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WOMEN'S HEALTH AROMATHERAPY

A Clinically Evidence-Based Guide for Nurses, Midwives, Doulas and Therapists

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Chapter 1

What Is Clinical Aromatherapy?

When one thinks of "aroma," one usually thinks of something scented. Images of spas, candles and beach massages come to mind when we hear the term "aromatherapy." In the past decade the world of aromatherapy has experienced phenomenal growth and popularity in the mainstream population outside of the traditional healthcare industry. In 2016, the global aromatherapy market was valued at USD 1.07 billion and is expected to continue to rise in the upcoming years (Grand View Research 2017). This rapid growth in the aromatherapy industry, brought about by profound company loyalty and business opportunities to sell essential oils without any medical background or clinical aromatherapy education, can prove a challenge to the nurse or midwife who is presented with a woman arriving to the hospital in labor with a large bag of blended oils she wants to use. What is safe to use? What will help the woman in labor? The purpose of this book is to provide specific information on essential oils, which can be used to support women's health and to educate the reader/nurses, midwives, doulas and therapists in what we know from aromatherapy research studies on women to inform your clinical practice.

In 2004, the Nobel Prize in Physiology or Medicine was awarded to physiologists Drs Axel and Buck for identifying more than 1000 odor receptors in humans, unraveling the mysteries of our sense of smell and thus highlighting the tremendous

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therapeutic potential for aromatherapy (Nobel Prize 2004). In my experience, the majority of North American people prefer light floral, citrus or familiar spice scents as an introduction to aromatherapy. We are repelled or warned by unpleasant scents and possess a lifetime of scent memories related to our cultures, traditions and life experiences which all influence our reactions to scent. When possible, particularly in treating emotional conditions, offer your patient a choice of scent, which enhances therapeutic effectiveness.

The tools of aromatherapy are essential oils, steam-distilled or cold-expressed from various parts of aromatic plants. They are very concentrated and, depending on the plant's yield, can be quite expensive. A commonly stated example of the concentration of an essential oil is "Twenty-eight teabags of peppermint herb produce one drop of peppermint essential oil." Very little oil is needed to enjoy the scent or produce a measurable outcome as in clinical aromatherapy.

In hospitals and clinical settings the type of aromatherapy practiced by nurses is known as *clinical aromatherapy*. The difference between mainstream personal aromatherapy and clinical aromatherapy is the educational background of the clinician and clinically evidence-based aromatherapy education specific to clinical areas. Nurses and midwives with advanced education in clinical aromatherapy learn about specific essential oils, their therapeutic properties and methods that have been researched clinically on humans and shown to be effective and safe. Clinical aromatherapy is defined as "the therapeutic use of essential oils for a measurable outcome" (Buckle 2001); in other words, much like a pain scale, we ask the patient their pre- and post-aromatherapy treatment numerical rating for a particular condition. This is known as a Likert scale (0 = no discomfort; 10 = worst discomfort) and is used daily by nurses and midwives in all clinical settings to determine the effects of various treatments.

There are specific essential oils and methods of administration that have been shown in studies (evidence-based) to be effective and safe for particular conditions. Lists of the clinically evidence-based

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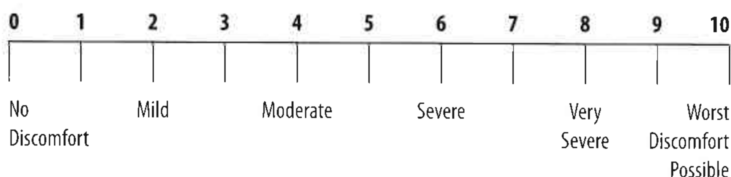
essential oils and methods related to specific conditions will be highlighted throughout the book. The treatments in this book require a maximum of five minutes, which is of utmost importance to a busy clinician.



Likert scale

Clinically evidence-based aromatherapy

For this book, we will focus on *clinically evidence-based aromatherapy*, specifically research conducted in approved clinical settings on female subjects (*in vivo*) by healthcare professionals educated in aromatherapy, measuring the before (pre-) and after (post-) effects of an aromatherapy treatment for a particular condition.

We will highlight and focus on the specific *clinical evidence base* for women's health conditions to inform safe and effective nursing and midwifery aromatherapy practice for the OB/GYN aspect of women's healthcare.

Is there more to aromatherapy than just pleasant scents?

