THE USE OF TOUCH IN CARING FOR PEOPLE WITH LEARNING DISABILITY

Evelyn Gale and John R. Hegarty

Introduction

Touch has many meanings. It can be interpreted as the acknowledgement of a person’s presence, a display of love, an act of aggression, a desire for comfort or a feeling of physical closeness. How one person interprets the touch of another depends upon each person’s cultural background, the nature of the relationship and each individual’s feelings at the time. Despite the importance of touch however, it has received very little attention in discussions of caring, and virtually none at all in learning disability.

The aim of this article is to consider how those who care for people with a learning disability use touch, and how clients interpret the touch they received. Physical contact with another person, to perform clinical procedures, is a fundamental component of caring for people who have a high dependency. The use of touch can therefore be seen to be central to the caring relationship. But touch can be used for more than completing routine procedures in that it can also communicate, and heal. Used in this way, touch is therapeutic, helping to improve a person’s quality of life, and emotional wellbeing.

In his analysis of touch in nursing, Watson (1975) described two general forms of touch, that of procedural touch and non-procedural touch. Procedural touch was ‘task-oriented’, such as checking a patient’s pulse, administering medication or monitoring blood pressure. Non-procedural forms of touch were those that were ‘not task-oriented’, including holding a patient’s hand while talking or placing one’s arm around the shoulder of another in a supportive gesture. Procedural touch has also been described by Weiss (1986) and by Jackson (1985) as ‘task-oriented’ touch. McCann and McKenna (1993) describe categories of touch as ‘instrumental’, ‘expressive’ or ‘indefinable’.

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Instrumental touch is a ‘deliberate physical contact initiated to facilitate the performance of another act that is the primary aim of the initiator’. Expressive touch refers to ‘spontaneous and affective touching by nursing staff. It is not a necessary component of the physical task’. This type of touch has also been described as ‘comforting touch’ (Weiss, 1986), ‘caring touch’ (Clement, 1987; Glick, 1986), ‘non-necessary touch’ (Barnett, 1972; Routasalo, 1996) and ‘affective touch’ (Burnside, 1973). A further type of touch to consider is ‘therapeutic touch’, a purposeful touching of a person to benefit the person either physically or psychologically, as in massage. However, this is not to be confused with Krieger’s (1979) ‘therapeutic touch’, described as an act of healing in which there appears to be a transfer of energy from the healer that helps the patient to re-pattern his/her energy level to a state comparable to that of the healer (see Krieger, 1979).

There is research evidence for the value of touch in therapy, for example, in the use of massage in clinical areas such as intensive care, the elderly, psychiatry and learning disabilities (Mackereth, 1987; Tommasini, 1990; Oliver and Redfern, 1991; Harrison and Ruddle, 1995; Hegarty and Gale, 1996).

If touching people who have high dependency needs (other than during routine procedures) has physical and emotional benefits, then such touch ought to be a regular part of the support relationship that carers have with their clients. However, there is no published evidence available as to how often carers touch their clients (people with a learning disability) in any way, and equally with what effect.

The general aim of the study reported here, therefore, is to document how nurses and other care staff touch people with learning disabilities in their everyday work, and how those people appeared to respond to those occasions of touching. The study set out to answer the following specific questions:

1. How frequently do care staff touch clients with severe dependence needs during everyday caring?
2. Do trained nursing staff touch clients differently than untrained staff?
3. How much of this touch is the “functional” touch of everyday caring, and how much can be described as “therapeutic and expressive”?
4. How do clients respond to these types of touch?

Method

Design

The study was designed as a non-participant, observational study of carers in their daily work-routines with adult clients with severe to profound developmental disabilities. Many had additional physical or sensory disabilities. The observations were made in the early morning and at different periods throughout the day in order to observe a full-day routine. This would allow observation of all mealtimes, washing and dressing in the morning and at other times as necessary during the day and to include periods of activities and relaxation. A recording chart was designed that allowed for the recording of:

1. What ‘type’ of touch appeared to be given?
2. Where on the body people were touched;
3. Who gave the touch;
4. The response of the individual touched;
5. The qualitative nature of the touch given, according to the categorisation of Weiss (1986).

