Using touch as a way to manage aggression

Susan Burns examines the practice and implications of using touch as a form of non-verbal communication with patients who are in distress

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Abstract

This article explores the positive effects of touch, in particular the benefits and implications of giving comfort through touch to distressed individuals in aggressive situations. This type of touch can be regarded as therapeutic communication. It is integral to the wider range of non-verbal communication skills, and acknowledges cultural and social differences. The article describes ethical principles in the practice of touch, clinical decision making, nursing team dynamics and the implications of staff training. Throughout, the terms 'nurse' and 'patient' are used, but the principles described relate to any relationship between service user and service provider.

Keywords
aggression management, relationships, touch, violence, mental health

EFFECTIVE COMMUNICATION is essential in all areas of nursing; it is the cornerstone of all nurse-patient relationships and fundamental to good nursing practice (Collins 2009).

The use of touch is significant in the wider continuum of non-verbal skills but should not be viewed as the most important factor in communication. Consideration must also be given to proxemics, or the use of personal distance between individuals; oculesics, or the use of eye contact; and kinesics, or the use of body movements, facial expressions and posture.

Coppa (2008) notes that therapeutic touch has been used in clinical settings as a means to alleviate anxiety, manage pain, boost immune systems and accelerate recovery. There are many publications that explore and support the use of therapeutic touch for specific ailments and how its effectiveness can be used in different patient groups.

Touch is used to augment verbal communication. It is beneficial to examine how it can facilitate relationships at an early stage and support non-verbal and verbal communication skills by all who use touch. It is also beneficial to examine how touch is used in various cultures and relationships. Mason and Chandley (1999) and Gleeson and Timmins (2004) consider touch the most effective and fundamental aspect of non-verbal communication. It is particularly significant when communicating with those who have limited understanding of verbal language or whose receptive skills are compromised by physical or sensorial disability. The different types of touch are defined and illustrated in Table 1.

It would be inappropriate to discuss how touch can be used without first acknowledging how it may be interpreted in a culturally diverse society. Andrews and Boyle (2003) state that it is beneficial for healthcare professionals to be culturally aware in order to ensure sensitive delivery of care. This awareness provides nurses with an understanding of what may or may not be culturally appropriate and therefore provides a sound platform for meaningful engagement.

It is not only verbal language that can differ between groups; non-verbal communication, and therefore the significance and interpretation of touch, can also differ. Some cultures welcome touch and find the experience supportive and comforting, while other cultures may find touch offensive. In different cultures there may be further variables to consider. For example, the gender, age, marital status and culture of the individuals interacting and initiating the touch will impact on its effective use.

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Table 1 Type of touch and functions

Type of touch	Relationship and message	Examples of application
Functional – professional	Touch is used simply to provide a function, as a means to an end	Carer dressing an infant; nurse touching a patient to aid examination; masseuse performing a massage on a client
Social – polite	Physical contact is made between acquaintances and colleagues	Generally demonstrated at the beginning and end of a social interaction: handshakes, kissing on cheeks or gentle use of a hand for guidance
Friendship – warmth	Demonstrated between good friends and some relations	Use of hugs as greetings and farewells, and to offer comfort when needed
Love – intimacy	Between significant others, life partners and close relatives	Involves close contact through hugs, cuddles and kissing to provide reassurance. May reinforce the unconditional aspect of the relationship
Sexual – arousal	Normally between consenting individuals, driven by sexual desire and to fulfil human needs for sexual pleasure	Physical touching of breast, genitals and other sexual areas of the body, normally resulting in sexual climax

(Adapted from Knapp 1980)

Although Table 2 illustrates basic considerations, Smith (1998) encourages caution in identifying cultural differences in this simplistic manner. We must acknowledge that cultural practices and customs are becoming more varied and complex in multicultural societies. As the number of subcultures increases, generalisations must not be made of particular groups. Religious beliefs may play a significant part in non-verbal communication. For example, practising Muslims do not touch each other with their left hand, as this hand traditionally fulfils personal hygiene tasks. In fact, to be touched with a left hand will be seen as disrespectful to many Muslims. The touching of a person's head in some Asian cultures is inappropriate as they believe it is the head that harbours the soul.

