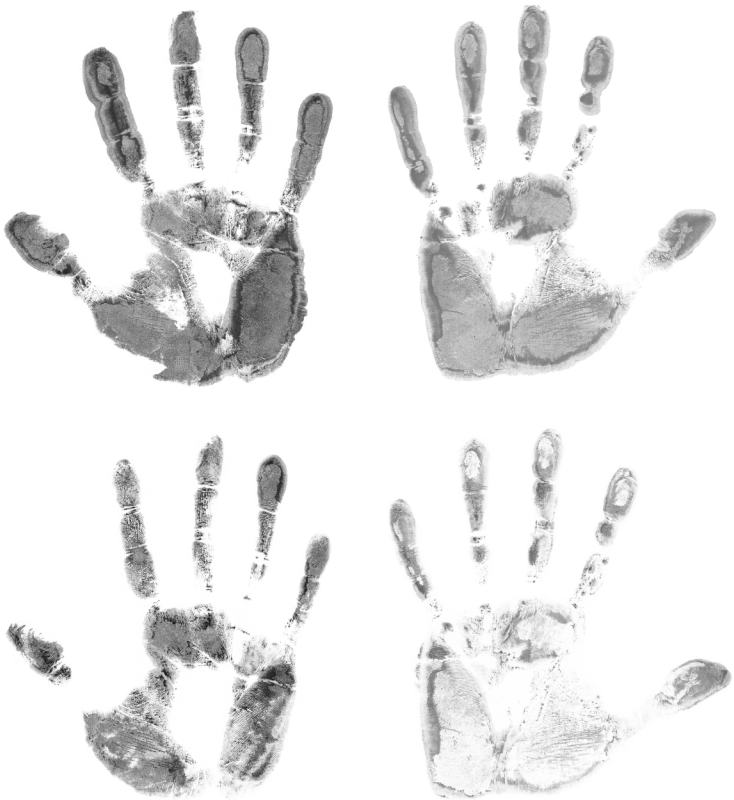
Manipulating practices

A critical physiotherapy reader

Barbara E. Gibson, David A. Nicholls, Jenny Setchell and Karen Synne Groven (eds.)



CAPPELEN DAMM AKADEMISK

CHAPTER 7

The desire for "hands-on" therapy – a critical analysis of the phenomenon of touch

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Abstract

The application of touch has arguably formed the cornerstone of physiotherapy practice. The phenomenon of touch, specifically its legitimisation as a professionalisation strategy has already undergone critical analysis. What has been explored to a lesser extent is the meaning of touch from the patient perspective. Why is the "laying on of hands" seemingly so important to patients and service users, especially given that interpretation of empirical research findings within an evidence-based practice paradigm appears to question the comparative effectiveness of touch-based interventions? The imperative of the increasing public desire for an embodied health experience will constitute a central theme of our argument. In this chapter, we aim to develop a better understanding of touch by critically analysing the phenomenon within the context of physiotherapy. We begin with a short history of

touch, highlighting its importance to our embodied self-knowledge. We then contextualise touch within a therapeutic context. We consider what constitutes therapeutic touch and body work, before addressing what touch might mean for professional identity and mandate. Finally, we draw on ideas from sociology of consumption (specifically touch as a consumer health technology). We do this in order to reconceptualise the narrative regarding the use of touch, as well as commenting on the impact of such a reconceptualisation for the future of the profession. Some suggestions are made in our conclusion regarding options for the framing of touch in physiotherapeutic work. Our suggestions could serve towards redefining our professional identity, our relationship with those who seek our care, and the nature of what society sees as a consumer health technology.

Introduction

In this chapter, we argue that touch in physiotherapy can be productively rethought. Touch has been a central notion within physiotherapy since the origin of the profession, so much so that the identity of the profession has been largely determined by touch and what touch is. Pre-dating its place in physiotherapy, touch has a rich sociological and philosophical history. This history can provide a context on which a modern reworking of touch as a professional device can be predicated. Further, a sociological lens can expose, in late modernity, the notion of touch as a consumer health technology – that is, something which members of a contemporary society desire as part of their human identity and function. This raises challenges and opportunities for the physiotherapy profession. Do we acquiesce to this modern consumerism and provide touch as a service despite empirical research findings that contest its therapeutic effectiveness (what we will call "scientific evidence")?

