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'How Should I Touch You?': A Qualitative Study of Attitudes on Intimate Touch in Nursing Care

IN GROUP INTERVIEWS, PARTICIPANTS SAID THEY WANT INFORMATION, AUTONOMY, AND CONTROL.

ABSTRACT

Objective: Although touch is essential to nursing practice, few studies have investigated patients' preferences for how nurses should perform tasks involving touch, especially intimate touch involving private and sometimes anxiety-provoking areas of patients' bodies. Some studies suggest that patients have more concerns about intimate touch from male than female nurses. This study sought to elicit the attitudes of laypersons on intimate touch provided by nurses in general and male nurses in particular.

Methods: A maximum-variation sample of 24 adults was selected and semistructured interviews were conducted in four focus groups. Interviews were recorded and transcribed; thematic analysis was performed.

Results: Four themes emerged from the interviews: "Communicate with me," "Give me choices," "Ask me about gender," and "Touch me professionally, not too fast and not too slow." Participants said they want to contribute to decisions about whether intimate touch is necessary, and when it is they want information from and rapport with their nurses. Participants varied in their responses to questions on the nurse's gender. They said they want a firm but not rough touch and for nurses to ensure their privacy.

Conclusions: These findings suggest that nurses and other clinicians who provide intimate care should be more aware of patients' attitudes on touch. Further research on the patient's perspective is warranted.

Keywords: intimate touch, male nurses, nurse–patient relations, qualitative research, touch

Perhaps no aspect of care is as essential to nursing as touch. Nurses touch patients to perform clinical tasks, communicate caring, and ensure comfort. Consequently, nurses may touch patients in ways that would be inappropriate in another context—touching a breast when auscultating an apical pulse or the genitalia when inserting an indwelling catheter.

Various terms have been used to describe this kind of touch. Harding and colleagues define *intimate physical touch* as involving "inspection of, and possible physical contact with, those parts of the body whose exposure can cause embarrassment to either the patient or the nurse."[1] We've expanded upon this definition and define *intimate touch* as task-oriented touch to areas of patients' bodies—genitalia, buttocks, perineum, inner thighs, lower abdomen, and breasts (as well as other areas, depending upon the patient, nurse, and care context)—that may produce, in patients or caregivers, feelings of discomfort, anxiety, or fear. We also include any touch that might be misinterpreted as sexual in nature. (Some nurses have told us that they object to the term *intimate touch*, saying that it implies unprofessional, even sexual, touch. We considered using the term *intimate care*, which has been used in the literature to describe care that involves sensitive areas,[2] but we wanted to focus on the touch itself and decided that *intimate touch* was the best term for this study's purposes.)

Many routine nursing procedures involve intimate touch, yet little has been written about it. Most studies

of patients' anxiety about nurses' touch have focused on male nurses but give little guidance on how to reduce that anxiety. Our study aimed to gain information from the public that could help nurses, both male and female, in providing care in a way that communicates professionalism and respect.

LITERATURE REVIEW

Between 2002 and 2010 we conducted periodic searches of two research databases, the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and PubMed. Keywords included *touch*, *nursing*, *male nurses*, *dignity*, *gender*, *intimate touch*, *accusations*, *anxiety*, *nursing student*, *touch style*, and *caring*, among others. We limited our reviews to studies published in English and excluded those on sexual misconduct by clinicians. It became clear that nurses and allied staff are the workers who use intimate touch most frequently, and that studies of physicians' intimate care of patients rarely discuss how such touch should be undertaken. Thus, we included only studies on nurses.

The topic of nurses' touch has been poorly researched, particularly *how* nurses touch patients and what effect it has. Before 1990 most studies focused on defining touch, explaining its purpose, and categorizing the types of touch.[3] Using various terms, authors have categorized the types of touch according to purpose, such as instrumental, expressive, and protective.[4] Instrumental, procedural, or necessary touch, as occurs when changing a dressing, are task oriented. Expressive, comforting, or unnecessary touch, as when a nurse holds a patient's hand, addresses emotional needs. Protective touch, as when a nurse moves a patient's hand away from ventilator tubing, prevents a potentially dangerous event and isn't often discussed in the literature.