Touch in a nursing context

O'Toole (1997) describes the use of touch as 'an intervention that consists of purposeful tactile contact with a client'. This implies that there must be a purpose to the touch or some form of benefit resulting from the interaction.

The touch could therefore be the completion of a task or to offer comfort. There is a dearth of empirical evidence that demonstrates the various ways that touch can aid the wellbeing of patients. Anecdotal evidence demonstrates that benefits include comfort, reassurance, pleasure, empathy and a reduction in feelings of isolations.

Watson (1975) distinguishes between two types of nursing-led touch: expressive and instrumental. The latter is used the most frequently during a nurse's daily work. It encompasses taking blood pressure, dressing a wound, the administration of medication, completion of invasive procedures and assisting the patient to dress and feed.

Most physical nursing duties use touch to complete a physical task. Expressive touch can be demonstrated by holding hands, a shoulder being stroked or a comforting embrace, or any action driven by an emotive response to someone's distress.

In the field of mental health care for older people, nurses must use a combination of instrumental and expressive touch. This is due to the likelihood of cognitive impairment, associated physical decline and the overall deterioration in patients' ability to self-care appropriately. In these care settings, instrumental touch is used to address patients' physical needs while expressive touch facilitates communication. Placing a hand on a patient's arm, for example, may prompt them to go to the bathroom. Alternatively, a hand massage may be used to help calm a distressed individual or indeed to increase the patient's awareness of their physical being. It is generally accepted that good quality care in care settings for older people has to focus not only on the physical health of the patient, but also on the need to maintain patients' cognitive abilities. Gleeson and Timmins (2004) advocate the use of touch to help maintain psychological health as well as patients' physical wellbeing. Therefore, nurses working in this setting need to use a combination of instrumental and expressive touch to address the individual's wider holistic needs.

There is little published research examining how touch is used with working-age adults in mental health care establishments, where patients may have few physical needs. Expressive touch in specific situations is beneficial to the patient,

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that it helps cement therapeutic relationships, and that using close touch can have a positive impact on patient care. For example, putting an arm around a patient's shoulder or offering or initiating a hug for patients who exhibit mild distress can alleviate a situation.

Stroking and rubbing the arm or head during the application of holding skills due to an aggressive outburst or general loss of control can also be beneficial. These interactions are aimed at offering comfort and reassurance, and at facilitating recovery and regaining a sense of control. It is the author's experience that, typically, these types of contact will be used predominately by female members of staff who are older than the patient. This implies that the interaction may be driven by maternal instincts to give comfort and reassurance to a distressed individual, mirroring the tactile communication that is essential to a young child's development. It is a useful exercise to identify the types of touch that are used in a particular work area and to reflect on the message that such touch conveys to the person who receives it.

Touch in aggression management

Most inpatient facilities, statutory and private, provide staff training in how to manage aggression. Training falls into two broad categories: physical disengagement skills that can be applied if staff are being physically assaulted, and a co-ordinated approach that will allow staff to physically hold a patient whose behaviour is aggressive.

Most training advocates holding the patient's arms, legs, head or shoulders while other areas of the body are designated 'no touch'. These include the genitals, chest and face. These areas are not only sensitive to touch and pain; they are also considered intimate and personal areas that are likely to elicit a negative response if unwanted touch occurs.

A fundamental piece of advice, which forms the basis of most disengagement-type training, is to maintain a safe distance while noting one's own posture and any unintentional signals that may be given to the aggressive individual. The use of proxemics is particularly useful when staff are attempting to de-escalate an aggressive situation. This phase of intervention relies heavily on the good interpersonal and negotiation skills of the staff members. Mason and Chandley (1999), Wilder and Sorensen (2001) and Linsley (2006) all present key communication skills for staff to adopt while de-escalating, and all emphasise that keeping a safe personal distance between the staff member and the patient is essential. Although this appears to be familiar and routine advice, it removes the possibility of physically touching the patient and loses the benefits that touch can offer.