Or do we abandon touch on the grounds of such "evidence", and in doing so risk alienating ourselves from the consumerist public? We offer here an analysis of the phenomenon of touch with these questions and this background in mind. The chapter begins with a focussed summary of touch as a human sense, followed by how touch can be aligned to therapeutic intents. Our sociological argument then unfolds.

A short history of touch

The role of the sense of touch in sensory consciousness has historically played understudy to other sensory modalities such as sight and hearing (Massie, 2013). In the Aristotelian treatise on the soul, for example, the sense of touch is ranked fifth in order of esteem relative to the other senses. Paradoxically however, Aristotle also acknowledges it as the most perfected sense in humans compared to animals, this discrimination rendering man the most intelligent of animals (Massie, 2013). The complex constitution of touch is equally well represented in the philosophical debate regarding touch as a unisensory or multisensory experience. Whilst this argument is beyond the scope of this chapter (instead cf. Fulkerson, 2011), the experience of touch is irrefutably diverse, involves innumerable receptors and nerve endings, and serves a multitude of functions (Routasalo, 1999). Touch is considered crucial to a reflexive, embodied existence; Husserl states that without touch we could never truly experience our own body, "*…when we are touched, our body appears to us; it appears as our lived body in a way that it cannot appear in vision*" (Mattens, 2009, p. 101).

A phenomenological perspective, and specifically the work of Merleau-Ponty, argues that it is our sensory experience that provides the foundation for our understanding and interaction within the world around us. Merleau-Ponty asserts that we relate to

the world not via a dualism of subject-object or micro-macro, but rather an intimately entwined relationship: "To belong to the world in this way means that our primary way of relating to things is neither purely sensory and reflexive, nor cognitive or intellectual, but rather bodily and skilful" (Thompson, 2005, p. 3). Touch is a unique sense in that it has the ability to bring objects, people and the world into proximity (Paterson, 2007). It is the lack of differentiation between body and world, the indivisibility between the moment of touching and the act of being touched, that contributes to a Heideggerian sense of "being-in-the-world" (Bjorbækmo & Mengshoel, 2016; Thompson, 2005).

Touch and the therapeutic context

From a developmental psychology perspective, touch is considered the primal sense, operant from eight weeks gestation (Valsiner & Connolly, 2002) and of fundamental importance during early infancy. In adulthood however, touch can be more problematic as we "accede to an understanding of ourselves as essentially singular, unified and bounded" (Price & Shildrick, 2002, p. 70). In acquiescing to an ethics of touch, we become quintessentially cautious about whom and how we touch, and what may constitute unwelcome or inappropriate touch (Nicholls & Holmes, 2012). For healthcare professionals, including physiotherapists, there has been a clear move to make a distinction between *physical* and *therapeutic* touch (Bjorbækmo and Mengshoel, 2016). For the purpose of this chapter, we align ourselves with this move and agree with Paterson (2007), for example, in defining *therapeutic touch* as the range of physiotherapy treatment practices incorporating touch. This distinguishes the nature of the phenomenon from the ubiquitous *physical touch*, which could be talked about within a range of professional and layperson contexts. We are not necessarily concerned

with some of the generic ideas of physical touch that relate across contexts and professions, but rather the notions of touch that have a therapeutic intent within the physiotherapy domain. Therapeutic touch in physiotherapy is often disguised and denoted by other terms:

> *"In physiotherapy, touch (both the word and the concept) is not necessarily referred to as such. Instead, it exists tacitly in such concepts as: palpation . . . , nonverbal skills . . . , and embodiment and body work . . . The term 'massage' also implies touch." (Bjorbækmo & Mengshoel, 2016, p. 11).*

Thus, what we mean by therapeutic touch in physiotherapy is some sort of assemblage of the above ideas. Concerning *body work*, we see this also as something which physiotherapy can clearly exemplify. Twigg et al., (2011, p. 171) refer to body work as "paid work on the bodies of others", and early definitions detail the notion allowing for dimensions including "the production or modification of bodies through work" (e.g. Gimlin, 2007, p. 353). We will soon juxtapose our idea of touch in the sociological sense with the hard-line empirical evidence of therapeutic effectiveness of the sort of touch we are referring to. This can be characterised by therapeutic touch "interventions" such as mobilisation and manipulation techniques. This will simply serve as a tool to allow us to make commentary about how the profession should respond if empirical evidence conflicts with a complex, more humanistic understanding of touch.

