The Response Of Elderly Hospitalized Patients To Nurses' Use Of Expressive Touch

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THE RESPONSE OF ELDERLY HOSPITALIZED PATIENTS TO NURSES' USE OF EXPRESSIVE TOUCH

BY
TERESA LYNN BURGETT
B.S.N., Creighton University, 1972

THESIS
Submitted in Partial Fulfillment of the Requirements for the Degree of
Master of Science in Nursing

The University of New Mexico
Albuquerque, New Mexico
December, 1979
Dedication

To Jack,
with love.
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The author wishes to express sincere gratitude to her family and friends for the kindness and encouragement and belief shown throughout the preparation of this study. An expression of thanks is extended to the thesis committee, Dr. Judith Maurin, Joann Weiss and Dr. Pete DiVasto for providing the patience, guidance and humor necessary to bring this project to a successful completion.

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ABSTRACT OF THESIS

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The purpose of this research was to determine the subjective reactions of elderly hospitalized patients to the use and non-use of expressive touch by nurses. Expressive and instrumental touch and personal and non-personal talk were operationally defined.

The sample of 23 elderly patients consisted of 15 females and 8 males. The mean age of the sample was 76.4 years.

The unit of study was the patient's bath. A repeated measures quasi-experimental design was utilized. Each patient received both the control and experimental interaction. The control interaction involved the use of instrumental touch only and the experimental interaction both instrumental and expressive touch.

The subjective reactions of the patients and the nurses were obtained by open-ended questioning. A chosen set of descriptive variables were identified.

Research questions were formulated which concerned the patients noticing the use or non-use of expressive touch, the subjective reactions of the patients and the nurses and the effect of expressive touch on the ratio of
personal/non-personal talk engaged in by the patient and the nurse.

The responses to the interviews were subjected to content analysis and coded by a panel of judges. Results were presented as frequencies of response patterns within each of the variables identified.

The major findings included none of the patients mentioning the use or non-use of expressive touch as the difference noticed between the two baths. The majority of the subjects mentioned an evaluation of the task function of the nurse as the type of difference noticed. The majority responded affirmatively to noticing the use or non-use of expressive touch when specifically asked. There were no negative responses to the use and only three to the non-use of expressive touch. The use or non-use of expressive touch exhibited no effect on the ratio of personal/non-personal talk. None of the nurses mentioned the touch when asked how they felt about participating in the study. The majority had no difficulty utilizing expressive touch.

Implications for clinical nursing practice and recommendations for further research were presented.
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The Elephant

Though mother may be short on arms,
Her skin is full of warmth and charms,
And mother's touch on baby's skin
Endears the heart that beats within.
(Harlow, 1958:678)
CHAPTER 1

THE PROBLEM

Introduction

Communication has always been a significant part of the nurse's interaction with the patient. A sizeable portion of any nursing curriculum focuses on the skills of communication. The skills of verbal communication, directed at obtaining information from the patient, are central in this area of education.

The use of nonverbal communication can be equally as important as verbal communication in the care of patients. One of these types of nonverbal interactions is the act of touch. Touch has always been considered an essential part of performing many nursing functions. However, touch of this nature usually imparts a message to the patient that he/she is being "done to" instead of being "interacted with."

With the life expectancy increasing, more elderly persons are coming into contact with hospitalization and nurses. Current estimates place ten percent of the population over the age of 65 years of age with a projected increase to almost thirteen percent by the year 2000 A.D. (U.S. Bureau of the Census, 1978:8-9). With this increase
in numbers of elderly persons there has been an awakening of awareness of the needs of the aged. A recent Post White House Conference on Aging Report (1973) addressed many of the concerns of the aged and was appropriately entitled Toward A New Attitude on Aging.

Inherent in this new attitude on aging is an understanding of the dynamics of aging. Among these factors are the losses which the elderly person has experienced. When these same elderly patients are hospitalized they are subjected to yet more assaults to their integrity, not the least of which is the loss of rights and controls related to the hospital experience (Saylor, 1977).

Patients who are elderly, hospitalized and experiencing anxiety over the losses occurred, will most likely have reactions to the use of nonverbal communicative methods such as the type of touch which tells the patient he is indeed being "interacted with" on some level. What this reaction might be has yet to be fully understood.

Significance of the Study

Nurses have always utilized touch in their caring for patients. Very few treatments could be accomplished without physical contact occurring between the nurse and the patient. This type of touch which accompanies procedural activities is known as instrumental touch. Instrumental touch is generally accepted by patients as a part of the nurse's care-giving activities (Allekian, 1973).
Touch can also be utilized for purposes other than "doing to patients." As a mode of communication, "touch is a means of expressing anger, frustration, excitement, happiness - any number of human emotions" (Barnett, 1972b:103). Expressive touch, "relatively spontaneous and affective" (Watson, 1975:104), can be utilized to communicate these messages to patients.

The difference between instrumental and expressive touch is not one of the actual physical contact. The difference lies in the content and intent of the message sent by the nurse and received by the patient. Instrumental touch imparts the message to the patient that he/she is being "done to." He/she is being cared for. Expressive touch, on the other hand, is a means of interaction, a two-way communication between nurse and patient.

In nursing practice this difference between these two types of touch is apparent. Daily contact with patients who are grieving, experiencing pain, or who just desire for the nurse to remain with them for a few more moments, often prompts the spontaneous use of expressive touch by the nurse. A desire on the part of the nurse to communicate a message to the patient is the underlying motive of these interactions. What message is received by the patient and the response to this message can only be guessed.

Elderly hospitalized patients were chosen as the target population as they have needs which are special and specific to aging. Some of these needs are the continuation
of the developmental tasks begun in earlier years. One of these persisting tasks, often overlooked in the aged by health workers, is the elderly persons need to find continued "emotional satisfaction in intimate contact with his loved one" (Duvall, 1971:439). Kubler-Ross (1969) advocates the person's continued need for the touch of one significant other, even until the time that death ensures.

When hospitalized, the elderly person is separated from his/her significant others. Many times, the aged have lost these significant others through death. In these instances, in a semi-intimate context, the nurse endeavors to meet the elderly hospitalized person's needs for understanding, comfort and support which are created by the hospitalization and, under normal circumstances, would be provided for by the patient's significant other(s). With this phenomenon, there is an added responsibility for the nurse to be sensitive to the reactions of the elderly patients.

Sensitivity to these reactions is based on knowledge. The need to know how the patient perceives the expressive touch of the nurse provides the impetus for this study. It is also important for nurses to be cognizant of their personal reactions to the use of touch. Knowledge about the nurses' and patients' reactions to the use of expressive touch by the nurse is essential to an understanding of the messages communicated by both the nurses and the patients.
Statement of the Problem

The message which expressive touch communicates to the patients is unknown. As nurses presently utilize this medium, and will continue to do so, there existed the need to determine the subjective reactions of both the elderly hospitalized patients and nurses to the use of expressive touch by nurses.

Scope of the Study

The problem central to this study was to identify the subjective reactions of a sample of the elderly hospitalized patients and their nurses to the use of expressive touch by the nurses. In order to investigate this problem, the research was designed to include a two to five minute interaction at the beginning and the end of an established nursing care intervention. These initial and final interactions provided the control and experimental interventions central to the study.

The patient's bath was chosen as the unit of study. Every hospitalized patient receives a daily bath unless there are unusual or intervening circumstances surrounding his/her care. The bath also required a length of time sufficient for observations and data collection related to the topics of conversation between the nurse and patient during this instrumental touch portion of the interaction.

Patients were told that participation in the research would consist of evaluation of two different
techniques for giving baths (see Appendix A, Patient Participation Consent Form). It was decided that informing the patient of the use or non-use of expressive touch would bias the research data by making the patient unusually conscious of the nurse's use of touch. It was hoped that any reactions which would be expressed or observed might be more natural and hold fewer experimental biases if the patient's attention was not focused on the use of touch. This was accomplished by the investigator's explanation of the research. The bath time was chosen for observation in order to provide a context for data collection.

Research Questions

1. Will the elderly hospitalized patient notice the use or non-use of expressive touch by the nurse? Within a set of chosen variables, which variables will be associated with their noticing or not noticing?

2. What will be the subjective reactions of the elderly hospitalized patients to the use or non-use of expressive touch by the nurses? Within a set of chosen variables, which variables will be associated with these subjective reactions?

3. What effect will the use or non-use of expressive touch have on the ratio of personal/non-personal talk engaged in by the patient and the nurse during the instrumental touch portion of the research interaction?
4. What will be the subjective reactions of the nurses to the use and non-use of expressive touch when interacting with the patients?

**Limitations**

The following are limitations of this study:

1. The study was limited to evaluation of two nursing interventions scheduled during the patient's bath on consecutive mornings.

2. The investigator was unable to control the nurse's attitude toward the patient and the quality of care he/she received.

3. The investigator was unable to control the staffing patterns to ensure that no two nurses were involved in performing the control and experimental interactions in the same combination and order.

**Definitions**

Expressive touch: physical contact of the nurse's hand and the patient's hand or forearm for the purpose of communication not related to direct nursing care

Instrumental touch: physical contact between the nurse and the patient for the purpose of performing nursing care functions (Watson, 1975:104)

Intensity of personal/non-personal talk: the ratio of the number of times personal and non-personal talk was engaged in by the nurse and the patient during the instrumental touch portion of the interaction

Personal talk: any conversation encompassing topics which directly relates to the patient's life such as his/her children, spouse, symptoms, home, etc.
Non-personal talk: all other conversation covering topics not included in the definition of personal talk
CHAPTER 2

REVIEW OF LITERATURE

Touch

The history of touch is as old as man himself. The eastern religions have long used touch as a part of their healing culture. The Hindus and the ancient Greeks are but two of the civilizations who relied on massage and the therapeutic "laying on of hands" in their medical treatment (Zefron, 1975:350).

This therapeutic touch has been all but lost in the highly mechanized practice of western medicine. Machines diagnose and chemicals cure what was once only in the hands of the physician to heal.

Mechanization is perhaps not the only explanation for the loss of the healing art of therapeutic touch. Since the Victorian age and its associated purity and taboos against sexuality and magic, touch has been declining in acceptability (DeThomaso, 1971). During the Victorian period the pleasures associated with the body came to be forbidden. Man was encouraged to forsake physical pleasure for the attainment of a higher, more spiritual goal (Burton, 1964:125).

The Victorian purity, combined with the onset of the influence of Freudian psychology, firmly sealed the
disapproval of the use of touch as a healing art. Even as late as 1950, one of the then leading texts of psychiatry carried this caution:

At times it may be indicated and wise to shake hands with a patient or, in the case of a very disturbed person, to touch him reassuringly or not to refuse his gesture of seeking affection and closeness. However, it is always recommended that one be thrifty with the expression of any physical content (Fromm-Reichmann, 1950:12).

