The 2001 Helene Hudson Memorial Lecture

13th Annual CANO Conference - Sponsored by Amgen Canada

The power of story: Using intimacy and love in oncology nursing practice

By Vivian Painter

Good morning, my fellow oncology nurses. It is such a privilege and an honour to be here among you today. When I was awarded this special opportunity, I felt an elation that I can hardly express: to be asked by your colleagues to speak! Well, I have held fast to the elation, working hard to drive away the sense of being overwhelmed so to arrive at this day, in this beautiful city in the presence of my friends.

Before I begin, I would like to acknowledge two people who cannot be here today, but to whom I am indebted. First, to Helene Hudson. While I have lived my entire nurse's life in Winnipeg, I did not have the opportunity to meet Helene before her untimely death. I do, however, feel as if I have come to know her through the many people she has influenced, and especially through this annual lectureship, her legacy. In a personal reflection on oncology nursing, Helene said, "The opportunity to reach out and help another human being in a meaningful way should not be taken for granted. It is the very essence of 'nursing.' Working with cancer patients brings joy, satisfaction and meaning." Helene, I hope my words today will be true to your reflection. Second, to Canadian artist Robert Pope: some of you may have met and even cared for this man; many of you may be familiar with his art. Robert Pope has captured the essential elements of the cancer experience in his drawings and paintings. I would like to thank him for giving us a window into that world, and hope that my use of his legacy, his art, today is done with the requisite respect and gratitude.

Many nurses experience moments of deep and intimate connection with patients which are so powerful that they sometimes surprise, and perhaps surpass personal experiences. This is particularly true in oncology nursing where illness is often sudden, perceived as life-threatening, and chronic in nature, causing patients to seek meaningful relationships with the nurse. Intimacy and love in practice, or therapeutic intimacy, has been described as a relationship based on trust, closeness, self-disclosure, and reciprocity that is used to alleviate suffering and promote healing – physical, emotional, or spiritual (Kadner, 1994). Can I tell you a story, my story?

Helene Hudson - 1945-1993

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? 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 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.

Purpose, problem, and questions

Engaging in intimate relationships with patients has provided me with experiences of extraordinary connectedness, incredible

Vivian Painter, RN, MN, CON(C), is Provincial Director, Patient Services, CancerCare Manitoba, and Nursing Director, Winnipeg Regional Health Authority, Oncology Program, Winnipeg, Manitoba. She presented the 2001 Helene Hudson Memorial Lecture at CANO's thirteenth annual conference in September 2001.

privilege, and knowledge of the power of nursing. These significant and lasting memories led me to want to explore this phenomenon, and to take a journey of discovery through the lived experiences of oncology nurses who deeply connect with patients, become intimate, and ultimately practise through love. I went first to the nursing literature and found that, while there was a good description of the tangible aspects of nurse care, the intangible, unseen practice of nursing was less defined, not clearly visualized or articulated, and perhaps not valued in the most meaningful ways.

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" (p.40). 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 form the string that gathers the parts together into a thing of beauty and meaning. I decided then, if this phenomenon, therapeutic intimacy, was real, I should ask nurses about their experiences; perhaps through the nurses who live in these therapeutically intimate relationships I could come to understand my own experience better.

The purpose of this paper is to describe the findings of this journey and to describe for you these experiences of intimacy and love in oncology nurse practice. I will share a series of stories of caring for patients, stories that help explain the phenomenon of therapeutic intimacy as it was described to me. I was told of the ingredients of intimacy, or what was necessary for that relationship to occur; the kinds of intimacy, or the range of relationships in which we can be engaged; and the meaning of intimacy, how it is used and to what end. The resultant rich tapestry of stories will describe the beauty and power of nursing, the need to remain connected to fundamental caring competencies, and courageous use of self as an instrument in oncology nursing practice.

On my journey, I was guided by three questions: 1) What is the nature of the experience? 2) How does therapeutic intimacy occur: What helps and what hinders its occurrence? and 3) How is it used and to what end?

Findings: Ingredients of intimacy

On my journey through the nurses' lives, I heard them speak of the things necessary to create an intimate experience with a patient. The *Recipe Card* (see Figure One) attempts to describe these findings. Nurses were both creating and participating in the ingredients of intimacy.

