Federation University

Federation University ResearchOnline

https://researchonline.federation.edu.au

Copyright Notice

This is an Accepted Manuscript of an article published by Taylor & Francis in Issues in Mental Health Nursing on 7 July 2020 available at:

https://doi.org/10.1080/01612840.2020.1764679

See this record in Federation ResearchOnline at:
http://researchonline.federation.edu.au/vital/access/HandleResolver/1959.17/180538

PHYSICAL TOUCH IN A CHANGING WORLD: GUIDANCE FOR THE MENTAL HEALTH NURSE

M CLEARY (Central Queensland University) and C HUNGERFORD (Federation University)

INTRODUCTION

Physical contact with other people is an essential human activity (Johansson, Åberg, & Hedlin, 2020). For example, caring for one another is expressed through physical touch, whether it be soothing a small child who is crying, embracing a lover, or physically supporting a frail, older person (Strozier, Krizek, & Sale, 2003). Likewise, physical contact is used to connect people socially through, for example, greeting one with a handshake or, in some cultures, kissing cheeks or touching noses (Prisco, 2014). Physical touch can also be used inappropriately, as evidenced by ongoing reports of child and elder abuse or exploitation through unequal or gendered power roles (Davin, Thistlethwaite, Bartle, & Russell, 2019).

In health settings, touch is an integral part of physical assessment and can include the taking of vital signs; inspecting for skins lesions; palpating lymph nodes or percussing the chest well or abdomen; or conducting external or internal physical examinations of the more intimate areas of the body. For nurses, physical touch is a central component of supporting patients to complete their personal care or enabling them to engage with medical treatment (Connor & Howett, 2009). To exemplify, it is the nurse who helps the unwell person to sit up in bed so that they can take their oral medications, brush their hair, turn them over in bed so that back-care can be administered, and help them to dress or walk to the bathroom. Each of these simple activities requires physical contact or touch between the nurse and the patient.

In light of the prominent place of physical touch in nursing practice, it is important to consider the associated challenges. These challenges include those experienced by people, worldwide, who have been physically exploited or abused by trusted staff at the institutional level. Likewise, questions have been raised about the misuse of physical contact in workplaces by advocates of the #MeToo movement, which recently swept across many countries; and more recently, populations worldwide who were required to limit physical and social interactions to reduce the possibility of spreading infection. Such questions include, in what ways can touch be safely or legitimately used by nurses in the course of their work? Who determines the necessary boundaries to ensure that the physical contact between nurses and patients is acceptable or appropriate?

In this column, we consider the benefits for patients and the challenges for nurses when physical touch is used to support the delivery of healthcare. We then discuss the options for nurses to manage the issues that can arise when using physical touch as part of their practice. It is anticipated that this discussion will help to promote the benefits of physical touch for patients and protect the professionalism of nurses.

DEFINITION OF TOUCH

A dictionary definition of the term 'touch' includes: "to come into or be in contact with" (Oxford English Dictionary, 2020). Connotations of the term, however, suggest a much wider generation of meaning. For example, human touch plays a key role in supporting optimal human development, with touch the essential mode of communication and bonding between a caregiver and baby. Moreover, research related to crying infants shows that touch, when used to alleviate distress, enhances attachment between caregivers and infants and is essential for infants to develop a sense of security and trust (Cekaite & Kvist Holm, 2017). Ongoing physical contact with caregivers also supports the physical, social, mental health, and interpersonal development of children as they grow into adults (Dobson, Upadhyaya, Conyers, & Raghavan,

2002; Walsh, 2018). Interestingly however, the type of physical contact needed or wanted by children from their caregiver(s) changes over time – for example, while physical cuddling and soothing from a caregiver will communicate love and caring to a young child, this approach will not be so acceptable to the teenager, with human touch communicating different messages within a family group across the lifespan.

Indeed, human touch and touching connotes a range of personal, interpersonal, social and cultural meanings (Calmes, Piazza, & Laux, 2013). For example, *personal* characteristics such as introversion and extroversion will determine the level of comfort people feel in relation to human touch, particularly when the touch involves strangers, including nurses (Hall, 2017). Specifically, the introvert may be less likely to respond positively to uninvited or unanticipated physical touch, viewing it as intrusive or inappropriate.