While some of the leaders in medicine and psychiatry were establishing and reaffirming the taboos against touch, other leaders were endeavoring to reverse this school of thought. Research with animals and human infants indicate that both respond to the presence or absence of physical contact in profound ways. In his classic research with animal behavior, Ashley Montagu (1953; 1971) observed the post-birth touch patterns of mothers and infants. He concluded that the licking of the animal infants by their mothers was essential to many bodily functions, especially in establishing the patency of the genito-urinary tract in the newborn. Montagu likened this post-birth licking in animals to the uterine contractions which occur during the birth of humans. He further concluded that if infants did not receive maternal touch they, similar to the animals he observed, would not develop fully, not so much physically as psychosocially.

Another researcher who observed animal behavior in an effort to determine the effects of maternal contact was Harlow (1959). In still another classic piece of research,
Harlow determined to measure the effect of maternal deprivation on infant rhesus monkeys. Using cloth and wire surrogate mothers, the fear response in the infants raised on each of the mothers was evaluated.

When Harlow introduced a fear-producing object into the cages of the infants he found that the infants who were raised on the cloth surrogate mothers ran to the mothers in a fright response. However, after a period of time with the mother, the infant was able to leave the mother and either begin exploring the fear-producing object or to ignore it and go on about other activities.

The infants who were raised on the wire mothers that provided no close bodily contact, did not return to the mother, but rather began to either rub against the side of the cage or to crouch and rock. Neither did these infants endeavor to explore the fear-producing object nor to return to other activities until the object was removed from the cage.

Harlow concluded that the wire surrogate mothers did not alleviate the fear in the infants as the cloth mothers had, and that this physical contact was essential for the infant monkeys to be able to develop a healthy response to fear-producing objects. The results "... indicate that the cloth mother provides a haven of safety and security for the frightened infant" (Harlow, 1959:425). These results were found to be enduring, even after the
infants were removed from their mothers for a period of time.

Research related to the use and importance of maternal touch has also been performed with human infants. Spitz (1945) compared infants who were raised in fondling homes, where the nurse to infant ratio was usually one to eight with little or no natural mother intervention, with infants raised in a nursery with the natural mother lavishing the infant with attention. During the first year of life the infants raised in the fondling homes were found to be developmentally retarded in comparison with the nursery raised children. The fondling home children also exhibited more abnormal reactions to strangers. The researchers were unable to account for any differences in environment that could explain the findings with the exception of the maternal deprivation variable.

Although there are more factors related to maternal deprivation than simply the lack of human touch, later research seems to support that touch does play a large role in the maternal-infant interaction. Premature infants who had been separated from their mothers at birth were studied to determine the effect of increased tactile stimulation. This stimulation was over and above the amount of touch which the infants received in the normal course of their care. Social development, as measured by the Gesell Development Schedule, was significantly increased in rate, but not in degree, in the infants who received the experimental
touch interaction (Kramer et al, 1975). Dominian (1971) similarly concluded that the use of maternal touch with the infant is associated with social development, more specifically with a sense of safety for the infant.

Rubin (1975) is considered a leader in nursing research related to maternal-infant touch. She observed the touching gestures of mothers with their newborn infants and discovered similarities between this touch and that found in other relationships. The mother begins the exploration of her infant by using her fingertips to touch the infant. The fingertips are usually used when the person initiating the touch is unsure of the receiver and how the message will be accepted. The touching then proceeds through a set pattern of touching gestures until body contact is made between the mother and infant as evidenced by the mother cradling the infant in her arms. The rate at which this pattern occurs depends on the response of the infant to each stage. Cannon (1977) utilized this framework in her own research and concluded there was a correlation between the rate at which a mother begins to explore and touch her infant and the rate at which she begins to know the infant.

Other researchers have also studied the types, forms and manifestations of maternal-infant touch (Clay, 1968; Barnett et al, 1970; Dunbar, 1977). Their findings are similar to those mentioned previously.

Researchers and theorists have been interested in the use and effects of touch on other age groups besides
infants. Hyperactive children have been, and are still, a group which has attracted the attention of researchers (Bauer, 1977a; Bauer, 197b). Emotionally disturbed children have also been observed. In a case study of a child with an emotional disturbance, Daly and Carr (1967) endeavored to measure the quantity of tactile contact between the child and the therapist. They observed that not only did the quantity of interactions increase with the use of tactile contact by the therapist, but also the quality of interactions changed from gross body contact to hand contact. As the quality and quantity of tactile contact increase, so did the quality of the verbal interaction.

Various researchers have been interested in the use of touch with adult patients also (Lynch, 1978; Krieger, 1975; 1976; McCorkle, 1974). Lynch (1978) reported the introduction of expressive touch into the care of patients with cardiac arrhythmias resulted in a change in the rate and rhythm of the heart of these patients. These changes were most often an improvement.

Krieger (1975; 1976), who has been responsible for reviving the interest in the healing powers of the "laying on of hands" concept among nurses, demonstrated a rise in the hemoglobin level of patients who were treated with this therapeutic touch. Krieger bases her use of touch on a concept known as "Prana" from Eastern philosophy. This type of touch is much more complicated than the actual physical contact of skin between two persons but deserves
mention at this point due to its increasing popularity and importance to the development of credence in the concept of touch.

In another study of seriously ill adult patients (McCorkle, 1974), there was not a significant increase of positive responses to the touching of nurses. Here, the researchers were not measuring a physiological change as were the previous studies cited, but were rather endeavoring to measure a psychosocial response. The authors concluded that the "findings suggest that it might be more realistic for a seriously ill patient simply to be less negative than more positive when touched." However, they reported that the touching did seem to exert "... a calming and comforting effect upon the patients" (McCorkle, 1974:131).

Adult in-patients in psychiatric units have also been observed (DeAugustinis et al, 1963) and experimentally studied (Aguilera, 1967) by nurses. Both of these studies support the previous findings cited that the use of nurses' touch with patients have a positive effect on the quality of the interactions. Even in studies with college freshman women (Boderman et al, 1972), this positive effect was demonstrated. The women who were exposed to the touch variable rated the experimenter as more likeable and preferable than those who did not experience touch.

Barnett (1972a) observed the touching behaviors of various categories of health workers in their interactions
with hospital in-patients. The amount and type of touch used by the health workers, the types of patients they touched, and where the patients were touched, were recorded. The health workers most often utilizing touch were registered nurses, 18-25 year olds, females and Caucasians. Those who touched the least were the Mexican-American health care personnel.

The types of patients that were most frequently touched were the 26-33 year olds, females and Caucasians. Touch on the hand was the most frequent location. Mexican-Americans and those patients 66-100 years of age received the least amount of touch from the health care workers. It is interesting to note that the Mexican-Americans both utilized and received touch the least frequently of all the ethnic groups measured. More important to this study was the lack of touch utilized in the care of the elderly adult patient.

Very little actual research has been published which relates directly to the impact of touch on the elderly person. Two such studies were found in the nursing literature.

In one study, DeWever (1977) was concerned, not so much with the specific psychological responses of the aged person to touch, but with the reaction to the types of touch which nurses utilize and the acceptability of this touch to the geriatric patient. She found that the elderly person in her sample was most comfortable with the nurse
who touched him/her on the hand or wrist as compared with touching a different portion of the body, such as the face or the shoulder. This research was based on that of Watson (1975) in which the same general conclusions had been reached.

The findings of studies with college age males and females may provide the basis for speculation on the reason for this attitude of elderly persons toward the touching practices of nursing personnel. Jourard (1968) administered the Body-Accessibility Questionnaire to over three hundred students and found that touching behavior was significantly higher among opposite sexed friends than same sexed friends or parents of either sex. This apparent learned context of touch as related to sexuality may carry over to the aged adult. Touching on the hand and/or forearm may be less threatening because it is the least likely part of the body to be related to sexuality and intimate contact.

Besides the research findings reported, Watson (1975) provided some important definitions of the touching behaviors which are performed by nurses. Instrumental touching is defined as "deliberate physical contact initiated to facilitate the performance of another act that is the primary aim of the initiator" (Watson, 1975:104). This definition is based on one similarly formulated by Morris (1964). Included in this definition is the touching which occurs when the nurse performs the following nursing care functions:
1. blood pressure measurement
2. temperature measurement
3. pulse rate measurement
4. medication administration
5. dressing changes
6. bathing
7. clothing changes
8. feeding
9. assistance with ambulation
10. assistance with elimination

Expressive touching is "relatively spontaneous and affective" (Watson, 1975:104). Touching that is utilized for communication and personality development fall into this category. Allekian (1973) explored patient's reactions to instrumental and expressive touch (these specific terms were not utilized by the researcher) and found that there was generalized indifference to both of these types of gestures.

On the item that describes aides holding the patient's hand, female patients had a mean score of 3.13. While this score is still within the stated range of neutral feelings, apparently the gesture was not welcome (Allekian, 1973:240). Allekian further reports that patients accepted the instrumental touch with indifference even when it involved caring for personal body parts. This was felt to be due to the necessity and importance of the treatments.

Despite the above findings other authors have continued to theorize on the use of expressive touch in communicating with the elderly. Burnside (1973; 1976:161-3; 1979:582-92) and Preston (1973) have contributed significantly to the amount of nursing literature related to touch and the elderly. Both argue for the importance of expressive touch in the continuing development of the aged.
person, and as a powerful tool of communication, especially among elderly persons who have suffered the loss of significant others and the loss of physical capabilities.

**Hospitalization**

The effects of hospitalization are as many and varied as the individual persons who are subjected to this experience. However, some factors are felt to be common to all persons who are hospitalized.

The most basic goal of each human being under normal circumstances is to stay alive, and so it follows that if there is something wrong with physical or psychological functioning, that, in itself, is a more than adequate cause of anxiety and fear (Walker, 1977:9).

Anxiety associated with hospitalization can cause a stress reaction which may develop into a crisis situation for both the patient and his family. This is dependent upon the seriousness of the illness, the more serious, the greater the stress (Stember, 1977), and the losses identified by the family and the family's coping mechanisms (Williams, 1974).

This anxiety was found to be significantly higher for the patient on the day of admission than any other day. Both depression and anxiety stayed elevated for up to five or more days after admission. After this length of time the patients reported a lessening in anxiety and depression as they began to feel more familiar with the ward personnel (Wilson-Barnett, 1978). At times, however, these feelings are not disclosed to the hospital staff or to the patient's
family. The patient presents a cheerful facade in an effort to hide the feelings of anxiety, fear, depression and loss of control (Levitt, 1975).

Loss is considered to be an important factor associated with the anxiety of hospitalization. Loss of control is associated with loss of privacy due to the necessary disclosure of personal information upon admission and during the hospital stay. Lack of knowledge and restrictions on independence (Saylor, 1977) and loss of roles within the family (Williams, 1974) are also considered anxiety producing during the course of hospitalization.