Most research since the 1990s has examined how often these types of touch are used, the parts of the body associated with them, and nurses' and patients' general perceptions of touch. Many studies suggest that instrumental touch is used far more often than expressive touch and that patients often accept the necessity of instrumental touch.[3, 5-9] Expressive touch is usually applied to the arms, hands, shoulders, and knees; some patients report that they find this kind of touch physically or emotionally comforting,[6, 10] although not all patients do.[5, 6, 8, 11, 12]

Estabrooks notes that a single encounter may comprise several types of touch,[2] such as expressive and instrumental, but most researchers don't specify how they distinguish one type of touch from another.[5, 6, 10-12] Therefore, it's not clear how one might categorize a nurse's firm, supportive grasp of the arm of a patient who has ataxia: is it instrumental, since it assists with ambulation; expressive, since it reassures a patient who might fear falling; or protective, since it guides a patient away from injury?

How nurses and patients perceive touch stems from a variety of influences. The nurse's gender has been a primary focus of research; authors have noted that male nurses fear their touch will be misinterpreted by patients and that patients have mixed feelings about intimate touch provided by male nurses.[1, 7, 13-17] In a 1998 qualitative study, both male and female nurses said they were "uneasy" when providing intimate care to patients of the opposite sex who were near their own age.[7] Morin and colleagues interviewed postpartum women on their views about receiving intimate touch from male nursing students and found that the women's opinions were shaped by several factors, including how they felt about their own attractiveness.[18] We found no studies that examined patients' perspectives on intimate touch provided by female nurses.

A 1991 survey by Mulaik and colleagues noted that 89% of 98 adult patients believed that touching

FOCUS GROUP INTERVIEW QUESTIONS

Broad Opening Question

What do you think about, or how does it make you feel when you think about, a nurse having to touch private areas of your body in order to take care of you?

Transition Questions

If a nurse had to help you take a bath, what things might a nurse do that would make you anxious?

Let's say you are confined to bed. After using a bedpan, you realize you accidentally soiled your pajamas and bedsheets, and the nurse has to clean you up. What things can the nurse do to help you maintain your dignity?

Key Questions

Let's pretend you have been in a terrible accident and have to have other people do everything for you. John is your nurse today, and he has come in to do your personal hygiene. What should John do to show you that he is professional and respectful?

How should John touch you?

Does anyone have a different thought about this?

Concluding Question

Is there anything else we should teach nursing students about touch?

Summary

The facilitator or recorder will summarize key points and comments from the discussion to validate accuracy and provide an opportunity for clarification.

should be taught in nursing school,[11] yet it's been our observation that few nursing textbooks cover the topic. Many nurses have said they learn such skills by trial and error on the job,[19,20] an inconsistent method that's not in line with evidence-based practice. And having few formal routes to talk about and reflect on touch has been shown to result in anger and repressed feelings among nurses.[20,21] Such feelings could have a negative impact on care.

We looked specifically for guidance on how nurses should provide intimate touch so that it communicates respect for the patient. What little we found is based only on the opinions and experiences of a few nurses. We found no study that asks patients or the general public how nurses should touch them when intimate touch is necessary. This surprised us, especially in light of the emphasis in recent years on patient-centered care in nursing.

A participant said, 'Any kind of hesitancy would make me feel more anxious and less inclined to let [a nurse] bathe me.'

STUDY DESIGN AND THEORETICAL SUPPORT

We set out to conduct an exploratory, qualitative investigation of laypersons using semistructured interviews in focus groups. Plummer-D'Amato says that focus groups "are not designed to achieve consensus"; rather, they "elicit a range of experiences, views, ideas and attitudes held by a selected sample from the target population on a defined topic."[22]

Theoretical support for our study came from the American Nurses Association's *Code of Ethics for Nurses with Interpretive Statements*,[23] Provision 1.1 of which outlines nurses' obligation to respect patients' dignity—a principle that underlies all nursing activity. We also acknowledged that different nurses apply this principle in different ways and patients may interpret those actions differently. Therefore, we hypothesized that asking patients about their preferences for intimate touch would be an important step in fostering collaboration and respect.

METHODS

We selected a purposive, maximum-variation sample of adults in an urban region of the western United States. Inclusion criteria were the ability to provide consent and to converse in English. Exclusion criteria were ever having been a nursing student or employed as a nurse. Maximum-variation sampling (also called heterogeneity sampling and diversity sampling), a method often used with small sample sizes in qualitative research, consists of selecting participants who are thought to offer diverse interpretations of the phenomenon of interest (in this case, attitudes about touch), with the purpose of gaining as broad a range of responses as possible.[24] In this study, we selected college students from a private Catholic university (where we teach), as well as middle-aged and older adults from our respective churches. We anticipated that these participants would represent a wide range of perspectives on the issue of intimate touch.

