selection of method, process and analysis of the research. Having arrived at the point in the research where the method was selected, the data were collected and analyzed the question of whether the framework guided the research adequately needs to be addressed. The purpose of the following discussion is, therefore, to determine what is the relationship of the findings to the frameworks used in this research. Two sensitizing frameworks are discussed: Watson's Model of Human Care and Carper's Fundamental Ways of Knowing as adapted by John's (1995).

Watson's Model of Human Care

In this section of the discussion, Watson's Model of Human Care is reviewed and consideration will be given to three questions. First, are the model and the findings congruent? Second, are there any additions or deletions to the model based on the illumination of the concept provided by the findings (was anything discovered)? Third, did the model guide the research sufficiently? Each question is considered individually and a summary statement is provided.

Watson is cited in Cohen (1991) as describing transpersonal caring as follows:

Caring begins when the nurse enters the phenomenal field of the patient (person's frame of reference, subjective reality composed of the totality of the human experience) and responds to the patient's condition of being (spirit and soul) in such a manner that the patient releases subjective feelings or thoughts that the patient has longed to release.

Watson (1988)

Watson's Model of Human Care, which appears as Figure 1 on page 37 is reproduced with some additions. The figure, Figure 6, p.135 contains all of the original elements of Figure 1, but additions were made as themes from the findings of the research were identified as having relation or congruence with the model. These additions should provide some clarity to the discussion that follows.

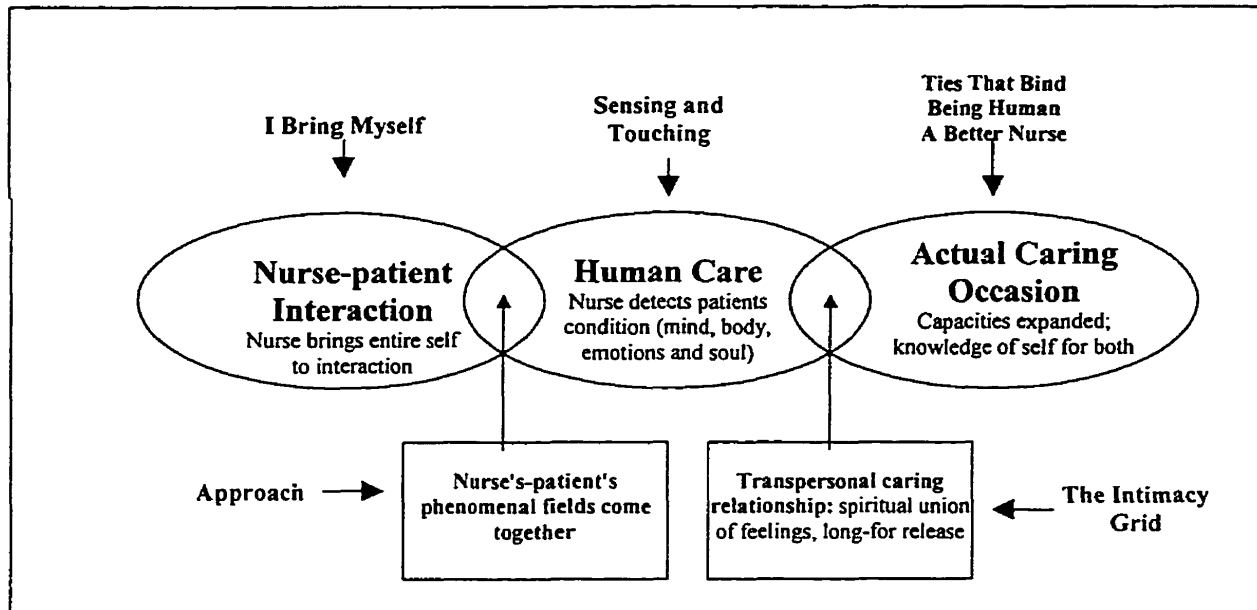


Figure 6: Watson's Model of Human Care - A Revisited Version

Congruence

The congruence of Watson's Model of Human Care with the findings of the research is assessed by attempting to match the themes as stated in the findings within the framework as depicted above. The model's elements will be discussed left to right and sphere to sphere, including the parts of spheres that overlap. I believe that through orderly discussion, the themes from this research that do not fit can be given closer consideration.

The first sphere in the model is that of the nurse-patient interaction. Watson speaks of the nurse bringing her entire self to the interaction. The participants spoke of Using Self and specifically of the theme I Bring Myself; this was found to mean all aspects of self, both as a person and as a nurse. The participants identified pivotal moments from their pasts that shaped who they were as people; they identified how nursing education had influenced them and what being an expert nurse versus a novice nurse meant to who they were at the patient's bedside. In the findings of the research this cluster and theme belongs to the category, The Ingredients of Intimacy.

The next area found in Figure 6 is not a sphere but rather an overlap of two spheres. This overlap depicts the actual coming together of the nurse and patient's phenomenal fields. This element in the Model of Human Care was clearly articulated by the participants in the findings. Under the cluster of themes called Using Self, the theme Approach appears to fit the model. The participants spoke of Approach as consisting of the formulated meanings Openness, Sensing and Touching and Silence. Participants spoke of actual occurrences where they were aware of opening themselves toward a patient and sensing the patient opening toward them: one participant spoke of being a nurse and walking in as if you were just two people and one person opened up and said 'come into my realm'. These themes can be found under the category of Ingredients of Intimacy.

The sphere, Human Care occurs next in the figure. Here, according to Watson, the nurse detects the patient condition: mind, body, emotions and soul. Again, under the category, The Ingredients of Intimacy, the participants identified sensing the needs of a patient. They were aware that sometimes the sensing required them to work through a

barrier, like a crust, but with persistence they were usually able to get through to the patient and provide humane care.

