Dynamic Chiropractic

HEALTH & WELLNESS / LIFESTYLE

Tactile Communication

Frequent, loving physical contact with other human beings: cuddling, snuggling, stroking, hugging, holding hands, walking arm-in-arm, arms around each other's shoulders, arms around each other's waists. All of us need it. And most of us probably don't get enough of it.

-- Anne Gottlieb

Before discussing the subject of laying on hands, and the practice of chiropractic, it would be fitting that a groundwork be established, that is, a cursory description of the role "touch" plays in our daily life.

Desmond Morris refers to us as a touch-starved society. Touch (tactile communication) brings people comfort, reassurance, pleasure, and self-gratification. Not only do we hug ourselves when we feel joy, but we also wrap our arms around ourselves when we are afflicted with feelings of desperation and despair. In both instances, the element of touch has definite survival value.

M.F.A. Montagu cites animal studies supporting the theory that touching satisfaction during infancy and childhood is of fundamental importance to the subsequent healthy behavioral development of adults. Lawrence Frank goes even further with regard to the importance of being touched. He submits that denying or depriving a child of these early tactile experiences may compromise his future learning, i.e., speech, cognition, symbolic recognition, and capacity for more mature tactile communication as an adult.

We are constantly using self-touch for physical healing. When we inadvertently strike an elbow or stub a toe, we instinctively reach for the injured part, rub it, and press on it to relieve the pain. Napoleon, in his familiar gesture of keeping a hand inside of his jacket, was actually massaging himself to ease the pain of a stomach ulcer.

Studies indicate that the American attitude toward touch is generally one of noncontact and nonimmediacy, i.e., a hands-off society. While touch is not totally forbidden, it is dictated by a set of rather culturally-explicit determinants. These include who is touching whom, reason(s) for touching, what part of the body is being touched, plus, when and where the act of touching should take place.

People touch one another for a variety of reasons. They are as follows: Touching for pleasure -- bathing, sexual gratification, sports; touching for profit -- health care, hairdressing, massage, prostitution; touching that attracts -- children who pull on their mother's skirt, tapping the shoulder of someone who has dropped something, poking someone in the ribs to get their attention; touching that distracts -- being kissed, hugged, or tickled while trying to read; religious touching -- being baptized, being circumcised, or having ashes applied to your head on Ash Wednesday; salutatory touching -- hand shaking, kissing, hugging, back slapping; palliative touching -- neck, back, or hand rubbing. All of these behaviors are subsumed under the rubric of tactile communication.

Some years ago, I happened to be visiting a patient of mine in a small California hospital. While standing at the front desk, I overheard a conversation between two neurosurgeons who had just

performed disc surgery on a patient. One said to the other, "Phil, my low back is killing me." The other replied, "Have you tried rubbing in some Ben Gay?" The moral of this story is that after all is said and done, rubbing it where it hurts is still the most innate response to pain.

Aside from members of the healing arts, others are empowered with the privilege of acceptable touching, e.g., barbers, hairdressers, manicurists, cosmetologists, etc. Each is licensed to touch.

Four theories attempt to explain why we have such an aversion to unauthorized touching. Burgoon and Saine contend that our noncontact attitude derives from the shift from tribal to urban, mass societies. In small villages, people felt secure with one another. With the rise of industrial society, along with its growth and mobility of cities, people soon found themselves in the midst of unfamiliar surroundings, among strangers. This, in turn, may have given rise to an avoidance of physical contact -- a defense reaction pattern.

A second explanation for the touch taboo is its strong association with sex. Religious teaching in the West regards premarital and extramarital sex as immoral. At the earliest ages, children are often discouraged from exploring their own or others' private parts. Families that prohibit nudity reinforce the notion that the naked body, with its implicit invitation to touch, is shameful.

A third theory attributes noncontact to economics. Private property often comes with a "hands off" (no trespassing) warning, i.e., get off my land, don't touch daddy's pipe, don't touch mother's new crystal, don't touch your brother's new bicycle. The list of things not to touch is endless.

Lastly, we have the view that as society becomes more technologically advanced and develops more sophisticated ways of communicating, it tends to abandon such primitive ways of communicating as the beating of drums or the use of touch. Quite possibly, the decline of touch might be a natural concomitant of the rise of printing and mass media for visual and auditory communication.

Now, we come to doctors who touch: dentists, the mouth; podiatrists, the feet; ophthalmologists, the eye; chiropractic physicians, the spine; and surgeons, the inside as well as outside the human body. Touch, regardless of which health care professional uses it, has the capacity to serve as a bridge by which one may enter a lonely patient's emotional world. For the individual who feels isolated, making physical contact with another human being -- especially a doctor -- may take on very special meaning; being touched can easily be interpreted (or misinterpreted) as an expression of caring or genuine concern.

