Touch for fragile clients

The gentle, repetitive nature of Jane Buckle’s ‘M’ technique makes it especially suitable for fragile and vulnerable clients. Here she explains how it is being used in a wide range of clinical situations to relax, calm and reduce pain.

This article, which is based on a presentation I gave at the IFPA Watford conference in October 2012, will focus on the ‘M’ Technique® and essential oils for:
• Alzheimer’s and dementia
• Special Needs children
• End of life patients

WHAT IS THE ‘M’ TECHNIQUE?
The ‘M’ technique is a registered method of gentle stroking movements done in a set repetitive pattern. It is suitable for fragile or actively dying people or when the giver is not trained in massage. Registered (patented) in 1998, the technique has been taught in the USA since 1996, the UK since 2004, The Netherlands since 2006, South Africa since 2009, and Japan since 2011.

This technique is different from massage in that:
• the pressure remains the same throughout and never changes
• there is a set sequence of movements which is the same for every client
• there is always a set number of strokes

The ‘M’ technique can be carried out on a clothed body and can be used with someone in a wheelchair. Just ‘M’-ing one hand can achieve measurable effects and the technique’s simplicity means that it is easy to teach to volunteers or to parents/carers. The fact that it is repetitive and always done in the same way makes it useful for research.

The technique can be used in situations when conventional massage may be inappropriate such as:
• Breathlessness
• Hypertension (high blood pressure)
• Deep vein thrombosis
• Immediate post-operatively
• Some cancers
• Actively dying

The ‘M’ technique is recognised as part of holistic nursing care in the USA where it has been taught in 40 hospitals. It is also used in 22 hospices in the UK. The ‘M’ is used to relax patients pre-operatively, and during operations where it has been found to reduce the level of drugs/anaesthetic needed. It has also been found helpful during labour to reduce anxiety and speed up delivery.

In intensive care units the ‘M’ technique can help to relax patients when invasive procedures are being carried out, and in palliative care it is used to improve patients’ quality of life.

ALZHEIMER’S AND DEMENTIA
For Alzheimer’s and dementia patients I advise using the hand or foot ‘M’ technique with essential oils that have familiar aromas. Choose three essential oils, mix, and use a three per cent dilution. If no relative is present I would suggest using one or more of the following – lavender, mandarin, petitgrain, frankincense and geranium.

A number of pilot studies have been carried out in the USA, mainly by nurses, on the use of the ‘M’ technique with Alzheimer’s and dementia. In one study (Quate 2002) when lavender was diffused at ‘sundowner’ time in a US care home, residents became calmer and quieter.
carried out with eight patients at the Heather Hill Hospital, Chardon, Ohio, Debbie Quate used a two per cent mix of lavender, mandarin, petitgrain and bergamot topically applied to the hands with the ‘M’ technique.

She used a standard Mapping tool for dementia (dementia care mapping is a systematic process for identifying patients’ experiences) and the mapping was carried out routinely every three months. Her results showed that 75 per cent of subjects had a positive psychological effect (see Table 1 above).

In 2003, a study was completed on 10 residents at the Mont Marie Health Care Centre in Holyoake, Massachusetts (Curran 2003). This is a specialised residential care home for people with advanced dementia and Alzheimer’s. The late afternoon between 4 and 6pm, when the sun sets, is commonly known as ‘sundowner time’. This time of day appears to really affect people with Alzheimer’s and dementia and they may become agitated, walk about, or shout. During those two hours, lavender was diffused in the residents’ common room (11 minutes on, 25 minutes off).

The residents were observed by the regular, experienced carers. It was found that the patients were much calmer, quieter and more tranquil during the lavender inhalation period.

The treatment should start with holding the foot only, then beginning the ‘M’ sequence with just one or two strokes. This short session should be repeated daily.

Attention Deficit Hyperactivity Disorder

Ritalin – the brand name of methylphenidate - is the most commonly prescribed medication used to treat Attention deficit hyperactivity disorder (ADHD). In recent years its use has soared four-fold, from 158,000 prescriptions in 1999 to 661,000 in 2010.

Although not technically an amphetamine, methylphenidate is a stimulant and is abused by teenagers wanting to lose weight or stay awake. Its code name is Vitamin R, R-Ball or the Smart Drug.

But, if a stimulant is used to control ADHD, why not try stimulant essential oils?

For children with special needs touch on the hands is preferable to touching the feet

SPECIAL NEEDS CHILDREN

For children with special needs, any kind of touch is often more acceptable on the feet than on the hands. Their feet are further away from their faces and they feel safer if their feet are touched rather than their hands. (Also, some children sometimes don’t like their hands being touched.)