In the same way, people will interpret and respond to touch according to their prior experiences. To illustrate, a person's level of comfort when they are physically touched can be linked to their attachment style (Pedrazza, Minuzzo, Berlanda, & Trifiletti, 2015), with those who have anxious, avoidant or anxious-avoidant attachment styles questioning the need or motivation of nurses who touch them without consent. Likewise, those who have experienced abusive touch may interpret physical contact negatively (Dobson et al., 2002), regarding nurses who take their hand during stressful times as controlling rather than caring; or nurses who use their index finger to make a point as aggressive rather than expressive.

There are also variations in conventions according to the *relationship* of those involved in the touching (e.g. lover, family member, caregiver, friend, colleague, manager, acquaintance, stranger); the *role* of the person (e.g. health professional, barber, school teacher, priest); the *motivation* behind the touch (e.g. accidental or intentional, soothing or sexual, to express emotion or wield power); and the *context* and *setting* in which the touch is experienced (e.g. during emergency situations or disaster) (Dobson et al., 2002). For instance, a person who

is distressed after experiencing loss may (or may not) appreciate close physical contact that may ordinarily be viewed as inappropriate (Cekaite & Kvist Holm, 2017).

To add to this complexity are the *socio-cultural* factors that influence the way in which touch is interpreted. For example, research related to the acceptable levels of social distance, personal distance and intimate distance, including physical distance and contact related to people from countries across the globe, points to definite differences between populations, cultures, genders and age-groups (Avakian, 2017). What is acceptable in terms of touch and touching in one society or culture, then, may not be so acceptable in another society or culture. These kinds of variations suggest reasons why there are specific rules for cross-cultural activities, such as contact sport or artistic performances (e.g. drama, film, dance).

These many differences point to the complex nature of physical touch, with personality characteristics, relationships, roles, motivation, context and setting giving rise to nuances that many nurses may understandably view as a minefield. With physical touch communicating a wide range of meanings, there is need for those involved to have common understandings of what is and is not acceptable behaviour in particular situations or circumstances.

PHYSICAL TOUCH IN HEALTH SETTINGS

A key role of health professionals, including nurses, is to communicate care and compassion (Cocksedge, George, Renwick, & Chew-Graham, 2013). This involves the provision of support to people who are experience dis/stress, who have been given bad news or experienced loss; or who need personal care on a daily basis. In this section, we consider the benefits of the physical contact between nurses and their patients. We then discuss the challenges involved, with these challenges arising from the diverse interpretations of what it means to experience physical touch.

Benefits of physical touch

Davin, Thistlethwaite, Bartle, and Russell (2019) argue that physical touch is central to the delivery of effective and compassionate care by nurses. They go on to suggest that there are two types of physical touch by nurses – procedural touch and expressive touch. Procedural touch relates to the clinical or health-related task at hand; expressive touch describes all other touch that occurs between the clinician and patient.

Interestingly, Cocksedge et al. (2013) suggest that most patients feel that expressive touch (e.g. a brief touch of the hand or forearm) is acceptable and helpful in times of distress. These kinds of views provide one possible explanation for the development of therapeutic approaches that promote or advance the use of physical touch by nurses. For example, 'Therapeutic Touch' (Bulette Coakley, Barron, & Donahue Annese, 2016) is a complementary nursing approach that has been found to reduce agitation in people with dementia (Hawranik, Johnston, & Deatrich, 2008); and to comfort and minimise anxiety amongst the elderly who live in nursing homes (Yücel, Arslan, & Bagci, 2020). Likewise, 'Compassionate Touch' is an approach that has found to be useful when supporting children with disabilities (Brennan, Westbrook, & Parry) and older people in long-term care (Han, Kunik, & Richardson, 2019). Approaches of this nature are useful as they are modelled or framed by a particular set of guidelines that provide clear boundaries, within which the nurse practises. This can minimise the risk of physical touch being mis-interpreted by the patient.

It is significant, then, that Pedrazza et al. (2015) do not include expressive touch in their categorisation of physical touch in health settings. Instead, each of the three types of physical contact that they identify has a clear clinical or health-related focus. The first of the categories identified by Pedrazza et al. (2015) is task-oriented contact, which is similar to the procedural touch described by Davin et al. (2019), as discussed in previous paragraphs. The second category is the physical touch used to promote comfort and could include repositioning the patient in bed or massaging painful muscles. Finally, Pedrazza et al. (2015) identify the

physical touch needed to ensure emotional containment. This category provides an important means of guarding the safety of patients, the public and staff, when emotions are running high (Vermeulen et al., 2019) and so is quite different to expressive touch.