The way in which the doctor of chiropractic lays on hands differs from every other branch of the healing arts. Whereas some massage therapists and physiotherapists might take exception to this claim, patients who have had the benefit of all three disciplines -- chiropractic, massage, and physiotherapy, will emphatically confirm that the way the chiropractor "lays on hands" is unmistakably different. Those who come closest to hands-on chiropractic are those osteopaths who still manipulate.

Accepting the fact that not all chiropractic adjustments are the same, they do share a certain commonality. Essentially, adjustive techniques fall into one of three categories: heavy, medium, and light. For our purposes we shall exclude such nonthrust, nonforce techniques as acupressure, reflexology, kinesiology, craniopathy or zone therapy.

Patients have been known to describe the adjustments they receive differently than the doctors who administer them. For instance, if you think your adjustment is very gentle, ask some of your patients to describe it in their own words. Don't lead them. Simply ask, "How would you describe

the adjustments I give you?" Carefully notice the adjectives they use, e.g., soft, gentle, deep, stimulating, relaxing, etc.

Patients also manifest different levels of tolerance; what one might consider a heavy adjustment, another might regard as rather mild or moderate. How, then, should practitioners evaluate the amount of force they are employing; or, should that not be a consideration as long as the desired result is achieved?

The experienced chiropractic patient can usually differentiate between a pair of "healing hands" from those that are not quite sure of what they are doing. Healing hands immediately establish a therapeutic rapport with the patient -- a bonding based upon touch. Touch, together with reassuring verbal communication, has been found to not only have a tranquilizing effect, but also a decidedly healing power.

Several other factors are capable of influencing a patient's touchability; gender is one of them. Because chiropractic involves so much manual contact with the pelvic area, aside from other possible reasons, there are some women who prefer a female practitioner. In contrast, certain male patients, when being examined for a possible inguinal hernia by a female doctor, might experience a degree of embarrassment. During a routine physical examination of both males and females, doctors manually explore for areas of tenderness, pain, and spasm. Neurologic and orthopedic tests, likewise, involve a great deal of touching, e.g., reflexes, Babinski, etc. In any of the aforementioned situations, patient touch reaction could be attributed to the touching taboo mentioned earlier, i.e., the association Western religions have made between touching, nudity, intimacy, and sex.

Consideration must also be given the sociocultural variable. Some people are born into families where there is a great deal of touching; others have been raised in families where touching is more inhibited. Such early conditioning most certainly carries over into adulthood. Some cultures are referred to as "contact" cultures, while others are "noncontact." Montagu, for instance, classifies upper-class Englishmen as being at one end of the continuum (preferring less touching) and Latins at the other end (preferring the most touching.) Whereas, a sweeping generalization is inadvisable in either case, existing differences should be taken into account by every chiropractic physician. Patients from different sociocultural backgrounds do have varying touching idiosyncrasies.

Patting, stroking, kneading, percussion, concussion, and sustained digital pressure are various forms of touching. Patients traditionally display a preference for one form and resist another. Since the pat is socially perceived as a friendly or playful type of touch, it is usually not included in the chiropractic treatment. A firm contact is generally applied. The location, or part of the body being touched is also relevant. Researchers have noted that women are especially attuned to the location of touch, whereas men are more attuned to the kind of touch that is used.

Despite the fact that the practice of chiropractic demands a superior sense of touch, its practitioners must also develop a sensitivity to the messages their patients send in response to being touched. Pulling away, appearing frightened, and the display of tense facial muscles are but three of the negative messages patients are capable of sending. Comfortable breathing, sighs of relief, muscular relaxation, and verbal affirmation are examples of the positive messages patients can send.

It must be said that the laying on of hands is the oldest form of healing. If the use of various modalities should supersede the "chiropractic touch" -- a characteristic that gives us a therapeutic advantage, our future identity in the health care field stands squarely in harms way.

Medicine today is on a testing roller coaster. A positive finding in one test often necessitates performing additional tests. The old- fashioned doctor who used to hold the patient's hand is a thing of the past. Healing has surrendered itself to technology.

As we approach the year 2000, "depersonalization" has taken on epidemic proportions. People constantly struggle to overcome feelings of alienation. Human contact, in the form of touch, may well be the final frontier. Our survival on the planet could well depend upon the degree to which we stay in touch, both physically and mentally. Chiropractic is the only profession capable of providing this desperately felt need.

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Editor's Note:

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