Loss of respect, feelings of anxiety and loneliness, and a sense of rejection have been found to be common sentiment among elderly persons admitted to hospitals (Pike, 1975). These feelings persisted even when the former patients were interviewed after their return to their home environment. However, some of these elderly persons did respond favorably to the hospitalization experience. These persons were felt to have a home situation that was less adequate in providing warmth, food and shelter than that provided by the hospital. Similarly, Volicer (1977) found that while elderly persons do experience stress during hospitalization, their level of stress is significantly lower than that experienced by the younger patients.

In a study (Laing, 1977) of patients who had been hospitalized due to a myocardial infarction, hospitalization was not rated as an overall negative experience. The
elderly patients in this sample viewed the hospitalization more positively than did the younger ones. This was interpreted to be due to comparatively increased dependency needs by the elderly person whose dependency needs were met by the staff of the hospital. The patients in this study were acutely-ill and experienced only short term exposure to the hospital. The nature of the illness may have had an important effect on the outcome. These elderly patients did not suffer the loss of income and jobs due to their illness and were perhaps more grateful to the hospital staff for their recovery at a time in life when death is so prevalent.

In other studies, illness has been shown to be more important to elderly subjects than to their younger counterparts. Utilizing the Holmes and Rahe Social Readjustment Rating Scale (SRRS) (1967), elderly persons were requested to rank order and assign a magnitude rating to the items (Muhlenkamp, Gress and Flood, 1975). These results were compared with the responses of the persons in the normative population in the original study, none of whom were over the age of 70. The elderly sample, ranging in age from 65 to 84, rank ordered "personal injury or illness" as fourth with a magnitude rating of 65. This compares with sixth and 53, respectively, by the normative population. Evidently the elderly in the sample viewed their own injury or illness as requiring a greater length of time necessary for adaptation than did the younger population.
While not specifically using the SRRS, Volicer (1975) utilized the technique for formulation of the tool in order to develop a Hospital Stress Rating Scale (HSRS). Lack of meaningful communication from hospital personnel was rated by these persons as highly stressful. This corresponds with previously cited research that loss of control was an important factor in contributing to stress among hospitalized patients.

Intrusion by the hospital staff on the patients' territorial space, as related to loss of control and rights of the patients, also causes anxiety and stress (Allekian, 1973). Territorial space was defined as that portion of the room which the person felt belonged to him/her for the duration of the hospitalization. Examples of territorial intrusion included moving the furniture and opening or closing the doors and windows by the staff without permission from the patient. Surprisingly, these same patients viewed intrusions of their personal space with indifference. Intrusions of "personal space - an area extending outward to a distance of four feet from the person's body" (p. 238) included both the acts of instrumental and expressive touch by the health workers. While the Allekian (1973) study was concerned primarily with the effects of hospitalization as an anxiety and stress producing experience, the general indifference to these acts of touch (intrusions of personal space) is relevant to the present research.
The difference in reactions to personal space intrusions and to territorial intrusions may be attributed to the fact that patients are somewhat prepared for personal intrusions but are unprepared for, and unwilling to submit readily to, territorial intrusions which may be seen as reducing their personal control, individuality, and identity (Allekian, 1973:241).

Hall (1966) identified the contact zones within which these interactions, cited above, occur. The intimate distance, zero to eighteen inches, is the zone in which comforting and protection occur. One and one-half to two and one-half feet is considered the close phase of personal distance. Within this zone, persons can easily touch each other but the distance is not as threatening to some as the intimate zone. It is within this zone that the majority of nursing interactions with patients occur. Evidently patients do not respond negatively to intrusion of this personal space when the action connected with the intrusion is appropriate and related to nursing functions.

Summary

This chapter outlines the important theory and research related to touch and hospitalization, the two major concepts of this study. The review of the literature reflects that touch is significant in interactions between all age groups. The calming effect of touch has also been shown to facilitate both positive physiological and psychological responses. It has also been hypothesized that touch is essential for the continued communication needs and development of the aging adult.
Research was also cited which shows that hospitalization produces anxiety, depression and stress among individuals. While conflicting reports have been presented regarding the intensity of this stress, it is generally accepted that the stress related to loss, does exist to some degree. Loss of significant others through the separation of hospitalization, may also contribute to this stress.

Elderly persons, who are experiencing the stress of hospitalization, may have subjective reactions to the use of expressive touch by the nurse. As demonstrated by the limited published literature available, these subjective reactions of elderly hospitalized adults to the nurse's use of expressive touch are unknown.
CHAPTER 3

METHODOLOGY

Design

An exploratory, or descriptive, approach was utilized in order to obtain the data necessary to answer the research questions. The research was designed, not to test hypotheses, but to determine what if any relationships existed between the concepts and variables identified (Diers, 1974:124-43). The concepts of instrumental and expressive touch were operationally defined, and the variables related to the characteristics of the sample were identified.

The research involved the manipulation of the independent variable of expressive touch. However, the condition of random assignment of each subject to either the control or experimental group could not be met due to the limited number of subjects available. In order to obtain the greatest amount of data possible the quasi-experimental repeated measures design was utilized. When manipulation of the independent variable is involved and randomization is not feasible, "this design has the advantage of assuring the highest possible degree of equivalence between subjects exposed to different conditions" (Polit and Hungler, 1978: 257).
In order to control for a carry-over effect on the subjects from one interaction to another counterbalancing was utilized. Half of the subjects received the experimental interaction first and the control interaction second. The remaining subjects received the interactions in reverse order.

**Setting**

The sample was chosen from patients admitted to the medical unit of a 100 bed private hospital in the Rocky Mountain West. The 33 bed medical unit is staffed by registered nurses, licensed practical nurses and nursing assistants. The unit was selected because the staff Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) are involved in giving direct patient care, including the patient's bath. Both RNs and LPNs were included in the study in an effort to obtain an adequate number of participants.

Consent for utilization of the facility for the research project was obtained from the Administrator and the Director of Nursing of the participating hospital (see Agency Participation Consent Form, Appendix B).

**Sample Population**

The sample was chosen from patients admitted to the medical unit who met the following criteria:

1. at least 65 years of age;
2. able to read, speak, understand and write English;

3. oriented to time, place and person;

4. not declared legally incompetent;

5. eligible for at least four consecutive days of hospitalization;

6. not receiving any narcotic or hypnotic medication within four hours prior to signing of the consent form and participating in the research;

7. not in a life-threatening condition; and,

8. admitted to the medical unit less than forty-eight hours prior to the first nursing interaction.

Demographic data were collected about the patients. This included the patient's age, sex, marital status, living status, past and present occupation, and ethnicity. The patient's diagnosis and amount of assistance the patient received from the nurse with his/her bath was also recorded.

Data were collected for a period of seven weeks, the time frame established by the nurse researcher before beginning the study. During this time, fifty-four patients aged 65 or over were admitted to the medical unit. Of these, thirty-two patients who met the criteria for inclusion in the study were contacted by the nurse researcher for participation. Seven of the thirty-two patients, four men and three women, denied consent. Two patients who had given consent were not included in the final results. One male patient was too well known to the staff nurse on duty,
who was participating in the research, to be included. The
second patient was excluded on the second day of the study
when a nursing assistant, who was not assigned to the
patient, inadvertently gave the patient's bath. A final
total of twenty-three patients participated in the study.

The sample ranged in age from 67 to 92 years with a
mean age of 76.4 years. There were fifteen females and
eight males. Eleven of the patients were widowed and twelve
were married. All of the married patients were living with
their spouses except one female patient whose husband was
living in a nursing home. There were no patients who were
single (never married), separated or divorced.

Thirteen patients lived with someone (not alone).
Besides the currently married mentioned above, this total
included one widowed subject who lived with a friend and
another who lived in a nursing home. The remaining widowed
subjects lived alone.

There is research which suggests that the occupa-
tional status of a person can affect his response to touch.
Usually persons of higher social status feel freer to touch
persons of lower status than the reverse (Henley, 1973).
As a possible explanation for the subjective reactions to
being touched data were collected regarding the patients'
former occupational status and coded against the rating
given nursing as an occupation. Using Treiman's Standard
International Occupational Prestige Scale (1977), the rela-
tive occupations of the sample were compared against nurses
as an occupation. It was found that only two of the sub-
jects in this sample had a higher occupational ranking. In
the case of such a small sample, two higher and twenty-one
lower than nurses, it was felt that any analysis would be
insignificant. Therefore, the occupational status ranking
is offered only as a part of the descriptive demographic
data.

All of the subjects in the sample were Caucasian.
Persons of other ethnic groups were admitted to the unit
during the research time frame. Unfortunately, they did
not meet the criteria for inclusion in the sample.

The patients' admitting diagnoses were recorded in
the expectation that there might be an association between
seriousness of illness and response to expressive touch.
The diagnoses were coded using the Seriousness of Illness
Rating Scale (SIRS) (Wyler, Masuda and Holmes, 1968). The
SIRS rank orders illnesses from least serious (1), dandruff,
to most serious (126), leukemia.

Volicer and Bohannon (1975) used the SIRS to cate-
gorize illnesses as either major or minor. Numbers one to
seventy-six were defined as minor and those over seventy-
seven as major. Any diagnosis not contained in the original
list were presented as unclassified.

Volicer and Bohannon's technique was applied to
this research sample. Sixteen patients had diagnoses of
major illness magnitude, three were minor and four were
unclassified. Again, due to the small sample these data
serve a descriptive role only. It should be noted, however, that 70 percent of the sample patients were suffering from a "major" illness.

The information related to the amount of assistance which the nurse gave the patient with his/her bath was also recorded. Initially, four categories of assistance were established: no assistance, assistance only with washing the patient's back, no assistance except perineal care and total assistance. These categories of instrumental touch proved to yield too few numbers of subjects per category for discussion. Therefore, the assistance level classifications were collapsed into the two categories of without (no assistance) and with (the remaining three categories) assistance.

Seventeen persons received some or total assistance from the nurse with their baths, six required no assistance.

The nurses in the study ranged in age from 26 to 50, with a mean age of 41. Five were LPNs, three RNs. Six were Caucasian, and two were non-Caucasian (one Mexican-American and one Black).

**Procedure**

Originally the patients who fulfilled the criteria for sample selection were to be approached the morning after the day of admission for inclusion in the study that day. However, this often required a change of nursing assignments that morning. It became too confusing for the staff to follow this protocol. As requested by the patient care
managers, the investigator approached the patients on either the day of admission, if admitted prior to three o'clock when assignments for the next day were made, or the first day after admission for inclusion in the study.

