Touch

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> “I have learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.”
>
> Maya Angelou

Touch

A confusing history of touch in hospital and residential programs

Touching and hugging children is a natural instinct for human beings that has both a psychological and a physiological basis. Studies point to the importance of touch for healthy child development and demonstrate that touch deprivation stunts growth and contributes to the decreased development of the hippocampus, a structure of the brain that is important for emotional processing and creating meaning and context to situations (Meaney, Aitken, Bhatnagar, Bodnoff, Mitchell, & Sarrieau, 1990; Schanberg, Kuhn, Field, & Bartolome, 1990). In cases where touch deprivation is severe and prolonged, children may have "lifelong vulnerability to psychiatric disorders" (Carlson & Earls, 1997).

For many years, residential and hospital programs for children encouraged different types of touch and agreed that regular touch was important for normal child development. More recently, programs have developed "No Touch" policies in response to concerns about protecting children from possible abuse by staff, protecting staff from false allegations by children, and protecting children with sexual abuse histories from being re-traumatized. However, the "No Touch" policies and practices sometimes inadvertently reinforce control-based practices by promoting the use of consequence-based systems in programs.

Although there are ongoing debates about whether it is appropriate to use touch in inpatient and residential treatment programs, the growing body of evidence on the value of touch emphasizes the importance of touch in normal child development. These findings combined with a national interest in strength-based treatment led many programs to revise their "No Touch" policies. These programs found that they can allow and encourage healthy touch opportunities and still be sensitive to issues of child abuse, allegations of abuse, and re-tramatization. For example, therapeutic touch techniques and massage have been found to be effective in reducing pain and anxiety, symptoms commonly seen in children who have experienced trauma (Field et al., 1992; Hughes, Meize-Grochowski, Duncan Harris, 1996).

Because the use of touch has been well researched and identified as a critical component of healthy child development (Shonkoff & Phillips, 2000), DMH has encouraged hospital units and intensive treatment programs to thoughtfully consider the issue and find reasonable ways to incorporate the appropriate use of touch into care and treatment. The topic of touch has been raised at DMH Grand Rounds, the Annual Provider Forum, and provider-organized Roundtables. The ongoing dialogue is helping all members of the Massachusetts mental health inpatient and intensive treatment community consider and implement this important element of compassionate care.

Families and children must define the types of touch that are helpful

Before embarking on any touch intervention, children need to be asked about their touch preferences when they are admitted to a hospital or residential treatment program, and these preferences should be honored. Sometimes children may not have the language to describe their preferences or circumstances in which touch was helpful or harmful. In that case, this information should be elicited from the parent or legal guardian who knows the child best. This information should be updated regularly, because children's preferences may change. Use of touch should be individualized based on the histories, preferences, and emotional needs of each child. For example, some children who have been sexually abused may prefer receiving "high five" hand claps rather than hugs. Other children may like the physical contact of a hug, but prefer a side hug, where a staff member stands beside them and puts his/her arm around the child's shoulders, rather than a hug that involves full body contact. Some children may not want to engage in any sort of physical contact with staff.

Useful questions to assess touch preferences include:

- Do you like (or mind) being touched?
- What types of touch do you prefer?
- Are there times when you would prefer not to be touched?
- Do you tend to like heavy blankets when you sleep?

- Do you like to play partner-games with touch like tag or wheel barrel races?

Touch is only positive when children and families and staff members provide the parameters for how touching will occur. Some staff members may not feel comfortable touching the children in their care, even after education about the potential value of touch for children, and it is important to respect their preferences and wishes. There are different cultural preferences around touching as well, which should be considered in treatment planning.

When children are admitted to hospital or residential treatment, programs should:

- Provide children and families with specific examples of the types of touching used by staff
- Ask children to identify preferred therapeutic touch strategies
- Ask families and children for permission to use therapeutic touch (if indicated)
- Gather comprehensive information about the child's trauma history (f any)

The human tactile system

As human beings, we are always touching things or being touched by elements in the environment. Standing with feet firmly on the ground, sitting in a beanbag chair, playing catch,

and wrapping in a blanket are all different ways people can experience touch. The sense of touch, also known as the tactile sense, helps people recognize whether something is cold, hot, soft, rough, smooth, dull or sharp.

