Aromatherapy for Posttraumatic Stress Sufferers and Their Caretakers

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Abstract

According to Kate Harmon (2009), writing for "Military Spouse" magazine, "In a given year, about 7.7 million American adults suffer from PTSD" (p. 48). Posttraumatic Stress Disorder (PTSD) is listed in the *Diagnostic and Statistical Manual of Mental Disorders*, and is usually associated with war experience, but victims of disasters and other violent events can also develop it. The impact of PTSD is not limited to those who have been diagnosed with the disorder. Anyone who lives with or cares for PTSD patients is also affected. Considering this, the consequences of PTSD are staggering. Aromatherapy has unique potential as integrated therapy for PTSD sufferers and caregivers. The sense of smell connects directly to the limbic system of the brain (Keville, 1995), which is the same system involved in the stress response and anxiety (Martin, 1951). Through psychoneuroimmunology (Borysenko, 1988), we can see how the mind affects the body, nerves, and immune system. Given the nature of this connection and the nature of the sense of smell, I believe that aromatherapy has unique potential as integrated therapy for PTSD sufferers and caregivers. Studies show how aromatherapy can be used for stress disorders, as well as give empirical evidence of its effectiveness. This is a summary of how and why essential oils can be used in this manner.

Etiology

Posttraumatic Stress Disorder is classed under anxiety disorders in the *Diagnostic and Statistical Manual of Mental Disorders*. It is caused by going through or witnessing an event that triggers intense fear, helplessness, or horror (Mayo Clinic, 2011). It is most commonly associated with combat, but natural disasters, rape, and other violent events can also lead to PTSD. Rescue workers can experience vicarious traumatization that is nearly identical to PTSD (Dossey & Keegan, 2013). The symptoms typically develop shortly after the event, but may take years. For diagnosis, they must last at least one month (Heffner, 2011). There are three categories of symptoms: intrusive memories, avoidance and numbing, and hyper arousal. Those

with PTSD can actually get worse over time. Common symptoms include nightmares, emotional numbness, memory problems, irritability, and insomnia. PTSD can also put one at greater risk for depression, cardiovascular disease, and muscular pain (Mayo Clinic, 2011).

Effects

The effects of PTSD can be severe and pervasive (Price & Stevens, 2009). Compromised parenting, family violence, and divorce are common. Family can be confused because the sufferer seems like a different person than the one they knew before the trauma. They can be triggered to relive difficult events in their own lives, and can feel hurt that they are unable to help their loved one. Normal routines and activities are disrupted, causing insecurity and a sense of helplessness. Feelings of hopelessness, guilt, and depression can develop in the family and caregivers. The term "compassion fatigue" was coined to describe this condition (Doctor & Shiromoto, 2010). The anger experienced by the patient can cause resistance to treatment and estrangement from family and the very people who are trying to help (Cash, 2006).

Standard Treatment

Treatment for PTSD includes both medication and psychotherapy. Commonly prescribed drugs are antipsychotics (usually prescribed for a short period of time), antidepressants, and anti-anxiety medications. Prazosin, a drug for hypertension, has been shown to help when the patient has nightmares (Mayo Clinic, 2011). Diet is very important. People with PTSD symptoms should avoid stimulants, such as caffeine and alcohol. Maintaining balanced blood sugar levels by eating frequent small meals that include protein helps stabilize mood. Avoid processed, refined, and simple sugars (Woods, 2009). Managing stress with physical activity is highly recommended.

Prognosis

Posttraumatic Stress Disorder is complex, as are its treatment and outcomes. The only sure thing is that it produces change. Individuals react differently. Those who are resilient, and have coping strategies such as optimism, appropriate emotional expression, and the use of social support tend to experience "posttraumatic growth" (Cash, 2006). In this way, they can make some sense of the event and get on with their lives. Individual attitudes determine how well patients return to normal functioning. It stands to reason that those with a positive, hopeful outlook, strong support system, and the willingness to try promising new therapies along with standard treatment are able to minimize or overcome the effects of posttraumatic stress.

Rational for Aromatherapy as an Integrated Therapy for PTSD

Part of the standard treatment for PTSD is the use of drugs, sometimes for long periods. Some patients develop unwanted side effects, or would rather not use pharmaceuticals. While aromatherapy is not without risk, the long-term effects are generally considered mild compared to other drugs. Essential oils used in aromatherapy are easy to use, non-addictive, and give quick results. They do not accumulate in the body as some drugs do; remaining only 3 to 6 hours in healthy individuals (Worwood, 1991). Some essential oils can react with conventional drugs, so exercising caution is critical to successful use. Aromatherapy has been used for years and research has proven that it affects the emotions (Keville, 1995). While I would not advocate the use of aromatherapy alone, I believe that it has a legitimate place in treating posttraumatic stress sufferers and their families and caregivers. Kate Harmon, writing in *Military Spouse* magazine (2006), agrees (p. 48). Kurt Schnaubelt (2011), in his book *The Healing Intelligence of Essential Oils*, states that "Essential oils are used to make everyday urban life healthier by providing easy means to manage crucial stress situations" (p. 107). There is scientific evidence of the benefit of essential oils for the management of anxiety, insomnia, and depression. Since those are some of the symptoms of PTSD, it follows that aromatherapy could be effective for it as well. Simply put, aromatherapy uses the sense of smell, which is unique in that the receptors for odor directly

affect the limbic system of the brain (Keville, 1995). The limbic system also triggers the "fight or flight" response (Martin, 1951). Anxiety disorders involve overload of the "fight or flight" response, so it follows that aromatherapy can have an effect on those disorders.

