3-2014

Evaluating the Effects of Intimate Touch Instruction: Facilitating Professional and Respectful Touch by Male Nursing Students

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ABSTRACT

Nurses are expected to touch areas of patients' bodies that are considered private and emotionally sensitive (intimate), yet little is known about how nursing students learn, rehearse, and incorporate appropriate touch strategies. Although touch education is important to all nurses, male students face additional challenges due to gender roles and negative stereotypes. The purpose of this quasi-experimental pilot study was to evaluate whether a 3-hour intimate touch instructional laboratory with subsequent clinical experience (intervention group) facilitated male students' development of intimate touch knowledge, skills, and attitudes, compared with having only clinical experience and no laboratory (control group). Findings revealed that intervention group participants were significantly more comfortable with cleansing genitalia, less apprehensive about touch being misperceived as sexual, reported less gender requirement rigidity, and scored significantly higher on measures associated with client dignity, comfort, and respect than control group participants in a simulated perineal hygiene demonstration. [*J Nurs Educ*. 2014;53(3):126-135.]

Received: May 4, 2013

Accepted: November 1, 2013

Posted Online: February 11, 2014

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The authors thank the Omicron Upsilon chapter of Sigma Theta Tau International for their generous funding of this research and Lindsay Kindler, PhD, RN, for her assistance with this study.

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doi:10.3928/01484834-20140211-08

Perhaps no other nursing action is as common as touch. Touch is central to nursing practice and is necessary for completing tasks and communicating caring (Estabrooks, 1987; Picco, Santoro, & Garrino, 2010; Riley, 2004; Routasalo, 1999). Touch is so central to nursing that few nurses give it much thought, unless that touch is likely to provoke discomfort for either the client or nurse. Such discomfort typically arises when touch involves private or emotionally sensitive areas of the body. Touch of this type is required of nurses when conducting physical assessments, performing procedures, or assisting with hygiene. Harding, North, and Perkins (2008) described this type of touch as *intimate touch*. Intimate touch is defined in this study as task-oriented touch to areas of the body that may invoke discomfort, anxiety, or fear among caregivers or clients or may be misinterpreted as sexual in nature. Such areas of the body include, but are not limited to, the breasts, lower abdomen, genitals, perineum, buttocks, and inner thighs.

Many task-oriented nursing actions require the use of intimate touch, yet this type of touch is often uncomfortable for nurses and does not come naturally (Picco et al., 2010), as there are no social models for the use of intimate touch in nonsexual contexts. Clients expect nurses to know how to touch clients appropriately (Van Dongen & Elema, 2001); unfortunately, minimal information is available to understand the nature and use of intimate touch in nursing (Harding et al., 2008; O'Lynn, 2007b, 2013; O'Lynn & Krautscheid, 2011). Furthermore, nurses report receiving limited instruction on any type of touch in nursing school (Estabrooks & Morse, 1992; Gleeson & Timmins, 2005; Keogh & Gleeson, 2006; Keogh & O'Lynn, 2007; O'Lynn, 2004; Paterson et al., 1996). The paucity of available evidence has led many nurses to develop intimate touch skills on a trial-and-error basis influenced by personal preferences and assumptions.

Intimate touch has been disproportionately problematic for men in nursing. Due to longstanding patriarchal influences and socially constructed gender roles, touch from men has become sexualized and something that should be viewed with suspicion (Evans, 2002). These perspectives are strengthened by in-depth reports of male pedophiles and sexual perpetrators in today's news and social commentary cycle, negative portrayals of male

nurses, nursing's historical nonwelcome to men seeking careers in women's health, and insistence on chaperones to supervise men when intimate touch is required (Bartfay, Bartfay, Clow, & Wu, 2010; Harding et al., 2008; O'Lynn, 2013; Stanley, 2012). Such perspectives have led to biases and stereotypes that place an added burden on male nurses (Prideaux, 2010). These perspectives have resulted in fear among male nurses that clients will falsely accuse them of sexual impropriety when they provide necessary intimate touch (Evans, 2002; Gleeson & Higgins, 2009; Harding et al., 2008; Inoue, Chapman, & Wynaden, 2006; Keogh & Gleeson, 2006; Keogh & O'Lynn, 2007; O'Lynn, 2004, 2007a).

These challenges require that nurse educators provide guidance and support for male students, but this assistance is rarely available (Harding et al., 2008; O'Lynn, 2004; Paterson et al., 1996; Prideaux, 2010). Furthermore, stereotypes around touch may contribute to client rejection of male nurses solely on the basis of their gender, which exerts an emotional toll on male nurses (Harding et al., 2008) and possibly scheduling difficulties within clinical agencies. Negative feelings about touch may impair the quality of client care if support and guidance with touch is lacking (Van Dongen & Elema, 2001).

