Moving beyond the therapeutic relationship: a selective review of intimacy in the sexual health encounter in nursing practice

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Aims and objectives. For the purposes of this study, a selective review of the literature was undertaken with the aim of examining nurses’ preparedness to engage in intimate interactions within the context of sexual health care. Kirk’s (2007) model of interactional intimacy is used as a lens to examine the literature.

Background. The provision of sexual health care is often a neglected area of nursing care despite being recognised as a component of holistic nursing practice. Despite theoretical discussion about various forms of intimacy and intimate care, there has been little examination of the interface between intimacy and sexual health care that usefully informs practice.

Design. Selective review and synthesis of the literature.

Conclusion. The literature of humanistic interpretations of caring that has dominated nursing discourse over the last half-century has limited progress on defining and developing forms of clinical interaction that are suited to promoting nurses engagement in sexual health care. We propose that Kirk’s model has useful utility in preparing nurses to engage more readily with sexual health care as a routine component of their practice.

Relevance to clinical practice. Sexual health adversity can often accompany ill health, and therefore, the provision of appropriate care is required to negate detrimental outcomes and promote positive well-being. Although sexual health care is often not prioritised in practice, nurses are in a prime position to promote sexual health care and well-being. By conducting sexual health assessments and providing sexual health care routinely, the gap that exists between patients’ sexual healthcare needs and the lack of sexual health care provided can be minimised.

Key words: interactional intimacy, intimacy, nursing, practice, review, sexual health, therapeutic relationships
image of nurses as working with intimate and emotional life experiences (Bennett 2011). Although nurses are in the prime position to provide sexual health care and can do so by engaging in interactions that enable disclosures of an intimate or very personal nature, provision of sexual health care is often a neglected area by nurses. Despite theoretical discussion about various forms of intimacy and intimate care, there has been little examination of the interface between intimacy and sexual health care that usefully informs practice. It is our contention that the dominance of humanistic interpretations of the therapeutic relationship that have dominated nursing discourse over the last half-century may be of limited utility in the field of sexual health.

The purpose of this study was to undertake a selective review of the literature to examine nurses’ preparedness to engage in intimate interactions within the context of sexual health care. The authors propose that drawing on Kirk’s (2007) model of interactional intimacy within the context of the therapeutic relationship can offer an alternative framework for nurses to engage in intimate interactions focused on the provision of sexual health care.

Background

Nursing practice is widely promoted as founded on intimacy and professional closeness (see e.g. Watson 1985, Peplau 1991, Newman 1992) with therapeutic care being central to nursing practice. It is said that the therapeutic nature of nursing caring promotes intimate nurse–patient relationships that require closeness and personal involvement through which individualised holistic care is enabled (Williams 2001a,b). The centrality of intimacy to the therapeutic nurse–patient relationship reflects the emphasis of nursing upon its role in the care of bodies and an understanding of the lived experience of embodiment, particularly during illness (Lawler 2006). Intimate care within the context of nursing caring is described as psychological, spiritual and/or emotional closeness that develops over time between nurses and patients (Bennett 2011) or arises from the provision of care that requires physical closeness and/or touching (Lawler 2006). Intimacy in the nurse–patient interaction is also commonly described as involving reciprocity (Kirk 2007), including self-disclosure by both the patient and nurse who are providing personal information (Timmerman 1991, Bennett 2011). These interpretations of the intimate nurse–patient relationship are grounded in knowing the person and are seen to require a connectedness or closeness between the nurse and patient (Timmerman 1991), with this closeness described as involving closeness on a psychological and emotional level (Williams 2001a).

