The objective of task orientated touch in trauma resuscitation is to bring about a recognised physical therapeutic result. However, while Driscoll’s (1993) approach to the resuscitation process does decrease the level of mortality, the technology used also reduces the need to touch the patient. Examples of these are spinal boards and electronic blood pressure machines. Watts (1998) claims that when a patient is touched, pain and loss of dignity are associated with the process, while Jay’s (1996) research into the effect of resuscitation highlights the patient feels abandoned, neglected and requiring physical comfort.

Comfort may be provided through different forms of therapy: silence, verbal communication, humour and touch. Touch as a therapeutic medium is by definition ambiguous (Carter 1995), due to the fact of its portrayal as an unwritten language. Autton (1989) claims that nurses who are comfortable and spontaneous in expressing themselves through the medium of touch can imply distinct and vital messages to patients. The patient becomes aware of the carer’s empathic response which indirectly conveys that the team is also rooting for him or her. To give structure to this ambiguous therapy, Pratt and Mason (1981) developed a model to illustrate the thought processes involved with touch:

- **INTENTION** – What do we hope to convey
- **EXPRESSION BY TOUCH** – How this message is conveyed through touch
- **PERCEPTION OF TOUCH** – How the patient perceives the carer’s touch
- **MEANING UNDERSTOOD** – Its meaning is mutually agreed.

This model offers a useful tool to explore each stage of this therapy.

Tippett (1994) implies that nursing in the acute setting is becoming dehumanised and that the use of non-task orientated touch can bring about a measure of comfort among the technological and systematic approaches used in resuscitation, which undoubtedly save lives. Patients, however, are psychologically traumatised by the event. The need to feel special, human and central to the process of resuscitation must be given recognition. There is a growing need for the nurse in these circumstances to step back and identify the need to support the psychological, as well as the physical. This can be supported by the careful use of touch not related to tasks to enhance the therapeutic relationship between nurse and patient.

Apart from the resuscitation team, the patient must be able to identify the nurse from with whom they will develop a therapeutic relationship; touch can be instrumental in this process. This article will explore the culture of resuscitation and how it leaves the patient feeling frightened and abandoned. Then through an
understanding of therapeutic relationships, recognise how touch can play a major role in achieving a therapeutic bond between nurse and patient.

It is claimed that a generation or so ago nurses were more likely to communicate through touch than they are today (Carter 1995). The rise in technology and systematic trauma care moved the priorities of touch to purely task orientated care, which in turn has reduced the provision of comfort (Watts 1998). Systematic, structured resuscitation, as described by Driscoll (1993) does decrease the level of mortality but the technology reduces the need to touch the patient. The use of a spinal board has ensured that a nurse no longer needs to cradle the patient’s head, to maintain spinal control (Watts 1998). Automatic blood pressure machines check the patient’s blood pressure, which encourages care from a subtle distance. The resulting effect is that the nurse needs only to look across at the monitor rather than have direct contact with the patient.

The trauma team, while encouraging a slick systematic approach to trauma care, also encourages the patient to realise the severity of his or her condition (Watts 1998). A further concern is that a sizeable team not only disturbs the patient but also may create a barrier between nurse and patient. This could be due to the patient not being able to identify the team member to develop a one to one relationship with.

Watts (1998) maintains that each time the patient is touched (task orientated), pain and loss of dignity are associated with the process. In addition, it also has the effect of dehumanising the patient and implies their emotional needs are a low priority; we appear to be treating the injuries and not the person.

Autton (1989) maintains that a patient exposed to crisis intervention will become frightened, feel helpless and angry. This will uncover a need to be accepted, from which they will feel a degree of security. Through interviewing patients following resuscitation, Jay (1996) also found that many appeared overwhelmed by the experience and often seemed muddled over the events. But although patients voiced feelings of abandonment and neglect, they were also reassured through touch and hand holding which was closely linked with comfort.