Table 1: Aromatherapy ‘M’ Technique to the hands of dementia residents

<table>
<thead>
<tr>
<th>Residents (n=8)</th>
<th>Control scores</th>
<th>Scores with treatment</th>
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<tbody>
<tr>
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<td>0.7 1.3</td>
<td>0.8 1.2 1.1 1.5</td>
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<tr>
<td>0.8</td>
<td>-0.2</td>
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<tr>
<td>-0.5</td>
<td>0.8</td>
<td>1.2 1.1</td>
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<tr>
<td>0.2 0</td>
<td>1.1</td>
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Dementia care mapping scale of ill-being and well-being

<table>
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<tr>
<th>5.00</th>
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If you are working with a child who has ADHD, try using stimulant essential oils such as spike lavender, rosemary, eucalyptus, or peppermint, and monitor the response. Or you may be working with a child who does not have ADHD, but may be hyperactive or have other special needs. In each case, ask the child to choose two essential oils from a selection of four. Mix the oils and apply in a two per cent dilution. I would suggest offering basil, geranium, lavender, or lemon.

It’s a good idea to have small smelling strips for children to select their favourite oil, and to let them call their special mixture of essential oils by a pet name that they choose.

Two examples from a USA case series effectively demonstrate how essential oils can be beneficial for children with special needs.

The first is a study with 10 special needs children, aged between seven and nine years, with ADHD. First, the baseline was compared to rosemary (3 drops on an aromastone) and two school-based occupational therapists measured the:

• number of times each child got out of his/her chair
• number of repeated directions that were necessary
• number of times child engaged in self stimulation
• length of sustained attention

The results demonstrated that six children showed an improvement. They were able to focus better, had fewer tantrums, and got out of their chairs less. Four children showed no difference and no child became worse.

In the second study 10 children without any special needs, aged between seven and 10 years, received one drop of rosemary on a tissue during a scheduled piano lesson, every other week. The study ran for six weeks and the music teacher evaluated each child’s attention span and ability to sit still.

The results indicated that rosemary appeared to sharpen clarity, and attention.

One child asked ‘what is that smell?’ Most children liked the smell but one child did not.

Autism
When working with children with autism the general rule is that sensory stimulation should be used with care so as not to overload. So, use touch without smell, or use smell without touch.

In the only relevant published study I have found (Williams 2006) lavender in an aroma massage on 12 children in a residential home showed no benefit over six weeks. However, in a three-week US pilot study carried out by one of my students using inhaled lavender with children with autism, some benefit was shown (Blyth 2011). In this study, parents administered two per cent lavender cream to their own children’s forearms before bed.

No difference was found in the number of hours the children slept but there was a reduction in the number of times they woke up during the night. It would be interesting to explore if lavender was more beneficial in a diffuser or in a bath.

Belarus Study
On 26 April 1986, radioactive fallout over 80 per cent of Belarus affected more than two million people. As a result, 50,000 children are now in 600 orphanages, many of which lack basic amenities.

A nurse volunteer from Ireland used the ‘M’ technique on 32 profoundly disabled children and found that, with the ‘M’ technique, the children were able to respond. Perhaps this was because the children felt relaxed as the technique is so gentle. Or perhaps it was because the technique is repetitive and hypnotic.

However, the study results suggest that, even when the situation is very challenging, the ‘M’ technique can have a measurable beneficial effect (Breen & Cordell 2012).
When you are working with patients who are in the terminal stage of life, it is very important to speak to them if they are conscious. This will help you find out about their lives and what kind of a person they are, and thus choose aromas that are familiar to them.

If the patient is unable to speak, ask the relatives to tell you about them - what were they like, what were their interests - for example, did they like to garden or cook? Then, in consultation with the relatives, choose aromas to fit with the picture you have of the person.

If there are no relatives present I would suggest using a three per cent mixture of frankincense, rose and lavender. I have always found that very beneficial.

In a large-scale study carried out in Texas in 2008, 30 patients received ‘M’ technique (Donaldson–Stevensen 2008). All were in the last week of their life and all were dying at home with hospice staff visiting.

A nurse showed family members how to do hand ‘M’ technique and gave them five per cent clary sage and frankincense. The family members gave aromatherapy ‘M’ technique every two to four hours when symptoms presented and documented the date, time and symptoms.

All patients had some symptom relief, for example a reduction in facial grimacing, agitation, calling out, general restlessness, fear, or plucking at bedclothes.

The ‘M’ technique plus essential oils have also been successfully used to reduce pain at end of life at the Beth Israel Hospice in New York and at the Fort Worth Hospice (Ocampo 2001, Anderson 2004). See Figures 2 and 3 respectively.