The next area of the figure is not a sphere; it is another overlap depicting an actual transpersonal caring relationship. This, for Watson, is where the spiritual union of feelings and the longed-for-release occurs. This longed-for-release is somewhat reminiscent of Kadner's description of the patient's being relieved of the lonely inner monologue. It is interesting that in both Kadner and Watson, the category in the findings that provides the best fit is *The Kinds of Intimacy*. The participants described this category and the corresponding themes by identifying the range of intimate experiences available to the nurse and patient. The result of this range is the Intimacy Grid: from simply Meeting Needs through a continuum of relationship that builds in authenticity to entering into relationship with a patient as the Trusted Partner. The Intimacy Grid is dynamic in nature and movement on the grid, from one quadrant to the other, is restricted only by the patient's needs. While the nurse is responsible for identifying the starting place on the Grid, the patient sets the pace. As one participant put it, 'it's like leading a horse to water but you can't make them drink right? You bring him there, you bring him to that point and if they do, they do, and if they don't, they don't'.

The last sphere in the figure identifies the actual caring occasion. Watson believes that it is through this actual moment of caring that the person's, the nurse's capacities are expanded and the knowledge of the self is attained. The area of the findings that appears to be most strongly related to this part of Watson's model is the category, *Meaning of Intimacy*. The participants spoke of deriving satisfaction, knowledge and becoming

better nurses (expanding capacity) by engaging in intimacy with patients. They spoke through a series of vignettes about Ties That Bind, Being Human and A Better Nurse.

Discovery of Missing Themes

Having assigned all areas of Watson's Model with the appropriate theme from the findings of the research, it is evident some themes generated from the research have been left unassigned. These themes are all constituents of the Ingredients of Intimacy; specifically, they are Space, Time, Contact and Directing the Flow.

It seems odd that so much of the research findings are congruent with Watson's model, yet these rather key elements, that were determined to be prerequisite to the intimate relationship, do not have a place to fit. After some thought, I believe I can offer an argument for this occurrence and a possible solution that would allow those elements entry into a modified model.

I will argue that Watson's Model of Human Care is not operational in the tangible, clinical world sense. Watson's model is a representation of what happens *in* relationship, not around it; it considers only the two people whose phenomenal fields are merging. This research asked more broadly about the phenomenon and the results were congruent with the question. The participants considered prerequisite elements outside the personhood of the nurse namely Time, Space and Contact.

With specific regard to Directing the Flow, one could argue that the internal elements or formulated meanings of this theme (Intent and Boundaries) could be seen as part of Watson's entire self in the Nurse-Patient Interaction sphere. I do not think this is made clear enough either semantically or figuratively and for these reasons I did not assign this theme in Figure 6. The participants spoke strongly of the importance of this theme to

their ability to understand their role and not lose sight of who they were in the context of the nurse-patient relationship. As well, they identified the consequences, to themselves and to patients, if the flow of the relationship was inappropriately directed. Therefore, I have decided to view the theme Directing the Flow to be another example of where the findings of the research are not congruent with Watson's model.

In considering the themes that were missed in Watson's model, it occurred to me that the elements could be viewed as more of a context in which the intimate relationship, actual human care, occurs. A solution to their lack of presence in Figure 6 is depicted in Figure 7:

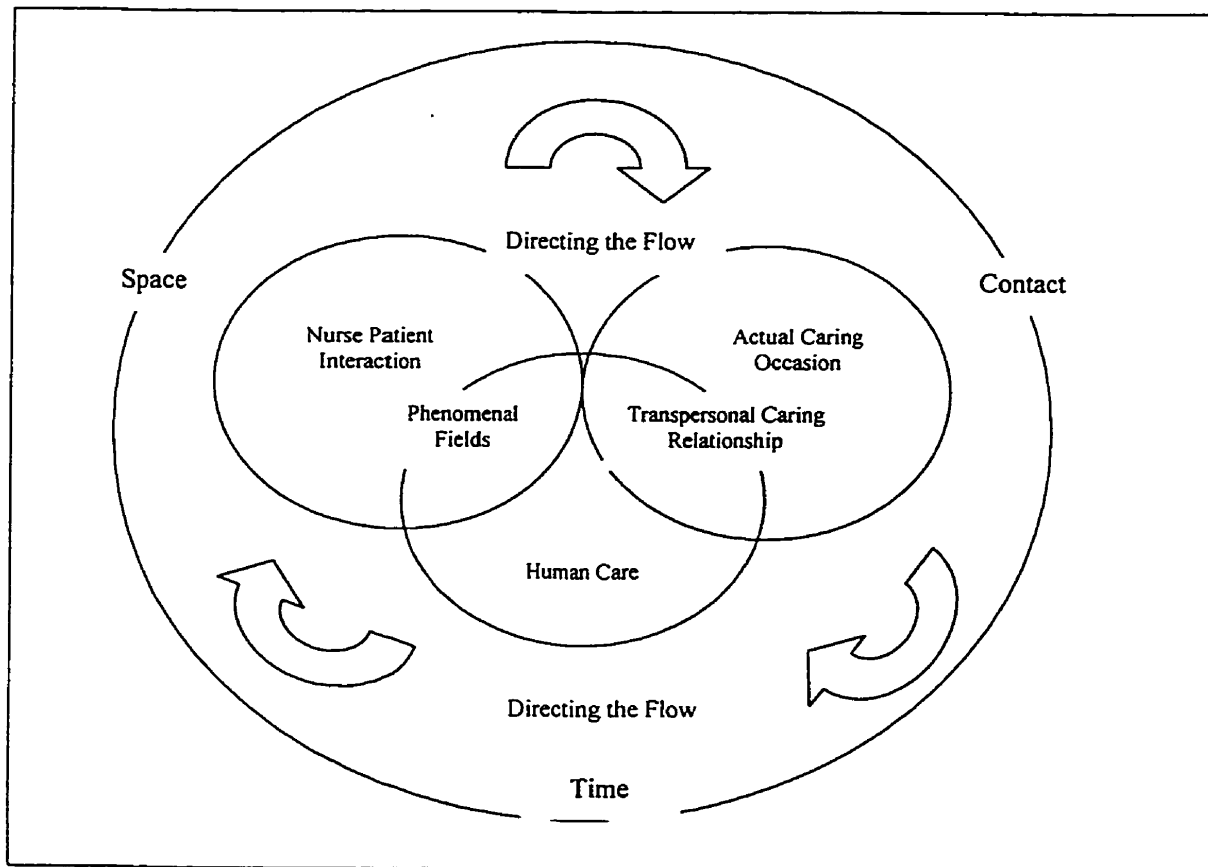


Figure 7: Modification of Watson's Model of Human Care

The depiction, Figure 7, provides all the features of the earlier figure, Figure 6 while placing the missing themes in the picture. The spheres and their overlapping areas in the center of the figure represent the transaction of care. Eleven of the 15 themes from the research findings are contained within the spheres and overlaps (see Figure 6 for detail). The four missing themes, those that place the activity in context, have been placed within the modified model in such a way that their efficacy is demonstrated. The transaction of care occurs within boundaries of Space, Time and Contact and is simultaneously directed in the most appropriate way.

Appropriateness

The purpose of a sensitizing framework is to provide an appropriate lens or view for the research. It is therefore appropriate to consider the findings or the product of research through the same lens used to guide it. The relationship between the findings and the model is one of overall congruence. The final question, with regards to this framework, is whether Watson's model was an appropriate guide: did it serve the research process well.

I believe this was a most appropriate framework for the research. I will provide three salient arguments to this end. These arguments should be perceived as summary statements about Watson's Model of Human Care and its relationship to the research findings.

One measure of appropriateness is whether the model and the research method are congruent. This research took a phenomenological approach with the goal of further developing and better describing the concept of interest, therapeutic intimacy. Cohen (1991) says Watson's nature is one of being "existential - phenomenological"(p.903).

This approach to thinking is evident in the Model of Human Care where actual phenomena, transactional relationships, are described and depicted. This research, too, sought to study phenomena. And in this way, Watson's framework worked well.

A second consideration ought to be made with regards to the appropriateness of using Watson's framework: the nature of unseen nursing work. The background to the research and literature review of this thesis attempted to demonstrate the problematic nature of the less tangible aspects of nursing work. Watson believes technical competencies are to the medical service paradigm what ontological caring competencies are to the modern nursing paradigm. Technical competencies are those tangible nursing interventions that use conventional tools and instruments in practice. Cohen (1991) calls these technical competencies of nursing the "trim of nursing (procedures, tasks, techniques)" and the ontological caring competencies the "core of nursing "(p.908). Watson believes strongly that the core competencies of nursing are the ontological caring competencies, like the therapeutic nurse -patient relationship and the use of self. It is, therefore, fitting that the selected framework is one sensitive to and valuing of the unseen aspects of nursing practice.

There is one last consideration that needs to be made with regard to appropriateness of the framework that guided the research. It has to do with what Cohen (1991) describes as Watson's emphasis on a "spiritual dimension to life, a capacity for growth and change, a deep respect and regard for person and human life and the importance of an intersubjective interpersonal relationship between patient and nurse." I believe the statement can be reduced to Watson's emphasis on being human. This being human is

most appropriate to the findings of the research because in the final analysis, the results of the intimate relationship, the results of the research were about being human.

Carper's Ways of Knowing – Using Reflexivity

The purpose of the discussion in this section of the chapter is to understand the relationship between the findings and the second sensitizing framework used in the research. John's (1995) adaptation of Carper's Ways of Knowing will be discussed from three perspectives. First, its effectiveness as a research process guide will be assessed. Second, the framework's use of story telling is discussed and an assessment of how the story telling process contributed to both the research process and the richness of the findings. Last, the framework is looked at in terms of its influence on the exploration of the concept within the findings of the research.

Johns (1995) describes the purpose of reflective practice as allowing the nurse to "access, understand and learn through his or her lived experiences and...to take...action towards developing increasing effectiveness...as desirable practice" (p.226). He proposed that by using a structured framework, based on Carper's Fundamental Ways of Knowing (1978), the nurse would have access to the unseen parts of her practice. The nurse could use the framework to reflect upon everyday practice. The goal of this exercise was to learn through experience and undergo development of self and thereby use self more effectively in practice.

Influence on Process

John's adapted Ways of Knowing framework was selected, primarily, to sensitize the researcher to the data gathering process: interviewing or the act of conversation with the participants. The concept that the research intended to explore, therapeutic intimacy, was

not well known in the literature and correspondingly, not well known in the clinical realm using that terminology. As with any phenomenology, the research seeks to discover, rather, uncover the essential structure of the concept and thereby understand the true essence of the concept. I believed, having had my own profound experiences, that therapeutic intimacy existed; I realized, though, that other nurses with similar experiences might not have named them therapeutic intimacy.

The problem I faced as a researcher, or as a nurse, seeking to better understand therapeutic intimacy, was how to get at the phenomenon in a genuine way. For instance, if I had chosen to simply ask participants to tell me about the phenomenon or define therapeutic intimacy, I think the data would have been rigid, without depth and ultimately trite and one dimensional. Having participants tell a story of the experience, therapeutic intimacy, and look reflectively at the experience from a number of perspectives allowed an unfolding around the phenomenon to take place: it was like slowly, gently and precisely peeling the translucent layers of the onion away until the core, delicate and white, was exposed for both researcher and participant to see.

From a practical operational point of view, story telling and the attempt to derive meaning from story through reflection, offered a pragmatic approach to data collection for two reasons. First, contact with each participant was limited to one interview and it was, therefore, important to ensure the data collected was complete. Second, without a way of examining the story, parts of the phenomenon may have been missed as a result of not applying organized, thorough and exhaustive examination technique.

