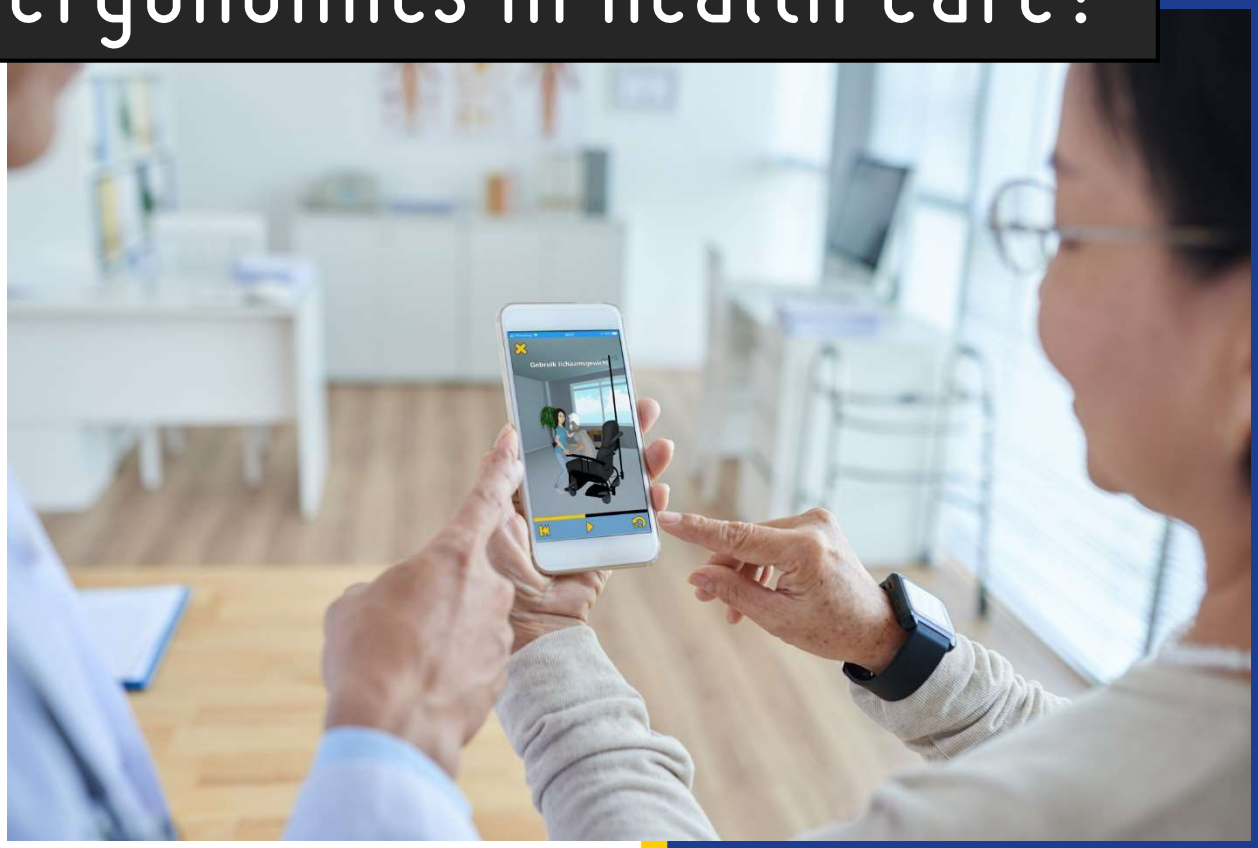
English version

How to use haptonomy for ergonomics in health care?



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English version

This article is a chapter from the handbook ‘Patient Handling for Caregivers’, edited by Goderis, T. & Ollevier, A. eUlift handbook:

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A special way of properly performing transfers, the proper use of (lifting) aids, and the ergonomic performance of other caring actions arises from haptonomy. Haptonomy originally comes from physiotherapy and literally means 'the teaching of feeling' or touching affectively (Elbers and Duyndam, 2018). When acting 'haptonomically', you try to feel and touch the client in such a way that he or she can move as much as possible. This means that the use of the principles from haptonomy runs perfectly parallel to the stimulation of self-reliance. If you forcefully touch someone, with a firm, almost squeezing hand, this can lead to resistance on the part of the client, he or she can work against you. However, if you touch someone invitingly, with an open, soft hand, the client is stimulated to move himself. You guide the client, with a soft hand, in the desired direction, via the desired movement.

Signals

In terms of haptonomy, our body is not an isolated device that we use. No, we are our body (Merleau-Ponty, 2009). This also means that many messages go back and forth between the care provider and the client, often unnoticed. Signals often go through the skin, the sense of touch. The skin, the organ with which we feel (touch), is the greatest system of sense that lets us communicate and interact through touch. Think for example of the handshake you get when you meet someone. Of his facial expression. This already says everything about the client's condition, but also about how much distance the client wants to keep from you.
But those signals don't just go through the skin. The eyes often speak volumes. You can quickly see whether someone is alert, angry, confused, etc. And this is also mutual. The client quickly feels or sees your (un)rest, understanding or irritation. Before you know it, you are together in an upward or downward spiral based on non-verbal cues. In everyday speech, we often say that someone, including you, 'radiates' something. There is 'something hanging around him'. And sensing and responding to those non-verbal cues is exactly what haptonomy is all about. Some caregivers do this naturally, others have to learn it. This can be done with a lot of practice.

