PHYSICAL TOUCH IN CARING: A CARE ETHICAL POINT OF VIEW

One morning, as I enter the closed ward for people with dementia, I come across an intensely frightened and distressed Clara. Sobbing and searching she wanders down the corridor. Almost instinctively, I take her in my arms, and she calms down.

During my studies to become a spiritual counsellor, emphasis was placed on learning conversation skills. Little attention was paid to the bodily aspects of this work, whereas, in my opinion, physical proximity in the care relationship is very important.

In recent years, I have studied this subject, particularly in relation to 'touch'. This is because I am a physically oriented person, also where my work is concerned. However, I lacked guidelines. Whom do I touch? When do I touch? And for what purpose? In order to get answers to these questions I searched for literature on the subject of touching in healthcare. My research focused on non-necessary touch. This implies the kind of touching that – strictly speaking – has no function, such as patting someone on the shoulder or holding someone's hand.

This article describes the possible meanings this kind of touching can have, both positively and negatively, in care settings. First the article examines what is said about non-necessary touch in developmental psychology. Next, research about touch in relational care is discussed. Special attention is given to people with dementia because these are the people I work with, and I have noticed that touching is often more appreciated than talking. The article ends with insights into how to apply touch, taking into account the risks and pitfalls.

Developmental psychology

From a developmental psychology point of view, touch is of great significance (Montagu, 1971). It is a primary necessity of life for (small) children, because physical contact stimulates the blood circulation and the central nervous system. Children also use their tactile senses to explore themselves and the world around them. Furthermore, touching is important for bonding with parents, and therefore also for the development of one's identity. An incomplete attachment may be followed by intimacy problems later in life, as it may complicate connecting to other people.
In childhood in particular, touch is associated with feelings (Davis, 1992). If a person has been touched in a pleasant way, touch will have a positive charge. In the case of traumatic experiences, such as neglect or sexual abuse, physical contact may be experienced as inappropriate or even threatening.

Affective affirmation remains important throughout adulthood. Touches convey – in the most direct manner – a message of affirmation. Touching can also be used therapeutically to evoke emotions, which are often concealed and become more accessible through the so-called body memory, as it is stronger than the cognitive memory (Boot, 2004).

Anthropologist Ashley Montagu has stated that in old age, 'tactile hunger' is more powerful than ever (Gleeson & Timmins, 2004). On the one hand, this is because elderly people are touched less, due to the loss of loved ones. On the other hand, they also feel less safe, as a result of the losses associated with ageing, and touch can provide a sense of safety. Like children, elderly people may seek the proximity of an adult when they are afraid. However, people will only do so if they have developed a healthy attachment style and if they have had enjoyable experiences of touch.

Cultural and gender-specific aspects

In addition to experiences in childhood in particular, cultural and gender-specific aspects also play a role in the experience of giving and receiving touch. For example, the Dutch are not especially physically oriented (Talma, 2010). Touching is also often associated with femininity (Montagu, 1971). Female nurses touch more, and female patients receive more touches (Gleeson & Timmins, 2004) – I also mainly touch female care recipients. It seems, however, as if these gender differences are not just a matter of gender roles; women respond much more strongly to tactile stimuli than men, who in turn appear to be more visually oriented (Montagu, 1971).

Meanings of touch in relational care

Philosopher Sung OK Chang (2001) researched the possible meanings of touch for the care recipient and concluded that the experience of touch is personal. Nevertheless, it can also be described in general terms. She writes that touching can improve both physical and emotional comfort, for example by reducing pain and agitation. In addition, the caregivers Chang interviewed consider touch as a way to help the patient accept his or her affected body. The spiritual dimension of touch is also mentioned; one nurse said that she touched patients 'in critical situations with a wish that the God's love in me may be conveyed to my patients'. This healing function has old roots that remain visible, for example, in the Christian ritual of the laying on of hands.

Researchers Edvarsson, Sandman and Rasmussen (2003) have investigated the meaning of touch from the perspective of the caregiver (mainly nurses). These caregivers all received training in tactile massage or stimulation. Tactile massage or tactile stimulation transcends the scope of spontaneous touching I focus on in this article. I choose to include these results here because this special technique goes beyond 'classic' functional touching in washing or dressing. It is – especially for nurses – a beautiful way to be physically present.