Figure One: Recipe card: Ingredients of intimacy	
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

Setting the stage

When creating the environment for intimacy, the nurses spoke of three things.

Creating 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. We started talking.

Having time

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 someone 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....

Making contact

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 spent in a year, because that person was in hospital for over a year, you realize that you almost can't help but become intimate.

Using self

While the nurses explained their responsibilities in creating and controlling space, time, and contact to ensure favourable conditions exist, these are things that are external to the nurse. The other ingredient of intimacy is the nurse herself: who she is as a person, a nurse, her approach to her work, and her ability to direct the flow of relationship.

Nurse as person

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 enough money to buy the pickles and I remember feeling horrible and wanting to help. 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 be a nurse and not do that because then I am not doing my job. Like the man with the pickles, I had to help, that was just me. That's been my life. My whole life has been a series of experiences similar to that. That has obviously shaped me, how I think and how I deal with people, I guess how I nurse people.

Person as nurse

I remember nursing 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 I 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.

Having brought herself, both person and nurse, to the relationship, the nurses told of a certain posture or stance they must assume. This

kind of positioning or approach is essential, and consists of the nurse's openness, her ability to sense and touch, and her use and comfort with silence.

Openness

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 all happened in five seconds: there was an intellectual part, an emotional response, and 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.

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:

Sensing and touching

I am not even sure why I offered her Reiki, to be honest, because it's not something I make offer of to everybody and she had no experience with those things. I guess it was an intuitive thing. I just sensed that it would be appropriate healing for her. Mariam 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 ingredient of intimacy, one's approach, consists of an openness of posture and heart, the ability to sense the patient's need, and, finally, the ability to work in silence. The nurses told of the great number of intimate relationships that occur in silence.

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 comfortable with silence. There were times when I would look after her for the whole day and we wouldn't say two words to each other. I was comfortable with that and she was comfortable with that, and actually, in the end, I realized she really appreciated that. I think part of it was there was a lot of buzz and commotion going on and she just wanted some peace and quiet. That was her home, that was her room, so keep the chatter out. She was at peace then.

The nurses explained that just as they are responsible for setting the stage using space, time, contact, and their approach, they must also direct the play: the nurse directs the flow of the relationship.

Directing the flow

I had an experience that lasted one morning when I cared for a woman who was dying at home - that was all the time spent with this family. The family felt very comfortable with the care that they had been giving, but this last bit of the journey, they needed a guide, that is all they needed. The woman was comfortable and what I felt I needed to do was just to let them know what a wonderful job they were doing, 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, that I would 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 watching as they engaged in those last moments with their mother. It had been really cloudy all that week and it was very grey that morning. All of the family was in the room and there was an incredible feeling 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 allow ourselves to be the centre of things.

Directing the flow was described as consisting of two elements: understanding the intent, and recognizing boundaries in relationship with patients. When the nurse employs these two elements, she is able to direct the intimate exchange in a therapeutic way. The nurse in the story above, while in awe of the incredible beauty of the experience, knows the intent of the experience is for the woman and her family, not for herself. She recognizes the boundaries: she is not a part of the family. Rather, her role is to support and facilitate the woman's death and her family's part in the experience. And in recognizing the intent and the boundaries, she is able to direct the flow of the intimate relationship. For many nurses, the question was, "Is this for me or is it for them?"

Intent

You have to be aware of and contain your ego, and guard against the build-up of the self-importance, because I am not that important - it's about the person, the patient. 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 who lose their sense of intention, but chaplaincy, social workers, other people in the caregiving professions. 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.

There was a consciousness about intent. When the focus of intent becomes the nurse and not the patient, you are no longer helping because the intent obviously would be for the nurse and not the patient.

That's sort of how I assess it, 'Is this for me or is it for them?' 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 you. The balance should be more going away than coming back, in terms of who's getting what out of the relationship. I have become self-aware; I check myself to make sure that the intent is on a professional level: that I am meeting the patient's needs, not meeting my own. I see myself as 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.

Boundaries

The filter she uses helps her direct the flow of relationship toward the patient while protecting herself from harm. While the filter helps direct the flow, the shield represents a boundary. Boundaries were said to be 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.