The Power of the Story

The Ways of Knowing framework was used in the development of the Interview Guide (Appendix C). The guide asks for a nursing story, clinical situation, of which the participant has strong memory of deep and meaningful connection or strong relationship with a patient. Once told, the story was revisited again and again from the different perspectives found in the framework: the empirical, personal, ethical and finally aesthetic ways of knowing. The building of insight into each story caused a cascade of other stories to pour out of the participants. All but one told more than one; most told more than five.

Boykin and Schoenhofer (1991) argue that story is a method of organizing and communicating nursing knowledge. They make the case that the story has a special place in nursing because “all nursing takes place within nursing situations, lived experiences in which caring between the persons of nurse and client promote well being.” They believe that the story has a meaningful place in all aspects of nursing, both practice and scholarly inquiry. They site Carper’s Ways of Knowing as an excellent framework for the reflection on nursing situation or story. The nurse shares her story and experiences acceptance and support while developing insight into herself. The story acts as a mirror where the teller may take a moment and look into her own face, her own nurse’s self.

In reflection on the data collection experience for this research, I was more struck with the nature rather than the number of the stories the participants shared. What was more significant was the pressure, passion and power of each participant’s story telling. Participants would complete a story and the resultant reflection only to say, “May I tell another” or “ I just thought of something else.” The stories were not a series of mundane

anecdotes. Rather, these stories were made of passion. Some participants cried and said, “I haven’t cried about him for a long time. I really loved him.” The power of each story was in the revelations experienced by the participants. Many remarked that they had not thought of an intimate experience as even necessarily therapeutic: they were unwilling to take credit for leading and directing the nurse-patient relationship in a healing way. Their humility was remarkable; they would say, “It just happens” as if any one could do it. Through reflection on their story, though, the participants gained an understanding of the wonderful and incredible work they do as nurses. Each had the opportunity to hold up that mirror to the beautiful nurse’s face and truly recognize themselves.

Influence on the Findings

Johns' model of structured reflection is adapted from and uses all the elements of Carper's work. Carper identified four inter-related ways of knowing: empirical knowing, ethical knowing, personal knowing and aesthetic knowing. While the interview probed the participant from the empirical and ethical ways of knowing, this approach bore little fruit. I believe this was a result of two things. First, empirics and ethics merely inform the aesthetic way of knowing; they do not influence. Second, because this research was interested in the less than tangible parts of nursing practice, the empirical way of knowing, knowing based on facts and that seeks to predict occurrences rather than grasping and interpreting phenomenon, did not fit. Discussion of the Ways of Knowing will, therefore, consider the personal and aesthetic ways of knowing only.

What is the relationship between the findings and the personal and aesthetic ways of knowing? Johns identifies personal knowing as the nurse’s awareness of her own feelings and prejudices and managing those feelings and prejudices in order to sustain

themselves. Aesthetic knowing consists of grasping, interpreting and envisioning; perhaps the art of nursing. I believe the conversation that occurred between researcher and participant guided by these two ways of knowing created an understanding and seeing of self in the nursing situation so that each participant developed an understanding of the art of her nursing practice. This revelation was interpreted earlier as rejuvenation where the participant was able to view the positives, or gifts and articulate how these gifts replenished them. This was the sustenance of the participants.

Summary of Discussion

The discussion section of Chapter Five has considered the findings in relation to four areas: sample, research questions, nursing literature and sensitizing frameworks. The purpose of the discussion was to link the findings of the research with the other elements of the thesis. Through this discussion I have had the opportunity to reconsider some assumptions and weave the separate parts of the thesis together.

The discussion allowed for the concept of therapeutic intimacy to be operationalized. I believe that we can now speak of this concept as a nursing intervention that belongs to the category referred to as ontological caring competencies. Having said that, where does the discussion, with the demonstration of some incongruities, and this better definition and rightful placing of therapeutic intimacy leave us?

Recommendations

As a result of the thorough discussion that precedes this section, recommendations pertaining to the findings of the study, both from process and definition points of view

can be made. This section will outline recommendations for nursing practice, education, administration and research.

Nursing Practice

I will make two recommendations with regards to nursing practice. They are providing nurses more control and support for caring practices. They are discussed below.

Provision of Control

There was a strong message from the findings about the need to have the ability to influence the clinical setting, both the physical environment and their patient assignments. The nurse is responsible for the care she delivers, yet the physical environment, both Time and Space, is often outside her control. The findings demonstrated that the right physical environment was an essential ingredient in the nurse-patient relationship. One recommendation would be that nurses have greater individual autonomy over physical space and time, like ward routine (medication times, schedule of ADL and the like).

Another type of control that needs to be afforded to the bedside nurse is the opportunity for consistent contact with the patient over time. The findings demonstrated this as being important to both nurse and patient. A recommendation to achieve this would be to make the primary nursing model the norm and not the exception in acute care settings.

Ontological Caring Competencies

Discussion of the background information and the literature that preceded this research demonstrated that there is not clear articulation of the parts of nursing practice that are unseen. While this is not a new problem, the emphasis on outcome-based interventions may make the unseen nursing interventions even harder to see. I believe that the findings of the research demonstrate that ontological caring competencies are alive and well and are living within many bedside nurses. If this were not the case, I think I would have generated a very different data set from what exists.

If it is safe to assume that many nurses use these kinds of interventions in their clinical practice, this research would recommend ways of encouraging use of ontological caring competencies. One way would be to encourage dialogue about these practices among nurses through sharing of nursing stories, perhaps, in a kind of sharing circle that would replace regular nursing rounds. This would encourage the sharing of nursing knowledge through story telling and reflection. As well, it would aid the development of our nursing vocabulary and lexicon so that we could begin to name and take ownership of and responsibility for our less tangible practice elements.