The absence of expressive touch as an explicit categorisation by Pedrazza et al. (2015) raises questions as to why it was not included as an appropriate form of touch – with suggested answers lying with the inherent challenges of expressive touch. These challenges are discussed in the next section.

Challenges presented by physical touch

As explained in earlier sections, the physical touch of patients by nurses is not always understood or considered to be appropriate or desirable. Patients can mis-/interpret physical touch as unnecessary and inappropriate, especially when it causes them discomfort or distress. For example, people with a borderline personality disorder have often been subjected to childhood abuse or neglect, giving rise to possible re-traumatisation by nurses who regularly use physical touch as a means of communicating (Galletly, 2004; Walsh, 2018). These same patients may also experience difficulties with maintaining appropriate boundaries, increasing the risk of physical touch that is used by a nurse being mis-interpreted as an intimate or sexual advance (Sheppard & Duncan, 2018). Likewise, people with schizophrenia may be vulnerable to the use of physical touch by nurses, depending on the symptoms experienced by the patient, medication side-effects, or the compulsory nature of their treatment. Of particular note is the physical touch used to provide emotional containment in acute mental health settings, with such contact notorious for violating acceptable boundaries and re-/traumatising patients (Cole, 2017). This can create challenges for nurses, who may go on to use expressive touch with these patients, who may lack the understanding or capacity to differentiate between the different types of physical touch.

While nurses are tasked with protecting the welfare of patients (Banja, 2014), there is nevertheless a power differential between the nurse and patients which increases the vulnerability of patients to exploitation by nurses (AbuDagga, Wolfe, Carome, & Oshel, 2019). For example, physical touch can blur professional and therapeutic boundaries, opening the door to inappropriate emotional connection or the arousal of sexual feelings (Calmes et al., 2013). This does not necessarily entail sexual misconduct, which sits towards the far end of the continuum of professional impropriety, but could involve expressions, gestures or behaviours that are interpreted as sexually suggestive, disrespectful of patient privacy, or even open to interpretation as being sexually demeaning to a patient (AbuDagga et al., 2019).

Professional boundaries, which may or may not include explicitly stated rules, enable nurses to guard against professional impropriety, limiting the multiple meanings that can be made by the recipient of physical touch (National Council of State Boards of Nursing, 2018). For example, a nurse who respectfully informs a patient, prior to touching them, of what is about to occur and why it is necessary, provides the cues by which a patient can interpret the interaction. In contrast, physical interactions that are not explained or not part of everyday routine will very often become the 'slippery slope' towards boundary transgression. This suggests the need for nurses to know the difference between a boundary crossing and boundary violation (Calmes et al., 2013) – for example, a crossing may include expressive touch, but a violation departs from accepted practice, leaving open the door to the potential harm of the patient.

In light of such risks and challenges, the question can well be asked as to why nurses would ever use expressive touch in their practice. It is therefore important to highlight the research that suggests that many patients appreciate the care and compassion shown to them by nurses, through physical touch, in times of distress (Cocksedge et al., 2013). Indeed, it is essential that nurses develop the knowledge and skills required to manage situations where

physical contact, including expressive touch, is helpful in supporting the patient, thereby minimising the inherent risks.

Overcoming the challenges

Broadly speaking, when considering whether or not it is appropriate to use expressive touch in a health setting, the nurse must utilise the ethical principles of nonmaleficence, beneficence, autonomy, fidelity, and justice (Calmes et al., 2013). If the interaction is for the benefit of the patient, means no harm, supports the patient to become independent, does not transgress professional boundaries and is fair for all concerned, then nurses can be reasonably confident that the interaction is ethical.

In practice, however, there is often little time or opportunity to carefully consider the ethics – or otherwise – of a situation that involves expressive physical touch. For instance, it can be difficult to predict when a person will experience distress or loss and so instant decisions are often made in relation to the rights or wrongs of using physical touch to (e.g.) comfort the person. The following list therefore provides a useful guide for nurses as they weigh the benefits and challenges of using physical touch to express care and compassion to a patient in distress:

- Do not make presumptions about a patient's preferences – for example, your comfort levels in relation to giving and receiving expressive touch are unique to you and will not be shared in exactly the same way by another person (Avakian, 2017)**.**
- Always explain to the patient why you need to touch them physically and ask permission to continue, particularly when using expressive communication (Davin et al., 2019).
- If the use of physical touch to express care or compassion to a patient in distress is unwise due to (e.g.) risk of infection or risk of boundary crossing, explain this to the patient and discuss more appropriate alternatives (Calmes et al., 2013).