The move to distinguish between types of touch is exemplified in the history of practitioners pre-cursory to physiotherapists: trained masseuses. Socio-political antecedents to the attempts of these masseuses to professionalise their trade, including the desire to legitimise their practices by establishing a disciplinary approach to therapeutic touch, have been described by others (e.g. Nicholls & Cheek, 2006). Such attempts have perhaps resulted in removing *"any association*

between touch and eroticism", and putting *"distance between themselves and prostitutes"* (Nicholls & Gibson, 2010, p. 500).

The use of therapeutic touch as a professionalisation strategy has, in the main, served physiotherapy well. Over one hundred years of rhetoric have supported the notion of physiotherapy as a "hands-on" profession, performing in a "high touch arena" (Owen, 2014; Roger et al., 2002, p. 170; Thornquist, 2006). Manual therapy and manual handling (as a way of facilitating movement) have become bastions of professional and clinical physiotherapy practice (Owen, 2014) – "manual" deriving semantically from the Latin *manualis*, meaning of, or belonging to, the hand (Oxford Dictionaries, 2012).

Owen (2014) noted that, as part of the professionalisation project, physiotherapists sought to distance themselves from the "low tech" hands-on practices associated with low status manual work. Specifically, "[t]he presence of technical equipment provided definition of the practice by differentiating physiotherapy's hands from the hands of the laity, and the plethora of other 'manual' workers… practicing in the healthcare system" (Owen, 2014, pp. 171-2). Perhaps more significantly, Owen also described how the development of hands-on therapy was implicated as an integral component of clinical reasoning and autonomous, embodied problem solving practices. She noted that touch allows the physiotherapist to "reconstruct" the patient's body, facilitating the assessment-inference-treatment sequence that is constitutive of professional practice. This observation is also supported by Rose (1999) who studied a graduate physical therapy programme that trained students in manual therapy skills and tactile discrimination. Rose noted that "…manual therapy places strong emphasis on the systematic manipulation of musculoskeletal structures through an array of hands-on techniques that are used **strategically** as the therapist, through careful observation, questioning and listening, **develops a hypothesis about the source(s) of a patient's problems; rejects or**

refines the hypothesis; formulates a treatment plan" (Rose, 1999, p. 137 emphasis added).

In this way, the embodied touching/moving practices of physiotherapy have served not only to define and distinguish the nature of the profession, but also to discriminate the tacit knowledge/skills that underpin it. As such, the haptic practices of physiotherapy have arguably provided the foundations for the "craftwork" or "art" of physiotherapy (Remedy Physio, 2015; Sennett, 2009). These haptic practices are visible through the eyes of service users, and the case vignette below offers such an example.

Service users' perception of touch

Case Vignette: David's Story
"Of course, I've had neck and back problems for years. Really struggled at times to manage it. I've tried all sorts of things, TENS, heat, physiotherapy. I've seen any number of physiotherapists! To be honest, my experiences have been mixed. Some have been brilliant, others not so. Do you know, one physiotherapist never even touched me? They went through the entire appointment without ever once laying their hands on me! Obviously I didn't go back. What sort of physiotherapist doesn't touch their patient? I eventually found a superb practitioner who I've used pretty much since. They instantly got me onto the treatment bed and gave my neck a good massage, a move around and a good 'click'. I go back periodically for more of the same – a bit of a 'sort out' to keep me in good shape." (Authors' paraphrase of personal communication with a patient)

Like David's story, anecdotal and empirical accounts have emphasised the significance that service users attach to touch and corporeal proximity in therapeutic encounters (Bjorbækmo & Mengshoel, 2016). Drawing on interviews and anecdotal accounts, Bjorbækmo & Mengshoel (2016, p. 17) described the physiotherapeutic intervention as a "silent, touching, moving dance" that ensues once an initial conversation has taken place. The interconnection between therapist and patient is predicated, the authors stated, on elements of both gnostic touch (cognitive, investigative, intellectual and technical), and pathic touch (emotive, expressive, attentive).

The authors assert that the result of this haptic encounter – a vital dialogue mediated through touch and movement - is that the patient "feels safe, heard, respected and ready to accept [the therapist's] invitation to explore new possibilities" (Bjorbækmo & Mengshoel, 2016, p. 19).

That touch is much more than a physiological, cutaneous sensation is a well-rehearsed argument (Leonard & Kalman, 2015). What Bjorbækmo & Mengshoel (2016) added was an exploration of the meaning of touch (to a patient or service user) within the context of the therapeutic encounter. However, might there be other ways to conceptualise the experience of touch that provides us with alternative understandings? Below we suggest that there is value in utilising notions of body work and consumption, and consequently considering touch as a form of consumer health technology.

