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ORIGINAL RESEARCH

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THE IMPACT OF LAVENDER AROMATHERAPY ON PAIN INTENSITY AND BETA-ENDORPHIN LEVELS IN POST-CAESAREAN MOTHERS

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ABSTRACT

Background: Caesarean section is one of the most common interventions to overcome labor complications. However, pain cannot be avoided after the surgery. Lavender aromatherapy is considered as one of non-pharmacological therapy to reduce pain and increase beta-endorphin levels.

Objective: To examine the effect of lavender aromatherapy on the intensity of pain and beta-endorphin levels in post-caesarean mothers.

Methods: This was a quasy-experimental study with pretest and posttest with control group at Sembiring Delitua General Hospital on December 2016 to February 2017. There were 40 samples selected using purposive sampling, with 20 samples assigned in the experiment and control group. Numerical Rating Scale (NRS) was used to measure pain and ELIZA methods to measure beta-endorphin levels. Independent t-test and paired t-test were used for data analysis

Results: Results of this study showed that there was a significant difference in the mean value of pain intensity levels ($p=0.000$) and beta-endorphin levels ($p=0.023$) between experiment and control group.

Conclusion: There was a significant effect of lavender aromatherapy on the decrease of pain intensity and the increase of beta-endorphin hormone in post-caesarean mothers. It is expected that lavender aromatherapy can be used as an alternative treatment to reduce pain and increase beta-endorphin levels in post-caesarean mothers.

Key words: Caesarean Section, Pain Intensity, Beta-Endorphin, Lavender Aromatherapy

INTRODUCTION

Caesarean section is one of the most common interventions to treat dystocia, especially in mothers with complications or risk factors of gestational distance, maternal age > 35 years, obesity, height <150 cm, and over-month pregnancy. Cesarean delivery also will be at a greater risk of 46% if there was a case of dystocia in previous pregnancies.¹

Research conducted at Liun Kendage hospital in Makasar in 2014 indicated that cesarean section increased 31.14% by various indications, namely: prolonged labor (27.55%), preeclampsia (24.55%), and narrow pelvis (16.76%).² Similar with Pirngadi hospital in Medan found that the incidence of c-section increased in 2014 was 62.4% with referral case (94%), eclampsia/preeclampsia (36.8%), complications of pulmonary edema (2.1%) and require treatment duration of 4-5 days (41.4%).³

Due to the use of narcotic drugs and painkillers after cesarean section, mothers often complain of dizziness, nausea or vomiting and excessive sleep, especially for 48 hours after surgery.⁴ In addition, postoperative pain, especially in the area of injury incision in two months after the operation that can take place constantly every day in the form of mild pain felt on the move and rest.⁵ Pain that occurs after c-section is a result of a tissue incision resulting in loss of tissue continuity that causes a pain response. The pain is also the result of the stimulation of nerve endings by chemicals released at the time of surgery or due to tissue ischemia because of impaired blood flow to one part of tissue that is disconnected due to wound of c-section. The pain perceived by clients after c-section varies from mild to

very severe pain, depending on factors that affect pain, as the nature of the pain is highly subjective.⁵

According to literature, it was found that 75% of surgical patients had moderate to severe pain after surgery.⁶ This is consistent with the results of the study found that 93% of patients with c-section suffered from moderate to severe pain using the Visual Analogue Scale (VAS).⁷ Similarly, in India almost 66.3% of post-caesarean women complained moderate to severe pain, and 15.4% of headache and 19.4% of back pain, which resulted in inability to breastfeed immediately after surgery due to inadequate breast milk.⁸ Another study also said that 76.5% of respondents did not breastfeed their babies for the first time because of pain post-caesarean section.⁹

Pain can last for 24 to 48 hours, but may last longer depending on how patient can tolerate and respond to the pain. In other studies it was found that women experienced pain level with pain intensity during the first 24 hours post caesarean section.¹⁰ Effort to reduce the pain in the post-caesarean mothers is to use pharmacological and non-pharmacological treatment. Implementation of pain with pharmacological treatment is by using analgesic drug either intravenously or intramuscular, such as the combination of 75 mg bupivacaine 0.5% and 30 mg clonidine, and 75 mg bupivacaine 0.5% and 25 mg fentanyl. However, these kinds of drugs have side effects, such as hypotension and shivering. Thus, non-pharmacological treatment could be an alternative, which is also affordable and no side effects.

