The sociology of intimacy in the nurse-patient relationship


Summary
This article examines intimacy from a sociological perspective. It reveals that ‘over-involved’ or ‘intimate’ nurse-patient relationships do not tend to be welcomed by nurses. The work of certain theorists is explored to provide a sociological explanation of intimate nurse-patient relationships and to highlight the complexities of nurses developing intimate relationships with patients in the workplace.

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NURSING IS ESSENTIALLY a social construct, that is, a mode of social organisation for the delivery of key caring, comforting and technical skills (Johnson 1999). However, these skills are not exclusive to the nursing profession. Nursing continues to search for its own unique body of knowledge and this has probably had a significant influence on nurse theorists adopting the nurse-patient relationship as the core of nursing practice. Nursing has followed the path of sociology in specific ways, for example, the terms used to distinguish nursing theories of different scope – meta theory, grand theory, middle-range theory and practice theory – are derived from sociology. Mulholland (1997) suggests that sociology is invaluable to nursing because it derives much of its knowledge base from disciplines such as sociology (Box1).

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

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

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

Intimacy
The term ‘intimacy’ as applied to nurse-patient relationships is difficult to define. However, there is agreement that it requires reciprocity, self-disclosure (Timmerman 1991, Kadner 1994), and self-awareness (Dowling 2003), which suggests a closeness coupled with a high degree of intersubjectivity. Reciprocity and self-disclosure involve: ‘Getting to know the patient, and allowing [him or her] to get to know you as well’ (May 1993). Self-awareness is the need to ‘...keep
looking at yourself”, as in the process of self-reflection or self-reflexivity (Henderson 2001).

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

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

Involvement is a related concept. The term ‘involvement’ suggests emotional investment on the part of the nurse in her or his relationships with patients, but may occur without reciprocity and self-awareness as experienced in intimacy. This issue is raised by Williams (2001b) who questions whether theoretical writings on intimacy in practice represent over-involvement. Morse (1991) describes the ‘over-involved’ relationship as one where the patient and nurse mutually respect, trust and care for each other. The use of the term ‘care’ in this context suggests an emotional investment by patients in their relationship with nurses. This description of over-involvement is interesting in light of the theoretical views proposed by new nursing. Perhaps the issue is not with mutual trust and respect between nurses and patients, but with the inclusion of caring for each other. Mutual caring may be perceived as the antithesis to the expected professional relationship between nurses and patients. The use of the term ‘over-involvement’ suggests a nurse who is not in control. Indeed, balancing engagement with detachment is reported by many nurses as a way of coping with the realities of a close nurse-patient relationship (Carmack 1997).

**Associations with identity**

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

Handy (1991) provides evidence to suggest that subtle actions were taken against mental health nurses who were perceived by colleagues ‘...to be deviating from socially acceptable norms’ by over-involving themselves with patients. Although conducted almost 15 years’ ago, Handy’s research is worthy of closer examination. She used a variety of data collection methods in her comparative study of stress among nurses in community mental health and hospital settings, such as interviewing, participant observation, analysis of nursing notes and in-depth interviewing. She found that one of the key strategies for controlling nurses who appeared to be deviating from socially acceptable norms was to label them as having psychiatric problems. This is summarised by one nurse participant who expressed the view that over-involvement with patients usually occurred with nurses described as ‘vulnerable...with problems of their own who identify with patients – and it’s usually the neurotic or manipulative patients they get involved with – if I ever see that happening I usually have a word with them for their own good...’ (Handy 1991).

This labelling of a colleague as ‘deviant’ can be examined from a symbolic interactionist standpoint (Box 1). George Mead, an American philosopher (1863-1931), is the originator of symbolic interactionism and proposed that persons adapt to, and survive, in their environment by sharing common verbal and non-verbal symbols (Bielkiewicz 2002). A significant symbol is a gesture that only humans can make, and becomes significant when it arouses the same kind of response in the individual making it as it was intended to elicit from the person to whom it was addressed.

**Box 1**

**Glossary of terms**

| Sociology | Sociology is the study of human social relations or group life. Sociologists examine the ways in which social structures and institutions, such as hospitals, influence society. |
| Symbolic interactionism | Symbolic interactionism emphasises the subjective meaning of human behaviour, the social processes and common-sense meanings. For interactionists, humans are practical and must adjust their behaviour continually in response to other factors. |
(Ritzer 2000). Therefore, nurses may perceive other nurses’ intimacy as over-involvement (Morse 1991), and possibly deviant because they have been socialised to believe that this is the case (Becker 1963).

The concept of identity is also relevant to understanding intimacy. An approach to identity has been developed within social psychology and refers to the location of identities within the social structure. For example, McCall (1987) states that society is composed of roles and describes the processes by which individuals assume roles that they believe are expected of them as they act out and attempt to live up to expected identities.