Touch as a consumer health technology

Our argument states that, in order to better understand patients' desire for hands-on therapy, we must situate it within the 21st century service economy and contemporary consumption practices and preferences. For example, Baudrillard (1998) has argued that, in modern society, consumption has become institutionalised and normalised as a duty of the citizen, whereby consumption relates not only to goods, but also human services and, therefore, relationships. As such, consumption has become an integral component of everyday life and thought, and influences our personal identity (Henderson & Petersen, 2002). We would argue that this is a relevant perspective for physiotherapists given the increasingly pervasive view of health as a commodity, patients as consumers, and a changing relationship between the state and the citizen in terms of "responsibility" for health and wellbeing (Henderson & Petersen, 2002).

Perceptions of health and disease have changed significantly since Talcott Parsons' structural-functionalist account of modern medicine (Parsons, 1951). In this account, illness was represented as a deviant or dysfunctional state preventing effective performance of normative social roles, and with the affected individual entering into a dependent relationship with a specific therapeutic agent or agency (Shilling, 2002). Late modernity (i.e. contemporary society) has instead become increasingly defined by health promotion and the pursuit of well-being – citizens as governed subjects who are deemed responsible for health-seeking behaviours, in the pursuit of physical, emotional and social wellbeing (Bunton, Burrows, & Nettleton, 1995). The "rationalities" and "technologies" of such government (Lemke, 2002) now extend far beyond the traditional confines of the "clinic", and instead pervade any number of diverse domains and discourses. The intent of this *new public health* is described as a paradigm shift from reducing disease, to improving health, via increasing reliance on empowered, autonomous and self-disciplining individuals rather than expert dominance (Vallgarda, 2011).

Foucault argued that self-government required individuals to act upon their own bodies, beliefs and behaviours as an ethical project of the self (Dilts, 2010). As such, individuals endeavour to create "appropriate" subjectivities (conscious/unconscious sense of self) and identities that are contingent on their interpretation of the socio-cultural context and the dominant discourses (Lupton, 1995). For Foucault, discourse was not simply the prevailing rhetoric that shapes thinking and meaning, but in fact the way that bodies, minds and lives become constituted and governed (Weedon, 1996). Bunton et al. (1995) noted that under late-modernism the notions of health and identity are inextricably and intimately related with that of consumption – we have become consumers of health information, vitamins and supplements, activity monitors,

calorie counting apps and cholesterol reducing margarine, for example. Furthermore, in this consumer culture (Bauman, 1989), one's reflexive self-identity becomes ever more linked to the "body as a project" (Bunton et al., 1995). Shilling (2003) attributed this body project (in part) to the fact that individuals are increasingly aware that the body is a work in progress, influenced and formed by lifestyle choices that are frequently products of consumption practices, for example purchasing (or not purchasing) gym membership, complying (or not complying) with national guidelines for physical activity.

Consuming touch: body work as part of the body project

What we propose here is that many individuals come to "consume" physiotherapy as an inherent part of this body project and in response to their self-identity as health seeking citizens. The service nature of physiotherapy is conceptualised by these individuals as a form of body work – in this instance, the notion that their body is attended to by another as a form of paid labour (Gimlin, 2007). However, to truly understand individuals' motivations, Bunton et al. (1995) advise that we must be cognisant of the symbolic meanings embedded within our health "commodities" – specifically, in this account, the symbolic meaning of touch within physiotherapeutic body work.

The symbolism of touch extends far beyond the "simple" process of mechanically influencing soft tissues or articular structures. Therapeutic touch ultimately affects the recipient's self-identity, purportedly creating an individual who feels "aligned", "mobile", "supple", "balanced", or "tension-free" (patients' anecdotal descriptors). Furthermore, touch – especially massage and manipulation – may be viewed as an example