The investigator identified herself as a graduate nursing student from the University of New Mexico. The patients were told that, as a part of her class work, she was asking patients to evaluate two different techniques for giving baths. They were informed that participation was voluntary and that the nurses who would be giving them baths, or assisting them with their baths, were employees of the hospital. It was reinforced at this point that the investigator was not an employee of the hospital and that anything the patients said would be held anonymous. The patients were assured that anything said in regards to the evaluation of the individual nurses would not be reflected on their job performance records.

If written consent was obtained (see Appendix A) patients were told that the investigator would return the following morning. If consent was denied, the patients were thanked for allowing the investigator the time to talk with them.

The patients who consented to participate were assigned, on an alternating basis, beginning with the experimental interaction, to receive either the control or the experimental intervention the following morning. At the
second bath the patient received the alternate interaction. The two baths were given by two different nurses.

The staff nurses were assigned to the patients according to whoever was on duty that day. The nurses had not cared for the patient prior to the morning of the interaction. Prior to the bath, the nurse's contact with the patient was minimal and limited to procedures which utilized only instrumental touch.

The following are the procedures for the control and the experimental interactions:

**Control Interaction Protocol**

The control interaction protocol was as follows:

1. The staff nurse greeted the patient by name and introduced herself. Last names preceded by the appropriate titles were utilized.

2. The staff nurse sat in a chair next to the patient within arm's length and conducted personal talk for 2-5 minutes.

3. The staff nurse carried out the nursing functions related to the patient's bath. This constituted the instrumental touch portion of the interaction.

4. The investigator made general notes of the nature of the discussion between the nurse and the patient.

5. The staff nurse finished the interaction with another 2-5 minutes of personal talk, again being seated within arm's length of the patient.
Experimental Interaction Protocol

The experimental interaction protocol was as follows:

1. The staff nurse greeted the patient by name and introduced herself. Last names preceded by the appropriate titles were utilized.

2. The staff nurse sat in a chair next to the patient within arm's length and conducted personal talk 2-5 minutes while engaging in expressive touch.

3. The staff nurse carried out the nursing functions related to the patient's bath. This constituted the instrumental touch portion of the interaction.

4. The investigator made general notes of the nature of the discussion between the nurse and the patient.

5. The staff nurse finished the interaction with another 2-5 minutes of personal talk and expressive touch, again being seated within arm's length of the patient.

After the second bath the investigator administered the Post Interaction Interview. When all of the interactions had been completed, the staff nurses were requested to respond to the Nurse Participant Interview.

Data Collection

The review of the literature showed that the area to be investigated was relatively unresearched in the particular aspect of interest. However, as the concepts of instrumental and expressive touch had been operationally
defined, the instruments utilized in this study were
designed according to the criteria for conducting "Relation-
Searching Studies" (Dyers, 1979:124-43).

The instruments were designed to obtain the data
necessary to answer the research questions. The data was
gathered by means of utilizing the instruments in an inter-
view approach and by non-participant observations. All
responses and observations made during the interactions
were recorded on the Data Collection Tool (see Appendix C).

Post Interaction Interview

The Post Interaction Interview (PII) was formulated
by the nurse researcher to answer the research questions
related to patients' responses to nurses' use or non-use of
expressive touch. The PII was administered after the com-
pletion of the second bath and interaction. After the
patient had responded to the PII, he/she was told the exact
intent of the study and invited to ask any questions. No
recording of comments or questions occurred after the de-
briefing.

The following questions constituted the PII:

1. Did you notice (perceive) any difference in your
bath between today and yesterday?

2. If yes, what was the difference?

3. Did you notice that one nurse touched you on the
hand and/or forearm (or held your hand) and the other did
not when she sat and talked with you?
4. How did you feel when the nurse touched you on the hand and/or forearm (or held your hand)?

5. How did you feel when the nurse did not touch you on the hand and/or forearm (or hold your hand)?

Nurse Participant Interview

This three item interview was composed by the nurse researcher to determine nurses' attitudes about the use of expressive touch. The interview was administered in oral form to the staff nurses who participated in the research study. The responses were recorded verbatim and only answers to the questions were included. Ad hoc conversation was not entered as data.

The following questions constituted the NPI:

1. How did you feel about participating in the study?

2. How did you feel when you were instructed to use expressive touch when talking with the patient?

3. How did you feel when you were instructed not to use expressive touch when talking with the patient?

Data Analysis

Due to the descriptive nature of the data, it was necessary to devise a method for classification and enumeration of the subjective responses. The technique chosen for handling the data was content analysis. Content analysis is considered the most appropriate method for identifying themes common in narrative data (Walizer and Wiener, 1978:343-9).
The data was classified into major themes and then categorized according to subthemes when appropriate. The Post Interaction Interview responses were then coded by two faculty members with medical-surgical nursing expertise to determine interrater reliability with the investigator. Questions 1 and 3 were not subjected to the panel of raters as the responses were only "yes" or "no."

After the first individual coding interrater reliability was less than .80. The panel therefore met as a group to discuss the discrepancies and to determine if further explanation was necessary. The responses to Question two had initially been given to the coders with the type of interaction (no touch or touch) accompanying the statement. The raters felt this information biased their judgments. Once the connotation of the responses were removed, interrater reliability on Question 2 was 1.00. Interrater reliability on Questions 4 and 5 were .91 and .86 respectively.

The responses to the Nurse Participant Interview were not subjected to the interrater panel for several reasons. The responses were very straightforward. Key words were utilized to form the categories. This data was not reported as being association with any other variable. The investigator and a senior researcher analyzed the data and established the categories as reported.

The categorical responses identified from the research questions were subsequently subjected to analysis.
of relative frequency (Mendenhall, 1975:20-4). The frequency of responses for each category are presented and compared with the responses within each of the variables identified. The responses within the chosen set of variables are reported only if they deviated from the total categorical responses by ten percent (10%), either higher or lower.

Limited statistical analysis of significance was performed on the data to provide an indication of the likelihood that the responses within each category could have occurred by chance. The type of data which resulted from the content analysis was nominal in nature. The appropriate nonparametric test of significance for this type of data is the Chi Square One-Sample Test (Siegel, 1956:42-57). Only those statistical analysis of the overall categorical responses which resulted in $\alpha > 0.05$ are accepted as significant and correspondingly reported.

To determine the ratio of personal to non-personal talk engaged in by the patient and the nurse during the instrumental touch portion of the interaction, each type was first assigned an arbitrary value. The values chosen were one for non-personal and two for personal. The amount of times non-personal or personal talk occurred was multiplied by its respective value and the two were added together. This figure was then divided by the total number of conversation topics to yield the ratio. If the total was less than 1.5, the entire interaction was classified as
having non-personal overtones. Those equal to or greater than 1.5 were designated personal in nature.

Summary

The patients in the sample were hospitalized, ranged in age from 67 to 92, married or widowed, living alone or with someone, generally of lower occupational status than the nurses and admitted with a diagnoses which constituted a major illness in over 70 percent of the cases. Description of the nurses was also presented.

Procedures utilized, including the protocol for the control and experimental interactions and the instruments for measuring the variables identified, were discussed. Data analysis which was performed was reviewed.
CHAPTER 4

RESULTS AND DISCUSSION

The problem investigated in this study was to determine the subjective reactions of elderly hospitalized patients and nurses to the use of expressive touch by the nurses. The lack of available information and instrumentation relevant to this problem shaped the methodology. Open-ended questions were utilized to obtain the descriptive data which could be classified into categorical themes.

The study was formulated as a repeated measures quasi-experimental design with each subject serving as his/her own control. The subjects received both the control and experimental intervention. The bath was chosen as the unit of study in an effort to make a clearer distinction between instrumental and expressive touch. Instrumental touch, by definition, is the type of touch which the nurse utilizes while assisting the patient with his/her bath. Expressive touch, in contrast, is used when the nurse is not performing specific nursing procedures, but when she is communicating with the patient in a mode other than these procedural functions.

After the subjects received both the control and the experimental interactions, data were collected from the subjects using the Post Interaction Interview. The nurses
responded to the Nurse Participant Interview upon completion of all the interactions.

Selected descriptive variables were identified prior to the beginning of the study and data from each subject were collected. The subjects' ages, diagnoses, ethnicities and occupational status were presented in Chapter Three as part of the descriptive subject data and will be treated only as descriptive data. Sex, marital status, living status and assistance level of the patient will be presented with the results of the interviews to determine what, if any, association exists between these variables and the subjective responses of the patients.

The age and licensure level of the nurses were similarly presented in Chapter Three. Only the ethnicity of the nurse will be utilized in the data presentation and discussion and only in relation to the responses of the patients to the Post Interaction Interview.

The results of the selected descriptive variables, the Post Interaction Interview and the Nurse Participant Interview are presented in this chapter. A discussion of the results is included. The data are presented according to the research questions asked.

**Question One**

Question One: Will the elderly hospitalized patient notice the use or non-use of expressive touch by the nurse?
Within a set of chosen variables, which variables will be associated with their noticing or not noticing?

None of the subjects spontaneously noted they had been touch "expressively." Even those subjects who noticed some kind of difference between the two baths did not attribute the difference to the use or non-use of expressive touch by the nurse.

Noticed Some Kind of Difference

Twelve (52%) of the twenty-three subjects responded affirmatively to "Did you notice (perceive) any difference in your bath between today and yesterday?". Within the chosen set of variables, some differences were found in the response patterns (see Appendix D).

Males and females had differing response patterns. The females were evenly divided between noticing some kind of difference and not noticing. The male responses suggested a trend toward noticing more often than not. Sixty-three percent (63%) of the males noticed some difference between the baths.

Married persons noticed some kind of difference more often (67%) than did their widowed counterparts. However, the pattern of noticing or not noticing some kind of difference between the baths did not vary according to the subject's living status or assistance level.

The ethnicity of the nurse was only important to whether the subject noticed or did not notice a difference
when the non-Caucasian nurse performed the expressive touch interaction. Eighty-three percent (83%) of the patients who received the expressive touch interaction from the non-Caucasian nurse noticed some kind of difference. When any other combination of nurse ethnicity and use or non-use of expressive touch occurred the subjects were more evenly divided in their responses.

Type of Difference Reported Between the Baths

Subjects who said they noticed some difference were asked to specify what the difference was. While twelve patients noticed a difference there are thirteen items reported in the data. One patient gave two codable responses.

The responses were classified into two major categories: the evaluative tone of the statement and the content of the statement. The themes identified for each category are:

A. Evaluative Tone of the Statement
   1. Touch Nurse More Positive
   2. Touch Nurse More Negative
   3. No Touch Nurse More Positive
   4. No Touch Nurse More Negative

B. Content of the Statement
   1. An evaluation of the task function of the nurse
   2. An evaluation of the personality of the nurse
3. A comment on the activity level of the patient

The "touch" nurse refers to that nurse who utilized expressive touch in the interaction. The "no touch" nurse refers to the nurse who did not utilize expressive touch in the interaction.