Nearly 10 years ago, O'Lynn (2007b) synthesized anecdotal and limited published findings to create a skills laboratory for undergraduate nursing students to address their specific concerns regarding intimate touch. The current authors built on O'Lynn's work to develop an intimate touch instructional laboratory designed to teach male nursing students how to provide intimate touch in a manner that communicated professionalism and respect for the client's dignity. An underlying assumption was that a professional and respectful approach to intimate touch would reduce anxiety among male nursing students and their clients, reduce the risk of misinterpretation of the intent of touch, and promote better nursing care. The skills laboratory was provided for all male undergraduate nursing students attending the authors' university beginning in 2009, following an initial pilot and evaluation that began in 2006. The aim of the current pilot study was to evaluate the efficacy of this intimate touch laboratory experience for male undergraduate nursing students in facilitating the professional and respectful provision of intimate touch.

LITERATURE REVIEW

Nurse authors have discussed touch for well over 100 years. Still, before 1990, much of the literature related to touch focused on defining the different kinds of touch (Routasalo, 1999). For example, Estabrooks (1989) described three kinds of touch used by nurses: instrumental touch, expressive touch, and protective touch. Instrumental touch is required simply to accomplish a task, such as applying a dressing. Expressive touch is given to provide comfort or emotional support. Protective touch is used to prevent injury, such as moving a client's hand away from ventilator tubing. A specific touch encounter may encompass several purposes. For example, all three categories of touch are used when holding a client's waist and shoulder during unsteady ambulation.

Since the 1990s, much of the touch literature has emphasized how often different types of touch are provided, who provides the touch, who receives the touch, and how touch is interpreted. Most studies have suggested that instrumental touch is used far more often than other kinds of touch and that clients are generally comfortable with instrumental touch (Edwards, 1998; Gleeson & Timmins, 2005; Palese, Brezil, & Coiz, 2010; Picco et al., 2010; Routasalo & Isola, 1996; Williams, 2001). Nurses typically touch clients' arms, hands, shoulders, and knees when expressive touch is used. Many clients find expressive touch pleasant, but others do not; the interpretation of expressive touch is highly variable based on cultural and personal experience backgrounds (Davidhizar & Giger, 1997; Estabrooks & Morse, 1992; Gleeson & Timmins, 2005; McCann & McKenna, 1993; Mulaik et al., 1991). Still, touch has been inadequately studied (Chang, 2001; Gleeson & Timmins, 2005), and little is known about learning how to provide intimate touch (Routasalo, 1999). (Therapeutic touch, a specialized healing modality used by a subset of nurses, has been discussed extensively in the literature and is beyond the scope of this review.)

Some anecdotal reports and expert opinions have been offered to guide nurses on how to administer touch. Estabrooks and Morse (1992) described two phases in touch: entering and connecting. The former requires seeking permission to touch, whereas the latter establishes reciprocal caring. The nurse must monitor verbal and nonverbal cues from the client to self-correct any negative touch actions. Others reported strategies used by male nurses when intimate touch is necessary (Edwards, 1998; Evans, 2002; Gleeson & Higgins, 2009; Harding et al., 2008; Inoue et al., 2006; Keogh & Gleeson, 2006). Many of these strategies are generic recommendations for the provision of privacy and maintaining a professional demeanor. However, some strategies used were simple avoidance techniques, such as delegating intimate touch to female nurses or seeking employment in areas where intimate touch is seldom used or used when others are present, such as in administration or mental health. Other authors provided recommendations for all clinicians to provide privacy, explain procedures, and allow self-care when intimate touch is necessary but no instruction on specific touch techniques (Bowers, 2000; Peate, 2005; Royal College of Nursing, 2002).

Only one study was found that queried lay participants on how they preferred to be touched by nurses (O'Lynn & Krautscheid, 2011). Participants stated that they wanted to be informed as to when and why intimate touch was necessary and alternatives to intimate touch, such as self-care approaches. Participants wanted to be asked about their preferences for the gender of the nurse providing intimate touch or the use of a chaperone. Participants also wanted to be touched in a professional manner, which they defined as not too fast, not too slow, not too gentle or tentative, and not too rough. Also, nurses should have professional behaviors and a professional appearance when touching clients. This limited evidence base was used in developing and implementing the intimate touch instructional laboratory.

CONCEPTUAL FRAMEWORK

Gender role conflict (GRC) theory was the conceptual framework guiding this study. Since its development in 1981, GRC the-

TABLE 1

Demographic Characteristics of the Vignette Reviewer Panel (n = 10)

Characteristic	Percentage
Gender	
Female	90
Male	10
Highest Degree	
PhD	10
MS	40
BSN	40
ADN	10
Mean age (y)	47.1 (range, 36-61)
Role	
Obstetrical–gynecological staff nurse	30
Medical–surgical staff nurse	20
Faculty	40
Administration (hospital)	10
Region of residence (United States)	
Pacific Northwest	50
New England	20
Midwest	20
Mid-Atlantic	10

Note. PhD = Doctor of Philosophy; MS = Master of Science; BSN = Bachelor of Science in Nursing; ADN = Associate Degree in Nursing.

ory has been tested and refined by more than 230 studies (O'Neil, 2008). Briefly, GRC is defined as "a psychological state in which socialized gender roles have negative consequences for the person or others," ultimately restricting human potential (O'Neil, 2008, p. 362). GRC occurs from rigid, sexist, or restrictive gender roles and masculinity norms constructed within a society and internalized by individuals, families, and peers. Psychoemotional distress, lower self-esteem, shame, and lower well-being result when men perceive conflict between self-accepted restrictive gender roles and the new behaviors and attitudes they are asked to embrace (O'Neil, 2008). Researchers have documented GRC in men of varying ages, sexual orientations, class and socioeconomic statuses, and racial and ethnic backgrounds.