Settings

Fieldwork for this study took place within three residential settings selected to be representative of care settings for people with high dependency needs and learning disabilities. The first setting consisted of a 20-bedded ward in a long stay hospital for people with a learning disability. The second setting was a purpose-built community home consisting of 4 bungalows with 6 clients in each bungalow. The third setting was a small private community home for six people. All homes and the ward had male and female clients, ages ranging from 20 to 60 years.

Participants

With the collaboration of the managers within each home, 9 clients were selected, three from each home, for inclusion in the study. The ages ranged from 20 to 50 years. The clients had varying needs and abilities. All clients had varying degrees of physical disability. One gentleman could get himself around by shuffling on his bottom, and two female clients, although in wheelchairs, could manoeuvre the chairs themselves. These clients also had varying degrees of speech: one female made her needs known by vocalisations and chuckles and two females could say one or two words. The other clients had no verbal communication.

Procedure and Data Collection

A total of 90 observation sessions were made on 9 different clients. Data collection was made by direct observation using a chart devised by the author (FIGURE 1). The chart recorded: types of touch, where on the body the client was touched, who touched the client, and the responses of the client being touched. The chart incorporated a diagram of the body to indicate where on the body the person had been touched. This was similar in style to the diagram used by Jourard (1966) in his study on touch taboos. The authors also took field notes, which were later detailed into vignettes for each observation session (examples of vignettes can be seen in the Appendix).

The types of touch recorded were produced from an analysis of the literature and informed by personal experience and observations of nurses working. The categories were:

1. Instrumental touch: purposeful touching of a person with the aid of an instrument or a piece of equipment, e.g. taking blood pressure, giving an injection.
2. Procedural touch: purposeful touching of a person following a set of nursing procedures or guidelines, e.g. bed bathing, dressing a wound.
3. Functional touch: purposeful touching of a person to help with their everyday functions, e.g. washing, dressing, feeding.
4. Expressive touch: touching a person spontaneously with emotional intent to express feelings, e.g. holding a person’s hand to convey empathy, hugging a person.
5. Accidental touch: touching a person accidentally, e.g. bumping into someone.
6. **Therapeutic touch**: purposeful touching of a person to give benefit either physically or psychologically, e.g. massage or therapeutic interventions as in physiotherapy.

   It should be noted that instrumental, procedural and functional touches are essential in patient care. In contrast, expressive and therapeutic touch are, however, used at the nurses's or carer’s discretion. Carers have a choice whether or not to use this type of touch in their patient care.

   The second main set of codes, listed below, is used on the chart to enable measurement of the client’s response to being touched. Identifying the responses of people with a learning disability can be a difficult task due to the clients’ intellectual and cognitive abilities. The authors therefore chose to directly observe their responses and record their non-verbal behaviours.

   Clients’ responses to being touched were categorised as:

   1. **F pos**: Facial expressions that appear
positive, e.g. smile.
2. F neg: Facial expression that appears negative, e.g. frowning, screwed up face.
3. E eye contact: Client’s eyes are open and focusing or tracking is displayed to the carer.
4. Voc. pos: Communication that is seen as positive. Client displays any form of vocalising from words to utterances.
5. Voc. neg: Communication that is seen as negative. Client displays any form of vocalisation such as groaning, shouting, screaming or crying.
6. T Touch: Client displays any form of contact towards the carer’s body. This can be accidental or deliberate as in pushing away or a slight touch.
7. BM: Body movement; client displays any form of body movement. This can take the form of stereotypic behaviours, e.g. repetitive rhythmic movements of body parts, or fine gross motor movements.
8. BP: Client body posture is either tense or stiff or relaxed and calm.

The status of the carer was also noted on the chart, as: ‘qualified nurse’, ‘health care support worker’ or ‘other’ (a discipline identified as ‘none nursing’).

Results

Types of touch

FIGURE 2 shows the total instances of touch in the six touch categories. A total of 193 instances of touch were recorded during the observation periods. Of these, the clear majority (106 instances, 54.9%) were of functional touch, concerned with the physical aspect of care. 51 (26.4%) were of expressive touch where the care staff were spontaneous in their actions. Only 19 (9.8%) were of therapeutic touch, usually in the form of massage or physiotherapy. In passing, it is worth noting that this pattern (or ratio) of the relative frequency of different kinds of touch can be seen in the data for virtually every client with two exceptions who were given more expressive touch than functional. That this consistency occurred is remarkable, given that there were not only nine separate individuals with learning disability but also many different nurses/carers, and three different care settings.