The sustained focus upon intimacy and ‘body care’ (Lawler 2006) as a feature of nurse–patient relationships fails to acknowledge the place of intimate interactions that may be brief or do not necessarily require physical or relational closeness. Importantly, reciprocal or relational approaches to understanding intimacy are particularly limiting in the field of sexual health where disclosures may be intensely intimate while the interaction is only brief. Furthermore, patients/clients may be seeking a form of care that is founded upon trust which allows intimacy, safety and self-disclosure without an interdependent close emotional relationship. Assessing and responding to the sexual health needs of patients/clients requires the capacity for sensitive communication, empathy and the establishment of trust. Self-disclosure by clients of personal information about sexuality, information that is rarely shared with others, is an intimate act that occurs with the expectation of acceptance and understanding (Kadner 1994).

Drawing attention to the need to expand theorising on intimacy, Kirk (2007) suggests two forms of intimacy occur within nurse–patient relationships – intimate interactions and intimate relationships. In relational intimacy, both the disclosure and response are intimate; in contrast, intimate interactions allow for meaningful and trusting exchanges that permit intimacy without interdependence, physical contact, close body work or self-disclosure on behalf of the nurse. Intimacy is defined within intimate interactions to be disclosure of personal significant information (by the client) that is validated and perceived important by the listener, the nurse (Kirk 2007). Kirk (2007) suggests mutual trust lies at the heart of the therapeutic nurse–patient relationship and intimate relationships between the nurse and patient can be interactional and complementary as well relational and reciprocal. Intimate interactions can occur during brief nurse–patient encounters, and these isolated or brief encounters do not rely on the development of relational rapport that is often perceived to be required for the development of therapeutic relationships. Considering the sensitivity and privacy that accompanies sexuality, the concept of interactional intimacy is a useful framework for nurses to apply to sexual health and nursing practice.

Moving beyond intimate relationships: the place of intimate interactions

In the following section, we examine the nursing literature to identify what is known about nurses’ preparedness to engage in sexual health care from the perspective of intimate nurse–patient interactions.
Methods

EBSCO databases including Academic Search Premier, AMED, CINAHL, plus with full text, Health Source Consumer Edition, Health Source Nursing/Academic Edition, Medline with full text, Psychology and Behavioural Collection and PsychINFO were searched using the combination of terms nurses*, knowledge, sexual health and intimacy. The search was limited to the literature printed in English and between the years of 2000 and 2012. Additional articles were identified through cross-referencing. The article is not a comprehensive review, but seeks to provide a collective overview of nurses’ preparedness and the perceived barriers to engaging in sexual health care and proposes an alternative model as a possible solution to promote the provision of sexual health care to clients by nurses.

Nurses’ lack of preparedness for intimate interactions

It is widely recognised that sexual health problems often accompany illness or stem from medical interventions, and traumatic or difficult sexual experiences and can be detrimental to positive well-being (Jolley 2002, Higgins et al. 2006, Krebs 2007, East et al. 2010). For nurses, conducting a sexual health assessment provides the opportunity to assess sexual health needs and to facilitate and promote sexual health discussions with clients in addition to promoting positive individual health outcomes and enhanced well-being (Julien et al. 2010). Assessing sexual health needs and providing information on sexual health is an important role for nurses, yet studies report that as many as 50% of patients have unmet health education needs with regard to their sexual health following nursing encounters (Faithfull & White 2008). The reported reluctance to initiate discussion about sexual health suggests that nurses are ill equipped to engage in sexual health assessment and education.

The recognition among nurses of the provision of sexual health care being an integral component of holistic care has been well documented in the literature (e.g. Dattilo & Brewer 2005, Vassiliadou et al. 2008). However, this recognition does not necessarily lead to the provision of care. Research focused on the exploration of nurses’ approaches to sexuality among adolescents attributed their lack of skills, education and training as the reasons for not providing appropriate sexual health care among this group (Rana et al. 2007). An Irish study focused on sexual counselling and discussions among healthcare workers inclusive of nurses found that the participants lacked training and knowledge to discuss sexual health with patients attending cardiac rehabilitation, a service that aims at delivering health promotion and care to promote client well-being (Doherty et al. 2011). Other research has suggested that even though sexual health care is essential particularly among groups that may have contracted a sexually transmitted infection (STI) or engage in high-risk behaviours and are therefore at high risk of sexual health adversity, this care is still not provided due to lack of education (Lees & Crouch 2003, Hughes & Gray 2008).