Aromatherapy is one of the non-pharmacological methods that can cause relaxation and comfort to encourage the release of neurotransmitters, such as encephalines and endorphins. Lavender (*Lavandula officinalis*) is one type of flowers that produces essential oil, so it can be used for aromatherapy with the main components of linalool oil (51%) and linalyl acetate (35%).¹¹ Lavender is considered having an effect of analgesic, antiseptic, antidepressant, antispasmodic, antiviral, diuretic, and hypotensive in which all the effects of lavender contribute to a relaxing effect.¹²

Lavender is also the most popular and safest oil to use, which can stimulate the sensory and ultimately affect other organs so that it can have a strong effect on the emotions. Aromatherapy is captured by a receptor in the nose, then provides further information to areas of the brain that control emotions and memory, and provides information to the hypothalamus which is the regulator of the body's internal system, sexuality system, body temperature, and reaction to stress and hormonal system diseases. Previous study suggested that lavender aromatherapy for 15 minutes may decrease the intensity of post-caesarean mother's pain.¹² Therefore, this study aimed to examine the effect of lavender aromatherapy to reduce pain in post-caesarean mothers.

METHODS

Design

This was a quasy-experimental study with pretest and posttest with control group. The research was conducted at Sembiring Delitua General Hospital for 2 months starting from December 2016 to February 2017.

Research subjects

There were 40 samples selected using purposive sampling, with 20 samples assigned in the experiment and control group. The inclusion criteria were a mother in the 1st day of post caesarean section, full awareness, not allergic with aromatherapy, could communicate verbally, and willing to be a respondent.

Instruments

Numerical Rating Scale (NRS) was used to measure pain in this study, ranging from 0 to 10 (0 = no pain, 1-3 = mild pain, 4-6 = moderate pain, and 7-10 = severe pain). The coefficient of reliability ranged from 0.66 to 0.84. While beta-endorphin levels were measured using ELIZA (Enzyme-Linked immunosorbent assay) method in laboratory. Pain and beta-endorphin were measured before and after given intervention.

Intervention

The experiment group was given an intervention of aromatherapy in a diffuser that has been spilled with essential oil lavender as much as 5 drops and water mixture according to tool size and connect to electricity. The diffuser was positioned 10-30 cm from patients. Before intervention, the researchers prepared the patient by positioning the patient in a relaxed and comfortable state and could be accompanied by the family. The intervention spent for 15 minutes to breathe and inhale lavender, and performed 3 times (4 hours, 8 hours, and 12 hours after surgery) for 2 days. While control group was given a diffuser but no essential oil.

Ethical consideration

Ethical clearance of this research was obtained from the ethics commission of Poltekkes Kemenkes Semarang No.066 /

KEPK / Poltekkes-Smg / EC / 2017. Each participant signed informed consent prior to data collection.

Data Analysis

To determine the influence of lavender aromatherapy on pain intensity and endorphin beta hormone levels, Independent t-test and paired t-test were used. Normality test has been examined, and its results showed that pain intensity and beta-endorphin levels were in normal data distribution.

RESULTS

Majority of the characteristics of the respondents as shown in the table 1 aged 27-28 years, in the second parity, having senior high school background, working and having moderate level of anxiety. Homogeneity test showed p-value >0.05 in all variables, which indicated that there was no difference of the characteristics of the respondents in the experiment and control group.

Table 1. Characteristics of respondents based on age, parity, education, working status, experience and anxiety level in the experiment and control group

Characteristics	Experiment group	Control group	<i>P-value</i>
Age (Year)			
Mean	27.25	27.70	0.075
SD	2.16	2.92	
Median	28	28	
Minimum	24	24	
Maximum	31	33	
Parity			
Mean	1.95	1.75	0.736
SD	0.75	0.63	
Median	2	2	
Minimum	1	1	
Maximum	3	3	
Education (%)			
Junior high school	50	35	0.178
Senior high school	50	65	
Working status (%)			
Working	60	55	0.555
Not working	40	45	
Anxiety level (%)			
Mild	30	40	0.216
Moderate	70	60	
Experience (%)			
Yes	60	50	0.379
No	40	50	

Table 2. Pain levels before and after given intervention in the experiment and control group using Independent t-test