Statements given by the patients, such as "This bath wasn't as thorough," reflected an evaluation of the task function of the nurse. An evaluation of the personality of the nurse was found in the response of "The second nurse was more interested in me." Only one patient made a comment on his/her activity level. This statement was "Today I was able to do more as my IV was taken out."

The tabulation and frequency of the responses of both categories, evaluative tone and content, are presented in Table 1. The Chi-Square One-Sample Test for the column

Table 1

<table>
<thead>
<tr>
<th>Type of Difference Reported Between the Baths</th>
<th>CONTENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Task Function</td>
</tr>
<tr>
<td>EVALUATIVE TONE</td>
<td>N %</td>
</tr>
<tr>
<td>Touch Positive</td>
<td>2 (15%)</td>
</tr>
<tr>
<td>Touch Negative</td>
<td>2 (15%)</td>
</tr>
<tr>
<td>No Touch Positive</td>
<td>3 (23%)</td>
</tr>
<tr>
<td>No Touch Negative</td>
<td>2 (15%)</td>
</tr>
<tr>
<td>Total</td>
<td>9 (68%)</td>
</tr>
</tbody>
</table>
totals was significant at $\alpha > 0.025$. This is indicative that, though the patients could have responded with any type of content statements, the type of difference they reported between the baths was significantly more often related to the evaluation of the task function of the nurse.

Considering first the evaluative tone of the statements, the responses appeared to be evenly divided among the four themes identified (see Table 1). The overall evaluative tone of the type of difference responses reported between the baths did not indicate that the patients viewed the nurses who utilized or did not utilize touch either more negatively or more positively.

With respect to the associations between the selected variables of sex, marital status, living status, assistance level and the ethnicity of the nurse, and the evaluative tone of the statement, several trends might be suggested (see Appendix E for raw data tabulation). Fifty percent (50%) of the females responded with statements that were more positive toward the nurse who did not utilize expressive touch. Conversely, the males were more positive (40%) toward the nurses who did utilize expressive touch and more negative (40%) toward the nurses who did not.

There was a trend among the widowed respondents to be more positive toward the "no touch" nurse. Married persons tended to make statements which were slightly (34%) more positive about the "touch" nurse.
Subjects living "not alone" were evenly divided among the four evaluative tone responses. Persons living alone tended to rate the "no touch" nurse slightly more positively.

The assistance level of the patient suggested limited patterns of responses between the amount of assistance given to the patient during his/her bath and the evaluative tone of the statements. Persons who received assistance tended to be more positive toward the "no touch" nurse. Those subjects who received no assistance with their bath made no positive statements about the nurse who did not utilize expressive touch.

The six persons who reported some type of difference between the baths received the expressive touch interaction from the non-Caucasian nurse. Only one of these six rated this nurse positively. However, three persons (50%) rated the nurse who did the corresponding (no touch) interaction more positively, even though the nurse who did this corresponding "no touch" interaction was also non-Caucasian in two of these three interactions.

The data suggests that patients are generally more accepting of the non-Caucasian nurse's non-use of expressive touch than his/her use. It should be noted that regardless of the evaluative tone of the statement response, when the non-Caucasian nurse utilized touch, the patients noticed a difference between the baths in eighty-three percent (83%) of the cases (see Appendix D).
With respect to the content of the statement categorical responses, an evaluation of the task function of the nurse was cited most frequently (68%) over the evaluation of the personality of the nurse or the activity level of the patient as the difference noticed between the two baths. There were patterns of responses suggested between the evaluation of the task function response and the selected variables of sex, marital status, living status and those patients who received physical assistance with their baths. Of the twelve subjects who reported some type of difference between the baths, nine had received assistance and three had not. Eight of the nine who received assistance responded with a task function evaluation. However, of those who received no assistance, two evaluated the personality of the nurse and only one the task function (see Appendix E for raw data tabulations).

While these responses are few in numbers they may suggest a trend. Maslow's (1968) hierarchy of needs theory may be applicable to these findings. A patient who is in a dependent position must rely on the nurse to fulfill his/her physical needs, such as the bath, before he/she can be concerned with the meeting of the psychosocial needs. The task function is more closely associated with meeting physical needs than the need to comment on the nurse's personality.

The ethnicity of the nurse was strongly associated with the content of the statement categorical responses.
One hundred percent (100%) of the statements made about the non-Caucasian nurse who utilized expressive touch were an evaluation of the task function of the nurse. However, all these six patients had also received physical assistance with their baths.

Those statements made about the Caucasian nurse who utilized expressive touch were evenly divided between the task function of the nurse and the personality of the nurse. When these nurses did not utilize expressive touch, the type of difference reported between the two baths more closely resembled the overall total frequencies for all subjects.

The nature of the responses might be attributed to the manner in which the research was initially presented to the subjects. The subjects had been told they would be evaluating the difference between two techniques of giving baths (see Patient Participation Consent Form, Appendix A). This was coupled with the investigators note taking during the entire interaction. Therefore, when the subjects were asked what difference they noticed between the two baths, they might have felt the investigator wanted them to evaluate the task function of the nurse. Any other type of response, especially the use or non-use of expressive touch, might have been contrary to the possible response set created by the investigator.
Noticed Touch

After the subjects had responded to the questions regarding noticing some difference between the two baths, they were specifically asked if they noticed the use or non-use of expressive touch by the nurses. Even though none of the subjects mentioned the use or non-use of expressive touch as the difference noticed between the two baths, it is important to note that sixteen (70%) of the twenty-three subjects responded affirmatively to noticing the expressive touch when questioned directly about it.

The selected variables of sex, marital status and living status were associated with the noticing or not noticing the use of expressive touch by the nurse. These associations were at approximately the same frequency as the overall totals for noticing (70%) and not noticing (30%) the touch (see Appendix F for raw data tabulation).

Those persons who received no assistance with their baths were equally divided between noticing and not noticing the touch. The frequency of the responses of those subjects who had assistance more closely resembled the overall totals given above.

The ethnicity of the nurse was also a factor in the associations between this variable and the patients' responses. Only when the nurse who utilized touch was Caucasian did the patients respond similarly to the overall total frequencies. However, when the Caucasian nurse did
not utilize expressive touch, the patients were equally divided in their noticing or not noticing. The subjects were more aware (83%) of the interaction when the non-Caucasian nurse was involved.

There was a relatively high percentage (70%) of patients who did notice the use or non-use of expressive touch considering that no one mentioned touch as the difference noticed between the two baths. A response set may have been created which explains this high incidence of noticing the touch. The patients were specifically asked if they had noticed the touch. Since the patients were not asked if they had noticed anything else about the baths, they may have felt this was important to the investigator.

**Question Two**

**Question Two:** What will be the subjective reactions of the elderly hospitalized patients to the use or non-use of expressive touch by the nurse? Within a set of chosen variables, which variables will be associated with these subjective reactions?

Even subjects who reportedly had not noticed the expressive touch responded with a reaction to the use or non-use of expressive touch by the nurse when questioned specifically about the use and non-use of expressive touch. These responses varied from indifference to negative evaluations of the nurses. The specific responses to the use and
non-use of expressive touch will be presented individually.

Subjective Reactions to the Use of Expressive Touch

The responses to "How did you feel when the nurse touched you on the hand and/or forearm (or held your hand)?" were classified into the following four categories:

1. Claimed indifference by the patient
2. A positive evaluation of the nurse's personality
3. A positive feeling engendered in the patient
4. Both a positive evaluation of the nurse's personality and a positive feeling engendered in the patient

Such statements as "It made me feel someone cares," "It makes me feel they are interested in me" and "It gives you a good feeling" are examples of the positive feeling engendered in the patient. "It felt like she was caring" reflects the type of statement which gave a positive evaluation of the nurse's personality. There were no negative statements made.

Seven (30%) of the subjects claimed indifference to the use of expressive touch by the nurse. The remaining sixteen responses had a positive evaluative tone. Ten of the sixteen patients who gave a positive response reported this was a positive feeling engendered in them by the touch of the nurse. Even some subjects who had initially not
noticed the touch responded with positive feelings (see Table 2).

Table 2

Subjective Reactions to the Use of Expressive Touch by Persons who Noticed and did not Notice the Use of Expressive Touch

<table>
<thead>
<tr>
<th></th>
<th>Evaluation</th>
<th></th>
<th>Feeling</th>
<th>Both</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Indifference</td>
<td>Personality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NOTICED TOUCH</td>
<td>N %</td>
<td>N %</td>
<td>N %</td>
<td>N %</td>
<td>N %</td>
</tr>
<tr>
<td>Yes</td>
<td>4(16.7%)</td>
<td>3(13.3%)</td>
<td>7 (30%)</td>
<td>1 (10%)</td>
<td>16 (70%)</td>
</tr>
<tr>
<td>No</td>
<td>3(13.3%)</td>
<td>-</td>
<td>3(13.3%)</td>
<td>2 (3.3%)</td>
<td>7 (30%)</td>
</tr>
<tr>
<td>Total</td>
<td>7 (30%)</td>
<td>3(13.3%)</td>
<td>10(43.3%)</td>
<td>3(13.3%)</td>
<td>23(100%)</td>
</tr>
</tbody>
</table>

The responses were first categorized with an evaluative tone of neutral, positive and negative. However, only the indifference statements proved to be of a neutral nature. The personality and feelings engendered statements were all positively coded. No negative connotations were found in these responses.

The categorical responses of the subjective reactions to the use of expressive touch were analyzed according to the selected variable list. The result yielded few numbers of responses per category. For this reason, interpretation is limited (see Appendix F for raw data tabulations).
The association between the responses and the variables of sex, marital status and living status corresponded closely with the total categorical responses (see Total Subjective Reactions, Table 2). Persons who had received no physical assistance with their bath varied from the total frequencies by giving more positive feeling (50%) and positive combination (both personality and feeling) (33%) statements. These persons did not make any statements which related only to the nurse's personality.

The total categorical responses were also associated with the ethnicity of the nurse. Patients who received the expressive touch interaction from the non-Caucasian nurse gave only one statement of indifference as compared with six for the Caucasian nurses. The patients also gave more positive statements about the personality of the non-Caucasian nurse than either for the Caucasian nurse or the overall categorical totals.

Subjective Reactions to the Non-Use of Expressive Touch

Subjects also responded to "How did you feel when the nurse did not touch you on the hand and/or forearm (or hold your hand)?". In an effort to make a comparison between the subjective responses of the patients to the use and non-use of expressive touch by the nurses, it was hoped the same categorical responses could be applied to both questions. However, with the exception of the indifference claimed by
the patients, the subjective feeling responses to the non-use of expressive touch were not of the same nature as those for the use of expressive touch.