The skin contains the tactile sensory receptors that detect sensations of temperature, pressure, vibration, movement, and pain. The tactile system includes both the discriminative systems, which help with body awareness and sensory perception, and protective systems, the body's defensive survival mechanism. The tactile system cannot work in isolation, and it functions in concert with the other sensory systems to help people make sense out of the world and to discriminate between touch sensations that are pleasurable and those that are not.

Please refer to the *Sensory Approaches* chapter of the *Resource Guide* for more information on sensory integration.

Problems with the tactile system

Dysfunctional tactile processing can be caused by many things, such as trauma, physical torture, prolonged stress, touch or sensory deprivation, injury, and immobility. These are just some of the possible reasons problems may arise in the tactile system. Children with problems with tactile dysfunction may display some of the following behaviors:

1. May have difficulty with **tactile discrimination**, which is difficulty in differentiating between different types of tactile stimulation (e.g., types of fabrics, hot/cold, pain perception). They may have difficulty recognizing the physical characteristics of objects (e.g., temperature, shape, texture, density, size). These children may demonstrate the following:

- May get burned easily and/or often
- May not be sensitive to cold temperatures
- May have difficulty distinguishing between different types of fabrics
- May appear indifferent to pain
- May appear to be a sloppy eater or have difficulty with self-feeding
- May have trouble learning to hold a writing instrument correctly
- May have decreased body awareness

2. May be **tactile defensive** (hyper-sensitive) to certain or many kinds of touch (e.g., may scream or strike out when touched; may crave the deep pressure of a hug but then appear to be trying to ward it off). These children avoid the kinds of tactile stimulation they are aversive to and proceed cautiously, and sometimes fearfully, when they have new tactile experiences. These children may demonstrate the following:

- May not like to have hair brushed, face washed or teeth brushed
- May only be comfortable wearing soft cotton clothing

- May not be able to tolerate seams in socks or tags in clothing
- May not be able to tolerate hugs, even from family members
- May not like to stand in lines out of fear of being touched or bumped
- May dissociate or self-injure in order to escape discomfort or when feeling overwhelmed by the stimulation within in the physical environment

3. May be **under-responsive** to tactile stimulation (lack of responsiveness)

These children may demonstrate the following:

- May not appear to notice when they get injured
- May constantly touch things (seeking more touch stimulation)
- May be unaware of tactile cues
- May seek deep pressure to increase their ability to feel (e.g., seem hyperactive, engage in risky behaviors, self-injure)
- May appear unkempt (messy dressers)
- May require visual cues to button or zip up clothing

These tactile processing problems, which can vary from mild to severe, often contribute to difficulty with body awareness, self-image, motor planning, the ability to form relationships, and the ability to engage productively in school, work and play activities.

Assessment of the tactile system

The following is a list of some of the questions that may be asked of children and caregivers to assess a child's tactile system:

Does the child:

- Like to be touched or held
- Become silly when touched
- Always seem to be touching things
- Always seem to try to avoid touch
- Pinch, bite, scratch, cut or punch self
- Head bang
- Seem overly sensitive to certain foods
- Avoid playing in dirt, mud or with clay
- Avoid silky fabrics
- Only like cotton materials
- Demonstrate indifference to pain or extreme temperatures

- Seek deep pressure activities (e.g., jump, run, climb, hug, push/pull, chew)
- Seem excessively ticklish
- Dislike being physically close to people
- Have strong reactions to getting hair brushed
- Have strong reactions to having nails clipped
- Have strong reactions to having face washed
- Seem unaware of bruises or cuts obtained
- Like to bite on objects (gum, pencils, straws)

Some therapeutic touch methods used in Massachusetts

Some programs in Massachusetts recognize that touch can play an important role in treating children who have been traumatized. The Child Assessment Unit (CAU) at Cambridge Hospital developed a parent assessment form that invites parents to comment on their child's sensitivity to sensorial stimuli, including touch. .

