Touch: a fundamental aspect of communication with older people experiencing dementia

Physical touch is integral to nursing practice yet there are gaps and inconsistencies in the literature informing care, particularly in relation to older people with dementia. Madeline Gleson and Fiona Timmins examine the issues using the journal Dementia Care using the key word ‘touch’, and four citations were retrieved.

General trends in the literature
The exploration of touch in the nurse/patient interaction is not new, studies having been performed since the 1970s in both the UK and the USA. Key researchers in this area include Kim and Buschmann (1999) and, while literature on communication and therapeutic touch abounds, research into physical touch and dementia comprises isolated, small-scale correlations studies using convenience samples. There is little experimental research on the topic and little exploration of the effects of physical touch per se.

The following themes emerged from the literature:
- physical touch as an aspect of nursing practice
- the effect of touch
- the use of touch with those clients with a diagnosis of dementia. These central themes guided the direction of the literature review.

Physical touch and nursing practice
Touch is a valued aspect of providing care as it is invaluable in enhancing the nurse-patient relationship (Arnold and Underman Boggs 1999). The use of touch in nursing is influenced by many factors such as age, education, length of service and organisational factors (Estabrooks 1989, Estabrooks and Morse 1992, Adomat and Killingworth 1994). As with all forms of communication, the touch gesture is made up of four components: the message; the sender; the receiver; the context of the situation (Ellis 1995).

Touch was noted to be a valuable channel of non-verbal communication (Nesbitt Blondis and Jackson 1982, Northouse and Northouse 1998) and was found to be an effective method of communicating with patients with a limited cognitive function (Norberg et al. 1986, Kim and Buschmann 1999). Touch calms, reassures, shares warmth and provides stimulation to older people (Norberg et al. 1986, Hollinger and Buschmann 1993, McCann and McKenna 1993).

In spite of its obvious importance, touch has received only marginal attention in nursing research studies of older people (Vortherms 1991, Routasalo and Lauri 1998). The subjectivity involved in touch and the multiple variables of touch are suggested barriers to general nursing

In the context of nursing a distinction is made between physical touch and therapeutic touch. Both types of touch may be experienced as therapeutic but they differ in their purpose. Therapeutic touch aims to heal the sick by the laying of hands, influencing the receiver’s energy fields (Meehan 1998). Research on nurses’ use of physical touch uncovered a variety of touch practices in the clinical setting and a multiplicity of interchangeable terminology.

Routasalo (1996) distinguished between two types of physical touch in nursing: necessary and non-necessary. Necessary touch is when a nurse implements a physical task. Non-necessary touch is involuntary and involves emotion such as when a nurse holds a patient’s hand. McCann and McKenna (1993) described touch as instrumental or expressive, while Estabrooks (1988) referred to task touch, caring touch and protective touch. Protective is task touch that protects the patient physically such as the wearing of gloves. The variety of terms used interchangeably in the literature makes interpretation of studies and use within clinical settings difficult.

Some studies have shown that instrumental, task or necessary touch is more common in nursing practice with older people than other types of touch. The result of this is that touching by nurses in many situations is associated with the work of nursing as opposed to an attempt to confer an emotional benefit to the client. McCann and McKenna (1993) demonstrated 149 touches of which 142 were instrumental and seven were expressive, highlighting that nurses in continuing care were more likely to use task-associated touch than emotional touch.

Routasalo (1996) observed interactions between nurses and older people in long-term care. Touch was observed in 182 nursing situations. A total of 99 situations were recorded as having involved non-necessary touch. This was very often used in connection with verbal communication, such as giving instructions, waking up the client, explaining, making requests, reprimanding and pointing to things. Where touching occurred without communication it was termed ‘touches for no particular reason’, and may have been used in some instances to reassure the client. Non-necessary touches by nurses were mainly accounted for by touches to the hand, touches to the flat of the hand, patting and stroking.

Touch is further delineated by the body parts that are touched most frequently, which include arms, shoulders, hair and forehead (Oliver and Redfern 1991, Routasalo and Isola 1996). Those of the body that are touched less frequently are the ankles, legs, abdomen and chest (Schoenhofer 1989, Hollinger and Buschmann 1993, Routasalo and Lauri 1998). Areas of the body rarely touched or not touched at all include the ears, neck and genitals (Oliver and Redfern 1991, McCann and McKenna 1993).

There are a number of variables that influence a nurse’s use of touch. These include culture, gender, age, length of service and the patient’s level of functioning or dependence.

