THE NATIONAL INSTITUTE OF MEDICAL HERBALISTS

Unpacking the Cupboard:

Hospice, Death, Bereavement, Grief, Trauma, & Loss: What Herbalists Can Do

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"You are not your struggles, as real as they are."

Presented with acknowledgments to Ben Zappin, L.Ac., for his shared insights based on extensive clinical experience, and Bill Gottlieb, for his personal experience and practice in helping people cope with traumatic loss, and all my teachers: scholars, patients, and plants.

This session is geared towards the professional herbalist or other health care provider who would like to have a strong foundation in supporting clients as an individual practitioner or as part of a team where common psychotherapeutic medications may play a role. This session does not cover mind-body emergencies requiring immediate professional treatment of every remedy. This session offers recommendations for practitioners with a general recommendation for further education and training to achieve full clinical competence. For those dying and those living with grief, herbal medicine can be a gift.

Notes are extensive. The day is experiential.

Outline (Exact timing Co-determined by Group):

10 – 10:45 Today's Objectives

Herbalists Are Ideal Providers for An Aging Population & Those In Crisis

Basics & Ground Rules

Tea Break

11.15am –12-30pm

Details

Herbal Strategies

Lunch Break

1:30pm – 2:30pm

Small groups – Practice

2:30 pm – 3pm

Integrate new learning with prior skills

3:00 pm – 3:45 pm

Exercise in Pairs

3:45 pm – 4 pm

Questions & Answer Session

Closing

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Unpacking Definitions:

Hospice – Care beyond curing, is an option in healthcare to affirm life rather than postponing death. "Hospice" is a term from the same root words that give us Hospitality and Hospital, first used in medieval times to shelter travelers in need of rest. In 1967, physician Dame Cicely Sanders applied the title of Hospice to St. Christopher's in London, where she established specialized care for the dying. The Duchess of Cambridge carries this tradition forward today with her sponsorship of East Anglia's Children's Hospice. Dame Sanders' lectures on holistic hospice care spread a vision later articulated by Dr. Elisabeth Kubler-Ross, with *On Death and Dying* (1969) and U.S. Senate hearings in 1972. She testified,

> "We live in a very particular death-denying society. We isolate both the dying and the old, and it serves a purpose. They are reminders of our own mortality. We should not institutionalize people. We can give families more help with home care and visiting nurses, giving families and the patients the spiritual, emotional, and financial help in order to facilitate the final care at home."

Recent decades have seen a sharp rise in the number of elders who cannot afford facilities, and most hope to die at home. Whether the people we serve are institutionalized or at home, herbalists are uniquely suited to add to available support when it matters most. Dr. Kubler-Ross articulated the stages of grieving: Denial, Anger, Bargaining, Depression, and Acceptance. These may not happen in order. Later researchers describe Shock/Denial, Disorganization, Volatile Emotions, Guilt, Loss/Loneliness, Relief, and Re-establishment. Herbalists can help family members who are at different stages since these are not sequential or predictable. No one "needs" to move along. Medicinal plants provide multiple avenues to support the dying, caregivers, and the bereaved.

Erik Erickson developed concepts on life stages that are helpful to herbalists working with the dying and their families, especially his theory regarding later life: integrity versus despair. Not for those over 60 years old only, Erikson's model suggests this is our opportunity to express regrets, reflect on a life path to identify what feels worthwhile to achieve ego integration, and in turn prevent hopelessness when facing

death. Louis Armstrong composed one healthy expression in his version of the song, "What a Wonderful World."

Death, whether or not accompanied by disease, is a natural part of the cycle of life. We are all faced with death sooner or later. Everyone here is going to pass into that mystery, whatever our beliefs.

Bereavement – As we see in the literature, even those who have prepared for years for the end of life of a loved one, the end may be compounded by older, unresolved losses and trauma. Acute grief is a form of traumatic stress. Healthy grieving involves similar symptoms included in diagnoses below but with less intensity, shorter duration, and a rolling wave of depression, etc., with times of appreciating life's complexity (acceptance, accommodation, and healthy growth). People may assume that the predominant experience when someone dies is sadness, possibly guilt, or loneliness. By far outstripping these is anxiety. Anxiety is catalytic in mourning. Western social conventions block successful grieving -- "Be calm, carry on."

Loss – Separation from loved one, care providers. May be due to bereavement, or interactions with the legal system (imprisonment, rehab centers), divorce, and geographical moves away from support (friends, familiar surroundings, extended family). Loss of familiar roles may also be traumatic. For example, when mother dies, older sister becomes guardian, so younger sibling loses both parent and sister.

"Life must go on.

I forget just why."