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 could have predicted it. And that doesn't mean 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 a long time and it is still sad. It was 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. You don't have to. You know you build on your relationship and [then] have it gone. I think that you have to remember, and what I have to remember now, is you are really only a small part of their life, and that when I think of it now, it's that.... You are there for just two months or whatever and that's really all there is, you know. I think that is what I think now, they lived forty years and we are involved in their care for such a short time.

Kinds of intimacy

I came to understand from the stories told that there was a range of intimate relationships the nurse can experience. They told of either seeking or finding connection. None of the kinds of intimacy are better or worse than the other: patients and nurses meet in relationship where the fit is right. Each nurse is responsible for determining the need of the patient, and the kind of relationship required. The relationship is not static: rather, things can change, and the relationship between patient and nurse can change as need is demonstrated. The authenticity of the relationship increases with the deepening connection developing, from merely meeting needs to being a trusted partner (see Figure Two).

Seeking connection

Having sensed the need of relationship, the nurse will seek intimacy in whatever form is appropriate for the patient. The nurse tries to connect as she explains below:

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. I find it frustrating with patients who never allow themselves to tell you how they are feeling, even though you might ask them. You can tell they're 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. 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 someone 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.

The nurse has three choices in a seeking connection relationship: To respect the barrier and provide competent, basic care; continue to push against the barrier hoping to break through the crust; or to use surrogate intimacy. One nurse told me of an experience with surrogate intimacy:

There have been instances where a patient is very sick and you can't really communicate because they're too sick to communicate. That's when you really link up with the family members. I remember one time, where a lady came onto the ward; she had metastatic disease and things were not good. There were a lot of family dynamics; things from the past that were unresolved and things were very tense. The dynamics were coming to a head because this patient was sick and quite obtunded and all the family was together in that room. You could just feel the tension in the room, especially when certain individuals were there. 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; people don't do that unless they have some trust.

The nurse develops a relationship based on surrogate intimacy. The relationship consists of the same ingredients as other intimate relationships with the patient, but it is the needs of the family that are served.

Finding connection

The seeking of intimate relationships is often rewarded with finding connection with another. These relationships build, from working through vulnerabilities of both patient and nurse, through simply clicking with the patient, to being there as a trusted partner. The nurses told of moving through this range of intimate relationships, and, as they did, the authenticity of the relationships became stronger.

Vulnerability

Vulnerability, or being vulnerable, is a kind of intimate relationship. Vulnerability can be seen in patients as they physically expose themselves to their caregiver, the nurse. Part of the nurse is vulnerable in this physical exposure and contact.

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 wheelchair and I will take you in there and give you a good shower." 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, and connected partners. The participants told of being allowed into this most private realm with their patients.

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 to do." So I went with the patient and his wife and we boosted him into the bed together. We changed him. So he felt comfortable with that.

Click factor

The relationships mentioned above describe people being brought together because of need, and working past their vulnerabilities. Many nurses 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.

Figure Two: The intimacy grid

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. There are times we really click, like when we have lots of things in common. Sometimes, I think it's when we find a kind of special place where the patient and I share a special bond, a kind of click like 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.

Being thereness

Whereas relationships that were a result of the click factor were perceived as close by the nurses, they did not have the same intensity as relationships that had *being there* at their core. Many nurses spoke of a certain *being thereness* that occurred. These relationships represented a kind of growing authenticity that occurred as the nurse moved from simply meeting needs to this kind of connection.

I admitted her in February on a Friday; I forget what the dates were. 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. For me, I felt a real sense of closure, like I was there with her through it all. And the family, they said that too. The family noticed that I had been there as the nurse all long. They said, '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.

Another nurse told a story about *being thereness*:

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 had told him he probably had arthritis in his back, but they discovered that he had a tumour 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 of 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 sharing of humanness: she cries with him, she shares the patient's pain. This nurse uses the *being thereness* of relationship to move to the next and most authentic relationship: *trusted partner*.