As new scientific studies emerge, surfacing patterns are demonstrating a wide range of physiological and emotional responses before and after clinical aromatherapy treatments. Implementing standardized scales for self-reported physical, emotional and behavioral changes in pain, depression, anxiety and nausea pre- and post-aromatherapy treatments demonstrates statistically significant differences from control groups. Alterations in the hormone and neurotransmitter levels of the neurological and endocrine systems positively correspond to the effects noted

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on the self-reported scales. This combination of repeated findings offers a glimpse of the future potential for clinical aromatherapy. As we proceed, take note of the number of varied studies indicating positive changes in cortisol, estrogen and serotonin levels and vital signs from simple, quick, economical and very low-risk *external* 1–2% treatments.

Obstetrics and gynecology (OB/GYN)

The book is divided into sections on obstetrics (pregnancy/*antenatal or prenatal*, labor and childbirth/*intrapartum* and after-delivery/*postpartum*) and gynecology (beginning of menstruation/*menarche* to end of menstruation/*menopause*). Each section provides guidance on the most common conditions that have a clinical aromatherapy evidence base. Simple specific guidelines for choosing and preparing aromatherapy treatments related to clinical conditions are given throughout the book. Relevant references are listed alongside the recommendations for quick and easy access to clinical evidence for practice and sharing with colleagues.

My background of 30 years in nursing, 20 woven with hospital and pharmacy clinical aromatherapy practice, program development, consultation and research without any serious complications to mother or baby provides you with an excellent template for safe and effective practice. In select cases a step forward has been the development of simple therapeutic nursing blends of 2–4 single evidence-based oils, thus creating synergies to increase the range of effects and maintain a minimal number of oils to clearly identify positive and negative responses and alter the blend as necessary to obtain a more positive response.

A woman's lifetime hormonal journey can be fairly turbulent physically and emotionally, from menstrual cramps, PMS, pregnancy and menopause; during pregnancy, despite the most perfect birth plan, many obstacles can arise requiring abrupt (and disappointing) changes in direction for the best outcome. Aromatherapy offers women physical and emotional support for

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multiple OB/GYN conditions and provides the nurse and midwife with safe, gentle, pleasant and effective tools to smooth the rough edges and provide satisfying caring comfort measures.

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CHAPTER 2

Methods and Safety

The four methods used in women's health clinical aromatherapy, all of which are external, are the following:

- **Inhalation:** 1–3 drops on a cotton pad or with a personal inhaler (direct), or with a diffuser (indirect). *Quickest route for anxiety, panic, fear, nausea and pain perception.*

- **Skin application/massage:** dilute 1–3 drops essential oils in 5 ml unscented lotion or carrier oil (e.g. grapeseed, jojoba, fractionated coconut). *Best route for any physical pain and discomfort.*

- **Baths (whole body, sitz or foot baths):** add 2–8 drops essential oils to carrier oil for dispersion, then add mix to warm bath water. Don't add to bath during labor. *If time permits, best for insomnia, stress reduction and perineal healing (sitz).*

- **Spritzer:** add oils (12 drops/1 oz bottle) to glass spray bottle, fill with sterile water, shake and spray. Excellent for hot flashes, refreshing for athletes and long days, enhancing the immediate area around women in clinical settings to create their own personal space.

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Preparing a single oil treatment

The normal concentration for a non-pregnant adult is 1–5%, a pregnant woman 0.5–1%, and for labor/postpartum 1–2%.

- 0.5% = 1 drop of essential oil with 10 ml/2 tsp carrier lotion.
- 1% =1 drop of essential oil with 5 ml/1 tsp carrier lotion.
- 2% = 2 drops of essential oil with 5 ml/1 tsp carrier lotion.
- 3% = 3 drops of essential oil with 5 ml/1 tsp carrier lotion.
- 4% = 4 drops of essential oil with 5 ml/1 tsp carrier lotion.
- 5% = 5 drops of essential oil with 5 ml/1 tsp carrier lotion.

As you can see, the amount of carrier lotion, oil, gel or water is always the same, but the number of drops changes to develop your 1–5% percentage. If you need to make it weaker, you add more carrier as in the 0.5% above which would be for pregnancy, young children, the elderly, ill or an individual with a dislike of perceived strong scents.

If blending more than one oil

First, blend the oils in an empty dropper bottle and label it. It's best to mix the oils together to get a blend of both/all oils and then to add drops of the blend to the carrier lotion, oil, gel or water to give your appropriate concentration (1 drop/5ml = 1%). Alternatively, you can mix oils first in a medicine cup then add the correct amount of carrier lotion or oil to obtain the accurate total percentage.

