Can massage and aromatherapy benefit the users of forensic psychiatric services?

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Introduction

Research into service users and survivors' experiences of managing and recovering from mental distress has revealed concerns that psychotropic medication can be unhelpful or damaging but that people are often offered nothing else (Faulkner, 1997; Wallcraft, 1998). Service users have also emphasised their desire to make informed choices in order to take control of their own distress and their lives (Faulkner & Layzell, 2000). This research also reports that complementary therapies can make a significant contribution to service users' well being. One participant commented:

"Complementary therapies are building up my tolerance to stress, and not just helping me relax. If I had these three times a week I would be able to go back to work. These therapies work alongside medication – I still had psychotic episodes when I was on medication alone. Also, complementary therapies do not dampen emotions as medication does. My zest for life has really come back due to these therapies". (Martyn, 2005, p.15)

Interest among service users in complementary therapies as an alternative to traditional medical approaches reflects increasing use by the general public (Lundberg, 1998) and public perceptions that medication may be more harmful than helpful and that non-standard treatments are the most helpful (Jorm et al., 1997). While such therapies have begun to be more frequently used in the treatment of addictions (Faulkner, 1997), they are not however routinely offered in psychiatric services.

As part of a wider strategy to promote awareness of a range of self-management techniques at a forensic psychiatric hospital, it was decided to investigate the possibility of providing complementary therapies. Contact was made with the local rehabilitation and recovery day service, which employs a qualified aromatherapist to provide individual and group relaxation and massage. These sessions were well used and reported to be of therapeutic benefit to the service users. The aromatherapist agreed to provide three taster sessions at the hospital, demonstrating a number of massage techniques and introducing the service users to the uses of esssential oils. These sessions were very well attended and service users responded positively to them. In order to inform consideration of regular provision of massage and aromatherapy at the hospital a review of the evidence of the mental health benefits was undertaken. The findings of this review are presented in the remainder of this paper.

Evidence of the benefits of massage and aromatherapy

Massage is claimed to reduce the intensity of anxiety and depressive symptoms, to reduce pain and stiffness in muscles caused by prescribed medication, and assist in stress management (Cochran-Fritz, 1993; Davey, 1993, as cited in Wallcraft, 1998). Massage is also claimed to produce chemical changes in the brain that result in a feeling of relaxation, calm and well-being, and reduce levels of stress hormones, such as adrenalin, cortisol and norepinephrine, which in some people can trigger depression

(Rethink, 2005). It has also been suggested that massage can help people to recognise tension at an early stage and thus to avoid it (Watson, 1993).

Only two randomised controlled trials of the mental health benefits of massage have been carried out. In the first, depressed children and adolescents either received massage over five days or viewed relaxing videotapes (Field, Morrow, Valdeon, et al., 1992). Those participants who received massage improved more on depressed mood and anxiety. In the second study, depressed adolescent mothers were randomly assigned to massage therapy or relaxation therapy over a five-week period (Field, Grizzle, Scafidi, & Schanberg, 1996). Only those mothers who received massage showed a reduction in depression. However, neither study assessed whether massage therapy had longer-term effects.

Additionally, there are numerous accounts of personal experiences of massage and its mental health benefits, including improvement in depression and associated reduction of medication, feeling valued and gaining confidence (James, 1993; Mental Health Foundation, 1999). Clinical case reports are also available; for example, Hilliard (1995) reports the benefits of carrying out executive massages (i.e. where the person is seated on a massage chair, which has been specially designed to enable the head, neck, back, arms and hands to be massaged) on service users, the majority of whom had diagnoses of schizophrenia. Hilliard suggested that massage met a need for safe touch. In her review of the evidence of the effectiveness of complementary therapies, carried out for the Mental Health Foundation, Wallcraft (1998) described three evaluated projects which report the benefits of massage for mental health service users, including relaxation and reduction in stress and anxiety, improvements in mood, energy and sleep and gains in self esteem.

There are also a number of studies showing the beneficial effects of massage on stress, possibly through its impact on the autonomic nervous system (Cochran-Fritz, 1993). Stress is thought to precipitate more serious mental health difficulties, including psychotic symptoms (Zubin & Spring, 1977) and massage could therefore serve a preventative function. Cochran-Fritz concluded that massage could be used as a supporting adjunct to drug therapy to potentially reduce dosages and duration of treatment, thus reducing the risk of side-effects.

One of the benefits of massage for psychiatric in-patients may be the opportunity to be touched in a safe way when few other such opportunities are available. However, some individuals, especially those who have experienced traumatic sexual abuse, may be very uncomfortable with the manual approach used in massage therapy. The use of massage may therefore not be appropriate in all cases (Rethink, 2005).