Space

Playing with space is one of the most important haptonomical principles we can use when activating clients. For example, if you leave little space between you and the client when getting up, the client will not be encouraged to get up on their own. Because in fact you indicate non-verbally that you think that the client cannot (largely) make the standing movement himself and that you take over the movement. Give it a try. The reverse is also true, if you are

quite far away from the client, you will not be able to direct the client sufficiently and he will not get up. So, there is an optimal distance somewhere that gives the client a sense of security, but also radiates sufficient confidence that the client can largely do the transfer himself.

Caring in a haptonomical way is therefore a bit like dancing (Mol, 2005). If the two dance partners are far from each other, it will not look harmonious. That is also the case when they dance very close to each other. That optimum is somewhere. And that differs per care provider and per client. What one person experiences as close, the other does not have to experience as such. That is not only in healthcare, also in daily life you see some people standing very close to each other at parties, while others prefer to keep their distance.

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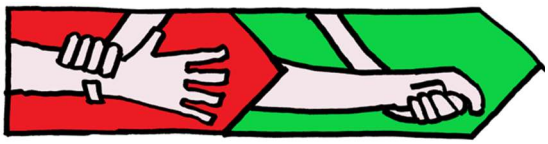
You cannot indicate this almost magical space in centimetres. You will have to feel that. The first contact with the client is crucial. Make time for that consciously. Have a chat, make eye contact, say the client's name or put your hand on the client's shoulder and wait for his or her response. Take it easy. The time you 'lose' with this first contact, you will gain it back amply later on.

Grip

The haptonomical thinking is also reflected in the way in which the care provider grips the client. If you touch his hand, arm or leg in a grasping, gripping way, you encompass a large part of that body part, it can trigger a fear response. This rarely happens with an open, non-catchy touch. So don't grasp unnecessarily. Keep your thumb next to your fingers. However, it is possible that the client has so little muscle strength that his arm or leg falls out of your hands. Only then is it really necessary to use the gripping function of your hand.

In addition, there are so-called 'power spots' (Mol, 2011). If you touch them, they can evoke a feeling of being dominated in the client. Although the exact location of these 'power spots' can vary enormously per person, you should especially think of the chin, neck and above the elbow. The police deliberately use these places, for example to manipulate a detainee, but in healthcare that's exactly what you don't want.



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There are also sensitive spots that, if you touch them on a client, can lead to violent shock reactions. Approach them extra carefully and continuously check (feel) how the client reacts. It concerns the abdomen, face, inner thighs and pubic area.

Finding a sensitive spot and activating it is often very subtle. For example, when you place your hands on the back of the client's hands, he or she can sense in which direction the movement should go according to you. If you firmly grab the hands (no matter where exactly) for some clients this can lead to a pulling away movement that you do not

want. But if you stand in front of the client and only lightly grab the hands the client will largely find the strength to stand on his own.

Of course, with such a standing movement, you need to know whether the client can stand up to any extent independently at all. Think of MK5 mobility class A or B. You should be able to find that in the file of this client. But even if you knew that the client has MK5 mobility class B and can therefore stand up fairly independently, it can happen that it does not work well. If you continue to communicate in a haptonomical way during the transfer, you will notice that soon enough.

Natural movement

When transferring, use the client's natural movements as much as possible (Hullu, 2018). That sounds nice and simple. Still, it's not always easy to figure out how your client gets out of bed, turns in bed, or puts on his shirt. First see how exactly you do it yourself. For example, check how you turn ower in bed or see how your partner does that. Then delve into how older people, or people with disabilities, do that. That is often different. For example, young, fit people get up quickly from a chair, without moving far forward. Because of the speed they make when standing up, they don't have to bend so far forward. After all, the energy of the speed helps them up. The elderly and people with limited movement often cannot build up that speed or become dizzy when they get up quickly from a chair. Therefore, they must move more slowly and bend much further forward before they can rise to stand.

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Something similar applies to clients who are extremely overweight. When people with the apple body type stand up, they first move their torso forward. People with the pear body type do that much less, they stand up more vertically.