Trusted partner

At the point of greatest authenticity, the nurse finds herself in relationship with the patient as a *trusted partner*. The nurses all spoke of this relationship based on authentic interpersonal respect, trust, and ultimately love. The following story is an exemplar of this kind of relationship. The nurse described an experience where intimate information was shared by the patient with her, and 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.

All the nurses shared at least one experience where they had become the trusted partners in a patient relationship. Nurses hold a position of remarkable trust. One nurse spoke of working with people at a most privileged time in their lives: at their 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 family members say their good-byes and let go is a role afforded to someone who is a *trusted partner*.

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 man 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 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 up until the very end. He died peacefully and that's what she needed.

Another 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 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, but at one point he went home and I was working one evening when 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.

Through the nurses' stories, the exemplar descriptions of the relationships they have shared with patients, I came to understand the range of intimate relationship. All the nurses use the same ingredients, but each relationship is different from the other. The nurse and patient meet where there are needs and where those needs can be met. I could perceive my own experience in the lived experience of these nurses. I knew that my experience was a shared experience with other nurses. I still found myself thinking, though, "What are the results of this intimate relationship? What do these relationships mean in the end?"

The meaning of intimacy

When I considered the question, "To what end?" and sifted through all of the nurses' stories, I found small but beautiful jewels left in quiet corners of the nurses' stories where a nurse would say what the intimate relationship, what therapeutic intimacy, really meant to her. I will share these stories so that each jewel, each gem, may be experienced. Ultimately, intimacy means having ties that bind, being human, and being a better nurse.

The ties that bind

Christmas

She had a daughter, Ester, who was 10 when her mom was sick, and I was her mom's nurse. One Christmas, I got a phone call from Ester. I didn't understand who was calling me at first, 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 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 was 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, you see her mom was very concerned about her and the other youngest ones. This woman had 10 children, but the youngest two were nine and 11 and she was most concerned about them. She figured the older 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 too, 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 goodbye. She sort of got what she wanted, but to me it was so neat, because I had a really deep connection with those people.

The stories the nurses told, like the one above, 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.

Being human

The nurses gave many examples of how they evidenced being human. They told stories of taking risks, feeling pain, shedding tears, and seeking closure. Again, the vignettes need no commentary, no interpretation. Their message, their beauty, is clear.

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 feelings. They're a person and you're a person. So you interact on a person-to-person level.

The experience of therapeutic intimacy means being human. By being human, the nurses contributed to who they are as persons, as human beings and, thereby, completed the circle of wholeness. I saw how, in completing this circle, they were able to replenish the ingredients they bring to the intimate relationship.

A better nurse

The nurses all told of what they gained from the intimate relationship with patients. The final result for them was being a better nurse; the experience of therapeutic intimacy made each one a better nurse. They learned important lessons, built their 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 give 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 might 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 it 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 you 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 care for and serve.

As I recounted all the nurses told me, I found myself thinking more and more about the nurses' 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 narratives: A necklace of intimacy (see Figure Three).

Insights into the results of intimacy

I began my journey of discovery about therapeutic intimacy by asking questions about my own nursing practice and that of others: "What does intimacy in practice consist of?" "What kinds of intimacy can be experienced?" and, finally, "How is intimacy used and to what end?" While the first two questions are important, they were easily answered by the stories told about the ingredients of intimacy and the kinds of intimacy. The third question was answered only after careful consideration of the meaning of intimacy. From this consideration, I have been able to understand more fully the meaning of intimacy in nursing practice. Ultimately, I have come to understand the results of the intimate relationship for the nurse. In this last part, I would like to explain these things about intimacy in relationship I have come to know.

My consideration of the meaning of intimacy in nurse-patient relationship caused me to ask, "To what end?" But more, "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/his 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. When the nurses spoke about the meaning of intimacy, they 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, one that you can touch, or measure, or observe, neither were the gifts the nurses received from their deep engagement in those kinds of relationships.

Satisfaction

The nurses, 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, the stories the nurses shared, spoke of ties that bind and ultimately told of being a better nurse. I remember my own nurse's stories, and in particular my own testimonial, and now know why they have lingered with me: I have been satisfied, I gained the ties that bound me to those people, I became a better nurse because of these relationships.

