Aromatherapy support during childbirth

Clinical aromatherapist Pam Conrad shares important data on 700 aromatherapy interventions, carried out in hospitals in Indiana, USA, for the relief of childbirth and postnatal anxiety, pain and nausea

As a qualified nurse, I had practised multi-specialty nursing in my home state of Indiana, USA for 20 years before I became interested in aromatherapy. My passion for aromatherapy began about 15 years ago when I attended a course run by an English nurse named Jane Buckle, in which she taught the multiple ways in which aromatherapy could enhance the care of patients. (Dr Jane Buckle is familiar to In Essence readers through her development of the ‘M’ technique® and as a speaker at IFPA conferences.)

In 2001 my family re-located to England for two years. By then I was a qualified clinical aromatherapist but was eager to learn more about UK aromatherapy and, in particular, its role in women’s health. My studies in the UK included an internship with Denise Tiran who specialises in the use of various modalities including aromatherapy with prenatal, labour and postpartum patients, as well as consulting with Ethel Burns and the team of midwives at the John Radcliffe Hospital, Oxford (Burns et al 2000).

At the time I came to England to study aromatherapy the British and American approaches to childbirth and labour were very different. In the US, obstetricians delivered the majority of babies, both normal and high risk. In the UK, normal pregnancies (about 60 per cent of all deliveries) were delivered by midwives while consultant physicians and midwives followed the high-risk pregnancies. Pregnancy and childbirth in the UK, then and now, are viewed as natural events in a woman’s life, with female midwives guiding and supporting women along the journey.

In the US, until the last few years, pregnancy and childbirth were medical conditions requiring specialised medical/physician intervention and treatment. The majority of women laboured on their backs in a hospital bed attended by nurses and delivered by doctors. Midwives were non-existent in hospitals and mainly found in rural areas where there were not enough physicians.

Inspiration and progress

Inspired by the work I had seen by aromatherapy practitioners in UK maternity services, I returned home determined to try to contribute to a change in the US attitude to pregnancy and childbirth. I am pleased to report that the situation in the US is now changing, due to the ongoing efforts and evidence-based labour strategies of women’s health nurses, nurse midwives and complementary medicine practitioners.

In 2008 I was fortunate to have the opportunity to set up a nursing aromatherapy maternity programme in a large Midwest hospital. This programme began with 12 nurses educated in the evidence-based use of essential oils in labour and childbirth (Burns et al 2000). The programme extended the use of aromatherapy to the postpartum patient and limited antenatal (Mandarin [Citrus reticulata] only) care (Tiran 2000).

In 2010-2012, women’s health nurses from eight Indianapolis hospitals completed the educational programme and the 700 aromatherapy interventions from this programme provide pre- and post-aromatherapy intervention data (see below).

The data show that women who have aromatherapy support during labour have an enhanced birth experience: they relax more and have reduced pain and nausea. My motivation in sharing this data is to inform and encourage safe, effective aromatherapy practice with this specialised population. It is especially significant because of the number of interventions involved, suggesting that the positive results were more than just a chance effect.

All aromatherapy interventions were measured using a pre- and post-treatment Likert scale, focusing on patient effectiveness ratings for anxiety, nausea and pain. Throughout the collection of this data, no negative side effects were reported. Maternal allergies, medical history and fragrance preferences always informed the essential oil selections.

All aromatherapy interventions were external, carried out with two per cent dilutions in unscented white
lotion or jojoba oil (one per cent antenatal Mandarin).

For safety reasons, interventions with *Mentha piperita* and *Mentha spica* (two per cent) were kept away from all infants.

The following essential oils were used: *Lavandula angustifolia*, *Citrus reticulata*, *Rose otto*, *Jasminum grandiflorum*, *Mentha piperita*, *Mentha spica*, *Boswellia carterii*, and *Chamaemelum nobile*. For all the oils used we had gas chromatography, mass spectrometry (GCMS) and Material Safety Data Sheet (MSDS) information.

**Postnatal aromatherapy pilot study**

The original hospital programme from 2008 continues to support nursing aromatherapy education and patient treatments. In 2011, with cooperation from Indiana University Health, it was the base for a year-long pilot study to find out whether aromatherapy improves anxiety and/or depression in high risk postpartum women and to provide a complementary therapy tool for healthcare practitioners. (Conrad P & Adams C 2012)

**DATA FROM 700 AROMATHERAPY INTERVENTIONS**

**Methods of aromatherapy**

**ANXIETY**

**Top four most effective oils for anxiety**

**Antenatal patient pre and post aromatherapy treatment anxiety ratings**

**Labour patient pre and post aromatherapy anxiety ratings**

**Improvement in antenatal anxiety with aromatherapy treatments**

**Improvement in anxiety with aromatherapy treatments in labour and childbirth**
Improvement in labour and childbirth pain with aromatherapy treatments

Patient pre and post aromatherapy treatments for labour and childbirth

Top five essential oils used for pain

PAIN

Improvement in postpartum anxiety with aromatherapy treatments

Patient pre and post aromatherapy treatments for postpartum anxiety

Top five essential oils used for pain

Improvement in postpartum pain with aromatherapy treatments

Patient pre and post aromatherapy treatments for postpartum pain

NAUSEA

Patient pre and post aromatherapy treatments for labour and childbirth pain

Top two essential oils used for nausea
Pam Conrad PGd, BSN, RN, CCAP spent two years studying advanced aromatherapy and graduate complementary therapies in England and France and had the opportunity to experience the therapeutic clinical use and benefits of aromatherapy with leading medical experts in the field.

She also studied at the Bristol Cancer Centre and at an advanced aromatherapy retreat in Provence, France studying antibacterial and antiviral essential oil applications. She completed a Postgraduate Diploma in Complementary Therapy Studies at the University of Westminster, London.

Pam’s current clinical practice in Indianapolis includes five years as Complementary Therapy Nurse Aromatherapist in pharmacy and hospital consultancy, education and programme development. She has shared her women’s health aromatherapy programmes and research in Ireland, Japan, Mexico and throughout the US.

Last year Pam Conrad decided to walk part of the Santiago de Compostela pilgrimage route and she knew the varied terrain and long days in boots would be a challenge. To help her keep going on the Camino de Santiago she decided to create a special aromatherapy kit that she calls the Aromatic CaminoTM, using essential oils from aromatic plants that grow near the various Camino routes.

She said: “These Mediterranean countries bless us with fragrant fields of plants such as lavender, rosemary, thyme, marjoram and chamomile. The therapeutic properties of the essential oils distilled from these plants are emotionally calming, mentally focusing and pain relieving for muscles and joints: the perfect companions for the long, varied terrain of the Camino journey.” This year Pam is accompanying groups walking the Camino, providing aromatherapy education and tips for a successful journey (more information in Positive Health Online, March 2014).