While some advice clearly states not to touch individuals from specific patient groups because of the risk of being struck (Videbeck 2006), consideration should be given to applying touch in a timely response. An awareness of the service user's typical assault cycle is crucial for staff to assess when, and if, touch may be applied. For example, intervening early may allow staff to touch an individual at the very beginning of the assault cycle and therefore de-escalate using effective interpersonal or communication skills.

If staff do not possess adequate information about the patient's personal triggers, or cannot identify when a patient is moving away from their 'normal' baseline behaviour, the opportunity for a timely intervention involving touch may be lost.

When a patient has escalated from their baseline behaviour, a co-ordinated staff approach to applying physical holding skills may be necessary. This type of touch is the instrumental type. Staff are using proximity and holding skills to complete what could be defined as an invasive procedure. In this situation, nurses are not required to gain consent from the patient beforehand because of the

Table 2 Cultural variations

Culture	Non-communication considerations
Asian	■ Women may avoid shaking hands and, because it may be regarded as rude and impolite behaviour, may avoid eye contact ■ Refrain from public touching, kissing, loud talking and laughter ■ Touch is generally perceived as a personal act between individuals, and a means of communicating loyalty and respect. Affection may be displayed in a more physically reserved manner. ■ It is considered disrespectful to touch the head, back or shoulders of an older Asian person ■ Preferred physical distance between individuals is at least two or three feet
European	Generally seen as expressive, with handshakes between familiar people, and generally more boisterous compared with people from Asian cultures. Eye contact is viewed as positive interaction when augmented with polite interaction. Southern Europeans are more tactile and expressive, with touching and cheek kisses common. A comfortable physical distance between individuals is two or three feet
Middle Eastern	■ Intense eye contact. ■ Close physical distance of less than two or three feet is acceptable.
British	■ Touch is minimal. ■ A comfortable physical distance is two or three feet.

(Adapted from Videbeck 2006, Giger and Davidhizar 2003)

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probable aggressive nature of behaviour and any subsequent risks. However, every type of touch conveys a message. In this situation the patient is likely to interpret the touch as a means of control and restriction, regardless of the physical holding skills and the professional intentions of the staff. Some patients may interpret the message as one of comfort, because the proximity of staff relays the messages 'You are okay' and 'We are here'. Although the initial rationale for holding was to bring a potentially aggressive situation under control, once this objective has been achieved the type of touch can change from instrumental to expressive. For example, when the initial risk of aggressive behaviour has diminished and the patient is moving away from the crisis phase and into the recovery phase, maintaining less restrictive holds serves a very different purpose; the message is no longer one of control, but of comfort and reassurance.

Ethical considerations

Beauchamp and Childress (2009) identify those suffering from mental illness as a population that may be viewed as vulnerable. The vulnerability of those individuals who receive inpatient or residential care can further be compromised. Tschudin (1994) states that they quickly become institutionalised, and this can erode their autonomy while increasing the likelihood of being subjected to care based on the personal values and beliefs of staff. The application of ethical principles to any concerns should facilitate an open, professional and wide-ranging discussion to ensure the delivery of sound and effective patient-centred care.

Table 3 Emergent and intuitive interactional styles

Emergent-style response	Intuitive-style response
Scenario 1: a patient with a long, well-known history of aggressive behaviours is pacing the floor and shouting. His behaviours are likely to continue escalating. His key worker has momentarily left the ward	
The nurse will discreetly summon other staff so the situation can be managed safely. The nurse may also make a judgement about how long the key worker will be away before intervening, as the key worker is likely to have the best relationship with the patient	The nurse will identify that the patient is becoming more agitated and quickly moving through the escalation phase of the assault cycle. The nurse may approach the patient and try to make contact and de-escalate the situation before it becomes high-risk
Scenario 2: two patients are involved in a verbal altercation. It is obvious that physical blows will be struck by both parties imminently	
The nurse will appeal for calm verbally while instructing the other patients to leave the area to maintain their safety. The nurse will co-ordinate this while summoning help to safely separate the individuals who are now fighting	The nurse will instruct the patients to stop arguing and approach their immediate vicinity while continuing to instruct them to stop. The nurse may even try to prevent physical blows by standing between the patients and pushing them apart, or by trying to move one patient away from the other