I remember a study with Susie (not her real name), a 28-year-old single mother with a nine-year-old daughter. Susie had ovarian cancer with infiltration of the bladder, bowel and pelvis and had received palliative radiotherapy and chemotherapy. She was on a multiple drug regime including morphine and diamorphine. Mother and daughter found it impossible to talk about Susie’s impending death and their relationship was deeply strained.

Both Susie and her daughter received hand ‘M’ technique. The daughter practised twice and then gave her mother a hand ‘M’ using her mother’s own scented hand lotion. Measurements of pulse, respiration, anxiety and pain (PRAP) were taken before and after M-ing.

Within five minutes this had produced both physiological changes (pulse rate dropped from 70 to 62, respiratory rate dropped from 18 to 12) and psychological changes (anxiety went from 8-10 to 2/10 and pain level from 3/10 to 2/10).

There were also mental and emotional changes. Susie was astonished that something “so simple could be so effective and so quickly”. She felt “no longer tense, much calmer, nothing could irritate me now” and, most importantly, she felt much closer to her daughter.

The daughter was proud that she could “really do something for Mum” and felt “more grown up, more able to cope. I feel much closer to Mum now.”

In a recent UK case study the ‘M’ technique was used to control pain for a 64-year-old woman with terminal cancer who had only days left to live. The primary tumour had been in the breast and the cancer had now infiltrated the bone and liver. The patient was in acute distress due to back pain and was using patient controlled analgesic (PCA).

The ‘M’ technique (without essential oils) was used on lower legs, feet, arms and hands. Within 10 minutes the patient was asleep and she remained asleep for four hours. The technique was repeated the following day and again the patient relaxed, fell asleep and slept for four hours. She died that night. Her relatives were so grateful that she had received comfort and pain relief through the ‘M’ technique (Trigg 2012).

Celebrate a life
A life celebration essential oil mix can be a great comfort, both for the dying patient and for their relatives. Ask the family about the patient’s favourite smells and make up a special ‘life celebration’ mix. Use the life celebration blend on the patient and give some to the family to use after their loved one’s death.

There are a number of published studies on end of life care with aromatherapy and massage – see Chang (2008); Wilkinson, Lobe & Westcombe et al (2007); and Nakano, Sato, Katayama & Miyashita (2012) in the references list overleaf.
Learning the ‘M’ technique broadens your skill set

RESEARCH

Current research on the use of the ‘M’ technique is currently being carried out at the St Louis Children's Hospital, Missouri, USA; the Red X Memorial Hospital, Cape Town, South Africa; the Sophia Children's Hospital, Rotterdam, The Netherlands; and the Valley Hospital, Ridgewood, New Jersey, USA.

In 2005, research was carried out at the University of Pennsylvania using SPECT (Single Photon Emission Computed Tomography) analysis (full details at www.mtechnique.co.uk/research.html). A radiopharmaceutical was injected intravenously into subjects before and after SPECT. The scans following a full body ‘M’ technique and conventional (Swedish) massage were compared in 65 areas of the brain.

The findings suggest that, although the ‘M’ technique and conventional massage both show blood flow brain activation changes, surprisingly, the participants’ responses were different. The ‘M’ technique revealed greater effects of the ‘M’ technique and massage on the brain. These findings have implications for future research into the potential mechanism of the ‘M’ technique and how it could be used in the treatment and care of patients.

For aromatherapists, adding the ‘M’ technique to your repertoire will give you the confidence to volunteer in a hospice or to work with terminally ill people, those with special needs, or those you might consider to be outside your normal comfort boundaries. There are several instructors throughout the UK – more information at www.mtechnique.co.uk (please note that the courses are not listed in chronological order). For more information on clinical aromatherapy please see the US website – www.rjbuckle.com. Please note RJ Buckle clinical aromatherapy courses are not available in the UK.

References


Zoller: Use of aromatherapy for children with ADHD. RJ Buckle certification. Used with permission. Personal communication.


Jane Buckle trained as a nurse in London in the 1960s, then specialised in intensive care, cardiac surgery and casualty. She has lived and worked in the USA, UK and Australia, completing her BPhil and MA degrees in the UK and her PhD in the USA. Supported by a US government-funded post-doctoral scholarship she completed an MSc in Biostatistics and Epidemiology at the University of Pennsylvania where she studied the effects of the ‘M’ technique and massage on the brain.


Jane has created curricula in clinical aromatherapy for UK and UK universities and her patented ‘M’ technique is used in Japan, USA, UK, The Netherlands and South Africa. She has instructors in each of those countries and has taught over 2,000 nurses and doctors. DVDs are available to purchase from www.mtechnique.co.uk. Dr Buckle is actively involved in research and is a reviewer for several medical journals.