The literature suggests that we are in danger of failing to provide comfort through therapeutic relationship during resuscitation in A&E (Tippett 1994). However, to understand if touch can assist in this process, there must be an appreciation of the therapeutic relationship between patient and carer. Pratt and Mason (1981) maintain that the function of a therapeutic relationship is to improve the physical or physiological capacity of the patient. This definition does not recognise the psychological support the patient may require or how it is to be achieved. The Oxford Dictionary (1993) defines therapeutic as: ‘Contributing to the cure of disease... contributing to general especially mental well-being.’

This definition encompasses the multifaceted aspects of therapeutic care both physiological and psychological. However, Jay (1996) claims that the priority of a therapeutic relationship is to convey sympathy and caring. My concern with this view is that a traumatised patient might reject sympathy but still needs to know that the nurse is aware of his or her injuries, pain and fears. In other words, the nurse must be empathetic to the patient’s physical and emotional needs.

My own interpretation of a therapeutic relationship based upon previous definitions but designed to encompass the unique context of A&E care is: “The supportive partnership between the patient and the nurse so that physical and emotional needs can be assessed and treated to achieve an optimum level of care for that patient.” This relationship is developed within the constraints of the priority of physical needs of the patient and their short time within the department. It should be remembered that
...touch is a reciprocal language in that the nurse and the patient will interact with one another. They will each dictate the meaning of the touch even if the nurse initiates it.

The average length of care within A&E departments is two hours (Cooke 1993). This places further constraints upon the building of therapeutic relationships.

To examine how touch can assist in developing a therapeutic relationship in relation to emotional support; a concise knowledge base must exist. The literature suggests that inherent in the nursing role is acceptance from patient that they will be touched in the process of their care (Adomat and Killingworth 1994, Hickson and Holmes 1994). The process of touch can be examined under two categories, necessary and unnecessary (Isola and Routasalo 1996). Necessary touch relates to touch which is required to carry out tasks, for example the taking of a pulse. Bottruff (1995) states that 70 per cent of touch is directly related to task, however, it is my belief that during resuscitation this percentage will be greater. Within the ‘golden hour’ many tasks will need to be carried out quickly; rarely does a patient not have someone touching them, but it is usually task orientated.

In relation to unnecessary touch, this is carried out for emotional reasons and to aid communication, not related to task (Isola and Routasalo 1996). This form of communication is described as a silent language, which has the ability to reflect true feelings (Carter 1995). Perry (1996) claims that all the senses touch is the only true reciprocal communication, in that you cannot touch without being touched. However with all nursing intervention there must be an understanding of the implied therapeutic effect brought about by touch. Feltham (1991) highlights this need further maintaining that nurses need to understand the language of touch, which enables a degree of control over this ambiguous therapy. To assist in this, Pratt and Mason (1981) developed a model to illustrate the thought processes involved with touch, which enables an organised structure to explore this complex therapy (Fig. 1).

**Intention**

The first stage implies we must first be aware of what message we hope to convey through touch. The intention to convey comfort and support will be initiated by recognising the fear the patient must feel in the resuscitation room. Adomat and Killingworth (1994) imply that touch can significantly contribute to the traumatised patient’s well being. It could also be implied that the nurse is demonstrating an empathic response for the patient’s situation. The question then arises, can this proof of empathy reassure the patient that the nurse, therefore the team, are in full knowledge of his or her fear, distress and pain? I believe that it does identify to patients that, as a team, we recognise their fear of the situation, and that we are working together to alleviate the cause of the fear. Older (1982) argues that through touch you are demonstrating that the nurse is ‘rooting’ for the patient to get better. The result will bring about an antagonistic effect to the dehumanisation of the patient during resuscitation procedures, which will in effect leave the patient feeling special and central to the process.