At the university, a Reserve Officers' Training Corps (ROTC) commanding officer invited us to recruit students from his senior leadership class. Seven ROTC students (all but one were male) as well as the commanding officer consented to participate. This formed our first university focus group. We recruited female undergraduates through a student worker in the nursing department. We then recruited participants at a Catholic church in a suburban area (more socially conservative) and a Protestant church in the downtown area (more socially liberal). Other groups were planned but not convened when analysis of responses from the first four groups showed redundancy.

Each participant reviewed and signed a consent form approved by our university's institutional review board. Both of us facilitated each focus group using a semistructured interview protocol that started with a broad opening question, followed by transition questions, and ending with questions on the nurse's gender (see *Focus Group Interview Questions*).[22] We decided to use the generic term *nurse* in our initial questions so as not to focus discussion on gender. We then asked questions about male nurses because several studies have described the difficulties male nurses have with touch,[1,7,13-17] and some studies have suggested that some patients prefer to be touched by female rather than male nurses.[5,7]

We asked the same questions in each group, and follow-up questions were posed by us and other group members. This allowed for more-detailed responses and more perspectives than individual interviews would have. For example, at least twice, a participant said, "I hadn't thought of that," and made additional

comments. After asking each question, we encouraged each group member to comment. We were mindful of not influencing discussion with verbal or nonverbal evaluative responses.[22, 25] For example, we maintained neutral facial expressions, leaned forward and made eye contact to indicate interest, encouraged discussion (by saying, for example, "Tell me more about that"), and didn't challenge negative or biased responses. Each session lasted 60 to 90 minutes and was tape recorded; one of us transcribed each recording. Also, we took independent field notes during each session, at the end of which we summarized important points with participants to ensure accuracy and to solicit further comment. Afterward, we discussed our notes and observations with each other, comparing responses with those from prior focus groups. We stopped data collection when redundancy in responses became evident.

We used a modified process of thematic analysis, as described by Aronson.[26] We read the transcripts independently, noting general categories of comments and labeling segments of the transcripts as belonging to one or more of those categories. We then met and discussed our analyses, identifying similarities and differences among our categories. Together, we refined these categories into broader themes and reclassified transcript segments. After reaching consensus on four themes, we again examined the transcript segments to ensure that they supported the themes. No new themes emerged in this last analysis, and we determined that the themes were robust.

RESULTS

A total of 24 adults (12 men, 12 women) participated in one of four focus groups, each consisting of five to eight participants. The sample was 83.3% white and ages ranged from 19 to 76 years (mean, 38.1 years). Ten of the participants had received intimate touch from nurses. (See Table 1 for more demographics.) The following four themes emerged from the data.

'Communicate with me.' Participants in each focus group said communication was of the utmost importance and must occur before intimate touch could take place. For example, one participant said that nurses should "explain what they are going to do before doing [it]"; another said, "Don't touch me without telling me." Also, participants said that communication should convey professionalism and respect. For example, one participant wanted to be looked in the eye; another detested being addressed as "Hon" or "Honey" and was angered when addressed with the pronoun "we" (as in "How are *we* doing today?"); another didn't want to be addressed by first name unless permission was given; some said nurses should speak clearly and with confidence. One woman complained that her nurses talked to others in the room while performing hygiene care; she felt excluded from the conversation. Participants discussed the importance of the nurse's appearance. They wanted nurses to dress professionally, have good hygiene, and not smell of tobacco.