The analysis shows that touching care recipients through tactile massage or stimulation constitutes a 'transformative experience' in several ways. The main transformation is that the caregivers no longer feel powerless because touching provides a way of easing patients' suffering. Touch may in this context provide a 'tool' – in the words of the researchers – for improving the situation without the use of medication. A second transformation is the way caregivers regard the patients: one is able to perceive the person behind the disease more clearly. As a result, caregivers more or less move away from the professional role. The third and final transformation is the move from 'doing to' to 'being with': the nurses experienced touching as a way to be meaningfully present. The touches strengthened the relationship between caregiver and recipient, according to Edvarsson et al. (2003).

Please do not touch

In healthcare, one works with vulnerable people. People who are ill or old, often are less able to indicate their boundaries. A caregiver has to guard the other person's boundary as well as their own, where possible. Everyone has personal space that should be respected. Both sides need to feel comfortable when touching.

If physical contact is not appreciated, inequality in the care relationship may increase further. A touch can be perceived as derogatory, patronising, or disrespectful by the care recipient, which is (partially) a consequence of the asymmetric nature of the care relationship.

Touching can be experienced as 'manipulation'. This is when touches are used – whether consciously or not – to perform the (care) tasks faster. This often occurs in healthcare, partly due to the high work pressure. Research also shows that people who are touched are more inclined to react positively and to cooperate (Konnikova, 2015). I sometimes catch myself doing this too. When I am on my way to the meditation centre with a resident, I tend to gently push this person in the back when things are going very slowly. In addition, when I don't have much time, I sometimes shake someone's hand or give them a pat on the shoulder to end contact. I hope the care recipient does not notice this, but research shows that people are able to perceive the intention behind the touch. Our brains can identify the basic feelings of the person touching (Konnikova, 2015).

As a caregiver, you may be inclined to project your own need for touching onto another person. This may even prove to be harmful at times. For instance in the case of a young woman suffering from borderline personality disorder. During moments of crisis she is unable to handle any touching at all. Whereas people want to touch her to comfort her, it makes her aggressive instead.

According to Edvarsson et al. (2003), the caregiver should be alert to signals that touching is not appreciated, and should stop immediately if necessary. This requires sensitivity on the caregiver's part. Another 'prerequisite' for touching, in addition to sensitivity, is an atmosphere of proximity and trust (Edvarsson et al., 2003).

Finally, it should be noted that care recipients can also take the initiative to touch, or express their need for physical contact. Often, care recipients look for safety or guidance, as described in developmental psychology. For this reason I am often touched and even clung to. This is why a caregiver should be

'touchable'. It becomes problematic if the boundaries of the caregiver are crossed, whether intentionally or not. Sometimes I come across care recipients I would rather not touch for various reasons. They might smell bad, or I may just dislike them. The question then becomes, how do I handle this situation? Do I deprive this person of physical contact? To me it is a matter of personal choice. If it does not feel right to me, I assume that the other person will feel my touch is not sincere. An answer to the question whether I should overcome my own repulsion becomes unavoidable, when I am not the only caregiver to deprive this person of physical contact and he or she is being excluded.

Dementia

I noticed that touching people with dementia can be quite meaningful to them. According to the work of developmental psychologist Rien Verdult (2009), the dementia process is conceived as a form of becoming childlike. In a way, people with dementia travel back in time to their early childhood, not only in terms of memory, but also concerning practical and immaterial 'matters'. They must be helped with more tasks, such as washing and dressing, and at some point they need others for structure and security in a world that is becoming increasingly complex to them.

Considering dementia as a return to childhood, it becomes clear that touching these people has three specific functions, in addition to the effects mentioned above.

Firstly, touching can offer safety and protection, as well as help to discharge emotions (Verdult, 2009; Miesen, 2010). People suffering from dementia lose everything that is familiar and loved because of their lack of memory. This often causes feelings of pain, fear and insecurity, especially in the early stages. In this context, 'safety' can also be a theme that emerges from the reversal of the life cycle. Physical contact can thus provide support and direction, which was noted above in the discussion of the aspects from a developmental psychology point of view. Touching is in fact attachment behaviour aimed at the proximity of a 'protective adult' – and that is why I held Clara in my arms.