GRC theory is an appropriate framework to support this study, given that the literature provides strong evidence that social institutions have facilitated conflicts between masculine gender roles and the roles and images of nursing over the past 150 years (O'Lynn, 2013). Of particular importance, touch behaviors, such as expressive touch given to nonintimate partners, conflict with traditional masculinity norms. Furthermore, the general public often perceives touch from men as having a sexual purpose (Evans, 2002), leading to opportunities for misperception and false accusations when male nurses utilize intimate touch (O'Lynn, 2013). GRC theory provides an explanatory foundation for why men experience a more challenging learning environment in nursing schools regarding touch than is typically present for women and why addressing men's needs are important. By recognizing the anxiety stemming from GRC, the authors anticipated that an intimate touch laboratory experience would foster improved intimate touch attitudes and behaviors among male nursing students. Such improvement would ultimately improve the care these men provide to future clients (O'Lynn, 2013).

METHOD

Design and Sample

A quasi-experimental research design was used to compare student outcomes between those who received an intimate touch laboratory with subsequent clinical experience (intervention group) and those who received only the clinical experience (control group). A convenience sampling strategy was utilized to recruit participants for both the intervention group and the control group. All nursing students at the authors' baccalaureate nursing (BSN) program were required to complete an intimate touch laboratory at the beginning of the junior year. From September 2009 to May 2012, all male nursing students were invited to enroll in the study following the laboratory. (Female students also completed an intimate touch laboratory but were not included in the current study.) Two BSN programs in the West Coast region of the United States agreed to recruit participants to serve as the study's control group. Institutional review board approval for the study was received from all participating institutions.

Procedures

Students in the intervention group participated in a 3-hour intimate touch laboratory at the authors' academic institution. Prior to the laboratory, students completed an Intimate Touch Survey, assessing their attitudes and comfort with intimate touch. Following the laboratory, students completed laboratory and clinical experiences required in the institution's program of study. When students had completed at least 90 hours of medical–surgical clinical experience at a local health care agency, they were invited to complete the Intimate Touch Survey a second time and to demonstrate taking an apical pulse and providing perineal hygiene on a simulation manikin; the student demonstrations were facilitated by faculty using a standardized script. Both demonstrations were videotaped.

Control group participants did not participate in the intimate touch laboratory. Instead, these students received their usual laboratory instruction and clinical experiences. Students were invited to participate in the study after completing approximately 90 hours of medical–surgical clinical experience at health care agencies in local areas. Participants completed the Intimate Touch Survey and were invited to demonstrate the same simulated procedures as the intervention group students. Control group faculty were provided with the simulation script and consultation from the authors via telephone and e-mail. Two control group students chose to come to the authors' institution to videotape their demonstrations. Videotaped vignettes from both the control and intervention groups were evaluated by a panel of

TABLE 2

Intimate Touch Principles

Principle	Description
Innocent until proven guilty	Assume and project this stance. Too often, intimate touch is accompanied by an air of suspicion or doubt. The provision of intimate touch is always professional and respectful.
No automatic chaperones, nonuse of the word *chaperone*	Policies that require the use of chaperones create a distrustful climate—either the nurse cannot be trusted and must be supervised or the client cannot be trusted to not make false accusations. The model adopted by the National Health Service in the United Kingdom is preferable: all clients should be asked if a chaperone is necessary if an invasive or prolonged procedure warranting intimate touch is expected, regardless of the sex of the nurse or client.
	Chaperones should not be passive untrained observers. Chaperones should be well-versed in the norms of the procedure and should actively assist the nurse in the procedure.
	The term *chaperone* has negative connotations. Instead, use the term *assistant* or *helper*. This implies there is a function to this person other than observer or supervisor.
Build rapport	Always inform the client that intimate touch is necessary and how and where touch will occur. If the procedure might be uncomfortable or painful, tell the client what he or she might expect to feel.
	Reduce the perception of a power differential by getting at the client's eye level whenever possible. Rarely should the nurse stand over or behind a client when performing intimate touch. Such positions give the client a feeling of vulnerability and powerlessness.
	Offer choices whenever possible. Allow the client to complete any task on his or her own so that intimate touch becomes unnecessary. Let the client control what is done to him or her.
	Get permission, explicit or implied, before providing intimate touch. During the procedure, monitor the client's nonverbal language to see if the client expresses any discomfort with the touch.
Ensure privacy	Close doors or curtains when appropriate. Keep sensitive areas of the body covered whenever possible.
Touch confidently and professionally	Project confidence. Avoid shaky hands. Touch that is too light may project hesitancy. Touch that is too rough projects insensitivity. Touch that is too slow projects a sense of lingering. Touch that is too rapid projects avoidance and disdain. Fine tune the physicality of touch by the client's verbal and nonverbal responses.
Provide directionality via progressive touch	Always make contact with the body in a less sensitive area before progressing to a more sensitive area. The first sensation a client feels should not be the nurse's hands on his or her genitals. For sterile procedures, the nurse could use his or her forearm or nonsterile hand to touch less sensitive areas.
Use distraction measures	Distract clients with meaningful conversation. Avoid periods of silence during intimate touch. Silence only focuses the client's attention on the intimate touch procedure. Engage clients in client-centered discussions, such as assessment or client education. Do not use humor or make light of the situation as an attempt to reduce anxiety.
	Distract clients with the use of concurrent touch. This occurs when the nurse has physical contact with a client in a sensitive and nonsensitive area of the body at the same time. Concurrent touch diffuses the sensory input going to the brain. This prevents the client from sensing only the contact made to sensitive body areas. For sterile procedures, concurrent touch could be made by use of the nurse's nonsterile hand, forearm, knee, or hip.
Cultural considerations	Respect cultural norms that forbid cross-sex intimate touch or those that require a family member to be present.

