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Short Note

Why don't We Use Touch to Comfort Bereaved Relatives?

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The evidence regarding positive effects and aspects of human touch [1-3] and gentle massage on symptom relief and increased wellbeing among patients are convincing in different care contexts [4-10].

Massage therapies are frequently used and appreciated by patients and has documented effects in a range of different conditions [6,11-14]. Evidence from research in neurophysiology reveal specific touch receptors in hairy skin, so called C- Tactile nerves associated directly to parts of the brain [1,2]. The studies show that slow and gentle touch and stroking of the skin activates the C- Tactile nerve fibers facilitating emotions of well-being [3]. Furthermore, it is also shown that gentle touch of the skin releases oxytocin with known positive effects on muscle tension, pain and relaxation [3,9].

Grieving relatives receiving massage as support early following the death of a family member in palliative care have experienced positive outcomes [15]. Still, no further research studies have been reported yet. Support offered to bereaved relatives is still quite conservative and mainly organized in a more traditional manner, often offered by the local communities and churches as either individual or group support. Previous research on bereavement support showed that bereaved relatives adhere to more traditional group support. This is in line with Gardiner and Ingleton [16] who pointed out that traditional support such as bereavement support groups and individual counselling and telephone calls were positive and described in the literature as the most common way to offer support.

In Nappa et al., study, relatives were randomized to an early support intervention, three to six months following the death of a family member. The study was conducted by the Swedish hospital church. The support strategy within the church is usually to offer support six months following the death of a family member (referring to pathological grief). The participants were randomized to either participation groups or non-participation groups. During a period of five weeks the participants in the intervention group met once a week. Each meeting remained for two hours including the social activity of drinking afternoon tea. During the support meetings the discussions were directed by staff from a palliative care unit as well as members from the hospital church. At baseline and after the intervention questionnaires concerning grief, anxiety and depression were sent to both groups. The results showed no differences between the groups concerning level of anxiety and depression. However, Nappa et al., reported that the bereaved relatives in the intervention group did experience decreased level of grief following the intervention, suggesting, that bereavement support early was experienced as positive. Here, one could argue that getting personal attention from staff as well as from other participants in the same situation may have helped during the initial grieving period and that the early support therefore could be motivated. This is also suggested in the Cherlin et al., study as they were able to show that more than one third of bereaved relatives sought support the first six months following a family member's death. This indicates that early interventions are beneficial during the initial grieving phase as it may help identify physical and psychological symptoms in bereaved relatives. In studies by Valdimarsdottir et al. [17,18], they were able to show that grieving relatives following the death of a family members in specialist palliative care disclosed increased symptoms of distress and depression. Important factors were the relative's experiences of information about their family member's prognosis before they died. Lack of information could generate symptoms of depression as long as five years following the death of a family member [19]. Heymann-Horan et al. [20], showed that a targeted psychological support intervention had positive outcome as to identify distress in relatives during and after a family member died from cancer, and reported positive effects on the relative's mental health.

Various support strategies are offered within the palliative care context, Aoun et al. [21], suggested that palliative care services in Australia offer bereavement support directed by guidelines rather than personal support. Aoun and colleagues [22] suggested that their results are transferrable to other countries and recommended that other palliative care services need to provide purposeful and targeted bereavement support for all. In a response made by Gardiner and Ingleton in 2010 [16] to my article on massage as early bereavement support [15], the ethical difficulties as well as the methodological challenges were discussed. The ethical concerns regarding the inclusion of bereaved relatives were considered especially sensitive. The early timespan and when to contact grieving relatives may be crucial when offering support as shown above. Still, studies show that bereaved relatives need early interventions. As shown in my own study [15] bereaved relatives did not hesitate to contact the research group soon after the death of their family member as they themselves voiced their need for early support.

An example of how to offer early support (individual and group) was when the Swedish hospital church at Örebro University hospital introduced a bereavement support group to massage and group discussions. The idea was generated from the Cronfalk et al., [15] study, that showed positive outcomes following soft tissue massage to bereaved relatives in specialized palliative care. Representatives from the hospital church as well as the university hospital (social workers) formed bereavement groups three to six months after the loss of a family member. The participants were presented with the option to receive soft tissue massage (20 minutes back, hand or head massage by a massage therapists) before or after the group discussions. The model of support was tested over a period of three years. Narrative evaluation was carried out following the support program, suggesting that it was appreciated and necessary among bereaved relatives as it made them feel included and valuable as persons. Even though it is not scientifically evaluated, each person´s tales and experiences of what physical touch meant to them contribute to our understanding of massage as an asset in bereavement support. In one aspect, this is appropriate to the results presented by Aoun et al. [22], as they emphasized that bereaved relatives need and wish for personal interactions and contact. In a new research proposal, I once again hope to focus on bereaved relatives and massage, including relatives that recently lost a loved one to Covid-19, following own or family member isolation from physical contact before death. I will therefore argue that physical touch, closeness and warmth by another person is humanly essential and that early and more diverse strategies of support are needed to meet each person's needs.

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