For example, the parent may write that, while their child does not usually like to be touched, he/she may tolerate/enjoy a small squeeze or rubbing lotion onto their skin helps to calm him/her down. This assessment is included as a resource at the end of this section. Cooley-Dickinson Hospital in Western Massachusetts teaches adolescents how to perform therapeutic brushing, beanbag tapping, and blanket wrapping

techniques so that they learn how to engage in using them independently.

Brushing techniques vary, but one formal brushing protocol, called the Wilbarger Deep Pressure and Proprioceptive Technique (DPPT), requires specific training before use (Champagne, 2006, Wilbarger & Wilbarger, 2002). Some programs use soft and careful touch methods, such as pats on the back, specific types of hugs, light touches to the arm, and hand hugs, as described in each child's treatment plan. Many programs offer different kinds of tactile manipulatives (stress balls, tangle toys, wikki sticks, different kinds of putty), lotions, blankets, sand/water tables, gardening activities, and art supplies.

Please refer to the Sensory Diet Checklist at the end of the *Sensory Approaches* chapter in the *Resource Guide* for more information on ideas for sensory strategies to help children decrease and/or prevent distress.

Types of touch

There are many types of touch that children can experience in residential or hospital programs. Each program should incorporate both formal and informal healthy touch opportunities. It is helpful for programs to use pictures to show children and families the different types of touch used in the program and types of touch that are not allowed.

Examples of touches that are used in some treatment programs include:

- Child to child touch, such as hugs, holding hands, and sitting close
- Staff to child informal touch, such as hugs, pats on the back, holding hands, sitting side-by-side
- Staff to staff touch, such as hugs, pats on the back
- Staff to child formalized touch, such as massage, playing a game that involves touching, like tag, wheel barrel races and certain types of dancing (e.g., square dancing)

The Cutchins Program for Children & Families – Therapeutic Touch Policy

The Cutchins Programs for Children and Families in Western Massachusetts created a therapeutic touch policy for their residential treatment programs for children with guidelines for staff members around the use of touch in the programs.

Their policy states:

> "One of the goals of treatment is to teach clients to use words to express affection, anger, and complex combinations of emotions. Touch is not a substitute for this learning process. Therapeutic use of touch is an educational piece of work that concerns appropriate vs. inappropriate boundaries. Touch can be a corrective emotional experience, but must be introduced in a mindful way that takes into account the individual and their unique history. Clients who have experienced violations should also be taught to use their voices to set boundaries. Clients should also be taught that warmth and affection could be communicated without touch."

The policy specifically states that staff members may never use the following touches:

- Touch that is sexual, aggressive, or intrusive
- Touch that is startling or hurtful
- Touch that is part of pretend fighting
- Touch that is part of competitive physical interactions

- Touch that includes stroking or kissing
- Touch that includes sitting in laps
- Touch that includes surprise embraces
- Touch that includes massages unless it is part of a group activity with permission, such as the program Spa Day.

Staff members are permitted to engage in the following touching (with the child and family's permission):

- Staff members may jostle children awake.
- Staff members may place a hand on a child's arm or shoulders or back.
- Staff members may engage in incidental contact (e.g., high five) that is appropriate as a greeting.
- Staff members may help children with special hygiene programs that are approved by the treatment team.

Experienced staff members who have been at the program for over a year and have received specific training may use the following forms of touch with the children:

- Playful touch (throwing kids in the water).
- Hugs with verbal or non-verbal permission.
- Picking children up off the ground.
- Putting sunscreen on a child's back.

Massage therapy

The Touch Research Institute (TRI) at the University of Miami School of Medicine was the first center in the world dedicated to the study of touch and its application to science and medicine (TRI, undated). In over ninety studies conducted on the positive effects of massage therapy, researchers found that touch therapy had a soothing effect on adolescents and on victims of sexual abuse of all ages. One study found that after a month of two chair massages a week, adolescents were less aggressive (Diego et al., 2002). Findings from other studies conducted at TRI suggested that physically neglected adolescents often behave aggressively, and massage therapy can be effective in helping them decrease their level of violence (Field, 2002).