The lack of training and education among nurses in the provision of sexual health care is not only a hindrance but also can equate to lack of confidence, which acts as a further barrier to providing this care. Moreover, even if nurses have been provided with sexual health education, they may still perceive this as being insufficient in enabling them to provide factual and effective education associated with the complexity of sexual health across the lifespan. Research focused on undergraduate child health nurses revealed that the students felt that they received limited and inconsistent education in their undergraduate programme. This perceived lack of education equated to the student nurses not having sufficient knowledge to enable them to feel comfortable and confident in discussing sexual health matters with youth (Johnston 2009). A study focused on school nurses (n = 167) and their preparedness to teach within the context of sexual health care revealed that although over 75% of the participants were involved in the provision of sex education, over half expressed the need for further development and education in this area (McFayden 2004). As a result of these participants coming from various backgrounds, they also had differing levels of education and knowledge in regard to sexual health; therefore, consistency of education provided to youths could not be guaranteed (McFayden 2004). Likewise, a UK study that explored the provision of sexual health education associated with nurses and schools found that education provided was dependent on the qualifications of the nurse providing this education (Formby et al. 2010). In summary, these studies suggest nurses may have limited knowledge and therefore lack confidence or are ill equipped to provide therapeutic sexual health care to clients – even if these intimate discussions are requested.

Personal perceptions as a hindrance to intimate interactions

The provision of sexual health care can be hindered as a result of nurses’ personal perceptions and social constructs with individual nurses believing that it is inappropriate to discuss or assess a client’s sexual health. This is in stark
contrast to the provision of holistic therapeutic care. These
perceptions and constructs can arise from and be associated
with age, gender, sexual orientation and identity, religion,
etnicity, culture and/or psychosocial factors (Krebs 2007,
2008). For example, nurses may perceive discussing sexual
health with individuals that are older than themselves or
whom they consider to be ‘an older adult’ as a barrier to
these discussions (Gott et al. 2004, Dattilo & Brewer 2005,
Hordern & Street 2007a) or may believe that older people’s
sexual needs are not a priority due to the perception that
this group is no longer sexual active (Stead et al. 2001,
Jolley 2002) particularly if they are not known to be in a
partnered relationship (Hordern & Street 2007b). Research
has found that nurses may feel uneasy discussing sexual
health issues with clients of the opposite gender (Dattilo &
Brewer 2005, Macdowall et al. 2010), with male nurses
expressing embarrassment and discomfort when providing
intimate care inclusive of sexual health for women (Inoue
et al. 2006).

Sexual health care can be further hindered by nurses’
assumptions pertaining to clients’ ethnic, cultural and reli-
gious background. Hordern and Street’s (2007a,b) research
postulated that healthcare professionals including nurses
felt that discussing intimate topics with clients from non-
westernised backgrounds could be considered inappropriate
based on preconceived beliefs and therefore often ignored,
a finding also supported by Macdowall et al. (2010) and
Gott et al. (2004). Although the preconceived notions of
ethnic, cultural and religious backgrounds are often based
on assumption rather than facts, in some instances where
both nurses and clients share the same ethnic background
that is strongly influenced by societal constructs, nurses
may feel uneasy about providing care to individuals who
are perceived to not conform to societal standards, albeit
the recognition of the ethical responsibility pertaining to
care (Klingberg-Allvin et al. 2007). This suggests that
nurses may lack education and knowledge associated with
not only the provision of sexual health care but also how
to approach such care within an appropriate cultural
context and therefore a holistic way.