Nursing Administration

While the nurse is responsible for her individual nursing practice, nursing administration is responsible for nursing practice in the more global sense. The role of the nurse administrator is to plan, organize, lead and control nursing work. There are two areas where recommendations, based on the research findings, will be made.

Workload Measurement

Workload measurement is used to capture information about nursing work so that appropriate staffing and other resources may be allocated. While workload measurement systems are well established, they are known to have measurement issues. Nursing interventions that are tangible, palpable, countable and can be planned in advance are the aspects of nursing practice that are easily captured with these systems. Practice elements that belong to the classification of ontological caring competencies, we know from earlier discussion, are difficult to name and even harder to perceive. Further, as Kadner (1994) pointed out interventions such as intimacy are almost impossible to plan; rather, the nurse maintains that psychological readiness so that she may take spontaneous opportunity to engage.

Clearly, there are significant issues that nursing administration must face with regard to the measurement of nursing work. But if we believe that it is the ontological caring competencies that are core and fundamental and the more easily measurable stuff is merely trim (Cohen, 1991), administrators must rigorously pursue a system that measures these essential aspects of professional nurse practice.

Clinical Supervision

One of the responsibilities of nursing administration is leading or professional supervision. Nurse managers are responsible to ensure that nursing staff in their areas of responsibility carry and maintain all the licensures and certifications necessary to perform their jobs. For the most part, these certifications tend to measure competency in interventions and procedures that fall into the category of technical competencies. Nurses

demonstrate competencies in a variety of annual checks for all manner of practice intervention.

Having said that, how does the nurse manager measure competency for interventions, like therapeutic intimacy, that fall in the category of ontological caring competencies? Recognizing the difficulty in measuring this kind of nurse work, supervising can be seen as equally problematic. One method, and a recommendation of this research, would be to develop opportunities for clinical supervision of nurses. Clinical supervision is used by some allied health disciplines and offers the professional the opportunity to meet with an advanced clinician on a regular basis to review clinical practice issues.

Clinical supervision would address some of the difficulties of the fast-paced, heavy workload environments that have made informal mentorship almost nonexistent. Clinical supervision could be peer to peer based and would need to be presented, implemented and managed as a support to the bedside nurse. As Boykin and Schoenhofer (1991) identified the nurse shares her story and experiences acceptance and support while developing insight into herself. The story acts as a mirror where the teller may take a moment and look into her own face, her own nurse's self. Nurses would learn through story and from one another.

This type of supervision is not to be punitive in nature. Rather, just as with the sharing circle mentioned in the recommendations for nursing practice, it needs to be seen as another opportunity to tell of nursing situations, share knowledge and experience and participate in reflection.

Nursing Education

Nursing education is responsible to prepare the person to be a nurse and enter into the practice of care. I will make two recommendations for nursing education.

A New Curriculum

Many of the participants identified that their nursing education did not prepare them to use ontological caring practice. I recognize that there is much to learn in a nursing program and very little time to prepare the graduate for practice. Further, the pace and acuity in the workplace has placed an emphasis on the graduate's ability to manage the technical competencies and there is little support for the new nurse. Formal nursing education provides a great amount of knowledge in a short time frame.

I feel I must reiterate that many nurses believe the ontological caring competencies to be core and fundamental and we must not lose sight of them. For this reason, it is probably more important, not less, to ensure they are a part of any nursing curriculum. Their absence, or lack of emphasis, has potential of great harm to the profession in the long term. I would recommend, therefore, that nursing education develop new curricula that is grounded in humanistic nursing theory.

Clinical Supervision

Having discussed this recommendation above as part of nursing administration, I will not provide any further detail about clinical supervision. I think if we adopt a recommendation like this for practicing nurses though, a parallel process for student nurses needs to be developed. Clinical supervision would have the student nurse experience reflection and methods of sharing nursing knowledge well before entering practice as a graduate nurse. As well, experience with clinical supervision, as a student

would prepare the new nurse for the new practice environment, one of sharing with colleagues about the caring we do.

Nursing Research

I will make two recommendations for nursing research. One recommendation is for continued investigation based on this research. The other recommendation is a research challenge.

Further Research on Therapeutic Intimacy

The first recommendation I would offer is to continue the exploration of the concept, therapeutic intimacy. I think two other studies about therapeutic intimacy should occur. First, this research used a small sample and perhaps a larger sample with participants from practice settings other than oncology would be interesting. It would be important to ascertain that therapeutic intimacy is not a phenomenon that is exclusive to a singular type of practice environment. Second, this research looked at the phenomenon from the nurse's point of view. It would be valuable to look at the intimate experience from the patient perspective. What is the intimate relationship like for the patient? Is it the same? Is it different?

Research Challenge

We live in a world that values the tangible and touchable, the countable and measurable. This is evident by the emphasis being placed on outcome-based research. It almost seems that if you cannot support or prove that a certain intervention caused improvement, then the intervention is seen to be without value. If this is the environment we face, it is imperative that out-come based research that measures the effects of ontological caring interventions on positive health outcomes be developed. There are

significant difficulties with this kind of research. But the benefit to the nursing profession will be great. The risk of not doing this kind of research is keeping ontological caring nursing practice, the jewels of the necklace, hidden from the world. If they remain hidden, we may lose them.

Conclusion

I arrive at this point in the thesis having examined and said all there is to say about therapeutic intimacy. I could provide a summary statement but I think the discussion and recommendations speak for themselves. I would prefer not to reiterate what has gone before. Rather, I would like to take the opportunity to speak about what I learned from this research.

I began this thesis because of my own personal experience. I wanted to know that what I experienced was what it really meant to be a nurse. I have learned the answer to the question: Engaging in intimacy means being a better nurse. I have learned a much about the process, both research and writing: I have been constantly amazed with the hidden patterns in our world. These patterns emerge and make themselves visible only when you have completed your work. They cannot be forced out into our reality by command; they must be lived through and lived out. Finally, I learned about the power of story in all of us: I have had the remarkable and incredible privilege of travelling through the life-worlds of the beautiful nurses who participated in this research and shared their stories. You have taught me.