10 experienced nurses not affiliated with any of the participating academic institutions. Demographic characteristics of the faculty panel are provided in **Table 1**.

Measurement

Because the authors were also faculty for the students and because the Intimate Touch survey solicited potentially sensitive information, extra caution was taken to ensure anonymity of responses; therefore, surveys were not coded, nor were demographic data collected given that such data could identify participants due to the scant number of men in each student cohort. This prevented the creation of matched groups. Further, although most students agreed to complete the survey at time 1, only students agreeing to participate in videotaping demonstra-

TABLE 3

Intervention Group: Intimate Touch Survey Results for Time 1 and Time 2

Item	Mean (*SD*)	
	Time 1	Time 2
1. Comfort with touching female genitalia	3.65 (1.10)	3.94 (1.09)
2. Comfort with touching male genitalia	3.76 (1.01)	4.24 (0.97)
3. Apprehensive about touching female genitalia	2.60 (1.14)	3.41 (1.28)*
4. Apprehensive about touching male genitalia	2.78 (1.21)	3.53 (1.18)*
5. Negative about cleaning female genitalia	3.94 (0.93)	4.11 (1.11)
6. Negative about cleaning male genitalia	3.94 (0.93)	4.12 (1.11)
7. Chaperones needed for male nurse and female client	3.60 (1.18)	4.53 (0.87)**
8. Chaperones needed for female nurse and male client	3.71 (1.17)	4.53 (0.87)**
9. Touch fast to avoid embarrassment	4.14 (1.12)	4.71 (0.47)
10. Use female nurse for female client	4.27 (0.81)	4.88 (0.49)**
11. Use male nurse for male client	4.35 (0.70)	4.88 (0.49)**
12. Worried touch will be misinterpreted by female clients as sexual in nature	2.50 (1.13)	3.24 (1.20)*
13. Faculty provided guidance on intimate touch	Not applicable	4.59 (0.94)
14. Learning touch should begin in laboratory prior to clinical experiences	4.55 (0.76)	4.70 (0.59)
15. I have developed strategies to help me provide intimate touch	3.20 (1.19)	4.18 (0.73)**
Summed comfort score (items 1, 2, 3, 4, 5, 6, 9, 12)	27.21 (5.13)	31.29 (5.80)**
Summed comfort with female client score (items 1, 3, 5, 12)	12.59 (2.75)	14.71 (3.01)**
Summed comfort with male client score (items 2, 4, 6)	10.48 (2.31)	11.88 (2.71)*
Gender requirement rigidity score (items 7, 8, 10, 11)	15.94 (2.97)	18.82 (2.56)***

*$p < 0.05$; **$p < 0.01$; ***$p < 0.001$.

tions of intimate touch completed the survey at both times 1 and 2. Group survey scores, then, were compared between time 1 and time 2 using an independent *t* test to evaluate changes in attitudes and comfort with intimate touch among intervention group students. Responses from intervention group students at time 2 were also compared with responses from control group students using an independent *t* test.

Each demonstration was recorded and coded separately so that each participating student contributed two vignettes (one apical pulse and one perineal hygiene). The vignettes were assigned randomly among the 10 panel members, with each vignette evaluated by at least two panel members using the Vignette Evaluation Tool. Scores were compared between intervention and control group students using an independent *t* test. Significance was established at $p < 0.05$.

