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# Commentary

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The concept of multi-sensory therapy and environments is not new, with reports of sensory therapies being developed for those with severe cognitive deficits as far back as the 1960s. These constituted living-areas equipped with sensory materials selected to give visual, auditory, tactile, olfactory, proprioceptive and possibly gustatory stimulation (Cleland & Clark, 1966). The aim of these areas was to facilitate choice and failure-free activity among a group of people for whom conventional leisure activity was unsuitable or difficult to facilitate. Cleland & Clark described these areas as 'sensory cafeterias'. This idea of a sensory environment has since undergone considerable development and its potential as a leisure resource has expanded to encompass a more therapeutic approach.

As with all new concepts, multi-sensory therapies have received mixed reviews. Some have criticised the lack of empirical evidence, but others have reflected on positive events that have occurred in a multi-sensory environment. Sadly, much of this reflection has been based on anecdotal evidence. There is also the misleading impression that sensory therapy automatically occurs by simply sitting the patient or client in a sensory environment rather than through facilitation by a member of staff. In response to this problem, pockets of training have emerged focusing on basic assessment skills, sensory activity analysis and reflection, in order to develop the skills of those using this approach. The initial developments of multi-sensory therapy in the UK have concentrated on the concept of 'enabling' (Hagger & Hutchinson, 1991), which focuses exclusively on the development of the therapeutic relationship with the patient using multi-sensory environments. Enabling encourages the facilitator to allow the patient to explore the equipment, select preferred stimuli and interact with them for as long as they wish. The facilitator monitors mood, behavioural responses and non-verbal communication in order to make the experience failure-free and enjoyable. Enabling

allows the facilitator to develop a therapeutic relationship with the patient that is built on trust.

It is important to view the multi-sensory environment as a 'tool-box' from which are selected the types of stimulation most appropriate for each person. It is highly unusual to use more than three different types of stimulation at any one time. It is also important to consider that multi-sensory therapy has the potential to either increase arousal or relax the patient. Thus, facilitators should be clear about what they are hoping to achieve with this approach. The research suggests that refining the type of stimulation can modify mood and behaviour (Kovach, 2000), with either increased awareness (arousal) or reduced agitation (relaxation).

Targeted assessment is paramount to the success of multi-sensory therapies and it provides a baseline from which progress can be monitored. Targeting can be achieved by developing a sensory profile charting the person's responses to various sensory stimuli. Responses to sensory input can be observed during daily activity, with the assessor noting likes and dislikes, and tolerance levels to the intensity and length of stimulus. These responses can be coupled with a more standardised assessment such as the Pool Activity Level instrument (PAL) Pool, 1999) to provide an indicator of preferred stimuli and functional activity level.

When using multi-sensory therapies, time should be spent introducing preferred sensory stimuli and sharing the experience with the patient. The focus should be on the sensory qualities of each piece of equipment and the memories it provokes. As the session develops, other sensory modalities (visual, auditory, tactile, olfactory or proprioceptive) can be introduced to increase the repertoire. Sessions may last as little as 10 minutes, owing to the patient's short concentration span. This approach appears to increase sensory awareness, improving perception of sensory components in the general environment for a limited period of time.

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For a more relaxing approach, several items of stimulation may be selected and a longer time frame organised for the session. The focus during these sessions is not so much the presentation of each individual stimulus, but rather their overall combined effect.

After each session, mood and behaviour should be noted, with reference to each type of stimulation used. This allows a more detailed picture of sensory awareness to develop and staff to be informed of procedures employed during previous sessions.

Reflection is also an important component of the session, allowing the member of staff facilitating it to consider what went well, what did not go so well and what could be done differently next time.

Multi-sensory therapies have also been proved to be useful when working with carers, both in providing the opportunity to share an activity with their relative and as an anxiety management technique for themselves. Research has shown that multi-sensory therapies have a significant effect by lowering pulse rate and anxiety levels in normal populations (further details available from the author upon request). This has relevance for staff working in this clinical area, who may also benefit from the calming effect of multi-sensory therapy.

Several pieces of research mentioned by Baillon *et al* (2002, this issue) have alluded to this hypothesis, if only through reported staff satisfaction.

Overall, multi-sensory therapies have the potential to be a valuable tool in managing the mood and behaviour of elderly people with dementia, with the added benefit of reducing anxiety and stress in carers and staff. However, more research is needed to clarify best practice and staff should remain vigilant to misuse of multi-sensory therapy.

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