Edna St. Vincent Millay

Grief – Defined in countless ways, a reaction to any significant loss, trauma, bereavement, or unhappiness. Grief is an emotion leading to feelings of helplessness, confusion, and passivity. In 1961, the psychiatrist George Engel compared it to a physical wound; it requires treatment, not just Time. C.S. Lewis concludes in A Grief Observed that there is no template; we find unique ways through with a few universal themes, such as telling the story, and finding outlets for painful stored energy.

Herbalists have empathy for patients seeking to understanding the natural process of grieving (how we feel) and mourning (what we do).

The Natural Process of Grieving and Mourning

Normal feelings include emotional waves of numbness ("This cannot be real"), depression, anger, guilt, exhaustion especially when patients hang on (see Four Things), a lack of confidence about what to do, remembering other losses, hope for a peaceful passing, and clinging to the person while trying to let them go.

The process of grieving is active. It takes energy to move through shock, volatility, guilt (anger and resentment turned inward), and loneliness, to acceptance, relief, and establishing a new mode of living well. Relief may trigger guilt. Guilt may be transformed by investing in another relationship or person in need of care. There is Survivor Guilt. This occurs in the HIV+ community, in the aftermath of school shootings, or following natural disasters. Our LBGTQ patients face complicated grieving when trying to cope with loss where social and legal barriers remain.

The family is not in constant pain. Imagine a cycle: crisis may be followed with times of coping, a new equilibrium, "normal time," returning in a circular or spiral pattern to crisis.

The family is our patient, not just the one who is ill. The more treatment made available to each member, there is hope – even hope for a change in the course of the patient's dying.

Roles change: someone has to come home from school, a career, an income, and prepare meals, coordinate services, or perform other functions in this new unit. Resentment over loss of one's own dreams, guilt over being angry, and the "tyranny of the ill" can corrode the setting for a peaceful, positive transition.

Acting out behavior on anyone's part is a cue that history includes unfinished business. Most of the general population knows how to support life. But where food is no longer as needed by the dying, the nurturers may insist on feeding to express love. When someone is actively dying, s/he may not want to see all the people who want to

see the patient. When some family and friends are not invited into the inner circle, these people may feel offended or abandoned.

Herbalists create bridges between suffering & resolution. To start, we listen rather than take sides. We can hand out Vervain, Linden, and Lemon verbena tea. Make sure it tastes good.

We can be on the lookout for warning signs in the family. Either the patient or a family member may withdraw as a way of distancing from emotional pain. If you feel judgment (sometimes unavoidable), vent with a trusted colleague later instead of challenging the shut-down person. It may help us to recall that "Loneliness is the flip side of denial." The self-isolated person may move toward self-pity and depression, worsened as memory of the deceased fades. Or the self-isolated person may respond to nonverbal stimulation. Artemisia vulgaris or bitters suited to the individual have been known to spark appetite, and in turn, appetite for community.

Unresolved loss may be denied by jumping into relationships with surrogates: a quick remarriage. Mourning that is avoided may lead quickly to behaviors associated with risk (substance use/abuse/dependence).
Healthy expressions of grief by the surviving family and the presence of an available support system are the two main indicators that allow people, young and old, to be able to say, "My sadness is okay… I will be okay."

Contemporary grief support is evolving rapidly, with Death Cafes and free or for-fee services. Herbalists with a philosophy of holistic care are well-suited to including discussion of local and online resources for patients in need as an integrated part of normal consultations.

Because social media is incalulably important to support systems, peers may provide significant aspects of support. For this reason, the herbalist/care provider will enquire what role social media may hold for those coping with loss. Social media has the potential to elicit self-soothing, "mastery," and healing, or it may be re-traumatizing. When a patient is in a state of distress, the consensus is to treat symptoms first, leaving "mastery" of grief for later.

Anxiety –

When loss from any cause is believed to be temporary, the response is predominantly anxiety. When loss is recognized as permanent, the response is often depression, yet this does not have to be pathological. Whole people with strengths and support integrate negative experiences. The frustrated yearning for return of the loved one drives a mourning process. Failure of pining eventually propels us past depression and anger, disorganization and withdrawal, to a place of accommodation and renewed hope and meaning.

Anxiety is now considered the most common psychiatric illness in the US and the UK, with a greater incidence than depression (estimated 1:10 people in North America at some point during their lives). In the U.K. a clinical disorder is diagnosed in 2-4% of the population, although 1/3 of the population reports they use alcohol to self-medicate for anxiety. Approximately 20 million people in the U.S. are diagnosed with some form of anxiety disorders each year. Like depression, with which it is often associated, anxiety is more common in women (20%) than in men (8%) (Anon., Pharmacist's Letter/Prescriber's Letter, 2000).