Recognising the need for intimate interactions

Variations in education and knowledge among nurses are
identified to influence nursing perceptions in relation to the
importance of provision of sexual health care. An Austra-
lian study involving sexual health nurses mostly working in
sexual health centres, family planning and women’s health
environments revealed that over 90% of the 201 nurses
assessed and provided sexual health care (Knight & Corkill
2003). Other studies have found that nurses may perceive
that sexual health care is only required when illness, diag-
nosis and area of speciality warrant this. Research among
undergraduate nurses suggests that the provision of sexual
health care may not be warranted in areas that do not
exclusively focus on sexual health or may only be war-
ranted when diagnosis or illness directly impacts on an indi-
vidual’s sexual health (Dattilo & Brewer 2005, Johnston
2009). This indicates that even when sexual health care or
education is initiated by nurses, it may only be done within
the confines of a medical and biological context rather than
a broader holistic approach, which addresses psychosocial
well-being. To illustrate this point, Hordern and Street
(2007a) found that nurses perceived that sexual health con-
cerns were adequately addressed when education and dis-
cussions were focused on medical treatments that affected,
for example, fertility and erectile dysfunction, rather than
the clients’ sexual psychosocial well-being. Similarly, among
cardiac nurses, sexual health education and intimate discus-
sion that focused on sexual health were confined to discus-
sions associated with medications, symptoms and disease
rather than the intimacy and emotional changes of patients
experiencing illness that impacted upon their sexual well-
being (Jaarsma et al. 2010). This finding is also supported
by another study that found sexual health discussions and
assessments were perceived as nonessential for patient out-
comes and well-being among cardiology nurses (Doherty
et al. 2011). This suggests that the importance placed on
conducting assessments and promoting sexual health well-
being among clients reflects nurses area of work and spe-
cialisation, which influences perceptions on the importance
of and provision of sexual health care.

As a result of differing perceptions and levels of knowl-
edge and education influencing the perceived importance
and the provision of sexual health care by nurses, it is not
surprising that the literature indicates that clients’ sexual
healthcare needs are not being met. Patients who had
received a cancer diagnosis stated they welcomed and
wanted to be provided with information from healthcare
professionals, including nurses, regarding their sexual
health; however, this was not commonly received, and the
patients perceived that in order to be provided with this
information, it was their own responsibility to initiate these
conversations (Cox et al. 2006). A study focused on women
being treated for ovarian cancer revealed that participants
expressed wanting information associated with sexual
healthcare postdiagnosis and a point of contact for enqui-
rries, women also expressed that healthcare professionals
should provide this opportunity through initiation, and by
doing so, anxiety associated with sexual health could be
Discussion

In examining the relationship between intimacy and sexual health care, we have drawn attention to the limitations of nurses’ preparation and personal perceptions that influence nursing practice. Overwhelmingly, there is a mismatch between the readiness and willingness of nurses to engage in meaningful communication around sexuality and the needs of clients. This is made difficult not only by structural constraints such as lack of privacy or opportunity and inadequate education, but also by personal attitudes, stereotypes and fear of engaging in intimate conversations, which create a sense of vulnerability for nurses (Hordern & Street 2007a, Kim et al. 2011). Nurses are ill equipped to recognise the need for sexual health care or to engage in a way that reduces their personal resistance to intimacy in such conversations.

The lack of knowledge among nurses can only be addressed by embedding sexual health care within nursing curricula. However, prior to the 1970s, sexual health education was seldom evident in medical and nursing curricula (Zawid 1994) and even when present education and associated care traditionally has medicalised sexual health in terms of only disease and reproduction health (Irwin 1997). Further to this, the challenges associated with education and the recognition of social and personal perceptions and associated educator bias need to be overcome to ensure quality informative education can take place. To equip nurses to provide effective sexual health care to clients, it is essential to prepare students to interact and create opportunities for constructive interaction around issues of sexual health.

The utility of Kirk’s (2007) model when applied to sexual health care may go some way to addressing the barriers perceived by nurses or resistance patients report in having their needs met. In expanding and deconstructing the meaning of intimacy and intimate interactions, that is, providing a safe space for the disclosure and discussion of potential sensitive information involving an active listener rather than the traditional perception of intimacy involving sexual activity and love when associated with sexuality (Kirk 2007), has the potential to pave the way forward for nurses providing effective sexual health care to clients.