Pain intensity	Experiment group				Control group				p-value
	Mean	SD	Min	Max	Mean	SD	Min	Max	
Pretest	6.90	1.021	5	9	6.55	1.146	5	9	0.314
Posttest	4.10	1.165	2	6	6.10	1.021	4	8	0.000
Mean difference	2.80	1.196	5	1	0.45	0.945	2	1	0.000

Table 2 shows that the mean of pain before intervention in the experiment group was 6.90 and in the control group was 6.55 with p-value 0.314 (>0.05), which indicated that there was no significant difference in the mean value of pain intensity before given intervention between experiment and control group. However, the p-value after given intervention was 0.000 (<0.05), indicated

there was a statistically significant difference on pain level intensity in both groups with mean value of pain in the experiment group was 4.10 and in the control group was 6.10. The mean difference of pain levels between pretest and posttest in the experiment group was 2.80 higher than pain level in the control group was 0.45.

Table 3. Beta endorphin before and after given intervention in the experiment and control group using Independent t-test

Beta endorphin	Experiment group				Control group				P-value
	Mean	SD	Min	Max	Mean	SD	Min	Max	
Pretest	217.61	36.96	120.17	278.63	229.58	49.52	137.72	306.82	0.392
Posttest	280.71	29.03	230.14	333.82	248.08	54.48	124.10	325.13	0.023
Mean difference	63.10	31.30	16.59	119.43	33.87	24.10	-22.79	86.57	0.002

Table 3 shows that there was no difference in beta endorphin levels before given intervention ($p=0.392$), which indicated that the experiment and control group started in the same level. However, after given intervention there was a

significant increase of beta endorphin levels in both groups with p-value 0.023 (<0.05), however, the increase levels of beta endorphin in the experiment group (63.10) was higher than beta endorphin in the control group (33.87).

Table 4. Mean difference of pain intensity and beta endorphin levels before and after given intervention in the experiment and control group using paired t-test

Variables	Experiment group			Control group		
	Mean	SD	p-value	Mean	SD	p-value
Pain intensity level						
Pretest-posttest	2.800	1.196	0.000	0.450	0.945	0.046
Beta endorphin levels						
Pretest-posttest	217.61	54.48	0.000	229.58	49.52	0.033

Paired t-test as shown in the table 4 shows that there was a significant decrease of pain levels in the experiment and control group with p-value 0.046 (<0.05). However, there was a higher decrease of pain levels in the experiment group compared to pain levels in the control group. Similar with beta endorphin levels, there was a significant increase of beta endorphin levels in both groups with p-value 0.033 (<0.05), but the level of beta endorphin in the experiment group

(217.61) was higher than the level in the control group (229.58).

DISCUSSION

The aim of this study was to examine the effect of the lavender aromatherapy on pain intensity and beta-endorphin levels among post-caesarean mothers. Findings of this study revealed that there was a significant decrease of pain level and

significant increase of beta-endorphin levels after given lavender aromatherapy ($p < 0.05$).

The results of this study were in line with previous study indicated that the use of lavender aromatherapy could be effective to overcome the pain and anxiety during the first stage of labor.¹³ Similar with Hutasoit stated that lavender has a calming effect so as to provide calmness, balance, and comfort. In addition, lavender aromatherapy can also reduce stress, pain, unbalanced emotions, hysteria, and frustration and panic.¹⁴

However, pain level in this study is closely related to the receptor and the presence of stimuli. Pain receptors referred to as nociceptors, are very free nerve endings that have slight myelin spread over the skin of the mucosa, especially in the viscera, joints, artery, liver, and gallbladder. Pain receptors can respond to stimulation. The stimulation may be chemical, thermal, electrical, or mechanical. Stimulation by chemicals such as histamine, bradykinin, acetylcholine and substance prostaglandins are chemicals that allegedly can increase the effects of pain and bradykinin. Furthermore, the stimulation received by these receptors is transmitted in the form of impulses of pain to the spinal cord by two types of fibers, ie fibers A (delta) tightly myelinated and slow fibers (C fibers).¹⁵ The impulses transmitted by the delta A fibers have the properties of the inhibitor transmitted to the fibers C. The afferents enter the spinal through the dorsal roots and the synapses on the dorsal horn. Dorsal horn consists of several layers or lamina interlocked. Between layers two and three form the gelatinous substantia that is the main channel of impulse. Then, impulse pain goes across the spinal cord

on the interneuron and connects to the most important ascending spinal path; namely the spinothalamic tract path (STT) or spinothalamus and spinoreticular tract (STT) pathways that carry information about the nature and location of the pain. From the transmission process there are two paths mechanism of the occurrence of pain, the path opiate and nonopiate path.¹⁵