Where on the body the client was touched

FIGURE 3 shows the total instances of touch in relation to where on the body the client was touched. The majority of the touch being to the hands, head, trunk, full body, and arms respectively.

Who touched

FIGURE 4 shows who touched the clients. The qualified nurses gave 100 (51.8%) instances of touch. The health care support workers gave 73 (37.8%) instances of touch. The non-nursing staff gave 21 (10.8%) instances of touch.

Responses of the clients

FIGURE 5 shows the responses by the clients on being touched. Facial expressions, positive or negative, including eye contact, were the most common response. Other body movements and vocalisations were infrequent.
Qualities of touch

Other variables that were considered in the touching behaviours of the nurses/carers are the primary qualities of touch described by Weiss (1986). These are: location, intensity, action and duration. The first of these, location, refers to the part of the individual’s body that is touched. The most widely touched parts of the body were the hands, followed by the head; the least touched parts of the body were the feet and the legs. Intensity can be strong, moderate or weak depending on whether the degree of skin indentation caused by the touch is deep, shallow or barely perceptible. This quality of touch however, was too difficult to be measured in this study. Action is that quality of touch typified by stroking, rubbing, holding or squeezing. All of these actions were observed in the study as the nurse would either stroke, rub, hold or squeeze the client depending on the type of touch that was being given. For example, the use of light rubbing was used when washing a client. The action of holding was used when holding a client’s hand to guide him/her or prompt him/her in a task. The action of stroking was used in expressive touch, for example when a nurse would stroke the client’s face or head, and in therapeutic touch when the client was massaged. Squeezing was used expressively when the client was given a hug. Finally, duration of touch is the temporal length of the touch from initiation of body contact by one individual to cessation of contact by either individual. Duration of touch was not recorded in this study but it was observed in all the touch interventions. Most of the duration of touch observed during functional touch was only fleeting or lasted for only a few seconds in order to help the client.

Discussion

Functional touch was the most widely used touch by both qualified nurses and health care support workers. Functional touch, similar to ‘task related’ touch previously described in the literature, probably constitutes the majority of touch in caring for people with a learning disability. It occurred approximately twice as often as expressive touch. Other types of touch were relatively infrequent.

All nurses used expressive touch. Expressive touch is seen as being a relatively spontaneous and affective contact which is not necessarily an essential component of a physical task. It was evident that the staff had developed a good rapport with the clients, possibly accounting for the expressive touch given. Burnside (1981) maintains that, all too frequently, nurses view touch as related only to tasks to be carried out as part of nursing procedures, thus conveying the message: ‘I have to touch you’. If, however, a nurse touches a patient when no task is involved she is clearly saying, ‘I don’t have to touch you, but I want to’.

Qualified nurses, health care support workers and physiotherapists all used therapeutic touch on a number of occasions with their clients. The majority of the therapeutic touch took place in the private community home in the form of massage and in physiotherapy sessions with the clients. The qualified nurses in the private community home had all attended massage workshops either during their training or post registration. The qualified staff had then taught the health care support workers some of the techniques. As the literature has indicated, therapeutic touch in the form of massage usually brings about positive feelings to the person being massaged (Farrow, 1990; Ferrell-Tory and Glick, 1993). The author
feels that the reason for the low positive responses given by the clients during physiotherapy is that physiotherapy, a therapeutic intervention, was included in the category of therapeutic touch. Although this intervention has a physical benefit to the client it was obvious from observing the clients that it did not always create a pleasurable experience. Therefore the types of touch used in physiotherapy should perhaps come under the category of procedural touch.

Procedural touch was not observed in any of the sessions of this study. One reason may be that this client group did not require any formal nursing procedures to be carried out. This could also be the reason for observing only one instance of instrumental touch, when a client was given an enema. Accidental touch took place on one occasion when a nurse, walking past a client, bumped against the client’s arm.

The responses made by the clients when being touched were mainly facial. They ranged from positive facial expression on occasions of being touched by a nurse using expressive touch to occasions of positive facial expressions when the clients were touched in a functional way by the nurse.

This study, then, shows how staff touch clients with high dependency needs. The broad picture confirms earlier studies of touch in nursing, in that it shows most touch to be that which is functional - an unavoidable part of care procedures. Non-necessary touch, called "expressive" touch in this paper, occurs half as often as functional touch but nevertheless does occur. The deliberate use of touch as "therapeutic" was limited in this study. It was given by physiotherapists as part of treatment procedures, and there were occasional hand massages.