At a theoretical level, intimacy has been increasingly valued in nurse–patient relationships. The findings of a number of metasynthesis of nurse caring and nurse presence (Timmerman 1991, Sherwood 1997, Finfgeld-Connett 2006) identify intimate reciprocal relationships between the nurse and patient as a feature of nurse caring. Applied to sexual health care, a potential limitation of this approach to intimacy is the notion of reciprocity in disclosures between both parties (Williams 2001a, Finfgeld-Connett 2006). Given the potential for cultural and gender boundaries, reciprocal disclosures in the context of conversations regarding sexuality would be problematic and may be in danger of breaching personal and professional boundaries. Further, given nurse’s reported sense of discomfort and vulnerability around conversations relating to sexuality, the centrality of reciprocity and empathy as a feature of caring and therapeutic relationships does little to open opportunities to break down the barriers to normalising sexual health care as a feature of nursing practice.

In his model, Kirk proposes that reciprocity is not necessarily central to intimate interactions and that the focus upon reciprocity ‘misplaces the therapeutic power of the conversation onto the phenomenon of disclosure itself’ (Kirk 2007, p. 238). Proposing intimate interactions as an alternative to intimate relationships, intimate interactions arise from the nature of the disclosure and the quality of the exchange between the nurse and patient. Thus, the focus shifts from reciprocity of the nurse response to the complementarity of the response. That is, if the patient perceives the disclosure to be intimate and significant, and the nurse’s response is validating, a complementary process that is intimate occurs (Kirk 2007). This complementary process acknowledges the meaning of the experience for the other without requiring the nurse to engage in reciprocal disclosure or to necessarily empathise or understand what the experience is like. Such intimate interactions do not require the nurse to engage in empathic understanding and perceive the emotion and meaning of the other; instead, what is required is a more interactional or discursive form of empathy which does not presume the nurse necessarily understands the patient’s experience. The complementary meaning-making process is interactional and allows for sense making or meaning to be apprehended through the interaction.

Although relational intimacy is clearly an important element of nursing practice (Stavropoulou et al. 2012), shifting from a predominant focus on reciprocal and relational intimacy towards complementary forms of practice-based intimacy is a useful concept for nurses. Responsiveness is a significant contributor to intimacy in relationships, yet
responsiveness can occur without the need for self-disclosure on behalf of the nurse (Welch 2005). In everyday nursing practice, intimacy can be a situated communicative act, an intimate intervention, a form of touch or more engaged forms of relational interaction that are part of an ongoing relationship between the client/patient and nurse. Intimacy in sexual health practice is dynamic and reflects the situation, the needs of the client or nurse, as well as the particulars of time and place – all of which have implications for how intimacy is enacted. Sexual health practice requires sensitive judgement, trust, ethical engagement, an understanding of the client and the situation, as well as both the affective and cognitive engagement of the nurse.

Kirk’s (2007) model is useful in the context of sexual health as it provides opportunities to understand intimacy outside of notions of therapeutic relationships that are established over time. Even though reciprocity and emotional response are often regarded as fundamental to building a trusting professional relationship (e.g. see Williams 2001a), interviews with parents seeking care suggest that this emotional reciprocity is not necessarily consistent with their definitions of effective communication (Young et al. 2011). For the client, disclosing intimate personal detail, reciprocal disclosure may diminish rather than enhance the experience.