- Discuss each situation transparently with colleagues or a peer-review group and refer the patient to another colleague if this is in their best interests (Galletly, 2004).
- Use clinical supervision, which is a well-established strategy for reflecting on practice, in situations where professional boundaries can be challenging (Chiarella & Adrian, 2013).
- Use the advance care agreement to guide discussions, with the patient, about their preferences in relation to the use of (e.g.) expressive touch, and refer to this agreement regularly when supporting the patient (Lenagh-Glue et al., 2018).
- Always respectfully explain what is occurring to the patient when using physical touch for emotional containment, to keep the patient or others safe – before, during and after the event (Cole, 2017).
- If a patient touches you or approaches you for hug, weigh up your knowledge of the patient and the context of the situation before accepting the physical interaction. If you do not feel comfortable with physical touch, offer the patient a smile and handshake instead. If you are concerned that the patient may harbour sexual feelings for you, be firm in your response (Medical Defence Union, 2018).
- If you are uncertain or anxious about the role of physical touch in your clinical work, seek out education or professional development on the topic (Davin et al., 2019).
- Always document an activity that involves expressive touch with a patient in their notes, including the patient's response, as this may help with ongoing care and may be useful if the interaction is later reported as being inappropriate (Medical Defence Union, 2018).

Finally, if nurses are in doubt about whether or not to use expressive physical touch when supporting a patient, then it is best to err on the side of caution. It is far better for a patient to complain about a lack of physical contact than to complain about too much physical contact.

CONCLUSION

It is impossible for nurses to undertake their work of caring for people with health needs, who are often in distress, without using physical touch. Yet the meaning produced by physical touch can be open to range of interpretations. In light of the increasing community awareness of the mis-use of physical touch in institutional settings, the influence of the #MeToo Movement, together with the recent global association of physical touch with an increased risk of infection, there is a need for nurses to be equipped with the knowledge and skills to provide compassionate healthcare in a way that is safe and appropriate. This column provided a discussion of the benefits and challenges of physical touch and includes practical suggestions for nurses to guide their practice.

REFERENCES

AbuDagga, A., Wolfe, S. M., Carome, M., & Oshel, R. E. (2019). Crossing the line: Sexual misconduct by nurses reported to the National Practitioner Data Bank. *Public Health Nursing, 36*(2), 109-117. doi:10.1111/phn.12567

Avakian, T. (2017, 2 May). People in these countries need the most personal space. *Travel and Leisure.* Available at: https://www.travelandleisure.com/travel-tips/offbeat/study-global-personal-space-preferences.

Banja, J. D. (2014). Preventing sexual attacks in healthcare facilities: Risk management considerations. *Journal of Healthcare Risk Management, 33*(3), 5-12. doi:10.1002/jhrm.21130

Brennan, H., Westbrook, J., & Parry, S. (2020). "An understanding, a way of life": An exploration of learning disability professionals' experiences of compassion. *British Journal of Learning Disabilities*. doi:10.1111/bld.12311

Bulette Coakley, A., Barron, A.-M., & Donahue Annese, C. (2016). Exploring the Experience and Impact of Therapeutic Touch Treatments for Nurse Colleagues. *Visions: The Journal of Rogerian Nursing Science, 22*(1), 4-16.

Calmes, S. A., Piazza, N. J., & Laux, J. M. (2013). The Use of Touch in Counseling: An Ethical Decision-Making Model. *Counseling and Values, 58*(1), 59-68. doi:10.1002/j.2161-007X.2013.00025.x

Cekaite, A., & Kvist Holm, M. (2017). The Comforting Touch: Tactile Intimacy and Talk in Managing Children's Distress. *Research on Language and Social Interaction, 50*(2), 109-127. doi:10.1080/08351813.2017.1301293

Chiarella, M., & Adrian, A. (2013). Boundary violations, gender and the nature of nursing work. *Nursing Ethics, 21*(3), 267-277. doi:10.1177/0969733013493214

Cocksedge, S., George, B., Renwick, S., & Chew-Graham, C. A. (2013). Touch in primary care consultations: qualitative investigation of doctors' and patients' perceptions. *British Journal of General Practice, 63*(609), e283-e290. doi: https://doi.org/10.3399/bjgp13X665251

Cole, E. (2017). New approach to restraint. *Nursing Standard, 31*(25), 22-23. doi:10.7748/ns.31.25.22.s23