The responses to the non-use of expressive touch did reveal both an evaluative tone and a content of the statement classification. The categories for each classification are:

A. Content of the Statement
   1. Claimed indifference by the patient
   2. A justification for the nurse's not touching the patient

B. Evaluative Tone of the Statement
   1. Neutral connotation
   2. Positive connotation
   3. Negative connotation

The subjects who responded with other than indifference did so in a manner which included a justification for not being touched by the nurse. These justification responses included such statements as "It isn't necessary for them to do that" and "It wasn't in her nature."

The tabulation and frequency responses are presented in Table 3. Chi Square One-Sample Test for the column totals was significant at $\alpha > 0.005$. This means that patients were significantly more neutral toward the non-use of expressive touch by the nurses than they were either positive or negative.
<table>
<thead>
<tr>
<th>CONTENT</th>
<th>EVALUATIVE TONE</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Neutral</td>
<td>%</td>
<td>Positive</td>
<td>%</td>
<td>Negative</td>
<td>%</td>
</tr>
<tr>
<td>Claimed Indifference</td>
<td>13 (57%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Justification</td>
<td>5 (22%)</td>
<td>2 (8%)</td>
<td>3 (13%)</td>
<td>10</td>
<td>(43%)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>18 (79%)</td>
<td>2 (8%)</td>
<td>3 (13%)</td>
<td>23</td>
<td>(100%)</td>
<td></td>
</tr>
</tbody>
</table>

With respect to the content responses females, persons married and widowed, those living alone and "not alone" and persons receiving assistance with their baths gave responses regarding the non-use of expressive touch which were reflective of the overall frequencies. The remaining selected variables (males, subjects who had no assistance with their baths and the ethnicity of the nurse) had patterns of responses which were different from these totals (see Appendix F for raw data tabulation).

Male subjects gave more justification (63%) than indifference statements. Their responses were almost inversely proportionate to the responses of the females.

Subjects who performed their own baths without assistance from the nurse responded to the nurse's non-use of expressive touch with indifference in five out of six instances. Persons who received assistance were more
evenly divided between being indifferent and providing a justification for not being touched.

The association of the ethnicity of the nurse and the content of the statement also varied from the overall total responses. When the Caucasian nurses did not utilize expressive touch, the subjects were more indifferent (75%) than when the non-Caucasian nurse was involved in this same type of interaction. Subjects were more likely to give a justification (64%) for the non-Caucasian nurse’s non-use of expressive touch.

The statements given about the nurse's non-use of expressive touch also revealed an evaluative tone component. As noted previously, these were either neutral, positive or negative. Neutral statements were generally (57%) those which also reflected indifference on the part of the patient.

Only three of the statements revealed a negative connotation. Two of these negative statements caused disagreement in coding among the interrater panel. Two of the raters felt the statements in question were negative, while the third person argued strongly in favor of a neutral rating. The statements under dispute were "This nurse is colored and they are funny that way, but it really doesn't make any difference" and "I never thought of it. She was interested in me but she is colored and I understand her position."

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The ethnic connotations of these statements may be interpreted differently depending on the background of the rater. This was evidenced by the discussion among the panel. However, due to the predominately rural western setting of the study, and the relative lack of minorities in the geographic area, the statements were judged by the investigator to have a negative connotation. The third statement which was listed as being negative was coded unanimously by the interrater panel.

Only those persons who lived "not alone" and both categories of assistance level had response pattern frequencies similar to the overall totals of neutral (79%), positive (8%) and negative (13%). The remaining variables (sex, marital status, subjects living alone and the ethnicity of the nurse) showed different patterns of responses.

Females were more often neutral about the non-use of expressive touch by the nurses than the males. While two of the males responded positively, none of the females did so. The three negative responses were made by two of the males and the one female who was not neutral.

Widowed persons and those living alone were neutral ninety percent (90%) and positive ten percent (10%) of the time. Neither gave any negative statements. Their married and living "not alone" counterparts were similarly more neutral but less so (67% and 69% respectively). These latter two groups of persons were responsible for all three of the negative comments.
Patients were generally indifferent to both the Caucasian nurses and the non-Caucasian nurses omitting expressive touch. However, all three of the negative statements were made in reference to the non-Caucasian nurses who did not utilize expressive touch.

**Total Evaluative Tone of the Subjective Reactions to Both the Use and the Non-Use of Expressive Touch**

To determine the overall evaluative tone of all of the statements given about the use or non-use of expressive touch, the data from Tables 2 and 3 were combined (see Table 4). The Chi-Square One-Sample Test for the column totals was significant at $\alpha > 0.005$. When all the statements about the use or non-use of expressive touch are combined subject are significantly more neutral than either positive or negative

**Table 4**

Subjective Reactions to the Use and Non-Use of Expressive Touch

<table>
<thead>
<tr>
<th>EVALUATIVE TONE</th>
<th>Neutral</th>
<th>Positive</th>
<th>Negative</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONTENT</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Claimed Indifference</td>
<td>20 (43%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Evaluation Nurse Personality and/or Feeling</td>
<td>-</td>
<td>-</td>
<td>16 (34%)</td>
<td>-</td>
</tr>
<tr>
<td>Justification</td>
<td>5 (11%)</td>
<td>2 (5%)</td>
<td>3 (7%)</td>
<td>10 (23%)</td>
</tr>
<tr>
<td>Total</td>
<td>25 (54%)</td>
<td>18 (39%)</td>
<td>3 (7%)</td>
<td>46 (100%)</td>
</tr>
</tbody>
</table>
Of the total forty-six statements given by the twenty-three subjects (one for each the use and non-use of expressive touch) only three (7%) were of a negative quality. It should be remembered that two of these three negative statements were disagreed upon by the interrater panel.

These findings are consistent with other reports of difficulty in eliciting any negative responses from patients when satisfaction with nursing care research is performed (Kramer, 1972; Nehring and Geach, 1973; Hale, 1974). Apparently, as the data suggest, if patients cannot respond positively, they will declare neutrality over negativism.

**Question Three**

Question Three: What effect will the use or non-use of expressive touch have on the ratio of personal/non-personal talk engaged in by the patient and the nurse during the instrumental touch portion of the research interaction?

The investigator intuitively felt from past observation between nurses and patients that the use of expressive touch by the nurses might have an effect on the type of talk (personal vs. non-personal) engaged in by the patients and the nurses during the instrumental touch portion of the interaction. This was not borne out (see Table 5).

The data revealed that the majority of the conversation (86%) in either type of bath was personal in nature. It should be noted that the nurses were instructed to utilize only personal talk during the initial portion of both
Table 5
Effect of Expressive Touch on Type of Communication

<table>
<thead>
<tr>
<th>CHARACTERIZATION OF COMMUNICATION</th>
<th>Non-Personal</th>
<th>Personal</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>TYPE OF INTERACTION</td>
<td>N  %</td>
<td>N  %</td>
<td>N  %</td>
</tr>
<tr>
<td>Expressive Touch Used</td>
<td>3 (7%)</td>
<td>20 (43%)</td>
<td>23 (50%)</td>
</tr>
<tr>
<td>Expressive Touch Not Used</td>
<td>3 (7%)</td>
<td>20 (43%)</td>
<td>23 (50%)</td>
</tr>
<tr>
<td>Total</td>
<td>6 (14%)</td>
<td>40 (86%)</td>
<td>46 (100%)</td>
</tr>
</tbody>
</table>

the "touch" and "no touch" interactions. This initial tone of the conversation most likely carried through into the instrumental touch portion of the interaction. Even though the nurses were specifically instructed to do and talk about whatever they normally would during the bath, the presence of the investigator during the instrumental touch portion of the interaction could have created a set tone of conversation in favor of the personal talk.

Although there were only twenty-three subjects, each received both a "touch" and "no touch" interaction. Both interactions were coded to yield the total of forty-six.

**Question Four**

Question Four: What will be the subjective reactions of the nurses to the use and non-use of expressive touch when interacting with the patients?
After the completion of all the patient interactions, the Nurse Participant Interview was administered to each nurse. The responses to all three questions were recorded and classified separately.

Subjective Reactions to Participation in the Study

Like the patients, the nurses did not mention the use or non-use of expressive touch as a subjective reaction to participating in the study. However, five predominate themes were extracted from the statements. Although there were only the eight participating nurses who responded to the interview, some nurses expressed more than one type of reaction. All of the reactions can be categorized under the major heading of discomfort and further sub-categorized according to the nature of the discomfort experienced by the nurses as a result of being in the study.

Two nurses responded that the study caused them discomfort with being observed by the investigator. Sitting with the patient and talking with the patient was reported by six of the nurses as creating discomfort for them. Four of these six nurses felt that it was both the sitting and the talking which was uncomfortable.

The study was evaluated to be very time consuming by three of the nurses. One nurse did not cite any of the previous four reactions but only responded "I was nervous at first, but then I became more relaxed."
Subjective Reactions to the Use of Expressive Touch

When questioned specifically regarding their reaction to being instructed to utilize expressive touch in their interactions with the patients, six of the nurses felt they had no difficulty with the expressive touch. Although two of these nurses had no difficulty with the touch, they further stated they felt the study situation of sitting and talking was contrived and unnatural.

The remaining two nurses responded that the ease of the use of touch depended on the individual patient. One of these nurses had difficulty touching only one particular subject during the entire research study. This patient established a physical barrier between himself and the nurse by placing the overbed table directly in front of him as he sat on the edge of the bed. The nurse was unable to sit next to him and utilize expressive touch as outlined in the experimental interaction protocol. She later stated that she felt he was trying to prevent this physical contact with the nurse. During the final portion of the interaction, after the patient had taken his shower and was again seated in the afore mentioned manner, the nurse stood next to him and placed her hand on his arm. When she had completed the interaction and began to leave the patient's bedside, he grabbed her arm and continued to talk with her. This patient subsequently responded with a statement that was both a positive evaluation of the nurse's personality and
a positive feeling engendered in the patient as a reaction to the use of expressive touch by the nurse. He also responded with indifference to the nurse's non-use of touch the previous day.

Subjective Reactions to the Non-Use of Expressive Touch

Seven of the nurses stated it was difficult not to touch the patients. Only one nurse responded with indifference to not utilizing expressive touch when interacting with the patients. This nurse was one who felt the ease of use of expressive touch depended upon the particular individual patient.

Two of the nurses who stated it was difficult not to touch the patients were actually observed by the investigator having this difficulty. In one instance, one of these nurses folded her hands in her lap to prevent her from spontaneously touching the patient during the final interaction. She clenched her hands together so tightly that her knuckles actually turned white.