Massage therapy and other forms of touch therapy are thought to decrease anxiety, reduce dopamine levels, and increase serotonin levels. Programs may want explore offering massages as part of the treatment that they provide, either through licensed massage therapists (LMT), certification programs, or by staff members trained in simple massage techniques by a LMT. The adolescent inpatient unit at Providence Hospital in Holyoke, Massachusetts offers hand and arm massages to children who find it helpful. The adolescent inpatient units run by the University of Massachusetts at Westborough State Hospital offer back massages with a weighted medicine ball and also have massage therapy interns working with the adolescents.

Please refer to the resource list at the end of the *Sensory Approaches* Chapter of the *Resource Guide* for samples of tools and additional resources that may be helpful in learning more about the therapeutic use of touch.

Pet therapy

The therapeutic use of animals is another way to integrate touch into hospital and residential programming. Several programs in Massachusetts offer pet therapy. For example, Taunton and Tewksbury State Hospitals have integrated the therapeutic use of horses (hippotherapy) into their treatment. Transitions and Centerpoint IRTP's, Metro-West Medical Center, and Cooley-Dickinson Hospital offer regularly scheduled dog therapy sessions as part of both individual and group treatment.

Self-injury and dissociation

Children who engage in self-injury and dissociate often report that they do so either to escape feeling overwhelmed, upset, or scared; when they feel as though they have no control over their lives; or in an attempt to experience feelings at times when they are "numb." Some of these children benefit from using "grounding" techniques, such as a child's preferred tactile and deep pressure techniques, to help them re-establish their mind-brain-body-world connection.

These techniques are often taught and used as alternative coping techniques, but it is important to understand that changing behavior patterns and learning to consistently use new coping skills usually takes patience, practice, and trained professionals. Treatment programs should make use of staff training and consultation with occupational therapists skilled in using these assessment and treatment techniques to help integrate them into program practices.

Additional resources

The Cambridge Hospital Child Assessment Unit's *Parent Assessment Sheet* is included as a resource at the end of this section. The assessment may be photocopied with permission from the CAU, and the program contact information is included in the *Additional Resources, Touch* section of the *Resource Guide*.

CAU Parent Assessment Sheet Child's Name

Date:

Our job on the CAU is to better understand what makes your child upset and to help him or her with this. Often kids get upset when they become frustrated. Some kids have figured out ways to deal with frustration and for other kids this is harder.

We would like to help your child when he or she is beginning to get '"frustrated" before it becomes a big deal and ends in a "meltdown". "Meltdowns" are times when someone is so upset and frustrated or angry that they "can't even see straight". At these times, it is very difficult to figure out what to do to make things better. The feelings of being upset, frustrated and angry may make it difficult to think clearly and make decisions to solve the problem. At times such as these it is very hard to feel in control and to problem solve.

Many of the children who come to this unit have problems managing frustration and stress. When they become very upset and lose control, it creates problems for parents/caretakers in knowing how to manage the situation.

We want to get to know enough about your child so that we can help when he or she is first beginning to become frustrated.
And we want to work on a plan with you and your child to help with this.

Here are some questions that will help us find the answers we need to help you and your child:

For the following, please answer as if you were answering this for your child.

Which of the following do you think is true for your child? Put a Y for yes or an N for No.

It is very hard for me to sit still

It is very hard for me to be quiet and not talk out loud.

It is very hard for me to switch what I am doing in a hurry, especially if I am having a good time.

I can't think straight if I am given more than 1 direction at once.

I have a hard time listening if people talk too long.

I need help trying to decide what I should do next and how to do it.

I have trouble remembering things especially when I am upset.

I have a really hard time thinking clearly when I am upset.

I have a hard time making and keeping friends.

I need people to tell me exactly what they want; I can't figure it out by myself by looking at them.

I am not good at taking hints or body gestures and knowing what they mean.

I know that I want friends but I do not know how to play with them.

I have a hard time trying to imagine ahead of time what will happen if I do something to someone.