Autonomous professional practice Nursing staff are deemed to be competent in clinical decision making and therefore able to practise safely and autonomously. Interventions become paramount when dealing with an individual who is displaying aggressive behaviour and where staff have to make judgements to deal with immediate risks. They often have to make swift decisions to safely manage an individual, and intervening early may be urgent to prevent low-risk incidents from escalating into high-risk situations.

Finfgeld-Connett (2009) identifies two interactional styles that staff may adopt when faced with aggression: emergent and intuitive responses. Emergent responses rely on the nurse taking time to reflect on previous clinical experiences, knowledge and alternative actions before initiating a response. Intuitive responses are executed immediately, with little thought or consideration. They are born from the staff member's instinct and derive from experiences and value systems.

Some staff will simply act instinctively. They view their actions as a natural humanistic response that will assist the patient's recovery and they pay no heed to the possibility that their actions could be deemed inappropriate. Table 3 highlights different responses to the same situation. However, the use of comforting touch between staff and patients in any situation, including aggressive situations, is rarely discussed between managers and care teams, yet some nurses employ it instinctively. Unfortunately, discussions may arise only when an allegation of inappropriate conduct is made or when different practices in care teams are questioned. In these situations it is likely that adhering to clear professional boundaries and task-oriented nursing will be favoured over a staff member's choice to offer comfort by doing what they deem to be a simple humanistic action.

The lack of open, honest and constructive discussions can lead to divisions and allegations in a team, and this, in turn, may lead to greater pressure on staff and more stressful working areas. Cornwell and Goodrich (2009) note that staff working in these situations will find it difficult to maintain a compassionate element to care delivery, which may compromise the patient experience.

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The patient should be at the heart of all nursing care delivery. Nursing professionals should strive to engage the patient when planning care and developing advance directives. This process needs to take into account the individual's beliefs, culture, religion and personal preferences regarding their treatment strategies. Staff should not only acknowledge individuality, but also empower patients to assert their own autonomy and choices. Actions that conflict with patient wishes and therefore deviate from care plans should be considered carefully and with regard to patients' capacity and any previously recorded wishes.

As part of the care planning process it may be useful to assess how the patient feels about personal space, privacy and familial relationships, in addition to their feelings regarding touch and general tactility. Although these may appear to be additional subjects to address with patients, there are many ways to assess them. Staff should use clinical judgement and self-awareness when observing the patient's reactions to instrumental touch during routine nurse-led tasks, such as physiological measurement. If the patient appears uncomfortable with this, then they are likely to feel uncomfortable with expressive touch, as routine medical interventions are accepted common occurrences in a hospital environment.

However, just as patient consent to undergo medical examinations must never be assumed, it should never be taken for granted that a patient who feels comfortable with instrumental touch will also feel comfortable with expressive touch. Patients who communicate feelings of being uncomfortable can provide the nurse with opportunities to discuss touch and their personal wishes. Boundaries can then be set as part of a wider patient-led directive.

Staff can also observe how the patient reacts to expressive interactions with visitors, familiar faces and fellow patients whom the patient perceives to be non-threatening. This will give insight into the patient's feelings about personal space and privacy. If conversations specifically addressing touch are not appropriate, then the layering of exposure to touch through carefully considered graded exposure may be beneficial instead. Ultimately, the patient must be allowed to guide the level of touch. If a member of staff acts intuitively or moves towards a patient to make physical contact and the patient moves away, then it is obvious that the patient does not wish to be touched. If a patient indicates that they feel uncomfortable or threatened, those wishes must be respected.