Aromatherapy involves the administration of pure essential oils of fragrant plants either through breathing the aromatic vapours using an aroma diffuser, or absorbing diluted oils through the skin in a bath or during massage (Rethink, 2005). For thousands of years, it has been believed that these oils have specific therapeutic effects, producing different emotional and physiological reactions (Thorgrimsen, Spector, Wiles & Orrell, 2003). Particular oils are recommended for particular symptoms, such as bergamot, geranium, German chamomile, lavender and rosemary for depression (Zand, 1999).

There have been no randomised controlled trials with large sample groups of the mental health benefits of aromatherapy. (Komori, Fujiwara, Tanida, et al., 1995) In a small pilot study by Komoroi et al., (1995) , 12 men with depression were exposed to citrus fragrance in the air and compared with 8 men with depression who were not exposed to the fragrance. Both groups were taking antidepressants. The authors of this study reported that the dose of antidepressants in the experimental group could be markedly reduced. However, the study was not randomised or blind and involved only a small number of participants with varying dose and type of antidepressants. Another small study of 4 psychogeriatric patients found that patients' sleep was reduced when medication was withdrawn but returned to the previous level with the use of lavender oil (Hardy, Kirk-Smith & Stretch, 1995). This study is again subject to similar limitations.

A small double blind RCT has been conducted on the effectiveness of two different types of lavender oil on stress in patients in intensive care after receiving operations (Buckle, 1993). Both types of oil had a similar positive effect on mood and coping but one showed twice as much anxiety relief as the other, suggesting that the therapeutic effect was not entirely due to the use of massage to administer the oil.

There are case study reports of aromatherapy leading to improvements in depression, anxiety and sleep problems (Sanderson & Ruddle, 1992) and reduction in disturbed behaviour, improved sleep and motivational behaviour in dementia (Brooker, Snale, Johnson et al., 1997; MacMahon & Kermode, 1998; Wolfe & Herzberg, 1996). Wallcraft (1998) reported accounts from three evaluated projects that aromatherapy led to improved sleep and relaxation, improved mood and reduced anxiety and tension. There were no reported side effects, although the impact of the therapy may have been short term, as with massage.

Concerns have been raised about the potential toxicity of certain aromatherapy oils and a need to be aware of potential interactions with prescribed medication. Advice from a trained aromatherapist is recommended before use of essential oils (Rankin-Box, 1991). As aromatherapy is frequently administered through massage, it is difficult to discriminate between the effects of the two treatments, although there is some evidence of the effectiveness of aroma in the person's environment. It is possible that it is the whole experience of receiving complementary therapies that is of benefit: the arrangement of the room, background music, and a warm, welcoming, and safe environment are all significant to patients who may feel vulnerable (Bain, 2005). It has also been suggested that aromatherapy has the potential to be and should be a "talking therapy", where patients are encouraged to self express and talk about the effects that certain oils and treatments have on them (Bain, 2005). In this way, aromatherapy could also promote self awareness.

Conclusion

There is some evidence that massage is beneficial in reducing anxiety, depression and stress and that aromatherapy can also lead to improvements in anxiety, depression and sleep patterns, independent of adminstration through massage. As with any treatment, there is a need for individual assessment to ensure that the therapy is acceptable to the individual and to eliminate the possibility of interactions with other treatments or conditions. The benefits of massage and aromatherapy may only be short term and not persist beyond the course of active treatment.

None of the small randomised controlled trials of these therapies were conducted with an equivalent population to that found in a forensic psychiatric hospital, who typically have diagnoses of psychosis. However, there is some evidence from evaluated projects and clinical case reports that massage and aromatherapy may be beneficial to service users with diagnoses of psychosis. Anxiety and depression are common experiences among individuals with such diagnoses and may be a consequence of the impact of psychotic experiences and contribute to what are seen as the negative symptoms of such disorders. Furthermore, psychotic relapse may be precipitated by stress and preceeded by subtle changes in mood and behaviour, such as difficulties sleeping, which if addressed could prevent relapse occurring (Birchwood & Spencer, 2001). Aromatherapy and massage may therefore be of benefit to users of forensic psychiatric services and represent strategies through which users could manage their own experiences of mental distress and gain a greater sense of control, thought to be of central importance in the process of recovery (May, 2004)

Further research is needed to establish the effectiveness of massage and aromatherapy for the forensic psychiatric population. Ideally this would consist of randomised controlled trials. However, the existing evidence suggests that users of the forensic psychiatric service may derive some benefit, and are unlikely to be harmed, by these interventions. Therefore the provision of sessions, with appropriate measures for evaluation seems warranted. This could include pre and post intervention self and observer ratings of mood and behaviour and comparison with users not receiving such treatments. This approach would ensure that the interventions were effective and contribute to the evidence base relating to the use of massage and aromatherapy in forensic psychiatric and similar settings.

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