As another of the staff nurses was preparing to leave the patient's room she reached over to pat the patient on the shoulder. Just prior to actual physical contact, the nurse turned toward the investigator as if suddenly remembering the nature of the study. She stopped her hand in mid-air and patted the air next to his shoulder. As the interaction was pre-defined as a non-use of expressive touch, no contact was made.
Summary

This chapter presented the results of the interviews with the elderly hospitalized patients and the nurses. The responses to the Post Interaction Interview and the Nurse Participant Interview were discussed according to their relationship to the set of chosen descriptive variables. The subjective reactions to the interviews and investigator notes, taken during the instrumental touch portion of the interaction, were utilized to answer the research questions.

Due to the descriptive nature of the data, the subjective reactions of the patients and nurses were classified and categorized for presentation. Discussion of the results and appropriate explanatory vignettes were included.
CHAPTER 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

Interest in the role of touch has prompted research related to the importance of touch in personal development and interpersonal communication. However, the thrust of previous research has relatively ignored the elderly hospitalized adult and his/her perceptions of the use of expressive touch by nurses. Nurses themselves have been similarly omitted as a focus in research on touch.

The exploratory nature of this study was prescribed by the current status of research related to touch. Lack of both qualitative and quantitative measurements of perceptions of touch caused the investigator to collect the necessary data utilizing an open-ended question interview technique.

In order to investigate the problem, the sample chosen consisted of elderly hospitalized patients. The fifteen female and eight male subjects ranged in age from sixty-seven to ninety-two years. The patients had been admitted to the medical unit of a small private hospital less than forty-eight hours prior to the first research interaction.
The patient's bath was selected as the unit of study in order to incorporate both instrumental touch and expressive touch into the interaction. Using a repeated measures quasi-experimental design, each subject served as his/her own control. Each patient received both the experimental and control interaction. Observations were recorded by the investigator during the entire interaction. These observations concerned the nature of the conversation between the nurse and the patient.

Data from a chosen set of variables were collected from each subject. The subjective responses to the interview were obtained after the completion of both the control and the experimental interactions. Nurses were interviewed when all the patient interactions had been completed.

Conclusions

The exploratory nature of the study proved to be a valuable method for obtaining the subjective responses of the elderly hospitalized patients and the nurses to the use and non-use of expressive touch. It enabled a discovery of the nature of the subjective responses which the investigator might not have anticipated for inclusion in an instrument.

The types of conclusions drawn from an exploratory study are generally tentative and suggestive rather than conclusive as are cause and effect relationships (Diers, 1979:124-43). The following discussion of the conclusions
reached will be offered with this understanding guiding the presentation.

None of the patients mentioned the use or non-use of expressive touch as the difference noticed between the two baths. This finding may be reflective of the societal taboos surrounding the implications of expressive touch. Touch is utilized less often in the American culture and less readily than in other European and Latin American societies (Jourard, 1968). Even taking into account a possible response set created by the methodology, the nurse's sitting, talking and touching or not touching them was not part of the usual hospital routine. This fact was not mentioned by the patients, either, possibly because of the consistency between the two interactions with the exception of the touch variable.

The emphasis on the evaluation of the task function of the nurse may be suggestive that patients, especially those who are more dependent, really are more concerned with the way the nurse ministers to them in meeting their physical needs than in the manner which he/she communicates. When patients are dependent on the nurse to provide physical care, they are apparently more conscious of the way he/she performs these tasks than in his/her personality or the way he/she provides emotional support.

As the patient becomes more independent the need to meet psychosocial needs may be more significant. As one elderly female patient stated, "It doesn't make any differ-
ence if she touches me when she talks with me. It is more important to me that she hold onto me when I am walking so I don't fall down."

Even though patients did not mention the use or non-use of expressive touch as the difference noticed between the two baths, the majority did respond affirmatively to noticing the use or non-use of expressive touch when questioned specifically regarding that fact. Perhaps patients take the expressive touch of the nurse for granted as a routine part of care, and thus tend not to see it as a special gesture.

The meeting of psychosocial needs was expressed as a subjective reaction to the use or non-use of expressive touch. Those subjects who were not indifferent to the use of expressive touch by the nurse responded with some type of positive statements seventy percent (70%) of the time. The majority of those positive responses were a positive feeling engendered in the patient.

Patients who are hospitalized experience anxiety which is often a result of a lack of meaningful communication from the staff (Saylor, 1977). The patients in this study reported a positive feeling as a result of the touch. While anxiety levels were not specifically measured in the questions, these positive feelings may be an indication that expressive touch, as a form of communication, may be useful in lessening anxiety by increasing communication.
The lack of negative reactions to the use of expressive touch, while there were three to the non-use of touch, was not statistically significant. However, it certainly may be suggestive of the importance of the use of expressive touch when nurses interact with elderly hospitalized patients. Taking into account that seventy percent (70%) of the responses to the use of expressive touch were positive, the predominate subjective reaction is neither negative nor neutral indifference.

The large percentage (43%) of claimed indifference to the use or non-use of expressive touch is as equally important to the discussion as is the lack of negative responses. Similar indifference to touch was noted in a study of territoriality and personal space among hospitalized patients.

Although some patients expressed favorable attitudes about the gestures of touch, stating they would consider the nursing personnel were demonstrating their concern by touching the patient, the mean scores for these items indicated that patients tended toward indifference (Allekian, 1973:240).

This indifference was attributed by Allekian to the acceptance by patients of intrusions of their personal space by nursing personnel. It should be noted that Allekian's patients had a mean age of 58.6 years which is younger than the sample in this study.

Besides indifference, patients appeared to demonstrate a need to justify the non-use of expressive touch by the nurse. This finding is of value, not only to the touch concept but also to patient reactions in general. Attribu-
tion of reasons why persons do what they do is a general phenomenon of human nature. Attributing the reason for the action to the sender's behavior rather than to the situation surrounding the incidence is known as an internal cause of attribution. More importantly, "...it is only when someone is perceived as violating the situational demands that an internal attribution is made to him or her" (Wegner and Vallacher, 1977:48). A situational demand is defined as behavior which is appropriate for the setting, such as being quiet at funerals and cheering at football games, and not the reverse.

Assuming this to be true, the need of the patients to justify (internally attribute) why the nurses did not touch them could be suggestive that the patients did not feel that non-use of expressive touch was appropriate behavior. Given this assumption about the non-use of expressive touch, the use of expressive touch might be more positive to patients than they were able to openly express.

Males offered proportionately more justification statements than did females. Traditionally males receive less physical contact than females, especially as children. However, male children initiate more of the contacts with their mothers than do the female children. It is usually the mothers who initiate contact in their interactions with the female children (Clay, 1968). These finds are suggestive of the males' needs to initiate contact while being prevented from doing so by the societal standards. Males
may feel that the omission of expressive touch is not situationally appropriate. However, for whatever reason, they are prevented from verbalizing these feelings.

The elderly hospitalized patient frequently has experienced many losses, not the least of which is the death of a spouse. It was felt by the investigator that this lack of intimate contact which is provided by the expressive touch between marital partners might be an important factor in the subjective reactions of the patients. For this reason, the patients' marital status and living status were included within the chosen set of variables. However, no distinctive patterns between any of the subjective responses and these variables was suggested. Apparently, elderly widowed patients who are living alone and are admitted to an acute care setting do not view the nurse's role of providing a semi-intimate contact any differently than their married counterparts.

The ethnicity of the nurse who performed the control and experimental interactions was recorded to determine if any patterns existed between this variable and the responses of the patient. Eighty-three percent (83%) of the subjects who received the expressive touch interaction from the non-Caucasian nurse reported noticing some difference between the baths. This compares with only forty-one percent (41%) noticing some difference when the Caucasian nurse performed the expressive touch interaction.
The patients also responded with more indifference to the Caucasian nurses than the non-Caucasian nurses. The non-Caucasian nurses elicited more justification statements, two of which were related directly to their ethnicity. The Caucasian nature of the sample may have directly influenced this type of response. Two of the three negative responses also were attributed to the nurses' ethnicity. As there was disagreement among the raters on the coding of these statements, it may be prudent not to speculate on any conclusions from these two statements.

From the nature of subjective reactions of the patients, when non-Caucasian nurses are involved in the care of Caucasian patients, the patients are more aware of the interactions. Since there were no non-Caucasian patients with which to compare, the findings should only serve to raise questions for further research.

The subjective reactions of the nurses to the use and non-use of expressive touch in interacting with patients was also explored. Like the patients, the nurses did not mention the use or non-use of expressive touch as a response to how they felt about participating in the study. This was a most interesting finding considering the nurses were aware from the beginning of the research that expressive touch was the focus of the research.

The nurses stated they had no difficulty with the expressive touch and even found it very difficult not to touch the patients. The only nurse who consistently stated
that her attitude toward using or not using expressive touch depended on the patient was Mexican-American. Recall that it was earlier reported that Mexican-American nurses infrequently used touch in their interactions with patients, even though "... in their culture, they use frequent physical contact" (Barnett, 1972a:202).

**Recommendations**

This study produced categories of subjective responses from elderly hospitalized patients and nurses to the use and non-use of expressive touch by nurses. However, the study design did not produce the indepth responses which are still in need of exploration. Therefore, the investigator recommends that the research be replicated using the following improvements in the research design.

The Post Interaction Interview proved to be a useful tool for data collection but should be expanded to gain more indepth subjective responses. Built into the interview should be questions which elicit further information. Of special concern are the data which were contained in the indifference statements which could be elicited with an improved interview tool. What the patient means by indifference, and why he/she responded in such a manner, should be thoroughly explored.

To prevent any possible focus on the touch, other types of questions should be included. Instead of just isolating the patients' noticing or not noticing the use of
expressive touch, patients should be questioned about noticing other activities the nurse performs. For example, "Did you notice the nurse sat by your bedside?" or "Did you notice the nurse closed the door during your bath?" might be included to prevent a response set.

The sample should be expanded to be large enough to include an adequate number of all the chosen variables, but especially, there should be a more diverse mixture of ethnic component. The area of Caucasian patients being more aware of their non-Caucasian caregivers raises important research questions regarding the reactions of patients of various ethnicities to nurses of various ethnicities.

Degrees of assistance with the bath should be included. Perhaps one of the many existing indices for Activities of Daily Living (ADLs) would be beneficial in determining the more exact nature of the subject's level of dependence and independence.

Instead of just marital status and living status, as defined, there may exist a need to explore the presence or absence of significant others in the subject's life. These significant others may be children or friends, and not just spouses. This may suggest an association between the response to touch and the role the nurse plays as a significant other to the patient.

Future researchers in this area should be cautioned to use the exploratory methodology with the above stated recommendations prior to endeavoring to commit this area
to more quantitative research. Eventually, forced choice instrumentation will be appropriate but only when it is based on the subjective reactions of a larger number of patients.