of service work associated with tending the body (Twigg et al., 2011). Service work of this type makes deep connections between healthcare and consumer culture (Maguire, 2001), and is perhaps best exemplified by those who seek out sports massage or osteopathic/chiropractic "adjustment" on a regular, prophylactic basis, and at their own expense. Therefore, we should ask: does touch - as a popular consumer health "technology" - reflect the habits and dispositions of late modern subjects embedded within both consumer culture and "new public health"? Critically, we should then question whether therapeutic touch begins to confer a symbolic status for the consumer? Indeed, the successful pursuit of a body project in general, is resolutely associated with individuals who possess financial resources, time, health literacy and/or sociocultural capital (Shilling, 2002). Could it therefore be that therapeutic touch (as a preferred consumer health technology) has come to be associated with such a status? If so, it is not surprising that consumers "shop around" (Shilling, 2002) in the way described by David (case vignette) in order to identify a practitioner who facilitates the formation of that self-identity via touch oriented body work. This consumerism also challenges the traditional power relations associated with healthcare body work, where the advantage is generally situated with the practitioner who possesses the expertise and authority that mandates how the body will be treated (Twigg et al., 2011). In David's case the power relations of body work become, arguably, more egalitarian as his consumer status affords him some element of choice.

Whilst the argument presented here is of significance in terms of expanding our understanding of health consumerism in particular, it also raises significant questions for the profession of physiotherapy. If the perceived success of physiotherapy rests (at least for a significant number of patients) with practitioners who interweave touch with their service users' self-identity and body projects,

what does that mean for a profession whose origins have been historically embedded in touch? Perhaps more fundamentally, what then happens to individuals' body projects if the profession reconceptualises its fundamental ideas of therapeutic intervention in response to a prevailing discourse influenced by a multitude of factors? Of particular interest for this debate is the profession's commitment to scientific bureaucratic medicine. With this in mind, we then explore the impact that "scientific evidence" may have for this critical analysis of touch.

The crisis of evidence - a catalyst for change?

The sociocultural argument presented so far offers a thick theory for understanding the relationship between identity and touch – touch being an integral notion for the body project and consumers of health. However, there may be a crisis at hand. What does the scientific evidence[1] tell us about the role of touch in achieving meaningful health outcomes in a cost-effective way? Moreover, what are we to make of developing contemporaneous models of healthcare that presuppose limitations in singular, passive, and biologically driven interventions? There is a well-rehearsed dialogue about "hands-on versus hands-off therapy". This is something we wish to avoid repeating, primarily because the usual framing of such dialogue not only fails to embrace sociocultural aspects of identity and consumerism, but also artificially characterises the utility of scientific data in developing some sort of

1 For the purpose of our argument, we are taking the narrow view of the term *scientific evidence* as shorthand for comparative quantitative data – the sort prioritised by practice frameworks such as Evidence Based Medicine. For example, systematic reviews of high quality randomised controlled trials.

professional consensus. What is necessary, however, is to attend to the knowledge and thought that this type of scientific evidence does provide, and wonder what that might mean to us professionally, and to users of our services.

It is not the purpose of this chapter to provide a detailed review of the evidence of therapeutic effectiveness for therapeutic touch. However, for the purpose of our argument we can surmise that such evidence leads us to believe that in terms of commonly utilised health outcomes, touch-based therapies might not be as comparatively effective as once thought (for example O'Keeffe et al., 2016)[2]. The effect of this belief extends to the recommendation that utility of touch-based therapies is seriously questioned in the management of many painful and movement dysfunctions (e.g. NICE, 2016). Similarly, biopsychosocial models of practice with limited understanding of what "psycho" or "social" might mean, may shift the emphasis away from touch-based interventions towards therapeutic strategies aimed at the (limited) empowerment of individuals through active pursuits such as exercise and physical activity. So without touch, what is physiotherapy?

Although we are interested in much more than just a scientific programme here, the interpretation of findings as presented above seem to be edging towards a shift in the way we as physiotherapists consider human identity and the role of touch. However, is this an opportunity to re-evaluate the sociocultural aspects of

2 Of course, there are interpretations, systematic reviews, and meta-analyses that do not explicitly or conclusively dismiss the comparative effectiveness of some touch-based therapies in particular conditions and dysfunctions. However, in this chapter we are anticipating a certain trend being witnessed in a specific area of practice (in this case management of pain in musculoskeletal dysfunction). This trend indicates a potential shift in the profession's scientific understanding of the human and, as such, a potential shift in what the profession might mandate as clinically effective. For our argument, this simply serves as a tool to use in allowing an advance in commentary on the nature and role of touch.

how humans interact in terms of body work? Of course, there are other options. We could work on the sociocultural theory irrespective of this interpretation of findings, and continue in a linear trajectory to build the story of humans and touch further. This, however, would lack some responsibility to that part of our professional commitment that strives towards an evidence-based framework normatively underpinned by data from prioritised research methods. Hence, at this point we are motivated to consider whether the rich reports of identity and touch so far can be reconceptualised in a way by which our profession can be better characterised, taking into account the "evidence base" as well as sociocultural understandings of touch.