The principle of justice embodies equitable and fair treatment but also acknowledges that the delivery of care may vary for each individual. We have already recognised that different staff members may view the same situation differently and therefore respond in different ways. These differing actions may be viewed as conflicting with the principles of fair and equal treatment.

The decision to use touch is loosely based on patients' age, gender, diagnosis and past behaviours, factors over which they have no control. Indeed, one staff member may view a patient's history and circumstances in completely different ways from another. They may be basing their judgements on their own personal experiences, morals and belief systems, yet it is these variables that may guide the staff member's decisions about the use of emotive touch.

Because touch is not readily discussed, some patients may find themselves being treated differently by staff members, even on a shift-by-shift basis. A patient may become distressed and receive a comforting arm around the shoulder from one staff member and, on another occasion, receive a different response from another, without the comforting touch. This can create an imbalance in the team and affect how the patient engages therapeutically with particular members of staff. Additionally, patients may observe how staff interact with other patients and draw comparisons with their own experience of the service.

Depending on the patient's preferences and existing advance directive or care plan, they may feel aggrieved at not receiving the same amount of affection and touch. They may then conclude that this perceived omission in their care is based on their age or gender, for example, and it may be viewed as discriminatory.

Conflicts between principles Beneficence and non-maleficence can be viewed simply as opposites of the same principle. Beneficence refers to one's duty to promote good or to benefit others, while non-maleficence is the duty to do no harm, either intentionally or unintentionally (Videbeck 2006). However, taking a simplistic view and applying all ethical principles to actual practice to assist in decision making presents difficulties. An act that was guided by beneficence can soon change into an act that brings harm to the person.

Frequently, nurses find themselves caring for patients without having information about their background, lifestyle, beliefs and previous experience of trauma. The person may be experiencing their first episode of mental illness and so a detailed personal history has never been undertaken, or they may not be known to local services, or documentation may have been poorly completed with little elaboration.

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There are many reasons why touch may not be accepted by individual patients. Staff need to be aware of those who may have a history of physical or sexual abuse. If touch were applied in this situation it may unintentionally cause psychological harm. Vickers (2008) states that patients who have suffered such trauma should receive careful consideration because of the possibility of them perceiving touch differently. Their perception is likely to be based on the negative touch they have experienced, as opposed to the positive aspects that genuine and caring touch can convey.

It is these considerations, among others, that were identified in Gleeson and Higgins' (2009) study that examined how staff working in mental health settings perceive touch. Male participants cited concerns that female patients might incorrectly interpret touch as having sexual intent and expressed their fear of inflicting unintended psychological distress. Reasons that staff may give for not using touch include:

- Patient may misinterpret touch as threatening, condescending or an intimate gesture.
- May invite unwanted touch from service user to carer.
- Blurring of professional/patient boundaries.
- Possible allegations of misconduct.
- Touch should only happen in communal areas, in front of witnesses. The principles of beneficence and non-maleficence are also attributable to the concept of subjectivity and patient experience. A staff member's interactional style may be viewed by one patient as professional and efficient, while another may see it as distant and cold.

Discussion

Acknowledging the positive effects and the significance of touch may empower those staff who refrain from using touch out of fear of possible recriminations. If staff apply ethical principles to initiate and frame discussions and debate in organisations, this may lead to the development of guidelines or directives, which can reassure staff who are cautious or fearful of false accusations.

With publication of the NHS Constitution: The NHS Belongs to Us All (Department of Health (DH) 2009), therapeutic engagement, including touch, has been brought into sharp focus. Cornwell and Goodrich (2009) state that compassion in nursing is a current political issue because of a number of widely publicised cases where alleged nursing interventions or organisational structures prevented compassion from being at the forefront of patient care. This has been further supported by the Francis Inquiry into Mid Staffordshire (2013), and the recent DH (2012) publication Compassion in Practice, which places empathic and compassionate care at the centre of all care delivery.