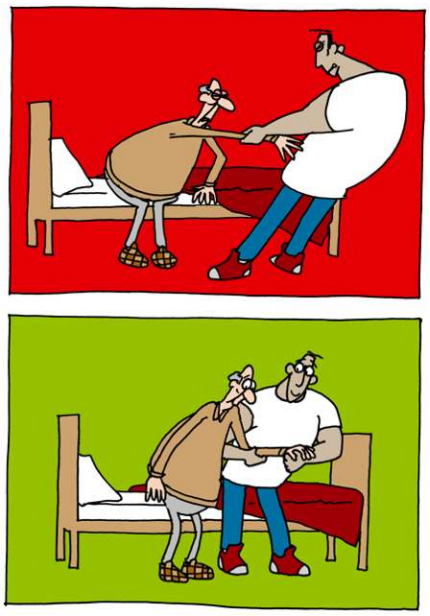
Contact

Haptonomical movement is all about contact. You do this by continuing to feel how the client reacts to what you do and say. But making and keeping contact goes both ways: investigate, check and feel how you respond to what the client does and says. Try to maintain contact continuously. That can be non-verbal and verbal. Therefore, always tell exactly what you intend to do and what you expect from the client. Vague indications such as 'will you cooperate' or 'we are going to the physio' are often not clear enough. Keep it short, limit your message. If necessary, cut what you want to say into small pieces. Many clients do not remember longer stories. Be specific, say, for example, 'Would you like to grab the parrot' or 'Do you want to put your feet well under the chair'.

But no matter how concrete these two examples are, always support them non-verbally. For example, grab the parrot yourself while saying "Would you like to grab the parrot?" and place the hands on the client's shins while saying "Do you want to put your feet under the chair?".

Nevertheless, it can happen that you lose contact, for example because a colleague comes in. Then you start making contact again. This applies to all clients, but to an even greater extent for clients who have neurological problems, memory problems or poor vision. If these types of clients don't see you for a while, for example because you walked to the sink or to the other side of the bed, they may think that someone else is suddenly next to them. That is confusing, frightening and increases resistance.

In this context, also consider whether it is not better to provide care for a particular client together with a colleague, or to go there alone. When you are alone it is often easier to keep in touch with the client. After all, there are fewer lines of communication: before you know it, you are chatting with your colleague, instead of with the client. And also, haptically it can be very confusing for the client if he or she feels four hands on his body, all sending out their own signals. That confusion can then turn into feelings of right or wrong, happy or sad, safe and unsafe. This arises pre-reflectively, it has already happened before we have thought about it (Finlay, 2005).



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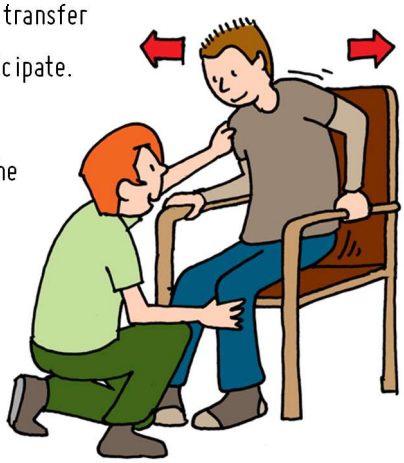
Timing

Another aspect in which we can make good use of haptonomical principles to make ADL care and transfers smoother for the client, and less physically demanding for the caregiver, is timing. Many caregivers count to three to indicate to the client and possibly a colleague when the transfer starts. There is nothing wrong with that in itself. Everyone involved then knows exactly when power must be supplied. Do this slowly, because explosive movement can lead to an enormous peak load on the musculoskeletal system.

However, it may happen that when you finished with counting, the client has not yet started to move. The client is in pain, stiff or just not fast enough. The temptation is then to largely take over the transfer itself. The client then experiences compulsion, resists and does not actively partiicipate. After all, he is being pulled or pushed.



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However, the haptonomy learns to wait (even if you are amply exhausted!) until the client initiates the movement himself. Only then do you follow that movement. In this way, the client is given the space to actually make a contribution, to be active and not to follow the speed of the care provider. Haptonomy is giving impulse, waiting and moving along.

Rhythm can also help with that 'promoting, waiting and moving' (Knibbe & Knibbe, 2010). Many clients are sensitive to rhythm. Moving (wiggling) together before a transfer can help to strengthen the sense of coordination in a certain rhythm. For example, in patients with Parkinson's disease, it can help to rock from one foot to the other while standing, so that they regain that sense of coordination a bit, so that they can start the walking movement again and continue. Do this slowly, continuously check whether the client goes along with the rhythm, support this with words and (the intonation of) your voice.

Practice haptonomy

Providing care according to haptonomical principles is not a trick that you can easily learn. After all, it is about systematically applying the basic attitude that you do not approach the client, as the founder of haptonomy already described it in the 1950s, as if he were a broken machine, but that you approach the client as a multidimensional human being (Veldman, 1988). That's complicated to learn through an article like this one. After all, it goes beyond words. We hope at least to have woken up your interest.

On the other hand, some caregivers already work very haptonomically by nature, often without their knowledge. They feel and know that it works. Coach each other in this, learn from each other. Be curious if a client reacts very differently to you than to your colleague.

In addition, as a care provider you can experiment and learn in contact with the client every working day. Explore what distance does, what touch does. And grip, contact, timing? With your client, but also with you. You can also practice haptonomy in private 24/7. Sit next to someone on a park bench. Which of the three urinals do you choose if the left one is occupied? What does eye contact do when you meet a stranger on the street? Or how do you feel when you get a hug from an uncle on your birthday? How does someone shake your hand? Realise you mainly learn haptonomy by doing it.

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