Privilege

The nurses' stories acknowledged their experience of being the recipients of privilege. The privilege they spoke of was about being human in their nursing practice. The privilege took many forms: risking (even if scary); feeling (even when it hurt); crying (even when you may not want to); 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 individual privileges can be seen as one greater gift, the privilege of being human within your practice.

Again, this paralleled my experience and my stories of being a nurse. It was in those moments of true intimacy, in deep relationship with my patients, that I came to know what a nurse does; that is when I learned the privilege of being a nurse and being invited into human communion with another.

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 journey I embarked on with the nurses, I could not help but be in awe of the deep and intimate human connection the nurse and patient share. The question raises itself though, "How can the nurse go from one tragedy to another without succumbing to the burden of care?" One nurse told of 10 significant relationships in four years; a remarkable burden. I will argue that this last question I asked on my journey of discovery, "To what end, or why do they do it over and over again?" is answered by looking at the meaning of intimacy.

While the nurses did not speak directly of receiving the gift of rejuvenation, they intimated to it through their stories. 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 nurses 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 of what she needs to create the opportunity for intimacy in relationship. I believe it is through this gift, this rejuvenation, that the nurses complete the circle. And in completing that circle, they can be seen to join the clasp of the necklace of intimacy, and in wearing that necklace they feed their nurses' souls.

Figure Three: A necklace of intimacy

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Insights into story and reflection

The experience of my journey into the inner world of nurses and their intimate relationships with patients has been profound. I think that part of the profoundness is related to the vehicle I chose to take this journey: I asked the nurses to tell a story, just one, about an intimate experience or relationship they shared with a patient, and then reflect on the experience from a number of perspectives. Having the nurses tell a story and look reflectively at it 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 of us to see.

From a practical point of view, story-telling offered a pragmatic approach to gathering together the experience of intimacy from several nurses. The reflective exercise was a way of examining the story so that parts of the phenomenon were not missed and then not understood. I spoke to each nurse only once, and so I had only the one chance to gather the story and understand it as fully as possible.

The power of the story

I asked each nurse for a nursing story, a clinical situation of which she had 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: 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 nurses. All but one told more than one; most told more than five.

Boykin and Schoenhofer (1991) argue that story-telling 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" (p.246). They believe that the story has a meaningful place in all aspects of nursing, both practice and scholarly inquiry. They cite **Carper's Ways of Knowing** (Carper, 1978) 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 my journey through story, I was more struck with the nature rather than the number of the stories the participants shared. What was more significant than the number was the pressure, passion, and power of each nurse's story-telling. Nurses 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 nurses 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 nurses. 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 anyone could do it. Through reflection on their story, though, the nurses 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.

Insights into reflection

Johns' (1995) model of structured reflection is adapted from and uses all the elements of Carper's work (Carper, 1978). Carper identified four inter-related ways of knowing: empirical, ethical, personal, and aesthetic knowing. When I probed the nurse 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 I was interested in the less-than-tangible parts of nursing practice, the empirical way of knowing, knowing based on facts that seeks to predict occurrences, rather than grasping and interpreting phenomena, did not fit. For these reasons and for this discussion, I have considered the personal and aesthetic ways of knowing only.

Through the reflective exercise, the nurse engaged in ways of knowing. There was the personal knowing as the nurse's awareness of her own feelings and prejudices, and managing those feelings and prejudices in order to sustain them. There was the aesthetic knowing, which consists of grasping, interpreting, and envisioning. This way of knowing is perhaps coming to understand the art of nursing. I believe the conversation that occurred between myself and nurse, guided by these two ways of knowing, created an understanding and seeing of self in the nursing situation so that each nurse developed an understanding of the art of her nursing practice. This revelation was interpreted earlier as rejuvenation, where the nurse was able to view the positives, or gifts, and articulate how these gifts replenished her. This was the sustenance of the nurses.

Conclusion

I arrive at this point in this paper having examined and said most of what there is to say about therapeutic intimacy. 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 journey into story.

I began this quest 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 much about the process, both the searching and the writing. I have been constantly amazed with the hidden patterns in our world. The patterns that help us make sense of our world emerge and make themselves visible only when we have completed our work; done all of the asking and searching, when we have heard and come to understand the stories. 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 shared their stories. They have taught me.

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