The most in-depth discussion among participants centered on their desire for rapport with the nurse if care involved intimate touch. One participant said, "I want some type of relationship with [nurses]. I don't want it to be cold." Another suggested, "Establish a relationship with the patient. Tell me your name. Tell me what's the next plan of action. Make a human connection." Participants wanted kind words and assurances that nurses "will be there" for them, that nurses

TABLE 1. Demographic Characteristics (N = 24)

	Male (n = 12)	Female (n = 12)	Total (N = 24)
Age range, years	22–76	19–76	19–76
Mean age, years (SD)	38.2 (18)	45.7 (22.2)	38.1 (19.8)
Race and ethnicity, n (%[a])			
White, non-Hispanic	9 (75)	11 (91.7)	20 (83.3)
Hispanic	1 (8.3)	0 (0)	1 (4.2)
Native American	0 (0)	1 (8.3)	1 (4.2)
Asian	1 (8.3)	0 (0)	1 (4.2)
Mixed race	1 (8.3)	0 (0)	1 (4.2)
Experience receiving intimate touch by a nurse, n (%)			
Yes	4 (33.3)	6 (50)	10 (41.7)
No	8 (66.7)	6 (50)	14 (58.3)

[a] Total may not equal 100 due to rounding.

RECOMMENDATIONS FOR CLINICIANS WHEN PROVIDING INTIMATE TOUCH

- Project a professional image in appearance and communication.
  - Ask patients how they wish to be addressed.
  - Don't address patients in an overly familiar or childlike manner.
  - Speak clearly.
  - Listen to patients' concerns and feedback.
  - Avoid slang.
  - Don't use time with patients as an opportunity to complain.
  - Don't monopolize conversations or focus on your own life.
- Offer patients choices.
  - Find out whether they can complete intimate tasks themselves.
  - If the task is invasive (such as urinary catheterization) or will require prolonged contact, ask patients if they prefer that you have assistance. The word *chaperone* may have negative connotations; instead, use *helper* or *assistant*, terms that imply the other nurse will participate rather than merely observe.
  - If a patient requires care that involves intimate touch, seek permission first and explain why it's necessary and what it will involve.
- Provide touch that's firm but not rough, unhurried but not so slow that it lingers.
- Look for verbal and nonverbal cues from patients, halting the intimate touch and asking for feedback if you sense discomfort.
- Ensure privacy.
  - Expose as little of patients' bodies as necessary.
  - Close doors. Don't leave a bathroom door open while you busy yourself with other tasks.
  - If you must provide supervision, explain why.
  - Avoid passive supervision; instead, assist physically, or give instruction and encouragement when patients complete tasks themselves.

understand what it's like for patients, and that they'll do what they can to ensure comfort. Participants welcomed some self-disclosure from nurses, such as hobbies or interests; this made the nurse "more human," they said, although they didn't want to hear nurses complain or use slang or vulgar language. Humor was helpful, they said, in reducing the tension around intimate touch, but others said that jokes about intimate touch were inappropriate. Some said that silence during intimate touch made them uncomfortable. Many said that rapport required mutuality—nurses should listen and not talk only about themselves—and that rapport with the nurse fostered comfort, trust, caring, and respect.

'Give me choices.' Choice recurred as a theme among participants. They discussed clinical situations in which they'd felt powerless and devalued by not being given the chance to express their preferences concerning intimate touch. Comments included, "They didn't really explain that to me," "It was almost like I wasn't there," and "They treated me like a two-year-old." One participant said, "They ignored my concerns and said, 'Oh, you're okay.'" Another stated, "They made me use a bedpan when I could use a commode." Several participants said that nurses assumed what patients wanted and needed.

Participants said they wanted to be involved in deciding whether intimate touch was necessary and whether there were alternatives. Several participants said something like, "If at all possible, ask me if I can do it myself. If I can, let me do it." One participant put it concisely: "Let me make the decision!" They were emphatic that if intimate touch was needed, they'd want control over the procedure. A participant described a nurse who came into her room with supplies, stating that she would bathe her, and immediately pulled back the blankets and began to clean her body, including her genitals. This angered the participant; she wanted to be given the option to bathe herself. But participants agreed that the exception was, "In an emergency, do whatever."

'Ask me about gender.' Participants varied in their responses to questions about the nurse's gender. They reported a belief that nurses are trained to "do a job" and would perform the work professionally, competently, and in a way that conveys respect. One said, "I don't think [the nurse's] gender makes a difference. You don't see that nurse as a male nurse or a female nurse; you see that person as someone who is there to try to help you." Another said, "For me, gender doesn't really matter. I just want them to be competent."

Most of the young female participants who'd never received intimate touch from a nurse said they'd prefer a female nurse, and young male participants were split in their preferences, especially if the care involved their genitalia. One man stated, "If it could happen that I could have someone of the same gender, that might make me more at ease." Another young man said, "I don't mind if a 45-year-old male nurse is brushing my teeth or if he has to give me a sponge bath, unless he has to touch my genitalia. Then I would prefer a female nurse." That participant felt so strongly, he said, that he would sit in his own excrement until a female nurse could help him.