Instruments

No tools assessing attitudes and comfort with intimate touch or assessing intimate touch skills were located in the literature. The authors developed tools informed by the literature synthesis and from the experiences of seasoned nursing faculty, thus establishing face validity. The Intimate Touch Survey asked respondents their level of agreement to each of 15 items, using a Likert scale ranging from 1 (*strongly agree*) to 5 (*strongly disagree*) with corresponding scores, ranging from 1 to 5. Eight items pertained to comfort with intimate touch in various contexts (e.g., comfort with cleansing the genitalia of female clients versus male clients). Three items pertained to gender requirement rigidity, defined as a belief that only same-sex nurse–client dyads are appropriate and that chaperones should be used for cross-sex dyads. The remaining items pertained to where intimate skills should be taught and self-developed strategies. Each item was scored individually, with higher scores representing increased comfort with touch or decreased gender requirement rigidity. Overall comfort scores and gender requirement rigidity scores were calculated by summing the items from each of those categories. The tool was piloted with students over two semesters prior to the initiation of the study for ease of use and ability to generate classroom discussion about intimate touch. The pilot led to several minor wording changes.

The Vignette Evaluation Tool was an 11-item tool formatted in a similar manner as described. Because the control group students did not previously receive instruction on specific intimate touch techniques, the tool asked faculty panel respondents how well students demonstrated professionalism and respect for client dignity—the anticipated behavioral outcomes from the intimate touch laboratory. Higher scores suggest higher levels of professionalism and respect. For example, one item stated, "The student minimizes exposure of the client's body." The first nine items addressed specific behaviors relevant to the touch encounters, whereas the final two items asked reviewers to evaluate the overall respect for client dignity and comfort provided by the student. Initially, the tool was reviewed for ease of use and face validity by three nursing faculty who supervised students in the clinical setting; this review resulted in recommendations for minor wording changes. One item pertaining to the use of humor was deemed to be confusing and was removed from the tool. The revised tool was then pilot tested with a panel of five experienced RNs from diverse clinical backgrounds (pediatrics, mental health,

medical–surgical, obstetrics, and emergency nursing). Each panel member evaluated four identical vignettes using the tool to assess interrater reliability. Data were entered into a statistical software program (SPSS version 20.0), and a Pearson's correlation score of $r = 0.89$ was obtained.

Intervention: Intimate Touch Laboratory

The intervention consisted of a 90-minute intimate touch skills laboratory experience. The laboratory started with an introduction, followed by completion of the Intimate Touch Survey. The items on the survey were then used to stimulate a general discussion about the kinds of touch, including intimate touch, and segue into a review of intimate touch principles (**Table 2**). Faculty reviewed how each of the principles fostered professionalism and communicated respect for client dignity. Students viewed video vignettes of a nurse performing an apical pulse and perineal care in a manner that is commonly seen in practice and similar vignettes in which the nurse incorporated intimate touch principles into the procedures. Comparisons and contrasts were discussed. The students then practiced intimate touch principles on laboratory manikins. The laboratory concluded with a debriefing.

TABLE 4

Control and Intervention Groups: Intimate Touch Survey Scores at Time 2

Item	Mean (*SD*) Control Group	Mean (*SD*) Intervention Group
1. Comfort with touching female genitalia	3.47 (1.41)	3.94 (1.09)
2. Comfort with touching male genitalia	3.80 (1.09)	4.24 (0.97)
3. Apprehensive about touching female genitalia	2.20 (1.14)	3.41 (1.28)**
4. Apprehensive about touching male genitalia	2.53 (1.19)	3.53 (1.18)*
5. Negative about cleaning female genitalia	3.33 (1.40)	4.11 (1.11)
6. Negative about cleaning male genitalia	3.48 (1.25)	4.12 (1.11)
7. Chaperones needed for male nurse and female client	2.87 (0.99)	4.53 (0.87)***
8. Chaperones needed for female nurse and male client	3.53 (0.83)	4.53 (0.87)**
9. Touch fast to avoid embarrassment	3.47 (1.46)	4.71 (0.47)**
10. Use female nurse for female client	4.47 (0.64)	4.88 (0.49)*
11. Use male nurse for male client	4.47 (0.64)	4.88 (0.49)*
12. Worried touch will be misinterpreted by female clients as sexual in nature	2.40 (0.91)	3.24 (1.20)*
13. Faculty provided guidance on intimate touch	3.33 (1.23)	4.59 (0.94)**
14. Learning touch should begin in laboratory prior to clinical experiences	4.73 (0.46)	4.70 (0.59)
15. I have developed strategies to help me provide intimate touch	3.07 (1.16)	4.18 (0.73)**
Summed comfort score (items 1, 2, 3, 4, 5, 6, 9, 12)	24.67 (5.95)	31.29 (5.80)**
Summed comfort with female client score (items 1, 3, 5, 12)	11.40 (3.46)	14.71 (3.01)**
Summed comfort with male client score (items 2, 4, 6)	9.80 (2.46)	11.88 (2.71)*
Gender requirement rigidity score (items 7, 8, 10, 11)	15.33 (2.09)	18.82 (2.56)***

