Sensory Approaches to Treatment in the VA System  
Karen Moore OTR/L

Sensory approaches to treatment can be the gateway to the transition to a person-centered, strength oriented, skill building model of care based on self-regulation and self-care. This approach complements other components of treatment including medical care and psychosocial interventions and the development of personalized crisis intervention plans. It adds tools and strategies that support Trauma Informed Care and Restraint and Seclusion Reduction Initiatives. Goals coordinate with those prioritized in the VA Clinical Guidelines for the Management of Post Traumatic Stress (VA/DoD, 2004).

Researchers and leaders in treatment for trauma including Beth Caldwell, Emily Holmes, Kevin Huckshorn, Janice LeBell, Robert Macy, Richard Mollica, and Stephen Porges are affirming the necessity of body oriented therapies. The VA Clinical Guidelines endorse sensory based approaches including EMDR (Eye Movement Desensitization and Reprocessing), massage, acupuncture/acupressure, and yoga. Sensory approaches are not only supported by regulatory agencies such as JCAHO but these agencies look for the competent use of sensory modalities and sensory rooms by staff from all disciplines. JCAHO is also looking for ways that treatment will be integrated into discharge plans and community re-entry. Sensory approaches to treatment teach skills and strategies that can be carried over to the home environment; family members and care providers become partners in recovery as they learn ways to support their loved ones in times of crisis or discomfort.

Sensory strategies initially focus on an essential underlying building block of self-awareness and self-acceptance. They then help a person move from self-awareness to self-regulation and on to self-care and eventually to self-healing. Sensory strategies are a critical component of healthy responses to life stressors that are easy to take for granted. Healthy people use sensory strategies as a matter of course. For example when people are stressed they seek the comfort of a loved one or pet, they curl-up in a blanket or seek a quiet space, they jog or work out at the gym, they clean the garage or do physically demanding work. These are perfectly natural and subconscious ways to combat stress and they are rich in helpful sensory input. Hospitalized veterans may not have the opportunity or insight to start re-engaging in these types of activities without support (Shay, 1994).

Sensory approaches to treatment are especially critical for Veterans of war who have experienced many traumatic events and atypical sensory experiences that can result in abnormal sensory responses that cannot be addressed through traditional psychosocial models of treatment alone. Additionally, soldiers’ training necessarily focuses values on the unit, comrades, and country and away from individual needs and the self-nurturing needed to recover from serious physical, cognitive, and emotional disability. Strategies for survival such as hyper-vigilance, physical strength, valor and self-sacrifice for the good of the country are no longer useful skills for health maintenance and adaptations to a totally new way of living that may involve adjusting to loss of limbs, paralysis, head injury and symptoms of Post Traumatic Stress. The immediate stressors are new and incredibly different and veterans need to develop a whole
new set of coping skills to self-regulate instead of resorting to angry outbursts, self harm, withdrawal and use of substances (Shay, 1994).

Additionally, veterans of war often struggle with visceral and sometimes catastrophic reactions to sensory triggers. Common triggers are thunder, sounds that sound like gun shot, and sounds in the middle of the night. Many Vietnam Veterans are triggered by the sound of waterfalls or other sounds reminiscent of the jungle. These sensory triggers can be very subtle to the point that the person is not aware of them. Dealing with sensory triggers like these require expertise on the part of a professionals in order to recognize them and to provide sensory strategies to mitigate their influence (van der Kolk 1994).

Sensory approaches require multi-discipline cooperation; all hospital professionals have an important role. This person centered model empowers staff members to help in a positive, meaningful, and hopefully sustainable way. For example, if a patient is starting to lose control and staff steps in and the person ends up in restraint it may keep the person safe for that moment in time. This will not however keep the person safe when he or she returns home. My mantra is this, “Take control and you help for a day, teach control and you help for a lifetime.” If the patient was educated in self-regulation techniques, the staff person could have asked what “tools” would help. The patient might know to ask for a weighted blanket or to go to the sensory room to sit in a beanbag chair and listen to music. Educated staff members will know how to best support patients in their use of these sensory strategies (Moore, 2005 & 2008).

Education of staff members is essential to the efficacy of this treatment approach (Champagne, 2003 & 2005). As staff members receive information on the senses and the way these treatment strategies work they become comfortable and confident in the use of these strategies. Investment in training is cost effective for many reasons including decreasing the incidents of restraint and injury as well as helping to avoid long hospital stays and re-hospitalizations. The most important benefit however is the empowerment of the patient to stay in good emotional control despite symptoms of flashbacks and PTSD and to avoid of the humiliation associated with drastic measures such as restraint.

Champagne, T. (2005, March). Expanding the role of sensory approaches for acute inpatient psychiatry. Mental Health Special Interest Section Quarterly.