For example:

1. Mix 3 drops of lavender and 1 drop of lemon together.
2. To make a **1% blend**, you would add 1 drop of this blend to 1 tsp/5 ml of carrier lotion.
3. To make a **2% blend**, add 2 drops/5 ml lotion.

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4. In a **2 oz bottle** to make a **1% blend** you add 12 drops total of essential oil blend to 2 oz/60 ml of lotion (1 oz = 30 ml; 2 oz = 60 ml).

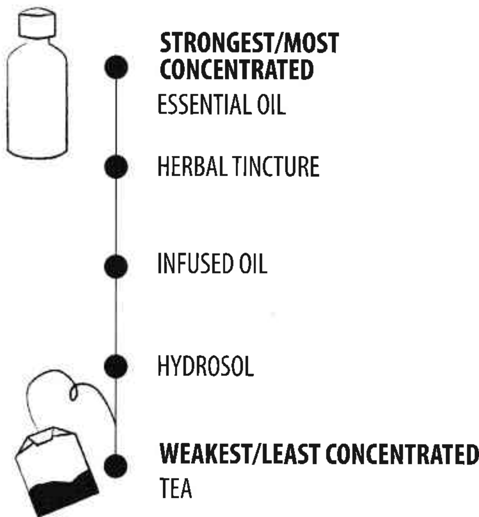
5. SHAKE WELL.

6. Always write your blends down.

Safety

An important aspect of the success with this gentle therapy, particularly with the obstetric patient, is honoring important parameters of safety to maintain as low a risk as possible. Essential oils are strong and very concentrated and therefore only a small amount (i.e. 1–2 drops OB, 1–5 drops GYN) is necessary for a therapeutic outcome.

The degree of concentration and strength of various plant-based remedies is demonstrated in the following diagram, with essential oils shown to be the strongest/most concentrated. When used externally at 1–2% they are a very economical complementary therapy for clinical use.



A comparison of the strength of various plant-based therapies highlights the concentration of essential oils is the strongest

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All of the clinical evidence has consistently involved external 1–2% applications with rare non-serious side effects that could be the result of the condition, not the aromatherapy. The following is a list of the guidelines that have endured for the past 30 years with thousands of women in hundreds of hospitals on more than three continents and which are recommended for the nurse and midwife to follow.

- Clinically evidence-based education for staff administering aromatherapy.
- All treatments are external (inhalation, skin application, baths and spritzers).
- Only use clinically evidence-based essential oils and methods.
- Essential oils are strong and very concentrated.
- Avoid ingestion.
- Always dilute the essential oils in an unscented white lotion, aloe gel or carrier oil before applying to skin.
- Only 1–2 drops per 5 ml carrier are required for a 1–2% clinical treatment.
- Keep essential oils away from infants, young children, eyes, open wounds and suture lines.
- Keep essential oils in a locked cabinet.
- Always have orifice reducers for droppers in bottles; no wide-mouthed bottles.
- Store in amber or cobalt-blue glass bottles.
- Keep away from sun in a cool, dark cabinet.
- Follow Material Safety Data Sheet (MSDS) for individual essential oils.

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- Dispose of oils, bottles and soaked paper towels in double Ziploc bags into hazardous-waste containers.
- Gas chromatography/mass spectrometry (GCMS) analysis for each oil.

OB precautions

- Avoid essential oils in the first trimester (only lemon inhalation after 10 weeks; Yavari *et al.* 2016).
- Follow current clinical evidence base for safe practice.
- External use only per clinical evidence base.
- Always dilute 0.5–1% until term, 2% labor/postpartum.
- Avoid with epilepsy, high-risk pregnancies, major cardiac, liver or renal disease, preeclampsia, eclampsia, pyrexia, anticoagulant therapy, polyhydramnios, placenta previa, reduced fetal movements, higher multiple pregnancies (Tiran 2016). See key terminology list at the beginning of the book for clarification.
- Exercise caution with twin pregnancies, breech, transverse or unstable fetal position, history of vaginal bleeding, diabetes, asthma, hypertension, hypotension, bleeding disorders, history of miscarriage, hemorrhage, seasonal or multiple allergies to plants, food, aromatics.
- Room spray only with preterm labor.
- Avoid using aromas that the woman dislikes.

Essential oil safety

- Do not ingest/take essential oils internally.