Secondly, touching is a way of making contact (Verdult, 2009; Miesen, 2010). People with dementia find communication increasingly difficult because their cognitive and linguistic abilities have diminished. As a result, they rely more and more on their senses, especially the tactile senses. They become more present in a tactile way, much like small children are. Touch can thus prevent them from unintentionally ending up in isolation. In addition, their body memory can be stimulated in this way.

Finally, touch responds to a need. Due to dementia, desires from childhood emerge; patients have tactile hunger as small children do (Verdult, 2009), and they do not hide this because of diminishing defence mechanisms (Ferman, Smith & Melom, 2012).

Verdult (2009) believes that people with dementia should be cared for by a 'good-enough mother'. He derives this term from the English paediatrician and psychoanalyst Donald Winnicott (1896-1971). A good-enough mother is someone to whom dementia patients can attach themselves, someone who offers safety and support and who meets their needs. Touching plays an important role in this.

When I first read about 'good enough mothering' I realised that being a mother myself helped me to make contact with people with dementia. Years earlier I worked as a trainee on a closed ward and I did not know how to approach them, because most of these people were not able to hold a conversation. After my children were born I became more physically oriented and more sensitive to the needs of people suffering from dementia.

The sense of touch increasingly offers a way to 'access' people in deteriorating stages of dementia. This said, it must be noted that touching these people may have an adverse effect. This is also the case in healthy people, but dementia creates additional complications. It means that boundaries can be crossed quickly because of increasing feelings of insecurity, and people with dementia can be over-stimulated because they are not able to process information as well. Sexual disinhibition and confusion of identities may also occur (Hajjar & Kamel, 2003; Benbow & Beeston, 2012). A study by Norberg, Melin and Asplund (1986) has even shown that to people in the later stages of dementia, touching can be threatening, as one enters their personal space. Care recipients may become aggressive or exhibit escaping behaviour. Due to the fact that they can no longer escape physically, they withdraw into themselves instead.

Insights

Caregivers cannot rely on protocols and guidelines concerning physical contact. Codes of conduct state only that healthcare professionals must not touch in a way that others may perceive as erotic.
In The Netherlands, touching in the care sector has recently been the subject of a fierce debate. In December 2015, the Healthcare Inspectorate ruled a handshake to be the only acceptable way of touching by a caregiver. This announcement received a great deal of criticism. Because the ruling had been somewhat taken out of context, the Inspectorate modified its statement. Now a touch is allowed as long as it is not perceived as 'unsafe or unacceptable' (IGJ, 2016).

The questions I ask myself are: Whom do I touch? When do I touch? And for what purpose? Based on the literature I found in my research and my practical experiences, I formulated some points of attention.
First of all, it is important that you are aware of your own body and of what your senses are 'telling' you. In this way you are better able to make use of body language, including touch. Moreover, you will then be more sensitive to both your own and other people's boundaries (Talma, 2010).
Be authentic and sincere. People will feel when a touch is not genuine, or is intended to speed up a certain task. A touch can be called 'good' if it is aimed at the whole person and if it invites the other to open up (Boot, 2004). You can extend that invitation by opening up yourself and being touchable.
Although a touch should remain spontaneous, as a healthcare professional you should always be aware of the purpose of your touch. It should never be about satisfying your own needs. Goals can be to offer comfort and/or safety, to discharge emotions, to bring peace and relaxation, to make contact, or to satisfy a client's tactile hunger.
The more familiar you are with the care recipient – their life history, marital status, clinical history – the better you can assess whether touching is appropriate and desirable. You should take into account the vulnerability of the care recipient, in part because of the ever-present inequality of power in the care relationship. Moreover, 'manipulative touching' is never far away as a result of the high work pressure.

Some care recipients require extra alertness. Some people have great difficulty touching due to trauma, such as abuse or neglect. Other people are sexually disinhibited or perceive you to be someone else as a result of brain damage. When there is great suffering or sadness, everything can hurt, including touch. I never touch crying people – who are cognitively competent – because it might make them feel like they have to stop crying. If at all, I touch them only after they have told their story. Finally, dying people have to let go of life. Sometimes this is more difficult to them when being touched.