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

RESULTS

Of 79 male students enrolled over 3 years, 17 students (21.5%) agreed to participate in the intervention group and return after their clinical experience the following semester for filming of their intimate touch demonstrations. Each student completed the Intimate Touch Survey at time 1 and time 2. Each student provided two vignettes, one demonstrating an apical pulse and the other demonstrating perineal hygiene, yielding a total of 34 vignettes. Fifteen students agreed to participate in the control group. Each of these students completed the Intimate Touch Survey at time 2, but only seven students agreed to videotape their demonstrations, resulting in 14 vignettes. Cronbach's alpha for the Intimate Touch survey was 0.82. The comfort and gender requirement rigidity subscales each had a Cronbach's alpha of 0.78. Cronbach's alpha for the Vignette Evaluation tool was 0.78. **Table 3** presents changes in comfort and beliefs regarding intimate touch between time 1 and time 2 for the intervention group students. **Table 4** provides a comparison of data between the intervention group scores and the control group scores on the Intimate Touch Survey at time 2, corresponding to completion of at least one rotation of clinical experience in which students provided intimate touch care with adult clients. **Table 5** compares the intervention students at time 1 with the control students at time 2. **Tables 6-7** compare the faculty reviewer panel scores between the control and intervention group students on the basis of the apical pulse and perineal hygiene demonstrations, respectively. Discussion of specific results follows.

DISCUSSION

The authors anticipated that an intimate touch laboratory experience would improve students' attitudes and touch skills, as evidenced by the demonstration of professionalism and respect for client dignity. Despite relatively small sample sizes for the two groups, findings from this pilot study suggest that the labo-

TABLE 5

Time 2 Control Group and Time 1 Intervention Group Intimate Touch Survey Results

Item	Mean (*SD*)	
	Control Group, Time 2	Intervention Group, Time 1
1. Comfort with touching female genitalia	3.47 (1.41)	3.65 (1.10)
2. Comfort with touching male genitalia	3.80 (1.09)	3.76 (1.01)
3. Apprehensive about touching female genitalia	2.20 (1.14)	2.60 (1.14)
4. Apprehensive about touching male genitalia	2.53 (1.19)	2.78 (1.21)
5. Negative about cleaning female genitalia	3.33 (1.40)	3.94 (0.93)
6. Negative about cleaning male genitalia	3.48 (1.25)	3.94 (0.93)
7. Chaperones needed for male nurse and female client	2.87 (0.99)	3.60 (1.18)*
8. Chaperones needed for female nurse and male client	3.53 (0.83)	3.71 (1.17)
9. Touch fast to avoid embarrassment	3.47 (1.46)	4.14 (1.12)
10. Use female nurse for female client	4.47 (0.64)	4.27 (0.81)
11. Use male nurse for male client	4.47 (0.64)	4.35 (0.70)
12. Worried touch will be misinterpreted by female clients as sexual in nature	2.40 (0.91)	2.50 (1.13)
13. Faculty provided guidance on intimate touch	3.33 (1.23)	Not applicable
14. Learning touch should begin in laboratory prior to clinical experiences	4.73 (0.46)	4.55 (0.76)
15. I have developed strategies to help me provide intimate touch	3.07 (1.16)	3.20 (1.19)
Summed comfort score (items 1, 2, 3, 4, 5, 6, 9, 12)	24.67 (5.95)	27.21 (5.13)
Summed comfort with female client score (items 1, 3, 5, 12)	11.40 (3.46)	12.59 (2.75)
Summed comfort with male client score (items 2, 4, 6)	9.80 (2.46)	10.48 (2.31)
Gender requirement rigidity score (items 7, 8, 10, 11)	15.33 (2.09)	15.94 (2.97)

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

ratory experience is beneficial for students and, ultimately, for the clients they will care for as nurses.

Although the amount of change for individual items on the Intimate Touch Survey was variable, the laboratory experience improved overall comfort with intimate touch and decreased rigid gender requirement perspectives for nurse–client dyads between time 1 and time 2 for intervention group students. Significant reduction in apprehension about touching both male and female genitalia occurred between times 1 and 2 for intervention students. At time 2, intervention students had significantly less apprehension than did control students. Comfort with touching both male and female genitalia showed improvement for intervention students and were better than controls, although not significantly. However, when survey items pertaining to comfort were summed, intervention students had significantly higher levels of comfort with intimate touch than did control students. Significantly improved comfort was also reported when items were summed separately for touching male clients and for touching female clients. These findings suggest that the intimate touch laboratory added benefit beyond routine-guided student clinical experiences, such as those received by the control students.

Item 12 surveyed students specifically about fears that their intimate touch would be misinterpreted by female clients and lead to false accusations of sexually inappropriate behavior by the male student. At time 1, all students expressed a level of apprehension on this specific topic beyond a neutral score. This level of apprehension is congruent with the literature (Gleeson & Higgins, 2009; Harding et al., 2008; Inoue et al., 2006; Keogh & Gleeson, 2006; Keogh & O'Lynn, 2007; O'Lynn, 2004, 2007a). At time 2, men from the intervention group showed significant improvement relevant to this specific fear, and they reported significantly less fear, compared with control group students. Although the control group students did not complete the survey at time 1, the findings suggest that without the intimate touch laboratory, routine clinical experiences are not enough to foster less apprehension about false accusations for male students.