The opiate pathway is characterized by receptor encounters in the brain consisting of the descending spinal path of the thalamus, which passes through the brain and medulla, dorsal bone marrow, conducts with a suppressive impulse nociceptor. Serotonin is a neurotransmitter in impulse in suppressive impulse. The suppressive system further activates nociceptor stimulation transmitted by fibers A. The nonopiate pathway is a descending pathway that does not respond to the less-known naloxone mechanism.¹⁶ Physiologically, the pain-induced trauma process occurs through four separate processes. Pain transduction is a disturbing process of stimulation that results in electrical activity in pain receptors. Transmission of pain involves the process of channeling impulse from the place of the transduction through the peripheral nerves to the terminal in the spinal cord to the brain. Pain modulation involves neural activity through the descending nerve pathways of the brain that can affect the transmission of pain as high as the spinal cord. Modulation also involves chemical factors that induce or increase activity in the afferent pain receptors. So the perception of pain is a subjective experience of pain that is somehow generated by transmission or neural activity.¹⁵

Aromatherapy practices include the administration of high concentrations of oils or essences that are distilled from the plant, the nerve fibers in the nose carry sensory input via the olfactory bulb directly to the limbic system in the brain that is the ancient center of our evolutionary instinct, memory and vital functions are established and organized. All other sensory information is first perceived by more complex parts of the brain and then sends that information to the limbic system. Thus, the sense of smell plays a key and encouraging role. Various odors are also absorbed through the alveoli and skin and then excreted through urine, feces, sweat and exhalation. Essential oils are used to relieve stress and are recommended for a variety of medical conditions.¹³

Literature said that the odor generated from aromatherapy is associated with steroid groups in the sweat glands called osmon. Osmon is potentially a natural chemical sedative that will stimulate brain neurochemistry. A pleasant odor will stimulate the thalamus to release enkefalin that acts as a natural pain reliever and produces a feeling of well-being. Enkefalin, like endorphins, is an endogenous chemical (produced by the body) that is similar in structure to opioids.¹⁶ Exercise relaxation breathing technique with lavender aromatherapy affects the circulation of blood, so that the supply of nutrients to the wound tissue can be fulfilled and the healing process will be faster. Deep breathing techniques can also give the individual self-control when there is a sense of discomfort or anxiety, physical stress and emotions that increase pain.¹³

On the other hand, in relation to beta endorphin, there are three main classes of

endogenous opioid peptides each derived from other precursors and have different anatomic distributions, namely enkefalin, beta-endorphin and dinorphine groups. Beta-endorphin is a peptide fragment derived from proopiomelanocortin (POMC), in the pituitary gland. Beta endorphin is present in significant amounts in the hypothalamus and PAG as well as slightly in the medulla and spinal cord. Beta endorphin is a faster-acting analgesic compared to enkefalin.¹⁷ Enkefalin and enkefalin are other substances in the body that act as inhibitors of pain transmission. Endorphins and enkefalin are substances such as morphine produced by the body that can inhibit the transmission of pain by blocking this impulse transmission in the brain and spinal cord.¹⁸ The presence of enkefalin and endorphins helps to explain how different people feel different levels of pain from the same pain stimuli. Endorphin levels vary among individuals, as do anxiety factors affecting endorphin levels. Individual with much less endorphins feel pain and those with slight endorphins feel more pain.¹⁸ In accordance with the results of this study there was a greater increase in beta-endorphin hormone in the experiment group ($p=0.000$).

CONCLUSION

There was a significant effect of lavender aromatherapy on the decrease of pain intensity and the increase of beta-endorphin hormone in post-caesarean mothers. There was a significant difference in the mean value of pain intensity and beta-endorphin hormone level before and after given lavender aromatherapy in the experiment and control group. Therefore, it is expected

that lavender aromatherapy can be used as an alternative treatment to reduce pain and increase beta-endorphin levels in post-caesarean mothers.

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