It must also be considered that the patient is in the centre of an alien environment looking at the ceiling surrounded by noise and bustle. This will bring about a degree of sensory deprivation; therefore, the challenge is to increase orientation (Feltham 1991). To assist with orientation to the environment, touch can enable the patient to identify the nurse responsible for establishing a therapeutic relationship. Apart from non-task orientated touch developing comfort and rapport, it also ensures that the patient gives full attention when questions are asked and information is being given. Pratt and Mason (1981) examined how touch supplements speech so that the meaning is fully understood. This is achieved by delivering a message through the use of two mediums (touch and speech). This in turn gives greater credence to what is being said, and so there is less chance of misinterpretation.

**Expression by touch**

Once the intention is clearly defined, the nurse should have the knowledge of how the therapy of touch is to be delivered. However, Carter (1995) maintains touch is an unwritten language which in turn may lead to ambiguity and misinterpretation. Pratt and Mason (1981) propose six categories of touch in an attempt to clarify their abstract meaning (Table 1). However, Autton (1989) maintains that the nurse must also be comfortable and spontaneous to touch the patient in relation to provide comfort and support. This raises the question, if spontaneity is a key element, can you dictate specific approaches to touch to between two people?

As stated, touch is a reciprocal language in that the nurse and the patient will interact with one another. They will each dictate the meaning of the touch even if the nurse initiates it. Kacperek (1997) recommends the use of tacit knowledge in the use of conveying support and comfort through touch. Meernabheu (1992) stresses the importance of tacit knowledge in practice, in that only with experience can the nurse gain an understanding of how touch, matched with other mediums, such as, silence or speech can convey the message. Therefore, to dictate what message various types of touch will convey can interfere with this spontaneous gesture and disregard the nurse’s experience and intuition.

However, the nurse should appreciate that there are ar-
Fig. 1. Thought process involved with non-task orientated touch (Pratt and Mason 1981)

dea of the patient’s body that should be avoided in non-task orientated touch. The literature agrees upon accepted areas that the patients feel comfortable with supportive unnecessary touch. Isola and Routasalo (1996) classify areas of the body which are touched during care into four zones (Table 2). The social zone is the area touched most frequently during non-task orientated touch (Isola and Routasalo 1996). However, Isola and Routasalo (1996) maintain that patients’ faces are frequently touched or patterned to convey comfort. This area I believe should be used with caution as it is identified as a vulnerable zone. Before touch can take place of such an area a relationship must have developed so that this touch is seen as comforting and not patronising.

Perception of touch
Appreciation of the patient’s perception of touch or lack of touch during resuscitation and what affects this perception is an inherent requirement for practice. It is claimed that your personal space dramatically alters when you are ill (Hickson and Holmes 1994), indeed patients would not find acceptable the same level of contact prior to the incident which brought them to A&E. Tippett (1994) verifies that, after trauma, there is an inherent need in patients to have increased unnecessary touch. Hickson and Holmes (1994) also describe how touch fosters greater interpersonal communication between the two parties which, I believe, helps to reduce the dehumanising effect of resuscitation and acknowledges the patient as special and central to the process. In turn, the patient is aware of the expression of empathy and is able to communicate freely with the nurse, which can encourage a degree of control over their care. Autton (1989) however claims that patients accept unnecessary touch only when a relationship has developed. From this he stresses that unnecessary touch should not occur until both parties have established such a relationship. As stated the average length of stay in A&E is two hours (Cooke 1993), and this may not be sufficient time to develop the rapport Autton feels is required. However, to deny touch at such a time must be questioned, as to withdraw therapeutic support would not achieve a positive effect. Hickson and Holmes (1994) claim that avoidance of touch conveys a lack of affection and the patient in turn feels rejected.

Isola and Routasalo (1996) argue that the wearing of gloves, can create a further barrier for patients. Overall, it is clear the perception of touch is deemed positive and necessary to the process of developing a therapeutic relationship. If however, the patient indicates that he or she is uncomfortable with non-task orientated touch, this should be respected and documented.