Four survey items pertain to the student's level of gender requirement rigidity, specifically whether cross-sex nurse–client assignments are appropriate and how chaperones should be used. Low survey scores on these items suggest more rigid gender requirements, such that cross-sex dyads are inappropriate when intimate touch is needed and that chaperones should be used. Rigid requirements could greatly affect the clinical setting in terms of staffing assignments and team functioning. Furthermore, these items were included to explore whether men believed chaperones were needed when they touched female clients but not when female nurses touched male clients, congruent with the well-described perspectives in the literature supporting the appropriateness of touch provided by women (Evans, 2002; O'Lynn, 2013).

Neither group at time 2 demonstrated overall rigid gender requirement perspectives in terms of assignments, although intervention students had significantly less rigid perspectives from time 1 to time 2 and were significantly less rigid than were control students. In terms of chaperones, intervention students were significantly less likely to report a need for chaperones in either cross-sex dyad at time 2 compared with controls. Control stu-

dents reported a need for chaperones when men provide care to female clients but not when female nurses cared for male clients.

It is not clear why control students reported different chaperone needs for male and female nurses; however, some explanations are plausible. Given that control students also reported apprehension about false accusations from female clients, control students may believe that chaperone use is a self-protective strategy. Such an approach has been reported elsewhere (Edwards, 1998; Inoue et al., 2006). Also, control students may have internalized larger societal messages that touch from men is sexualized and suspect; thus chaperone use for male nurses, but not female nurses, has been normalized (Evans, 2002; Gleeson & Higgins, 2009; O'Lynn, 2013; Routasalo & Isola, 1996). Further, control students may have been told by faculty and staff that chaperone use is required (Harding et al., 2008). Conversely, intervention students were more likely to adopt the principle of "no automatic chaperones," which states that the necessity of chaperones should be determined by the client and not by the organization or clinician (Prideaux, 2010; Royal College of Nursing, 2002).

TABLE 6

Control Group and Intervention Group Results for Apical Pulse Demonstration

Item	Mean (*SD*)	
	Control Group	Intervention Group
1. Student asks permission prior to touch	4.57 (0.51)	4.57 (0.81)
2. Student informs client where touch will occur	4.50 (0.85)	4.51 (0.70)
3. Student explains what client might feel	3.50 (1.10)	3.4 (1.10)
4. Student offers choice to have assistant present	1.57 (0.51)	1.74 (0.74)
5. Student speaks calmly (defined on tool)	4.43 (0.51)	4.40 (0.98)
6. Student does not show anxiety (defined on tool)	4.36 (0.48)	4.37 (0.88)
7. Student provides privacy	2.21 (1.12)	4.23 (0.94)***
8. Student minimizes exposure of client's body	4.29 (0.61)	4.60 (0.76)
9. Student engages client in conversation	3.21 (0.98)	3.57 (1.12)
10. Student demonstrates respect for client dignity	4.36 (0.50)	4.57 (0.50)
11. Student provides comfort to client	4.07 (0.73)	4.37 (0.81)

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

Of note, control students who had completed routine laboratory instruction and student clinical experiences showed no significant differences on all but one survey item, compared with intervention students who were just beginning their nursing programs (**Table 5**). (Intervention students were less likely to report a need for chaperones for male nurses.) This suggests that student clinical experiences alone may not afford male students the opportunity to reduce apprehensions and adopt more positive attitudes about intimate touch in a nursing context. When placed early in the program of study, the intimate touch laboratory and faculty attention to gender role conflict may have planted the seeds for formation and growth among intervention students.

Videotaped demonstrations of intimate touch procedures were evaluated by a panel of experienced nurses using the Vignette Evaluation Tool. The findings showed no significant differences between the intervention and control groups for the demonstration of taking an apical pulse except for the provision of privacy. Upon further examination, the authors noted that the vignettes from the control group included only close-up views of the students and the bedside. It was not possible to determine whether these students were able to pull curtains or close a door. Conversely, intervention students were filmed in a simulation suite in which closing of the door was visible. Meaningful interpretation of this particular item cannot be made.

Reviewers scored the intervention students significantly better on several items for the perineal hygiene demonstration, including demonstration of respect for client dignity and comfort. It is not clear why the two procedures yielded different findings. Both apical pulse assessment and perineal hygiene are common procedures for nursing students. One possible explanation is that a nursing assessment of the apical pulse is easily performed without exposing the breast by sliding the hand under the client's gown. However, it is impossible to adequately clean the perineum without some exposure of the genitals. Also, cleansing the perineum often takes longer to complete with more individual steps than when checking an apical pulse. The need for exposure and the increased amount of time required to complete the perineal hygiene procedure may increase the risk of demonstrating less-than-optimal behaviors. Nevertheless, the higher ratings given to the intervention group students for the more complex perineal hygiene procedure suggest that the laboratory may promote favorable touch behaviors for other complex or invasive procedures requiring intimate touch, such as urinary catheterization, perinatal cervical assessment, and enema administration.