While intimacy as an interpersonal process has been examined within partner relationships and understood as reciprocal (Laurenceau et al. 1998, Manne et al. 2004), Kirk’s emphasis upon complimentary responses draws attention to interpersonal sensitivity and the subtle nuances of nursing presence (Welch 2005). The spectrum of nursing presence is vast and can refer to simply a nurse being in a client’s room or having a sense of connection with the client and being actively and consciously involved in client care (Sabo 2011). Within the context of intimacy and sexual health care, when the nurse is actively involved and has presence for and with the patient, a complementary interaction can occur, which affords opportunity for clients to share their thoughts while providing the nurse with a sense of caring and therefore satisfaction (Sabo 2011). Developing a more situated understanding of intimacy as a feature of nursing practice has the potential to illustrate how nurses can engage in intimate interactions that normalise sexual health education within mainstream nursing practice. To be open and responsive to the opportunities for clinical intimacy requires a purposeful attitude on behalf of the nurse (Kadner 2006) and the willingness to acknowledge the narratives of another through gestures and communicative acts that are complementary (Kirk 2007).

For educators, providing opportunities for students to develop skills in learning and demonstrating behaviours that illustrate listening and the display of attention and interest following self-disclosure from patients is important. Communication or gestures that display to a patient they are accepted, understood and validated are at the core of relational intimacy. This complimentary interpersonal model of intimacy includes simple acts such as talking to patients and providing them with the opportunity to express their concerns and responding in a manner that communicates they have been heard. Importantly, patient self-reports note dissatisfaction with the frequency that nurses talk to patients, suggesting students need to learn the value of periodically reflecting on their own attitudes and their sensitivity to communicative opportunities (Papastavrou et al. 2012).

However, in order for such intimate interactions to occur, expanding nurses’ knowledge of sexual health and how to engage in discussions on sexual health concerns is required. The provision of specialised education pertaining to sexual health difficulties and the possible adversity that can be associated with sexual health is recommended to be provided by skilled sexual health educators who are well equipped with this knowledge and who have the ability to converse in sexual health discussions. Through further education and provision of skills focused on communication and discussing difficult concepts, the amalgamation of sexual health knowledge with the nature of the therapeutic nurse/client relationship can be achieved enabling meaningful complementary intimate interactions focused on personal issues to take place.

Sexual health and well-being is a personal component of an individual’s life, and often when adversity occurs, individuals feel perplexed and unsure as to where to receive information and care. Provision of a safe space and interaction to discuss and provide sexual health care has the potential to provide for sexual health well-being. Although limitations and barriers such as time constraints have been identified to limit the occurrence of such encounters, routine assessment of sexual health on admission or initial consultation (a generally uncommon practice with the exception of sexual healthcare clinics) can indicate the need for such interactions to be scheduled and overcome the immediate barrier of lack of time. The provision of a safe space, time and intimate interaction has the ability to overcome adversity and foster healing and well-being in addition to enabling the provision of holistic nursing care.

Conclusion

Despite the recognition of the provision of sexual health care being a component of holistic nursing care, sexual health is often a neglected area among nurses. Although
education associated with sexual health can only be effective by identifying and overcoming nurses’ perceived barriers of social and personal perceptions, the provision of sexual health care within the context of intimate interactions has the potential to address clients often unmet sexual health-care needs. It is our contention that the dominance of humanistic interpretations of caring and the therapeutic relationship which have dominated nursing discourse over the last half-century have limited progress on defining and developing forms of clinical interaction that are suited to promoting nurses engagement in sexual health care. Applying Kirk’s model as a lens to examine a selective review of the literature identified that nurses are underprepared to engage in sexual health care. The utility of Kirk’s model as a possible conceptual approach to education and practice may go some way to enhance nurses’ capacity to engage in sexual health care.

Relevance for clinical practice

Provision of sexual health care is an essential component of holistic nursing practice regardless of area of work or specialisation. Although sexual health care is often not prioritised in practice, nurses are in a prime position to promote sexual health care and well-being. Through the provision of appropriate education to equipped nurses with the ability to conduct sexual health assessments and provide sexual health care on a routine basis, the gap that exists between clients’ sexual healthcare needs and the lack of sexual health care provided can be minimised.

Contributions

Study design: LE, MH; data analysis: LE, MH and manuscript preparation: LE, MH.

References