Some young male participants mentioned the sexual orientation of the nurse. One said that he'd be uncomfortable with a male nurse who was overtly gay; another said that sexual orientation wasn't important as long as the nurse was professional and competent.

Prior experiences with both intimate touch and male nurses influenced the participants' responses. For example, one said, "At first I was embarrassed [by being touched by male nurses], but they were professional, and I became comfortable." Another said that her young son was less comfortable with care provided by a male nurse: "My son mentioned to me after his treatments that it was easy [with a female nurse] because women are like mothers and mothers do those things. From his perspective, when a man did something, it

was different." Some participants who had experiences with male nurses made positive comments. One noted, "They were stronger, and that was good." A woman said she preferred male nurses because they asked permission before touching her, but female nurses never did.

We also asked questions about chaperones and received mixed responses. Many participants saw a chaperone as unnecessary. One said: "If a nurse of another gender has to come in to chaperone [the primary nurse], then why not just have them do it instead of having extra eyes on me?" Several participants said that the word *chaperone* has a negative connotation, a "parental image" needed by "someone who needs their hand held," suggesting that the nurse needed a chaperone because of incompetence.

In contrast, some said they'd feel more comfortable with a same-gender chaperone in attendance. They acknowledged that sexual abuse from nurses was possible and felt that a "safe ratio" should be maintained for the benefit of all. One said that chaperones would improve quality: "I would want two people in the room just for accountability. I wasn't thinking about the sexual abuse part. I think that people tend to perform their jobs better when someone else is there watching." Another said, "What would provide the most comfort is knowing that I have the option of having another person."

'Touch me professionally, not too fast and not too slow.' Participants had much to say on *how* intimate touch should be provided when it's necessary. Above all, they wanted to be touched professionally. We asked specifically what that looks and feels like. Responses centered on the nurse's approach and the quality of the touch.

In terms of approach, participants said nurses should project a confident and professional appearance. One said, "Stand up straight and act like you know what you are doing." They wanted eye contact, but gave instructions not to allow the eyes to linger or gaze on private areas of their bodies. And they addressed the need for privacy. They preferred closed doors, not just to their room but also to the bathroom, if that's where the intimate touch occurs. They wanted minimal exposure, they said, with other body parts covered by blankets and gowns that don't flap open when they're turned. And they were irritated by what they perceived as "spying" by nurses. They said that, when necessary, nurses should supervise care by being active and engaging rather than passive and silent. For example, of a nurse who supervised a shower, one participant said, "Don't just stand there and watch me bathe. Help or get out!"

In terms of touch quality, participants insisted on warm, gloved hands and clean equipment. They wanted a firm but not rough touch. For example, "Touch firmly and with a purpose"; "Touch firmly, not tentative, not caressing"; and "Any kind of hesitancy would make me feel more anxious and less inclined to let them bathe me." Intimate touch that was too quick might result in incomplete or poor care, lead to rough and painful handling, or indicate embarrassment or incompetence on the nurse's part. One participant said, "Too fast almost seems like they are trying to avoid the situation." But neither did they want nurses to touch them too slowly. Nurses should not "linger too long in one area," which would be "creepy" or "make the person feel disrespected." Although these comments might suggest a Goldilocks scenario—too fast, too slow, or just right—participants emphasized that nurses should solicit feedback from patients while providing care.

> Several participants said something like, 'If at all possible, ask me if I can do it myself. If I can, let me do it.'

DISCUSSION

Nurses must exercise clinical judgment in deciding when, where, and how to touch patients. Our results, in providing the patient's perspective on intimate touch, can help them in those decisions. Overall, our participants said they want to know *before* intimate touch is provided why it's necessary and what it will involve. They expect nurses to seek permission before initiating intimate touch, and they want to be involved in deciding when and how it's given. They expect nurses to project a professional image and speak in a professional manner. They want rapport and interaction with their nurses but not conversation focused solely on the nurse. They want nurses to listen to their concerns and answer their questions. All of these things, they said, increase their comfort with intimate touch.