Estabrooks and Morse (1992) revealed that a nurse’s touching style is learned and very much influenced by the nurse’s cultural background, nurse education, working style in nurse-patient interactions, and feedback from patients. Studies have also found that female nurses use touch more frequently than male nurses, and female patients receive more touches than male patients (Whitcher and Fisher 1973, McCann and McKenna 1993). Edwards (1998) conducted an ethnological study of nurses’ and patients’ perceptions of the use of space and touch. Results showed that touching between a nurse and patient of the same sex was more common than between a nurse and a patient of the opposite sex. In Estabrooks (1989), all female nurses described themselves as ‘touchers’.

According to McCann and McKenna (1993), older male patients expressed concern about male nurses touching them as it conveyed feelings of homosexuality. In Edwards’s (1998) study, one male patient stated that it ‘did not feel right having a male nurse doing such intimate tasks’. But according to Caris-Verhallen et al. (1999) study of the factors related to nurse communication with older people, gender plays only a minor role in nurses’ use of touch. These results reveal inconsistencies in this area.

Age may also influence the nurse’s use of touch and patients’ receptivity to touch. However, Adomat and Killingworth (1994) found no significant relationship between age and touch type. Conversely, in Edwards’s (1998) study of older patients’ and nurses’ interpretation of space and touch, findings revealed that patients perceived older nurses as having more knowledge, which had a positive effect on patients’ perceptions of space and touch. Nurses with a long length of service working with older people were found to use touch very skillfully (Routasalo and Lauri 1998).

The effect of touch

The impact of touch on the older person has been reflected in studies from a physical, psychological and spiritual dimension.

Physical impact

Lange-Alberts and Shott (1994) examined the effects of touch on nutritional intake. A convenience sample of 17 cognitively functioning older patients in long-term care was used. All of these patients were identified by the staff as having poor nutritional intake. Data collection involved the calculation and recording of the kilojoules and protein consumed at each meal. Results showed patients who were given a gentle touch and spoken to during eating had a significant increase in calorie intake.

Norberg et al. (1986) studied the reactions to touch of two patients with Alzheimer-type dementia. Direct observation and recordings of pulse rate were taken. There were no significant reactions during touch.

Kim and Buschmann (1999) explored the effect of expressive physical touch with verbalisation (EP/T) on anxiety and dysfunctional behaviour in clients with dementia. Expressive touch was defined as the use of touch behaviour for 5.5 minutes (hand massage). The findings revealed that anxiety was lower and episodes of
dysfunctional behaviour reduced with the use of EPT/V. The authors of the study believe there is a need for nurses as a profession to acknowledge the use of expressive touch with verbalisation when caring for patients with dementia as it might be the only way that contact can be made with these patients.

**Psychological and spiritual impact**

Some studies have found non-necessary touch promotes calming, comforting, relaxing and cherishing effects on patients (Adomat and Killingworth 1994, Moore and Gilbert 1995, Routasalo and Lauri 1998).

Chang (2001) examined the conceptual structure of physical touch in caring. A field study was implemented using in-depth interviews with 39 adult subjects consisting of healthcare professionals and patients. Findings revealed that touch in caring centered around five aspects of goals for touch: promoting physical comfort; promoting emotional comfort; promoting mind-body comfort; performing social role and sharing spirituality.

As each individual is unique so too are the experiences of touch. Experiences may differ depending on cultural backgrounds, gender, environmental factors and parts of the body touched.

Moore and Gilbert (1995) examined 25 older clients' perceptions of nurses' comforting touch. Data collection involved showing the candidates a video containing four examples of nurse/client interaction: the nurse touched the client's arm in two of the scenes. Each scene was shown to the clients twice and this was followed by the completion of a questionnaire. The results showed that while in all four situations nurses displayed affection and immediacy, where touch was used the respondents indicated significantly higher levels of both.

**Experiences of touch**

As each individual is unique so too are the experiences of touch (Day 1973). Experiences may differ depending on cultural backgrounds (Estabrooks and Morse 1992, Adomat and Killingworth 1994), gender (Hollinger and Buschmann 1993, Edwards 1998), environmental factors (Adomat and Killingworth 1994, Estabrooks and Morse 1992) and parts of the body touched (Hollinger and Buschmann 1993).

Routasalo and Isola (1996) explored the experience of touching among older patients in long-term care. The sample comprised 25 older clients and 30 nurses. The clients described touch by nurses as warm, gentle and comforting. The nurses placed emphasis on the meaning of touch as a form of communication when clients were unable to communicate verbally or were anxious. Routasalo and Isola (1996) reported that non-necessary touches by the nurses added to the clients' sense of safety, comfort and self-confidence and helped to calm. The study reported that the clients felt positively about being touched by nurses.