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I have a hard time figuring out what someone means or wants just by looking at their face, or listening to their tome of voice.

I have a hard time finding the right words to say when I want to tell someone something important.

I often have a hard time figuring out what someone is saying to me.

It is very hard for me to describe my emotions in words.

I feel cranky, grouchy, irritable most of the time.

The littlest thing can make me very grouchy.

I have a hard time getting out of a grouchy mood.

I always imagine the worst.

I don't expect good things to happen to me.

I think that I am stupid, or fat, or ugly.

I do think that people like me.

I don't like my life.

I feel I need to look out for myself or people will hurt me.

I worry about a lot of things.

I expect bad things to happen. I wait for bad things to happen to me.

I feel scared a lot of the time.

I am afraid of people.

I want the same things to happen over and over again.

I do not like changes in my routine. I want each day to be the same.

I am sensitive to:

Temperature I don't like it too hot or too cold.

Clothing I only like certain types of clothes and it depends on the way they feel.

Food I only like certain foods. The way food feels in my mouth is important.

Motion. I like to sit, stand, jump, move a certain way.

Sound I do not like certain noises. I don't like loud noises.

Touch I do not like people to touch me. I like it when people squeeze me a little.

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Tell us what really "bugs" your child.

For example: I can't stand it when someone interrupts me when I am speaking.

I don't like it when people get too close to me.

When your child becomes really upset what helps him/her calm down?

Being left alone

Being given some time to go to my room

I like to throw things when I am upset

I like to yell when I am upset

I like someone to stay with me until I am a little calmer

I need to feel that grown-ups understand why I am upset

I need someone to help me understand what I did but to tell me in a soft voice.

I need to wait until I am calmer to talk about what happened

I don't like to talk about what made me upset.

I can write down why I am upset.

I t helps me to calm down if I can talk to my mother, father, grandmother, aunt, foster mom, etc.

I like to read in my room.

I like to take a bath or shower

I like to rub lotion on my skin

I like to comb my hair

I like to take pace up and down the hall

I like play with my toys (Gameboy, stuffed animals, cars)

I like to shoot hoops

I like to rollerblade

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What else would help your child to calm down?

What should we watch for as a sign that your child is beginning to have a "meltdown?

I clench my fists

I mutter to myself

I curse

I yell

I argue with people

I try to start a fight

I try to throw things

I start to sweat

I turn red in the face

I run as fast as I can

I refuse to move

I repeat what someone says

I start to talk loud

I talk faster

I make faces

I cry

What other things would tell us your child is very upset?

What things would make it worse for your child when he/she was very upset?

Closing the door to the room I am in

Male staff coming close to me

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Female staff coming close to me

Being in the dark

Being in a room with bright lights

Being held down by staff (all staff, male staff, female staff)

Warning me about the consequences

Trying to talk to me

Not letting me make a phone call to my mom, dad, etc.

Making me sit still

What time of the day is harder for your child?

No time

I have a hard time getting going in the morning.

I have a hard time at night.

I have a hard time in the afternoon, before dinner.

Are there times or places that make him/her afraid or scared?

I am afraid to fall asleep

I am afraid to be in a room alone at night

I am afraid to be in a room with other people

I can't fall asleep without music being on.

I need the light on to fall asleep.

I am afraid of the bathroom

I don't like having to go into a closet.

I get scared when someone yells

I am afraid of strangers

I am afraid of certain types of people (big men, big women, etc)

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What else is important for us to know about your child?

Additional information that is very important for us to know about has to do with experiences your child may have had or witnessed. Please share with us this personal information so that we can not only help your child but also insure that we do not make things any worse for him or her.

Has your child experienced any physical, sexual or emotional abuse? (If your are not sure what this would be, please ask the staff person who asked you to fill out this form.)

No

Yes, (Please explain)

Was this experiencing a one-time occurrence or did this occur repeatedly?

No

Yes, (Please explain)

Has your child or family experienced other upsetting or traumatic events? (fire, flood, witnessed a death of relative or friend, etc.)

No

Yes, (Please explain)

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