Connor, A., & Howett, M. (2009). A Conceptual Model of Intentional Comfort Touch. *Journal of Holistic Nursing, 27*(2), 127-135. doi:10.1177/0898010109333337

Davin, L., Thistlethwaite, J., Bartle, E., & Russell, K. (2019). Touch in health professional practice: a review. *Clinical Teacher, 16*(6), 559-564. doi:10.1111/tct.13089

Dobson, S., Upadhyaya, S., Conyers, I., & Raghavan, R. (2002). Touch in the Care of People with Profound and Complex Needs:A Review of the Literature. *Journal of Learning Disabilities, 6*(4), 351-362. doi:10.1177/146900470200600402

Galletly, C. A. (2004). Crossing professional boundaries in medicine: the slippery slope to patient sexual exploitation. *Medical Journal of Australia, 181*(7), 380-383. doi:10.5694/j.1326-5377.2004.tb06334.x

Hall, A. (2017, 7 Dec). 10 Ways Introverts Interact Differently With the World. *Huffington Post.* Available at: https://www.huffingtonpost.com.au/entry/physical-behavior-of-introverts_n_6069438

Han, A., Kunik, M. E., & Richardson, A. (2019). Compassionate Touch® Delivered by Long-term Care Staff for Residents with Dementia: Preliminary Results. *Journal of Social Service Research*, 1-8. doi:10.1080/01488376.2019.1626320

Hawranik, P., Johnston, P., & Deatrich, J. (2008). Therapeutic Touch and Agitation in Individuals With Alzheimer's Disease. *Western Journal of Nursing Research, 30*(4), 417-434. doi:10.1177/0193945907305126

Johansson, C., Åberg, M., & Hedlin, M. (2020). Touch the Children, or Please Don't – Preschool Teachers' Approach to Touch. *Scandinavian Journal of Educational Research*, 1-14. doi:10.1080/00313831.2019.1705893

Lenagh-Glue, J., O'Brien, A., Dawson, J., Thom, K., Potiki, J., Casey, H., & Glue, P. (2018). A MAP to mental health: the process of creating a collaborative advance preferences instrument. *The New Zealand Medical Journal, 131*(1486), 18-26.

Medical Defence Union. (2018). *Hugging a patient could land doctors in hot water, MDU advises*. Available at: https://www.themdu.com/press-centre/press-releases/hugging-a-patient-could-land-doctors-in-hot-water-mdu-advises.

National Council of State Boards of Nursing. (2018). A Nurse's Guide to Professional Boundaries. *Chicago, NCSBN.* Available at: https://www.ncsbn.org/ProfessionalBoundaries_Complete.pdf.

Oxford English Dictionary. (2020). Oxford, UK: Oxford University Press.

Pedrazza, M., Minuzzo, S., Berlanda, S., & Trifiletti, E. (2015). Nurses' Comfort with Touch and Workplace Well-Being. *Western Journal of Nursing Research, 37*(6), 781-798. doi:10.1177/0193945914527356

Prisco, J. (2014, 8 April). *7 Ways to Say Hello Around the World*. Canberra: Australian Broadcasting Corporation (ABC).

Sheppard, K., & Duncan, C. (2018). Borderline personality disorder: Implications and best practice recommendations. *Nurse Practitioner, 43*(6), 14-17. doi:10.1097/01.NPR.0000531923.24420.6e

Strozier, A., Krizek, C., & Sale, K. (2003). Touch: its use in psychotherapy. *Journal of Social Work Practice, 17*(1), 49-62. doi:10.1080/0265053032000071457

Vermeulen, J. M., Doedens, P., Boyette, L.-L. N. J., Spek, B., Latour, C. H. M., & de Haan, L. (2019). "But I did not touch nobody!"—Patients' and nurses' perspectives and recommendations after aggression on psychiatric wards—A qualitative study. *Journal of Advanced Nursing, 75*(11), 2845-2854. doi:10.1111/jan.14107

Walsh, J. (2018). The appropriateness of physical contact with clients who have schizophrenia. *Social Work in Mental Health, 16*(1), 34-45. doi:10.1080/15332985.2017.1304497

Yücel, Ş. Ç., Arslan, G. G., & Bagci, H. (2020). Effects of Hand Massage and Therapeutic Touch on Comfort and Anxiety Living in a Nursing Home in Turkey: A Randomized Controlled Trial. *Journal of Religion and Health, 59*(1), 351-364. doi:10.1007/s10943-019-00813-x