Nursing students are exposed to the theoretical concepts of relating to patients, such as those proposed by Peplau (1952), who believes that nursing is essentially an interpersonal process in which the nurse and patient respect each other as individuals and learn and develop as a result of their relationship. However, in practice, their experiences may socialise them to behave differently in their relationships with patients than they intended. For example, both the nurse and the patient play equally important roles in the therapeutic relationship, but in practice the experience of illness renders many patients vulnerable and dependent on nurses for support. This alters any attempt to maintain equality between nurses and patients in the therapeutic relationship.

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

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

Parsons’ status role

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

Nursing students are socialised in nursing mainly in the acute hospital setting. Jourard (1971) states that such institutions are public and deprive nurses and patients of privacy, concluding that where there is no privacy, there is maximum opportunity to control behaviour and produce conformity. Nurses often undergo an unofficial socialisation process where it is considered unprofessional to become too close to patients. Too close in this case is similar to the over-involved relationship described by Morse (1991).

This is reflected in the findings of Handy (1991), who found that younger psychiatric nurses often expressed concern about the control-orientated ethos of their activities and spoke of their desire to develop more effective therapeutic relationships with patients. This indicates a theory-practice gap. Nursing theories such as those of Peplau (1952) encourage a close nurse-patient relationship, but in reality practice...
is often quite different. However, the context of the care setting is important. Froggatt (1995) states that in hospice care, the shorter duration of the nurse-patient relationship encourages intimacy, as the time-limits can promote a more urgent engagement between nurses and patients. Intimacy with terminally ill patients also has a moral value beyond providing relief from the routines of nursing work (May 1993). Nurse-patient relationships are often lengthy in mental health settings which may mean that intimacy is not encouraged.

**Interactive relationships among individuals**

Parsons presents a multidimensional scheme for classifying relationships containing five dichotomous pattern variables, which he argued structured all social action (Lidz 2000). The first of these patterns reflect the reality of intimacy in nursing practice.

The first of these patterns is the dichotomy between affectivity and affective neutrality, with neutrality referring to the amount of emotion (affect) that is appropriate in an interaction. Nurses are encouraged to find a safe equilibrium between these two extremes. They are expected to care with empathy and kindness but at the same time maintain a degree of emotional detachment. Davies (1995) proposes that nurses should be engaged with patients being neither distant nor involved. Being engaged in this context suggests the presence of reciprocity, where the nurse would self-disclose some personal details that he or she considered appropriate, such as if he or she had experienced death of a parent when asked by a bereaved patient.

Research evidence has also found that nurses balance their engagement with detachment by not getting too involved or feeling responsible for the outcome (Carmack 1997). Feminist theory also informs views of intimacy related to the nurse researcher and study participants. According to feminists, there is reciprocal sharing of knowledge, with the researcher and those being researched becoming collaborators and partners in the research endeavour (Schutz 1994). Such reciprocity between researcher and study participants is also important in participatory action research.

The second dichotomy outlined by Parsons is between collective orientation and self-orientation (Lidz 2000), and defines whether an individual pursues his or her personal goals or those of the nursing team. In relation to intimacy in nursing, the nurse is expected to consider the social order and not stand out from the crowd (collective orientation). Menzies-Lyth’s (1988) study highlighted that nurses were considered interchangeable and all the same, as were patients. The nurse who follows a more self-oriented pattern, by for example, approaching the care of patients in a manner that may deviate from colleagues, may be considered different and even threatening. Handy (1991) found that nurses caring for psychiatric patients were ‘controlled’ by the organisation by being labelled as having psychiatric problems if they appeared to be deviating from the socially acceptable norm by singling out specific patients for special attention, spending more time with them and befriending them.

In clinical practice nurses have learnt informally that communicating their feelings to a particular patient is often criticised (Muetzel 1988, Handy 1991, May 1991, Morse 1991) and results in restrictions against them (Aranda 2001). Institutional structures control interpersonal relations by defining acceptable expectations of behaviour (Parsons 1951).

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

Collective orientation appears to fit with a task-orientation model of nursing care where each nurse performs a task or number of tasks for patients. The dominance of collective orientation is evident in Menzies-Lyth’s work, which was first published in 1960 at a time when task-oriented care was the predominant method of organising the delivery of nursing care. She showed how nurses in the organisational structure of the hospital developed socially structured defence mechanisms against anxiety. By using task allocation, nurses were prevented from developing relationships with patients and were considered to be protected from their feelings (Menzies-Lyth 1988). Her work also demonstrated how nursing management attempted to protect nursing students from anxiety by moving them frequently within and
behaviours such as touch, and the client communicating caring through the use of caring intimacy to occur. This is achieved by the nurse nurse readiness and client comfort is required for individual nurses make (May 1993). Relationships with patients is a choice that extent to which the nurse invests in interpersonal response if needed (Allan 2001). However, the emotional response from nurses caring for them was not always demanded of patient action rather than being initiated by nurses. Patients did not always demand an intimate relationship. Kadner (1994) argues that nurses should assess which patients ‘...are most needful of an intimate relationship’.