In a later study Routasalo and Lauri (1998) explored the expressions of touch in nursing older people. The sample comprised five patients and five matched nurses. Ten nursing situations were recorded on film, and the data were analysed to identify the main expressions of touch occurring. Three themes emanated from the data: touch in performing a nursing procedure; touch in calming a patient; touch in cherishing a patient. A 'gentle' touch was used to calm patients and touch in cherishing a patient rendered the patient 'quiet and motionless, clearly enjoying the treatment'.

Edwards (1998) explored how nurses and older clients perceived the use of touch using an ethnographic approach. The sample comprised seven nursing staff employed on a medical ward 'with a bias toward the elderly' and six clients. Data were collected during 30 hours of visual observation and semi-structured interviews. Themes that emerged were: the initiator of touch, and the abuse/power of touch. Clients reported that they did not feel vulnerable when they were touched; it was actually an expectation of the hospital experience. It was observed that nurses, on occasion, used touch as a means of persuasion.

**Touch and people with dementia**

Dementia has been defined generically as any condition that leads to progressive and usually irreversible deterioration of mental capacities, and is characterised by Alzheimer's disease (Jenkins and Price 1996). The course of dementia is extremely variable and Jenkins and Price (1996) describe the deterioration in communication ability, due to cognitive decline, as one of the most distressing aspects for families, signifying a gradual loss of the 'person' that once was. These authors highlight that physical aspects of care become paramount and that this focus on physical caring is often very unsatisfying to the family.

They suggest that consideration of 'person' can assist relatives in finding more meaning in their interactions with their relative. More attention could be drawn to the person, rather than their physical needs. The authors suggest that personhood is 'something that encapsulates expressions of physical affection', adding that 'touch could have a potential valuable role' in this area but 'is yet unexplored'.

Crum (1998) supports this view, highlighting how people experiencing dementia often become depersonalised within care settings as their physical needs become the central focus of care. The provision of a safe, clean, comfortable environment, which he describes as the central tenet of many institutions, does little to 'offer excitement, opportunity or variation' and inhibits clients from realising their full potential. While the environment was often caring, nurses, Crum (1998) suggests, entered into a parent-child relationship, which had the effect of closing down communication channels.

In Bartol's (1979) experience of clients with Alzheimer's disease, listening behaviour and attention was enhanced in the clients by 'reaching out and touching, holding a hand, putting an arm around the waist, or in some way maintaining physical contact'.

Similarly, DeVos (1989) highlights that non-verbal communication is critical when dealing with clients with dementia and advises use of a 'gentle, soothing, supportive touch and a firm grasp; avoid quick, startling, or hurried movements'. DeVos also suggests 'a gentle soothing touch' as one intervention to use when the client seems 'out of control'.
Discussion
It is clear from the literature reviewed that touch is a special type of non-verbal communication which is very much part of nursing practice. While touch is not an emotion, emotions are formed through the physical, psychological and spiritual effects one experiences. Care of the older person in formalised care settings involves a considerable amount of touch, generated mainly by the level of dependency of these clients and the subsequent physical care needs.

Nurses working with older clients often touch them. For the most part it is perceived that these nurses, perhaps due to workload and time constraints, confine their use of touch to that associated with the delivery of physical care or information/instructions. Where nurses have been observed to use touch, clients' responses are favourable. It was perceived as comforting and reassuring. Studies that examined the benefits of touch found that it reduced anxiety in clients with dementia and improved dietary intake. Although negative perceptions of touch were not revealed, there are varying cultural and attitudinal responses to touch that must be considered. Some clients may feel uncomfortable with this aspect of care.

The older person in a formalised care setting is very often deprived of emotion and deprived of touch. Nurses are in a unique position to offer comforting touch that is acceptable to clients and potentially beneficial. A particularly vulnerable group within older care settings contains those people with dementia. Often these clients, through cognitive impairment, lose their ability to communicate effectively. Touch remains a lifeline for them to retain some of the 'personhood' that they have lost. The reported benefits of touch in the general literature, together with small studies in this field, indicate that the use of expressive touch with clients with dementia is likely to improve their emotional wellbeing. It may be used to transmit emotion and care, connect to the client and provide reassurance and comfort during distressing situations.

Conclusion
Clearly, further research is required in this area. In the meantime, we suggest that nurses reflect on the nature, meaning and impact of their current touch practices. Caring is fundamental to nursing and touch displays care. It is imperative that nurses working in older care settings recognise the touch deficits encountered by their clients and seek to address this in appropriate ways. Following initial assessment of the client's views in this area, incorporating a simple hand pat/hold or stroke into daily care could contribute much to a client's emotional bank account and restore some of the personhood that has been lost.

Madeline Gleeson RPN, RGN, BNS is Clinical Placement Co-ordinator, St Patrick's Hospital, Dublin; Fiona Timmins RGN, BNS, RNT, FFNRCISI, NFESC, MSc is Lecturer, Trinity College Dublin

References