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APPENDIX A

Invitation to Participate in a Research Study

My name is Vivian Painter and I am a student in the Master's of Nursing Program at University of Manitoba. One requirement of my program is to conduct a research study. My study is entitled: Therapeutic Intimacy: The Lived Experience of the Primary Oncology Nurse. I believe that oncology nurses connect with patients on deep and meaningful levels and that this connection and relationship is an integral part of clinical practice. In the nursing literature and the clinical setting, this connecting with patients is often referred to a care. Care, however, has not always been tangibly defined. Nurses frequently refer to having provided care or behaving in caring ways. Perhaps if the components of care could be reviewed some clearer understanding of the caring nurse-patient relationship would be more visible.

In my own clinical practice I experienced moments of deep intimacy with patients and their families; I recall these moments as true privilege. I witnessed these relationships and moments of intimacy occurring between my colleagues and their patients. These experiences with therapeutic intimacy have been of such a powerful nature I wanted to discover the nature of other nurse's experience has been with therapeutic intimacy.

You are invited to participate in a research project that will seek to understand the experience of the primary oncology nurse with therapeutic intimacy. Specifically, I am looking for nurses who:

1. Are currently providing direct patient care in an oncology setting.
2. Have 5 years experience in oncology nursing.
3. Have had experience with nurse-patient relationship in their practice.

The University of Manitoba Ethical Review Committee of the Faculty of Nursing has approved this research. Your participation in this research will involve a 1 to 1 1/2 hour interview about your experience with intimacy as an oncology nurse. The time and place of the interview will be at your convenience. Your interview will be tape recorded, transcribed and analyzed. I will ask you to verify the findings. All information collected will be kept strictly confidential. Your participation is voluntary.

If you are interested in participating in this research please fill out the tear off portion below, place it in the envelope provided and place it in the file folder located on the unit. I will collect this information and call you at your home.

If you have any questions, you may contact me at (phone number);
Vivian Painter, (Address), Winnipeg, Manitoba, (Postal Address)

Tear along line; place in envelope; place in folder

I am interested in participating in this research. Please call me at your earliest convenience.

Name: _____ **Home Phone:** _____

APPENDIX B

Consent Form

I understand that I have been invited to participate in the research proposed: **Therapeutic Intimacy: The Lived Experience of the Primary Oncology Nurse**. Vivian Painter, a Master of Nursing student at the University of Manitoba, is conducting this research. Dr. Erna Schilder, a professor at the University of Manitoba, is supervising this research.

I understand the purpose of this research is to explore the use of therapeutic intimacy by oncology nurses. I understand that I have met the inclusion criteria: I currently practice in the oncology setting, I have practiced in the oncology setting for at least five years and I have experienced meaningful relationships with patients.

I have read the invitation to participate in the research and I have attended a group session that explained the research. I have been given the opportunity to ask questions of the researcher both in person and during initial telephone contact. I am aware that the Ethical Review Committee of the Faculty of Nursing has approved this research at the University of Manitoba.

I understand the nature of my participation to be an interview of approximately one hour and the opportunity to verify the research's findings. I understand my participation to be completely voluntary and that I am free to withdraw my participation at any time. I may suspend or withdraw my participation at any time, including during the taping of my interview.

I understand that I will gain no benefits related to my participation in the research. I am aware that my participation is completely confidential. The researcher has guaranteed that use of numeric coding and the use of a pseudonym will protect my identity. The data I contribute to the research will be seen the researcher, her thesis chair, the transcriptionist and the researcher's thesis committee members only; no others will be given access to the data I contribute. I understand that the data gathered will be stored in a secure, locked place for the period of 10 years; after this period the data will be shredded and destroyed as confidential waste.

During the course of the research, I understand that I am free to contact the researcher, Vivian Painter at (phone number) and/or Dr. Erna Schilder at (phone number).

I, _____, voluntarily consent to participate in this research and I have received a copy of this consent form.

Date

Participant's Signature

Researcher's Signature

APPENDIX C

Interview Guide

Part A: Demographic Information

1. Gender: M___F___; Age range: 20-29___ 30-39___ 40-49___ >50___
2. How long have you been practicing nursing?
3. How long have you practiced in the oncology setting?

Part B: Semi structured Interview

1. The Nursing Story

- A) Is there a clinical experience, a nursing situation, of which you have strong memory that involved relationship between you and a patient?
- B) Please tell me the story of this experience. Take as much time as you need and explain the situation as fully as your memory allows.

2. The Reflection on the Nursing Story

- A) Empirical knowing: Looking back on this situation, where there aspects of the experience that you understood as fact? What things about the situation were you able to predict?
- B) Ethical knowing: Did you feel any tension about how you should proceed? Did you face any dilemmas?
- C) Personal knowing: Do you recall being aware of you owns feelings? Could you manage your feelings? Did any anxiety result from your feelings?
- D) Aesthetic knowing: Did you understand the nature of the interaction with the patient at the time? Did you feel differently about the experience later or did you interpret the patient correctly during the clinical situation. Were you able to know where you wanted to take the patient in the experience (goal)? Did you understand your role in the interaction and if so, were you able manage the interaction?

3. The Experience

- A) In your memory, what aided the intimate interaction with the patient?
- B) What, in you memory, detracted from the intimate interaction?
- C) In you mind, what is beneficial about using intimacy in clinical practice?
- D) Can you think of any risks you or the patient might incur as a result of using therapeutic intimacy
- E) Having participated in a reflection on your practice, would you say you value this caring behavior in you practice?

4. Understanding of Concept

- A) Do you perceive the relationships you have with patients to be especially close or intimate?
- B) Are you able to use this closeness or intimacy as required? Can you use initmacy when you choose?
- C) If I were to ask you to define "Therapeutic Intimacy" how would you do so?