What determines how and why nurses touch others? Factors influencing nurses’ use of touch are determined by how the nurse has been socialised to view and to react to touch through culture practices, family relationships, previous experience and institutional policies (Goodykoontz, 1979). They include daily individual variables, such as tiredness, personal physical health, emotional state that can affect a nurse on any particular day and as such can affect his or her ‘touching behaviour’. Estabrooks (1989) states that, “In general, the better a nurse feels physically and emotionally, the more therapeutic the nurses’s touching behaviours are likely to be” (p. 398). Other variables relate to the daily working conditions pertaining that day, for example, the number of staff on duty, whether the staff like each other and the amount of non-client centred work that has to be done. Again, any of these variables could influence the touching behaviour of staff. There were occasions, for example, when the author would observe no touching of the clients at any time within the observation period. The reason for this may have been staff shortages or other work to be done or the nurses did not feel as though they wanted or needed to interact with their clients.

Estabrooks also categorised a further variable as the ‘patient variable’. This falls into two sections. First, the ‘facilitators of touch’, those patients whom the nurse determines to have a greater need for touch, or patients who reciprocate the nurses’ caring touch, or somehow express their appreciation. The second section she described as ‘inhibitors of touch’. This included patients with aggressive behaviours, or who presented some ‘risk’ to the nurse due to their present condition. These ‘patient variables’ did have an influence on the staff in this study as all the clients had a great need for touch due to their conditions of physical disability and
thus were deemed facilitators of touch. There were also occasions when, as facilitators of touch, the clients responded to being touched in a positive way thus showing their appreciation.

An important implication of this work is whether or not nurses should be encouraged, and trained, to increase their frequency of non-necessary touching. Perhaps it would be beneficial to clients and staff for more expressive and therapeutic touch to take place. However, the issue of touching and being touched is highly personal. An individual's need for touch is variable. The primary goal of the nurse should therefore be to evaluate the client's response towards the touch interaction and be aware of what touch could convey. The type and quality of touch-contact may affect the client's physical, psychological and social care needs. Understanding the use of touch could provide the nurse with a potent therapeutic tool with unexplored potential. The authors accordingly believe that expressive touch, used deliberately and professionally, as a therapeutic medium, should be incorporated into the provision of care. A first step in developing such an approach might be by considering the incorporation of hand and face massage into nursing procedures. If used in a professionally structured and deliberate way, for increasing the self-esteem and well-being of the client, valuable benefits could ensue. This argument is examined and illustrated in a case study in Hegarty and Gale (1996).

Areas for further research are suggested in this study since touch, as an element of caring, has received little attention. Further research (and debate, for there are many ethical issues), is required to investigate how touch can be a therapeutic approach in its own right and to document the benefits to clients.

APPENDIX
The following vignettes give examples of observations made during the study.

**Miss C (long-stay hospital)**

<table>
<thead>
<tr>
<th>VIGNETTES FOR MISS C</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Observation 1. (7.30 a.m. to 8.00 a.m.)</strong></td>
</tr>
<tr>
<td>Miss C was awoken and dressed by a nurse. There were numerous types of touch observed during this period. Functional touch was used during washing and dressing. The nurse displayed expressive touch on two occasions when she stroked Miss C’s face to reassure her. Therapeutic touch was displayed in the way the nurse administered talcum powder, with slow stroking movements, to Miss C’s body. Miss C appeared to respond very favourably to being touched, smiling and making chuckling noises during all types of touch. The noises that Miss C made while the nurse was performing the therapeutic touch were much more pronounced and louder than normally emitted.</td>
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| **Observation 2. (8.30 a.m. to 9.00 a.m.)** |
| Miss C was sitting in her wheelchair in the dining room away from any other clients and not next to any tables. The carer who attended to Miss C was a health care support worker. Functional touch was used as Miss C was being fed her breakfast by the support worker. The support worker would spoon feed Miss C with cereal then occasionally wipe her chin where milk was dribbling. This was done on three occasions. The support worker did not speak to Miss C, she remained silent or spoke only to another member of staff. Miss C’s facial expressions were nondescript; she just appeared to be enjoying her breakfast. After Miss C had taken her breakfast she was left in the dining room in her chair. No further touch was observed. |
Observations in the private community home

Miss V (private community home)

**VIGNETTES FOR MISS V**

Observation 1. (10.30 a.m. to 11.00 a.m.)