Mary Anne La Torre (2003), writing in "Perspectives in Psychiatric Care," suggests that "As a tool that is both safe and potent in its possibilities, aromatherapy is an approach that should not be ignored…what is often called for is a creative approach…aromatherapy is just such a creative technique" (p. 37). The decision to incorporate aromatherapy into therapy sessions is made jointly between the therapist and client after evaluating the effects of essential oils on the individual. The choice of oil and method of use is as varied as each particular client/therapist relationship. What works for one may not be effective for another; however, research has indicated certain oils that have a particular affinity for relieving anxiety and other symptoms.

Therapeutic Properties of Essential Oils

In their article, "Aromatherapy and the Management of Psychiatric Disorders," Perry, L., and Perry, E., state that "The effects of an aroma can be instantaneous and include both direct and indirect psychological effects" (Perry N. & Perry E., 2006). Each essential oil contains a unique combination of compounds. The compounds are classed into groups according to their chemical properties, and each group has known physiological effects. The oils most frequently used for symptoms related to PTSD, their chemical groups, and physiological action follow:

Essential Oil	Chemical Group	Therapeutic Use
Bergamot Citrus bergamia	Monoterpene Alcohols	Antidepressant, calming, relaxing, sedative
Chamomile (Roman) Chamomelium nobilis	Esters	Analgesic, hypnotic, relaxing, sedative
Clary Sage Salvia sclarea	Esters	Analgesic, antidepressant, antistress, calming, relaxing, uplifting
Frankincense Boswellia carterii	Monoterpene Hydrocarbons	Calming, relaxing, promotes sleep, sedative, brings out feelings

Geranium Pelargonium graveolens	Terpene Alcohols	Analgesic, antidepressant, uplifting
Jasmine Jasminum grandiflorum	Terpene Alcohols	Antidepressant, aphrodisiac, euphoric, relaxing, stimulating
Juniper Juniperus communis	Monoterpene Hydrocarbons	Analgesic, aphrodisiac, mentally clearing, nervine
Lavender Lavendula agustifolia	Esters	Analgesic, antidepressant, calming, hypnotic. relaxing, sedative
Lemon Citrus limonum	Monoterpene Hydrocarbons	Mentally stimulating, reviving
Neroli Neroli bigarade	Monoterpene Alcohols	Sedative, uplifting
Rose Rosa damascena	Terpene Alcohols	Antidepressant, aphrodisiac, relaxing, sedative, soothing, uplifting
Sandalwood Santalum album	Esters	Analgesic, antidepressant, calming, euphoric, relaxing, sedative

(Bell, 2002; Harmon, 2009; Perry & Perry, 2006; Schiller, 2008; Silver, 2013; Woods, 2009)

Other oils can be used according to individual preference.

Method of Use

Essential oils can be used alone or in blends. Any of the oils above can be used either way. Personal preference and therapeutic property are the main criteria when choosing an oil. The most common ways to use aromatherapy for PTSD are inhalation, topically, and baths (La Torre, 2003). There are standard precautions to follow for all essential oils. First, they should never be used undiluted. Always try a small amount first, and proceed with caution, no matter which method of delivery is used. Second, avoid using oils when pregnant or nursing, or on children younger than six. Also, use caution around animals. Whole body massage with essential oils can lead to overexposure and should be avoided. Discontinue use if unwanted effects develop. Essential oils are not to be used internally (Keville, 2009). Further, there are some precautions associated with particular oils. Lavender, for instance, should not be used on the skin (Bloch, Henley, Korach & Lipson, 2007), and citrus oils can cause photosensitivity, so should not be applied topically before sun exposure.

Inhalation is a quick (immediate to a few minutes), easy way to deliver aromatherapy. Several drops in a tablespoon of water in an electric or candle diffuser will fill the room with the scent (Harmon, 2009). This can be done 2-to-4 times a day or whenever needed. When away from home, keep a scented cotton ball in a plastic bag to inhale the scent as needed. Danielle Sade, in "Relief of Anxiety with Aromatherapy," writes that "Inhalation is the best way to use essential oils when anxious" (2002). For topical use on hands and feet, use 10 to 12 drops of essential oil in one ounce of carrier oil, lotion, or cream (Keville, 2009). It takes 5 to 30 minutes for onset of effects when diluted oils are applied topically. Baths and footbaths are a relaxing way to enjoy the effects of essential oils. Three to ten drops in a tub or three to five drops in a foot bath is the standard dose (Keville, 2009). Soak for ten to thirty minutes.

Studies have shown that essential oils are effective to relieve anxiety, depression, stress, and irritability. They are easy to use and are safe when simple standard precautions are followed. Aromatherapy with essential oils is a valid and valuable tool for treating sufferers of posttraumatic stress and their families.

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