5. Closure

- A) Is there anything we have not discussed that you believe we should?
- B) Has this reflective experience been of value? If so, how? If not, why?
- C) Thanks you for your time.

APPENDIX D**LETTER TO NURSE MANAGERS (Sample)**

Vivian Painter
(Address)
Winnipeg, Manitoba
(Postal Code)
(Date)

Nurse Manager
Oncology Unit
Health Sciences Centre
Winnipeg, Manitoba
Postal Code

Dear Nurse Manager:

I am a Master of Nursing student at the Faculty of Nursing, University of Manitoba. I am conducting a research project as part of the course requirements. I am writing you to request permission to present an invitation to the oncology nurses on your unit to participate in my research: *Therapeutic Intimacy: the lived experience of the primary oncology nurse*. My research proposal has been approved by the Ethical Review Committee of the Faculty of Nursing, University of Manitoba. I have attached a copy of this approval for you to read.

The purpose of this research is to explore the use of therapeutic intimacy by oncology nurses. While there is much information on the broader concept of nurse care, there is little knowledge of the actual components of nurse care. This research hopes to illuminate our understanding of caring competencies used by nurses in the oncology clinical setting.

I would like to attend a staff meeting in the near future. I will provide small posters for you to place on staff bulletin boards identifying the research and the upcoming opportunity to hear an explanation of the project from the researcher. Participants will hear a 10-minute presentation on the proposed research, be given a written explanation (invitation to participate) and a mechanism to forward their names to me. Participation is completely voluntary and strict confidentiality will be maintained with respect to participation by staff. All aspects of the research will occur outside of the workplace and work hours.

I will follow up this letter with a phone call in 5 days to discuss any opportunities you can afford me. If you wish to contact me, I can be reached at (phone number). As well, you may wish to contact my Thesis Chairperson, Dr. Erna Schilder at (phone number).

I wish to thank you in advance for your assistance.

Most Sincerely,

Vivian Painter, RN, BA
Master of Nursing Student
University of Manitoba

APPENDIX E

POSTER INVITATION

**RESEARCH PARTICIPATION
OPPORTUNITY!****THERAPEUTIC INTIMACY:
The lived experience of the primary oncology ***

Have you experienced deep and moving relationships with patients? Have you sometimes wondered at the privilege of being a nurse and being able to connect with patients in very close ways?

Have you been practicing in Oncology Nursing for at least five years?

Are you currently practicing oncology nursing?

If you have answered yes to the above questions, you may be eligible to participate in a research study designed to explore the experience with therapeutic intimacy by oncology nurses.

Vivian Painter, a Master of Nursing student at the University of Manitoba will be making a short presentation about this research at your upcoming staff meeting.

Date:

Time:

Location:

*This research has been approved by the Ethical Review Committee of the Faculty of Nursing, University of Manitoba

APPENDIX F

EXAMPLES OF SIGNIFICANT STATEMENTS

Formulated Meaning	Paraphrase	Significant Statement
Creating Space	The nurse takes action to create the appropriate physical setting.	You need a quiet place...drawing the curtain...we could hear the noises going on in the ward but that gave us our own little space. (3: 313-315)
Controlling Space	The nurse recognizes the elements in the physical setting that are within her control.	<p>...someone comes barging in there and rips the curtain back, "Here's your meal tray." (3: 322-23)</p> <p>Sometimes the setting itself. Four bed rooms. A two bed room is easier...part of it is not only the sense of people listening but part of it is also the sense that you don't, I don't want these other three people thinking that I don't care for them in the same way... Because people in the hospital spend a lot of time lying around and listening to what is going on around them. (10:221-226)</p>
Finding Time	The nurse evaluates her work constantly in order to create the time she needs to intervene.	<p>...your whole day is organized enough and you're not so busy that you have to leave the patient because you have so many other things to do ...you may not actually say, I have to go and get Mr. M his medications, or I have his dressings to do, but it's always in the back of your mind. (6:616-619)</p>

Formulated Meanings	Paraphrase	Significant Statement
Nights	The nurse recognizes the different rhythm the night shift offers as opportunity to be intimate with patients.	...a lot of times, patients who are going through this terminal diseases ...they wake up at night and all they do is think about it and its a quiet time. There is nobody around. That's when they need some one to come in and speak to them...so often times, if I happened to be on, you check your patients every so often, and if he was awake, we would always exchange a few words and gradually he would start to open up a bit...(3:89-95)
Amount	The nurse spends significant amounts of time with the patient.	I think, when people are there with you for that long period of time, I mean I spend more time with them I do with my husband, twelve hours in a shot, three days in a row, one day off, and three nights. It was very intense and I think just that being together, that you do develop a certain level of closeness. (2:382-394) if you look how many hours you spend in a year, because that person was in hospital for over a year, it's incredible because you really have to realize that you almost can't help but become their friend in some ways. (6:128-131)
Consistency	The nurse recognizes that working with the same patient promotes the development of intimacy.	you look after them a lot, so you get to know them (6:8) ...primary nursing,...really allowed you to develop more relationships with your patients...because of the consistent contact. (7:370-74)