The concept of particularism is reflected in research evidence which states that nurses only become intimate with certain patients and that this depends on a subtle blend of personalities and the context of interaction. For example, it has been reported that nursing students prefer to care for cheerful and communicative patients who are accepting of their illness and the nursing care offered, which demonstrates that the characteristics of patient communication are essential variables in the nurse-patient relationship (Baer and Lowery 1987). Fosbinder (1994) is in agreement, stating that the patient’s interpersonal competence has an important influence on nurse-patient communication. Pettigrew and Turkat (1986) identify that patients may have a greater impact on and responsibility for the healthcare relationship than has yet been revealed by research.

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

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

Social differentiation is achieved through norms that set dominant and subordinate groups apart in their behaviour. Generally, when nurses are promoted and enter the realms of dominant groups, such as nursing management, they also move further away from the patient’s bedside. Thus, they may be removed from direct patient care and their opportunities for intimate relationships with patients are limited (Muetzel 1988). Less dominant groups, such as nursing students, are, therefore, most likely to be in a position to develop intimate relationships with patients, but because of a lack of experience they often have less developed interpersonal skills to do so effectively. As nurses progress professionally, they discard some of their involvement in nursing care interventions (Morral 2001). It is precisely such essential nursing practices, like bed bathing and toileting, that encourage intimacy with patients, as they require time, privacy and space, which are necessary for intimacy (Allan 2001). However, roles such as the clinical nurse specialist role promote intimacy by facilitating expert nurses to remain directly involved in care delivery.

Self-awareness

Perhaps only those nurses who are truly self-aware can engage in intimate relationships with patients. Self-disclosure is considered essential for intimacy (Cline 1989, Howell and Conway 1990, Timmerman 1991), but can vary greatly depending on the circumstance. For example, nurses often self-disclose that they have children if asked by patients. However, self-disclosure requires an acute degree of self-awareness in certain situations, for example, when a distressed patient probes the nurse with questions to ascertain his or her personal experience of coping with stressful events. In these situations, the nurse should measure self-disclosure carefully as the outcome of sharing may have a positive or negative effect on the patient.

Self-awareness and knowledge of the self develop over time with experience. Menzies-Lyth’s (1988) work was carried out with nursing students who, as a result of their youth, found it
difficult to develop and manage intimate relationships with patients. She reports that some nurses resorted to ‘irresponsible action’, which manifested in them becoming emotionally attached to patients. This appears to suggest that an appropriate intimate relationship requires the ability to achieve balance. Experienced nurses have been found to care intimately, but do not have such an intense reaction to the experience (Aranda 2001).

It is also important to highlight that the act of engaging in intimate disclosure involves relational and personal risks, as the discloser risks betrayal of personal information as well as rejection (Cline 1989), and increased vulnerability during the process of ‘letting go’ (Schubert 1989). However, these risks appear greater if the nurse has not developed self-awareness. Jourard (1971) argues that if nurses are afraid or ignorant of their own self, they consequently feel threatened by any self-expressions of patients. A positive correlation is thought to exist between the nurse’s level of understanding of self and his or her openness and honesty in interactions with others (Barnard 2002). There is some evidence to support these views. For example, Henderson (2001) found that the more self-reflexive the nurse, the more likely he or she was able to appreciate emotional connection with patients.

Conclusion

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

This article has addressed intimacy in nursing from a sociological perspective. Such a perspective sheds light on the organisational and personal issues that affect intimacy in nursing. The literature suggests that although patients and nurses do engage in close and intimate relationships with each other, the organisation plays a role in facilitating or hindering such relationships. Nurses may consider that other nurses’ intimacy with patients has the potential to interfere with the organisation of nursing work. Therefore, nurses who become

References


over-involved with patients may be ‘pulled into line’ by other nurses.

Discussions on identity highlight that the nurse who engages in an over-involved relationship with a patient may be viewed as deviant. Nurses strive for a safe equilibrium to avoid standing out from the crowd and possibly disrupting the social order in the organisation and delivery of care. The need for even distribution and orderly organisation of care plays an important role in nurses’ intimate relationships with patients. However, in certain roles, for example, that of the clinical nurse specialist, where a high level of autonomy within individual practice exists, constraints on intimacy such as organisation and delivery of care are less evident.

Intimacy in nursing may be a theoretical aspiration that nurses want to embrace. However, they are cautious of doing so because of the possible chaotic consequences to the social order of the profession. This disparity between

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