Interference or meaning understood
There is a need to evaluate the therapeutic value of the touch used, which is an inherent need in the use of any therapy. Most care plans, acknowledge the need to reassess the difficulties related to the evaluation of this care. Jay (1996) highlights the difficulties in evaluation of such care due to the vague nature of such an act. There must also be recognition whether touch as a therapy was useful in supporting a therapeutic relationship. Isola and Routasalo (1996) maintain that there are patients who do not wel-
come unnecessary touch and gain comfort through task orientated touch. This ability to gain an insight whether the use of touch was effective in fostering a therapeutic relationship lies, I believe, again within tacit knowledge. Meerabeau (1992) maintains this type of knowledge and awareness is the hallmark of a professional. In that we know something only by relying upon our awareness of it. This implies that our instinctive perception that we have been understood and a productive therapeutic relationship achieved should not be dismissed. A startling revelation from Tippett (1994) identified that 93.3 per cent of patients could not remember the act of being touched to foster comfort during resuscitation. However, when touch was used, the patient was more aware of the nurse’s interest, concern and caring for them. A patient departing the resuscitation room with this impression is proof that we have fulfilled our responsibility in achieving a therapeutic relationship.

The literature clearly shows that the culture of A&E resuscitation does not foster the development of a wider knowledge base. This in turn would enable clarification of its effect in the resuscitation process. Finally, the therapeutic relationship must achieve a partnership to achieve optimum support of physical and emotional needs. The patient must not reflect that the process has been a collection of painful and humiliating tasks with no regard for the patient’s distress. The patient must not reflect that the process has been a collection of painful and humiliating tasks with no regard for the patient’s distress. This demonstrates that psychological support must be a priority and not a nicety, the therapy of non-task orientated touch can only assist in this process.

Conclusion

It is acknowledged that the act of touch to provide comfort and support is usually spontaneous and natural to the individual nurse. But there is a need to uncover valuable tacit knowledge through the use of reflection, which in turn can be supported by the literature. This in turn can support a knowledge base to assist in the development of the therapeutic relationship. To give greater credence to the theory of non-task orientated touch; descriptive research would assist in the development of a wider knowledge base. This in turn would enable clarification of its effect in the resuscitation process. Finally, the therapeutic relationship must achieve a partnership to achieve optimum support of physical and emotional needs. The patient must not reflect that the process was a collection of painful and humiliating tasks with no regard for the patient’s distress. This demonstrates that psychological support must be a priority and not a nicety, the therapy of non-task orientated touch can only assist in this process.

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Table 1. Pratt and Mason’s categories of touch (1991)

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIRM</td>
<td>Strong, using much muscular tension and energy, forceful.</td>
</tr>
<tr>
<td>SUDDEN</td>
<td>Urgent, sharp, instantaneous, of a moment’s duration, excited.</td>
</tr>
<tr>
<td>DIRECT</td>
<td>Direct, on a straight line, undeviating, purposeful.</td>
</tr>
<tr>
<td>SUSTAINED</td>
<td>Slow, smooth, legato, lingering, prolonged, indulgent of time, unhurried.</td>
</tr>
<tr>
<td>FLEXIBLE</td>
<td>Indulgent of space, roundabout, plastic, wavy, generous in attitude towards space.</td>
</tr>
<tr>
<td>FINE TOUCH</td>
<td>Delicate, light, with slight tension, buoyant, sensitive.</td>
</tr>
</tbody>
</table>

Table 2. Zones of physical contact

<table>
<thead>
<tr>
<th>Zone</th>
<th>Area of Physical Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social zone</td>
<td>Hands, arms, shoulders and back</td>
</tr>
<tr>
<td>Consent zone</td>
<td>Mouth, wrists and feet</td>
</tr>
<tr>
<td>Vulnerable zone</td>
<td>Face, neck and front of body</td>
</tr>
<tr>
<td>Intimate zone</td>
<td>Genitalia</td>
</tr>
</tbody>
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