Formulated Meaning	Paraphrase	Significant Statement
Myself as Person	The nurse brings aspects of herself as a person (her personal history and experience) to the intimate relationship with the patient	I remember as a kid, going to the store and this old man didn't have any money to buy jar of pickles and I felt horrible and I gave him my milk money... Like this man with the pickles. That was just me. That's been my life. (6: 472-75) and (6: 150-152)
Myself as Nurse	The nurse brings aspects of herself as a nurse (her nursing history and experiences) to the intimate relationship with the patient	...you become much more comfortable with the technical aspects of nursing...and with time, I was able to focus on other aspects of care, hence developing relationships with patients (6:119-122)
Openness	The nurse takes an approach to the nurse-patient relationship that is obviously and tangibly open to intimacy.	It's something that you can't force it on them, you make yourself available and if that person opens up to you, boom, it's like the plug in goes into both people. (6: 479-81)
Sensing and Touching	The nurse uses all her senses to assess the patient's need, readiness and interest in an intimate relationship. The nurse has implicit permission to physically touch the patient in meaningful ways.	...the patient opening their realm...it's almost that we are taking about the nurse opening his/her realm. Sensing the need. You wonder if the same thing isn't happening both ways. (6: 512-15)
Silence	The nurse is comfortable using silence as a medium for communication when developing an intimate relationship.	I understood that she just wanted me to do my work; to be quiet and do my work and that was most important to her and that created the connection even though we never really talked a lot, she valued what I could give her in my silence taking care of her life. (2: 75-78)

Formulated Meaning	Paraphrase	Significant Statement
Intent	The nurse is aware of the intention of the relationship between herself and the patient and directs the flow of the relationship towards the patient and away from herself.	The flow or the intention of the flow should always be giving in the direction of the patient. Not that you don't ever receive back. But it shouldn't ever be the one wanting to take for yourself... (2:971-975)
Boundaries	The nurse maintains an awareness of the limits and boundaries of the nurse patient relationship.	There is that optimal distance where you can help but you are still able to be analytical and logical and objective, so to speak, where you're still not detached, but where you are still on the other side of that magical line. (2:952-955) You have to draw boundaries because there are limits (5: 464)
Meeting Needs	The nurse maintains a relationship with the patient that ensures that the perceived needs of the patient are met.	But it may not be the way they want to connect with the nurse. Maybe, they want the nurse to just come in and do the pills or do what it is that needed to be done. They're not interested in connecting and that was o.k. They may have the support in other places, or maybe that is they only need to be met (the physical care)...(8: 400-404)
Surrogate Intimacy	The nurse, unable to engage in full relationship with the patient, seeks relationship with the significant others connected to the patient.	I think some of the close connections I have had have been with the family member rather than with the patient themselves. (8:438-441)

Formulated Meaning	Paraphrase	Significant Statement
Vulnerability	The nurse develops a nurse-patient relationship that recognizes aspects of her and others that requires challenge to ways of thinking and relating.	I can disagree with how somebody chooses to live their life but still connect with and make them feel valued and cared for. (2:719-720)
Click Factor	The nurse develops a relationship with the patient where the two parties just “click”.	You know when you click with a person. It just happens. You are on the same wavelength. It’s like you know that you are tuned on the same frequency and boom, it’s there. (6:174-78)
Being There-ness	The nurse develops a relationship with the patient that is based on being available to the patient at important times of need.	And there is often nothing you can say that will make this person feel any better, but you are there, the physical presence of being there that is important. (6: 417-19) It’s by the invitation, the invitation by physically being there. (9:338-39)
Trusted Partner	The nurse develops a close and authentic relationship with the patient where she becomes the trusted partner in the life experience of illness.	I thought, ‘I wish I could tell you, that as bad as it is, we can help you deal with it, to whatever the end might be and neither of us knows what that is’. I felt this was one more long journey dealing with this very difficult disease; and that really, yes it’s bad, but it is not the end, not yet. (9:43-49) I felt very privileged to be allowed to offer help and provide care to the dying and their families ...it is a very powerful experience when you are with someone when they take their last breath. Your life is not the same you know, there is something very profound about that. (8:214-223)

Formulated Meaning	Paraphrase	Significant Statement
Ties That Bind	The nurse experiences relationship with a patient that continues past the death event, maintaining connection with family or significant others in such a way that the nurse becomes inextricably tied to the patient. The family has opportunity to experience their loved one through the nurse.	Please see vignettes: "The Exhibit" (p. 106), "The Dream" (p. 106) "Christmas" (p.107)
Being Human	The nurse experiences relationship with the patient resulting in her ability to grow and develop characteristics of being human in her interactions with the patient. The nurse is comfortable showing her human side, in contrast to remaining detached, and joins the patient-family in true sharing of human emotion and response.	Please see vignettes: "Risk" (p. 108), "Pain" (p. 108), "Tears" (p. 109) "Closure" (p. 109)
A Better Nurse	The nurse develops into a better nurse by learning about relationship, developing a repertoire and ultimately making a difference in relationship with the patient. The nurse reapplies all she has learned and gained from each relationship so as to be a better nurse in future interactions.	Please see vignette: "Lessons" (p. 110) "Repertoire (p. 110) "A Beautiful Experience" (p. 110)

APPENDIX G

COVER LETTER FOR VALIDATION EXERCISE

(Home Address)
Winnipeg, Manitoba
(Postal Code)
May 24, 1999

Dear Participant:

I would like to start by thanking you for your participation in my research project. Your individual contribution was important to the outcome of the research. I am grateful for your time and effort.

I have now finished Chapter Four, The Findings. This chapter consists of the categorized data you and your colleagues contributed for my thesis **Therapeutic Intimacy: The lived experience of the oncology nurse**. I have one more request to make of you. If you remember when I interviewed you, I told you I would ask you to review my findings to ensure that they make sense to you as an oncology nurse expert. I have enclosed Chapter Four in its entirety: There are approximately 50 pages of text and tables and figures that attempt to summarize the data in the chapter.

I believe that I have categorized your comments to reflect your interview. If I have not done so, I need to hear from you. If you have questions, comments or concerns about the findings I would appreciate you telephoning me. I can be reached at work (phone number) or at home at (phone number). Please leave a message and I will return your call. I would appreciate a call from each of you. If I don't hear from you I will interpret that to mean you accept my findings.

Again "Thank you". I have been so privileged to hear and retell your stories. I hope I have retold them the way you would want.

Sincerely,

Vivian Painter, RN, BA