These findings are congruent with those of other studies, although most of those studies reflect the nurse's and not the patient's perspective. Harding and colleagues[1] and Inoue and colleagues[16] found that male nurses felt they should seek permission and explain procedures before providing intimate touch, but those actions were to protect themselves rather than to foster rapport. Those authors also note that humor can be used to reduce tension for both nurse and patient. Edwards notes that nurses use small talk as a distraction that reduces the nurse's and patient's embarrassment.[6] Estabrooks and Morse identify cueing, in which nurses monitor verbal and nonverbal cues from patients in evaluating the effectiveness of their touch, as a "core variable" in the development of an ICU nurse's touching style.[19] We deduce that nurses should converse with but not mindlessly chatter at patients.

gender of the nurse than with the nurse's professionalism and communication skills. Lodge and colleagues report that obstetric and gynecologic patients had no preference concerning their nurse's gender if they'd had prior experience with male nurses.[27] While our participants said they expect to be asked about chaperones, we found no studies that explored patients' preferences concerning chaperones when nurses, rather than physicians, provided the intimate care. Several studies report on the use of chaperones by male nurses as a way to protect the nurse.[7, 13, 15, 16] We didn't find any study that discussed the use of chaperones by female nurses, although the British government has created policies recommending that all patients be asked about their preferences for chaperones and that guidelines on chaperone training and use be developed.[28] Automatic and indiscriminate use of chaperones may

> One said of being touched by male nurses, 'At first I was embarrassed, but they were professional, and I became comfortable.'

Estabrooks and Morse stress the need to seek permission from patients prior to touch and conclude that a "significant component of the propriety of touch is related to patient consent."[19] We believe that most employers don't require nurses to obtain formal consent from patients before performing any task requiring intimate touch; however, we suggest that, whenever possible, nurses seek permission from patients before using intimate touch.

Our participants said that they expect to decide whether or not intimate touch is necessary (except in cases of emergency or inability to give consent). This expectation has less to do with giving consent and more to do with providing their own care when possible. Participants were angered by situations in which nurses assumed they couldn't provide their own personal care. In addition, participants expect nurses to abide by their preferences for how intimate touch is to be provided when it's necessary. We didn't find any study addressing these expectations. Evans notes that some male nurses modify procedures to avoid the need for intimate touch, such as giving an intramuscular injection in the arm instead of the buttock.[13] Again, this strategy protects the nurse rather than the patient.

Regarding nurses' gender, participants who'd received intimate touch from nurses and those with experience with male nurses were less concerned with the foster a climate of mistrust, some of our participants said.

The need for nurses to ensure privacy is covered clearly in most basic nursing textbooks. Typically, privacy is discussed as minimizing exposure of patients' bodies and drawing curtains, yet our participants also mentioned the perceived "spying" of nurses. We found no discussion in the literature of how well nurses explain the need to observe those who provide their own care.

Our participants wanted the nurse's touch to be firm but not rough, unhurried but not lingering, and confident but not hesitant. No other study commented on such qualities of touch. Of course, preferences are quite subjective, and nurses should pay attention to cues from patients.

Limitations. Although participants varied in age and experience with health care, the sample lacked ethnic and racial diversity. Patients who aren't white Americans or who have recently immigrated to the United States may express stronger preferences about touch and nurses' gender. For example, Rashidi and Rajaram report on Muslim women immigrants from Asia and the religious restrictions on exposure of a woman's body that practitioners should be aware of.[29] Also, our participants lived in a metropolitan area and may not represent the attitudes of rural residents. And even though only about half of the university's student

body is Catholic, our recruitment from faith-based institutions may have limited the range of responses we received. Consequently, further research is warranted.

Recommendations. Our findings provide initial support for the following recommendations for clinicians, nurse educators, and nurse researchers (see *Recommendations for Clinicians When Providing Intimate Touch*). First, nurses should reflect on how they approach intimate touch—some practices may run counter to patients' preferences—and be mindful of communication styles; Black notes that respect for patients requires communicating well, soliciting patients' input in decisions, and honoring patients' values.[30] Second, nurse educators should consider discussing with students the anxiety and uncertainty some clinicians feel when providing intimate touch. Finally, patients' preferences must be considered in the development of evidence-based strategies for intimate touch. Nurse researchers should test such strategies, and they should be included in nursing textbooks and be accessible to all clinicians.

Although these recommendations may seem obvious to clinicians, our data imply that they aren't necessarily practiced. Additional research will support the development of further and more specific strategies. ▼

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