Research suggests that the effectiveness of treatment is influenced by the level of compassion displayed by nursing staff during the care episode (Epstein *et al* 2005). This is reflected in how the patient may view the therapeutic relationship with nursing staff. For example, a patient is more likely to engage and discuss their illness, symptoms and concerns with a staff member whom they feel to be compassionate and sincere.

The Nursing and Midwifery Council (2007) identifies compassion alongside 'care and communication' and therefore rules that these are essential skills that all student nurses must be assessed as competent in before they can register. However, Davison and Williams (2009) acknowledge that assessment of the care and compassion given by staff is extremely difficult to determine precisely and measure against written competencies.

Conversations regarding touch may reduce divisions in nursing teams and create a more accepting, open and equitable philosophy of care. Therefore, organisations should be considering training staff to apply touch judiciously and thereby offer them the skills needed to assess a patient's receptiveness.

The teaching of concepts and beliefs behind the use of touch would be positive if included in a wider communication and self-awareness syllabus. However, any instruction on how to apply touch in a given scenario is likely to render the

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interaction ineffective, devoid of authenticity or empathy and result in staff touching patients just because they feel obliged to. If organisations were to offer training in the application of touch, it would open some key issues. How would the learning be assessed? What core components should be evident before an interaction is deemed therapeutic, humanistic, compassionate or empathetic?

The application of touch must be complemented by a nurse's self-awareness and as part of key communication skills. It should be congruent only with the patient's needs and not with the need to fulfil any target-led directive.

Conclusion

Expressive touch has a significant role to play in all care settings, and should be available when patients are experiencing distress, confusion and fear. Staff may feel an obligation to adhere rigidly to a set of taught physical holding skills for fear of reprisals from colleagues in case any injuries occur, or to avoid a general feeling of loss of control regarding the patient's behaviour and management. As a result, staff may be inclined to use unnecessarily restrictive practices. To relax a hold slightly in order to stroke the patient's arm or shoulder may seem unacceptable. The application of touch is most likely to be applied safely and to maximum effect during the early escalation phase and once a patient has started to enter the recovery phase of the assault cycle. However, it is accepted as good practice to ensure that all efforts are made throughout the violent episode to maintain good communication and to strive towards de-escalation of the patient's behaviours.

There have been many publications exploring the power of touch and its significance as a means of communication, and more recently some have covered the use of touch in mental health settings. But there is still very little research regarding patients' perception and acceptance of touch, how therapeutic relationships are formed or the subjective experiences of how aggression is managed in nursing establishments. There is also little research into how gender and age may affect nurse-patient relationships. This work is imperative to ensure that staff teams encompass a diversity of age, gender, culture and lifestyle experiences and are not based solely on academic achievements.

The use of touch in mental health care was once viewed as a foolhardy interaction, neatly illustrated by a quote from Older (1982): 'Touch a paranoid and risk losing a tooth, touch a seductress and risk losing your licence, touch a violent patient with a short fuse and risk losing everything!' Although this quotation is more than 20 years old, unfortunately elements of the reasoning behind it still inform some nursing practice today.

As nurses, we should strive to see through a diagnosis and harmful behaviour, and remember that there remains a distressed individual who may or may not need comfort and reassurance. We should continue to explore strategies to offer care and reassurance and begin to challenge any barriers that may prevent us from doing so.

Implications for practice

In raising awareness of touch, encouraging professional discussions and drawing up guidelines, you can:

- Ask your line manager whether there are existing policies or procedures regarding touch
- Find out how complaints about inappropriate touch are managed in your workplace
- Find out how colleagues and managers would view the injury of a colleague due to the relaxing of holds
- Talk to colleagues about how they feel about touch. Find out if they are relaxed about touching service users or if there are service users who they would not touch. Also find out what guides their opinions, such as gender, diagnosis, previous negative experiences or the possibility of a complaint against them
- Consider the introduction of more tactile activities for some service users, hand and foot massages, nail care, hair care and even craft activities using clay-type media

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Conflict of interest
None declared

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