The findings of this study support the use of GRC theory in understanding and addressing the needs of male nursing students. Although the students in this study likely believed it was appropriate for men to become nurses (otherwise, they would not have enrolled in nursing programs), scores reflected the men's apprehension about intimate touch, fears of false accusations of sexual impropriety, and beliefs that male nurses, but not female nurses, required chaperones. These perspectives are congruent with the dominant masculinity norms and gender roles in Western society (O'Neil, 2008). Intervention students demonstrated change in their perspectives after re-

TABLE 7

Control Group and Intervention Group Results for Perineal Hygiene Demonstration

Item	Mean (*SD*)	
	Control Group	Intervention Group
1. Student asks permission prior to touch	3.36 (0.93)	4.12 (1.00)**
2. Student informs client where touch will occur	3.00 (1.11)	3.92 (1.20)*
3. Student explains what client might feel	2.86 (1.17)	3.19 (1.22)
4. Student offers choice to have assistant present	1.50 (0.52)	1.89 (1.09)
5. Student speaks calmly (defined on tool)	3.71 (0.73)	4.17 (1.03)
6. Student does not show anxiety (defined on tool)	3.57 (0.85)	3.97 (1.18)
7. Student provides privacy	3.14 (1.17)	4.08 (0.91)**
8. Student minimizes exposure of client's body	3.43 (1.16)	4.19 (1.01)*
9. Student engages client in conversation	3.07 (1.27)	3.92 (1.16)*
10. Student demonstrates respect for client dignity	3.57 (0.76)	4.42 (0.73)***
11. Student provides comfort to client	3.57 (0.76)	4.39 (0.60)***

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

ceiving the intimate touch laboratory and routine student clinical experiences. Control students, who received no intimate touch laboratory, provided responses similar to those of the intervention students before the intimate touch laboratory. Further, intervention students demonstrated significantly better intimate touch skills on at least one simulated exercise. Clearly, exploration of possible causation between changed perspectives and better skill with intimate touch is warranted. Such exploration would be heeding O'Neil's (2008) recommendation to explore how to assist men coping with GRC to improve psychoemotional health and behaviors.

LIMITATIONS AND IMPLICATIONS FOR FURTHER RESEARCH

The small sample size and lack of paired groups were important limitations of this study. Despite multiple reminders, assurances of confidentiality, and receipt of a $10 gift card, the authors struggled to encourage male nursing students to participate. When questioned, nonparticipating students stated that they were too busy to come in to tape their demonstrations; however, the authors, who are also faculty at the students' academic institution, suspected an unstated fear among the students of demonstrating poor performance. Contending with multiple administrators, institutional review boards, laboratory faculty, and tight laboratory schedules created logistical challenges for the inclusion of control students. A possible fear of being filmed proved telling within the control group, where 15 students agreed to complete the survey but only seven agreed to be filmed. The authors increased the panel of reviewers from five to 10 to better account for the reduced number of vignettes. The small sample size precludes inferences for nonsignificant items on the surveys; however, the strength of significance on a number of items is noteworthy, despite the small sample size. Additional study with larger samples is necessary for stronger conclusions and to determine which component of the intervention (e.g., video, demonstration, or skills practice) is most likely to produce desired results. Intervention group students in future studies should represent multiple nursing programs to minimize any advantage one individual program might offer in its unique teaching and learning practices. In addition, larger samples would allow exploration of construct validity and the psychometric properties of the study tools. Further studies should use paired samples to allow for more robust analysis and improved validity. These limitations require that this study be viewed as a pilot in nature.

CONCLUSION

Touch is an essential aspect of nursing commonly used to communicate caring or to complete a task. Nurses must frequently touch sensitive areas of clients' bodies, such as when completing an assessment or providing hygiene. Intimate touch is rarely discussed in the nursing literature or by nurse educators, yet the literature is clear that nurses experience discomfort with intimate touch and that they learn this skill through trial and error or administer this type of touch according to personal preference. Intimate touch is especially problematic for male nurses, who have repeatedly reported fears of false accusations of sexual inappropriateness when intimate touch is necessary. Guided by GRC theory, the authors designed and tested an intimate touch laboratory experience with aims of improving men's comfort with intimate touch, thus decreasing rigid gender requirements for nurse–client dyads and improving demonstration of professionalism and respect for client dignity when providing intimate touch in a controlled simulation environment. Findings from the study suggest that the laboratory experience successfully met these aims. The intervention students had significantly more comfort and less rigid gender requirements for intimate touch and demonstrated intimate touch better when providing perineal hygiene, compared with control students. Further study using larger samples of students is warranted. Further studies examining the possible relationships between reducing gender role conflict among male students and improved outcomes are recommended. Possible learning needs

that female nursing students might have about intimate touch should also be explored. When women's needs are identified, exploration of the applicability of the intimate touch principles and laboratory instruction presented in this article could begin for both female and male students.

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