Conclusion

Touch can contribute to the provision of 'good care'. A prerequisite is to be well aware of the possible meanings, positive and negative, of touching and to be aware of the power inequality in the care relationship.
It is important to note that it is impossible to prevent touching from occasionally having unintended consequences and uneasy questions. It remains a matter of 'trial and error' before you know how someone will react to physical contact. Some caregivers avoid any contact out of fear of being misinterpreted, but because of the positive effects it is a risk that must be taken in 'the most sensible way possible' (Polspoel et. al., 2010). And sometimes you need to overcome your aversion to prevent care recipients from being excluded. So that we can give full expression to being in close physical proximity to the care recipient.

About the author:

Marieke Schoenmakers (1980) studied Ethics of Care and Policy at Tilburg University (NL). Her thesis concerns touching in spiritual care, particularly with respect to people suffering from dementia, and can be downloaded from: https://zorgethiek.nu/masteropleiding-zorg-ethiek-en-beleid/scripties-zeb-wall-of-fame . Marieke works as a spiritual counsellor for care organisation De Riethorst Stromenland.

Literature

Benbow, S.M. & D. Beeston (2012). Sexuality, aging and dementia. *International Psychogeriatrics* 24(7), p. 1026–1033.

Boot, B. (2004). *Haptonomie. Een kwestie van gevoel*. Amsterdam / Antwerp: Uitgeverij Archipel.

Chang, S.O. (2001). The conceptual structure of physical touch in caring. *International Journey of Advanced Nursing*, 6, p. 820-827.

Davis, P. (1992). *The power of touch*. Carson: Hayhouse.

Edvardssson, J. D., P-O. Sandman & B.H. Rasmussen (2003). Meanings of giving touch in the care of older patients: becoming a valuable person and professional. *Journal of Clinical Nursing*, 12, p. 601-609.

Ferman, T.J, G.E. Smith & B. Melon (2012). *Understanding behavioural changes in dementia*. Lewy Body Dementia Association. Retrieved from: https://www.lbda.org/content/understanding-behavioral-changes-dementia .

Gleeson, M. & F. Timmins (2004). Touching: a fundamental aspect of communication with older people experiencing dementia. *Nursing Older People*, 2, p. 18-21.

Hajjar, R.R. & H.K. Kamel (2003). Sexuality in the nursing home, part 1: attitudes and barriers to sexual expression. *Journal of the American Medical Directors Association*, 5 (2), p. S43-S47.

Inspectie Gezondheidszorg en Jeugd (20 January 2016). *IGZ kent géén knuffelverbod*. Retrieved from: https://www.igj.nl/actueel/nieuws/2016/01/20/igz-kent-geen-'knuffelverbod'.

Konnikova, M. (2015). The power of touch. *The New Yorker*. Retrieved from: https://www.newyorker.com/science/maria-konnikova/power-touch .

Miesen, B. (2010). Care-giving in dementia: contours of a curriculum. *Dementi*a, 9 (4), p. 473-489.

Montagu, A. (1971). *Touching. The human significance of the skin*. New York, HarperCollins Publishers.

Norberg, A., E. Melin & K. Asplund (1986). Reactions to music, touch and object presentation in the final stage of dementia. An exploratory study. *International Journal of Nursing Studies*, 4, p. 315-323.

Polspoel R., K. Cornette, L. Casteur, B. Defreyne, A. Gessler, D. Hooft & L. Lissnijder (2010). Leren uit ervaring. Lichamelijke nabijheid in het pastoraat bekeken vanuit enkele casussen. In: G. van Edom (red.). *Lichaam en levensadem. Pastorale zorg voor de hele levende mens*, Antwerp: Halewijn, p. 205-218.

Talma, D. (2010). *Het lichaam als verhaal. Haptonomie in het dagelijks leven*. Amsterdam: Uitgeverij Artemis & Co.

Verdult, R. (2009). Prenatal aspects in Alzheimer's disease. *Journal of Prenatal and Perinatal Psychology and Health*, 23 (4), p. 235-262.