Miss V was sitting in the lounge on a beanbag. Four other clients were in the room, no interactions were observed between these clients. Two staff were helping the other clients with drinks. Miss V had her hands in her mouth and a nurse removed them from her mouth and placed them onto Miss V’s lap (functional touch). Miss V only kept her hands down for a few minutes, putting them back into her mouth. The nurse again took Miss V’s hands out of her mouth and put them on her lap (functional touch). This situation was repeated four more times. Miss V’s response to this touching was to frown and turn her head away from the nurse. The nurse then gave a drink to Miss V (functional touch) and Miss V stopped frowning. The observation period ended.

Observation 2. (12.30 p.m. to 1.00 p.m.)

Miss V was sitting in her wheelchair at the table. A support worker was standing next to Miss V helping her to eat her meal (functional touch). The support worker kept wiping Miss V’s mouth after each mouthful (functional touch). After Miss V had finished her meal she was left in the dining room and the nurse went to another client. No further touch was observed during this observational period.

Observations in the purpose built community home

Mr. P (purpose built community home)

**VIGNETTES FOR MR. P**

Observation 1. (11.00 a.m. to 11.30 a.m.)

The staff in the unit appeared to be busy doing various tasks. One member of staff was sitting at the table doing paperwork. Mr. P was sitting in his wheelchair at the same table. The nurse did not speak to Mr. P but spoke to me. Another nurse came into the room and asked if anyone would like a drink. She touched Mr. P’s hand and asked him if he would like one. Mr. P responded by lifting his hand. This I was told was Mr. P’s way of communicating ‘yes’. Mr. P would lift his hand slightly off the chair to indicate ‘yes’ and would not move his hand to communicate ‘no’. Mr. P was given his drink, which he drank very slowly. No other touch was conveyed to Mr. P in this observational period.

Observation 2. (12.30 p.m. to 1.00 p.m.)

Four clients were sitting at the dining table eating their meal. The nurses were not sitting at the same table. One nurse was in the kitchen and two nurses were sitting at another table drinking coffee and talking to each other. One nurse did occasionally ask the clients if they were enjoying their meal and one client responded and said ‘yes’. Expressive touch was observed during this observational period as the nurse who had been in the kitchen placed a drink in front of Mr. P, ruffled his hair and spoke to him in a pleasant manner. Mr. P responded to her by looking up at her and giving a faint smile.
These examples of vignettes are the author's personal field notes. The vignettes cover the full observation period of 30 minutes duration, and detail all the data contained in the observation chart and the subsequent activities which surround the context of the touch occurring. Two examples from each care setting were chosen to illustrate the diversity and complexity of both the nursing activities and the client groups.

Summary

Background

Touch has many meanings. It can be interpreted as the acknowledgement of a person's presence, a display of love, an act of aggression, a desire for comfort or a feeling of physical closeness. How one person interprets the touch of another depends upon each person's cultural background, the nature of the relationship and each individual's feelings at the time. Despite the importance of touch, however, it has received very little attention in discussions of caring, and virtually none at all in learning disability.

Aim

This study was to examine how people who care for people with a learning disability use touch and how clients interpret the touch they receive.

Method

The study was designed as a non-participant, observational study of carers in their daily work-routines in three different residential settings with adults with severe to profound learning disabilities. A recording chart was designed that allowed recording of: who gave the touch, where on the body the client was touched, the response of the clients and the type of touch that was given.

Results

The results of this study showed that clients received more ‘functional’ touch than ‘expressive’ or ‘therapeutic’ touch. The majority of touch the clients received was to the hands. The results showed that the qualified nurses gave more instances of touch than the health care support workers did. The responses of the clients on being touched resulted in equal positive and negative non-verbal responses.

Implications

This study shows the types of touch used by nurses, and clients' responses, and it is hoped that it has developed not only new knowledge in the use of touch within learning disability nursing but that this knowledge could lead to improvements in nursing practice. As such, the authors are hopeful that the findings will be acted upon by both service personnel and nurse educators, incorporated into standards and will inform the development of practice.

References