Navigating the future of physiotherapeutic touch

This discussion must inevitably close with consideration of the issues at stake for physiotherapists working in late modernity, where the concepts of new public health and consumerism remain significant leitmotifs. How are physiotherapy professionals to address the issue presented here – that is, that our emergent "evidence base" does not necessarily align well to consumer preference?

Owen (2014, p. 194) notes that when attempts to "devalue" or undermine therapeutic touch have been encountered historically, professionals have stalwartly sought to defend the value of such work. She argues that this has been achieved in one of two ways: either by adaptation or development to create an alternative touch "technology", or by maintenance of the "*movement/touch rhetoric*". The motivation for this, she contends, is preservation of historical physiotherapeutic identity and its occupational jurisdiction (Abbott, 1988). Nevertheless, is there value in blithely pursuing the same strategy at this particular nexus?

Instead, is this an opportunity to re-evaluate the corporeality of physiotherapy work?

It appears that there are (at least) three options for the profession and its membership (Figure 7.1: Options for the future framing of touch in physiotherapeutic work). The first is that we respect the professional and social values of touch and elect to retain it (in all its therapeutic guises) as a principal component of our management approaches. The implicit risk however, is that having aligned the profession with a commitment to a particular type of evidence based practice, we jeopardise our credibility within the wider scientific and healthcare community. The second alternative is to accept the abandonment of all "non-evidenced" therapeutic touch as a treatment option. However, historical precedents suggest that this abandonment of touch will be unsuccessful and has the potential to alienate a considerable proportion of the professional membership and the general public/health consumers.

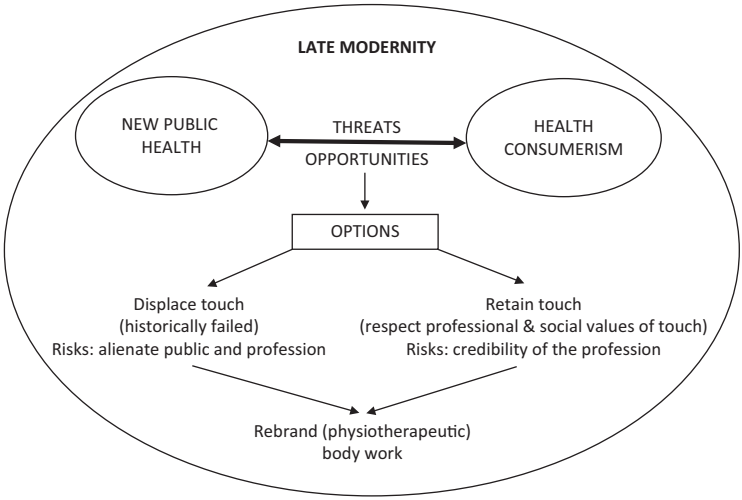

Figure 7.1: Options for the future framing of touch in physiotherapeutic work

The third option offers a reconciliatory position. Here we suggest the value of re-branding physiotherapeutic body work and redefining sociocultural conceptions. This reconceptualisation would encompass body work in a range of iterations: work done to the body by the health consumer themselves (e.g. physical activity / self-management programmes), work facilitated remotely (e.g. via tele-rehabilitation), as well as work that entails physical touch of the body. This option acknowledges that touch is an important part of professional identity and consumer preference and therefore prevents it from being displaced by evidence, whilst still creating space for interventions that are therapeutically effective. Many physiotherapists will already use this approach in their practice, but our challenge here is to complete this reconceptualisation process *en masse*.

Conclusion

The sociocultural analysis of touch offered within this chapter reveals further opportunities for a deeper understanding of both the profession, and the relationship between physiotherapists and those who consume our services. We propose here an opportunity to redefine body work, whilst preserving a recognisable dimension of professional and human identity. The profession's rich history of "holding on at all costs" to the idea of touch now seems to do us no favours. Subtly, health consumers might be persuaded of an empowerment and identity that derives from the interaction between themselves and physiotherapy - a profession committed to aligning itself with the resolution of global health burdens whilst being conscious of humanity and some of its deepest and complex desires. To do this, we need to understand being human not only as body, but also as a social consumer.

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