The research performed has some important implication for clinical practice. Patients do have subjective reactions to the use and non-use of expressive touch by nurses. While the majority of the responses (70%) were positive relative to the use of expressive touch, some patients did respond with claimed indifference. Until the exact nature of the indifference is known, nurses should not proceed by using expressive touch with all patients. Sensitivity to the patient's reaction to touch is implored.

The responses of the patients who required assistance with their baths in relationship to evaluating the task function of the nurse is another important implication for nursing practice. Meeting the physical needs of the patients before concentrating on the psychosocial needs is apparently very important to the patients. Only when these physical needs are fulfilled can the person be concerned with their emotional requirements (Maslow, 1968). This does not predispose omission of psychosocial needs but is a recommendation that they be placed in proper perspective.

Nurses also have subjective reactions to their using expressive touch. In this study these seemed to be proportionately more favorable towards the use of touch than were the reaction of the patients. This somewhat over enthusias-
tic favoring of touch combined with the difficulty the nurses expressed in not touching the patients may provide difficulties in interactions with patients. Nurses may utilize expressive touch when interacting with patients on the assumption that the patients have the same level of acceptance of touch as possessed by the nurses. If for no other reason than this, the issue of the use of both instrumental and expressive touch needs to be more thoroughly explored.

**Summary**

This chapter presented a summary of the research study, including methodology and sample population, conclusions reached and further recommendations. The conclusions were based on the research results. Recommendations included future studies with an improvement in methodology and the implications of the study for clinical nursing practice.
APPENDICES
APPENDIX A

The University of New Mexico
College of Nursing

PATIENT PARTICIPATION CONSENT FORM

Purpose

The purpose of this research is to study the various techniques of giving baths.

Procedures

The graduate nursing student will observe the activities of the staff nurses according to a predetermined checklist. Two different nurses will be evaluated. After each nurse has given you a bath (or assisted you with your bath), you will be asked questions which will assist in the evaluation of the care you received.

Risks

As both nurses are employed by this hospital and licensed by the State Board of Nursing you are assured of receiving care which meets their standards.

Benefits

The research being conducted may benefit the patient by assisting the student in evaluating those activities which the patient rates as preferable.

This research is being conducted by a graduate nursing student of the University of New Mexico College of Nursing, Albuquerque, New Mexico. The results of individual nursing action will not be reported to the administration of this hospital. Any report of this research will protect the identity of both the patient and the nurse.
You are invited to ask questions or obtain further information. You are free to withdraw from this research project at any time without fear of negative prejudicial effects.

I have read the above consent form and understand the risks and benefits of being involved in this research. I consent to participate in this research project.

________________________  _______________________
Date                        Signature

________________________
Witness

________________________
Researcher
APPENDIX B

AGENCY PARTICIPATION CONSENT FORM

Purpose

The purpose of this research is to determine the effects of expressive touch as a nursing intervention on patient satisfaction with nursing care.

Procedures

The staff nurses of this agency will, in conjunction with the patient's morning bath, perform expressive touch to clients selected and consenting for this research project. The staff nurses will conduct one experimental and one control nursing intervention per client as outlined by the protocol attached to this consent form. The graduate nursing student researcher will administer the Patient Satisfaction Questionnaire to each patient after each interaction. Demographic data concerning the clients' age, sex, ethnicity, living status, occupation and diagnosis and the nurses' age, ethnicity and sex will be obtained. All information will be utilized in reporting the final results. Individual evaluations by the clients will not be made available to the agency. All nurses and clients will have a code number to ensure the privacy and rights of the individual. There will be no monetary remuneration of the clients or the staff nurses by the graduate nurse researcher. All participation will be voluntary and will not reflect in either a positive or negative manner.

Risks

The potential risks to the agency are considered by the nurse researcher to be minimal as the experimental interaction does not interfere with the nursing duties of patient care established with the hospital's policy. The clients may view expressive touch as invasive in nature. After both interactions are completed and the client has responded to the Patient Satisfaction Questionnaire the exact nature of the intervention will be explained to the clients.
Benefits

The research will have the potential benefit of identifying client reactions to expressive touch. This may have long-range implications for nursing of increasing patient satisfaction with the care provided by nurses. The outcome will have the effect of adding to the body of nursing knowledge in identifying expressive touch as a nursing interaction.

The agency is invited to ask questions or obtain further information. The agency is free to withdraw approval of use of agency clients and staff nurses from this research project at any time without fear of negative prejudicial effects. Any report of the findings will hold the identity of the client and the nurse in confidentiality. The final report will also protect the identity of the agency.

I have read the above consent form and understand the purposes, procedures, risks and benefits of the agency's involvement in this research. I give consent for the graduate nurse researcher to engage in the proposed research utilizing the services, clients and nurses of this agency.

_________________________  __________________________
Date                        Signature

_________________________  __________________________
Title

_________________________  __________________________
Signature

_________________________  __________________________
Title

_________________________  __________________________
Date

_________________________
Researcher

_________________________
Witness

_________________________
Title
APPENDIX C

DATA COLLECTION TOOL

Patient Code _______ Nurse Code _______
Age _______ Age _______ Sex _______
Sex (1) Female (2) Male Ethnicity __________
Ethnicity (1) Anglo (2) Spanish-American (3) Black
(4) Asian (5) Oriental (6) Other ________
Living Status (1) Alone (2) Not Alone
Occupation: Present ______________________
Formal ______________________
Assistance Level (1) Without (2) With - Type ________
Diagnosis ______________________
Observations:

POST INTERACTION INTERVIEW

1. Did you notice (perceive) any difference in your bath between today and yesterday? (1) no (2) yes

2. If yes, what was the difference?

3. Did you notice that one nurse touched you on the hand and/or forearm (or held your hand) and the other did not when she sat and talked with You? (1) no (2) yes

4. How did you feel when the nurse touched you on the hand and/or forearm (or held your hand)?

5. How did you feel when the nurse did not touch you on the hand and/or forearm (or hold your hand)?
APPENDIX D

Noticed Difference Between the Baths

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82
# APPENDIX E

## Type of Difference Reported Between the Baths

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<th>CONTENT</th>
<th>EVALUATIVE TONE</th>
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<td>A Comment on the Activity Level of the Patient</td>
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<th>N %</th>
<th>N</th>
<th>N %</th>
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<td>2 (40%)</td>
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<tr>
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<td>1 (12%)</td>
<td>2 (25%)</td>
<td>4 (50%)</td>
<td>1 (12%)</td>
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<td>1 (50%)</td>
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<td>1 (11%)</td>
<td>3 (34%)</td>
<td>2 (22%)</td>
<td>2 (22%)</td>
<td>2 (22%)</td>
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<td>-</td>
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<td>1 (20%)</td>
<td>2 (40%)</td>
<td>1 (20%)</td>
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<td>6 (75%)</td>
<td>1 (12%)</td>
<td>1 (12%)</td>
<td>2 (25%)</td>
<td>2 (25%)</td>
<td>2 (25%)</td>
<td>2 (25%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*One patient in this category gave two codable responses
| NOTICED DIFFERENCE BETWEEN BATHS | TOTAL | YES | | NO | N % | TOTAL | | YES | N % | TOTAL | | YES | N % | TOTAL | | YES | N % |
|----------------------------------|-------|-----|---|---|---|---|---|---|---|---|---|---|---|---|
| Variable                        |       |     |   |   |     |     |     |     |     |     |     |     |     |     |
| Level of Patient's Age          |       |     |   |   |     |     |     |     |     |     |     |     |     |     |
| Caucasian                       | 3     | 43% | 6 | 100% | 9 | 100% | 3 | 43% | 6 | 100% | 9 | 100% | 3 | 43% | 6 | 100% |
| Non-Caucasian                   | 4     | 67% | 2 | 50%  | 6 | 67%  | 4 | 67% | 2 | 50%  | 6 | 67%  | 4 | 67% | 2 | 50%  |
| Ethnicty                        |       |     |   |   |     |     |     |     |     |     |     |     |     |     |     |
| Caucasian                       | 6     | 100%| 4 | 67% | 10 | 100%| 6 | 100%| 4 | 67% | 10 | 100%| 6 | 100%| 4 | 67% |
| Non-Caucasian                   | 4     | 67% | 2 | 33% | 6   | 100%| 4 | 67%| 2 | 33% | 6   | 100%| 4 | 67%| 2 | 33% |
| NURSE                           |       |     |   |   |     |     |     |     |     |     |     |     |     |     |     |
| Touch                           | 3     | 43% | 2 | 33% | 5 | 67% | 3 | 43%| 2 | 33% | 5 | 67% | 3 | 43%| 2 | 33% |
| No Touch                        | 6     | 100%| 4 | 67% | 10 | 100%| 6 | 100%| 4 | 67% | 10 | 100%| 6 | 100%| 4 | 67% |
| Evaluative TONE                |       |     |   |   |     |     |     |     |     |     |     |     |     |     |     |
| More Negative                  | 1     | 33% | 3 | 100%| 4 | 100%| 1 | 33%| 3 | 100%| 4 | 100%| 1 | 33%| 3 | 100% |
| More Positive                  | 2     | 67% | 1 | 33% | 3 | 67% | 2 | 67%| 1 | 33% | 3 | 67% | 2 | 67%| 1 | 33% |
| No Nurse                        | 4     | 100%| 2 | 50% | 6   | 100%| 4 | 100%| 2 | 50% | 6   | 100%| 4 | 100%| 2 | 50% |
| CONTENT                         |       |     |   |   |     |     |     |     |     |     |     |     |     |     |     |
| Patient's Level of Education   | 3     | 100%| 1 | 33% | 4 | 67% | 3 | 100%| 1 | 33% | 4 | 67% | 3 | 100%| 1 | 33% |
| Patient's Ethnicity            | 6     | 100%| 4 | 67% | 10 | 100%| 6 | 100%| 4 | 67% | 10 | 100%| 6 | 100%| 4 | 67% |
| A Comment on the Nurse          | 1     | 33% | 3 | 100%| 4 | 100%| 1 | 33%| 3 | 100%| 4 | 100%| 1 | 33%| 3 | 100% |
| An Evaluation of the Task       | 2     | 67% | 1 | 33% | 3 | 67% | 2 | 67%| 1 | 33% | 3 | 67% | 2 | 67%| 1 | 33% |

*One patient in this category gave two codable responses.*
### APPENDIX F

Subjective Reactions to the Use and Non-Use of Expressive Touch

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<td>N</td>
<td>%</td>
</tr>
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<td>75%</td>
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<th>Positive Indifference in the Patient</th>
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<td>%</td>
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<td>12.5%</td>
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### APPENDIX F (Continued)

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</tr>
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<td>11(65%)</td>
<td>6(35%)</td>
</tr>
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<td>6</td>
<td>5(83%)</td>
<td>1(17%)</td>
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<td>6(50%)</td>
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REFERENCES