Though most human beings experience nervousness and feel anxious at some point in their lives, people with anxiety disorders may experience "persistent, unremitting anxiety that can be debilitating." In a vicious cycle, those with persistent anxiety worry about their present and future vulnerability to repeat attacks of anxiety.

There are more varieties of anxiety disorders than can be adequately discussed in terms of cause, incidence, natural approaches, and supporting evidence. Two common diagnoses are generalized anxiety disorder (GAD) and panic disorder. In addition, in part due to media and popular cultural influences, there is a growing awareness of obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), and specific phobias, all classified as anxiety disorders.

Risk factors for anxiety are legion; they are usually grouped in four areas:

- Traumatic experience
- Drugs
- Stressful situations: Illness, death, divorce, financial stress, family tensions
- Endocrine imbalance: hyperthyroid state, premenstrual symptoms, post-partum symptoms (see below), midlife changes for both genders.

Brock Travis, Ph.D., suggests a three-tier diagnostic structure for increasingly somatized or pathologized symptoms of grieving, loss, and bereavement:

Normal Response	FEAR	ANGER	GRIEF
Emotional Response	PANIC	IRRITABILITY/RAGE	DESPAIR*
Physical Diagnosis	GAD, ANXIETY	EXPLOSIVE Sx	MAJOR DEPRESSION

(* "Suffering without meaning equals despair," Viktor Frankl, 1905-1997)

Travis further suggests that healing comes from balancing input and output:

Input	NUTRITION	WAYS OF KNOWING, INTUITION
Integration	RELAXATION	DREAMS, ART
Output	EXERCISE	SHARING, LEADERSHIP

(www.**brocktravis**.com/tag/**mindfulness**/)

Depression –

Depression is a recurring state of persistent sadness and the symptoms that go along with this mood. It may have an identifiable trigger event, it may be a response to systemic disease, or it could be a drug reaction. It affects 1:10 Americans of all ages, ethnic and socioeconomic groups, but is more common in women, in the UK, North America, and globally. In the UK, one out of five older people have some degree of depression, with one out of four people experiencing symptoms in the course of a year. English men are three times as likely to die by suicide as English women, at one of the highest rates in Europe (400 per 100,000).

Current research has not confirmed the causal co-factors to be genetic, although family history is often present (Goodyer, IM, et al, 2000, Lowe, JR, et al, 2012). The pathophysiology may involve neurotransmitter systems beyond those specifically addressed by current medications (DSM-IV-TR, 2000). Though biochemical imbalances may be confirmed by measuring neurotransmitters, or presumed due to symptoms, other risks in all populations affected include environmental and familial factors such as neglect and abuse, physical illness (pain, cancer, side effects of treatment), social causes such as exposure to violence and poverty, and psychological factors. Psychological causes include feelings of helplessness and vulnerability, anger, low self-esteem, and pessimism, often noted as isolation from resources (Seligman, L, and Reichenberg, L, 2007).

Despite cultural or personal beliefs, evidence demonstrates depression is prevalent and dangerous (Seligman, L, and Reichenberg, L, 2007, Patterson, J, et al, 2006). Depression is more common in women, especially those who are or were married, in contrast to men (Seligman, L., and Reichenberg, L, 2007, Patterson, J, et al, 2006). Socioeconomic status is significant in this subset, as in all populations.

Also, for women, the joy of a new baby is fraught with challenge; elation gives way in a matter of days for one out of ten new mothers with post-partum depression (PPD). The increased incidence of depression among women raises concerns regarding safety and efficacy of treatments with pregnant, lactating, and new mothers who seek alternatives (Freeman, MP, et al, 2010, Freeman, MP, et al, 2008, Linde, K, et al, 2011).

Risk factors for PPD (Post-Partum Depression) include a positive family history, PPD after a previous birth, personal history of mood illness, low thyroid, sleep disturbance, being raised in an alcoholic or dysfunctional family, an unusually fussy or needy baby, delivering a premature or compromised baby, discord in the primary relationship, severe PMS prior to pregnancy, ambivalence toward becoming a mother, isolation from family and friends, lack of emotional or financial support, and lack of self-care (eating well, regular exercise, interest in life). Diagnosis requires individual assessment with lab evaluations, while treatment may include family and personal counseling, education and support groups. Many women resist antidepressant drugs during this time, and prefer to try natural, less aggressive remedies.

Children

Moods in children and adolescents are considered ubiquitous while disorders are not (DeRobertis, E, 2008). Normal life tasks and stress contribute to individuation. Depression affects between 2% and 8% of children and adolescents (one out of ten in the UK); this appears to peak during puberty. Depression may be self-limiting, but an estimated four out of ten depressed children have a recurrence, with one-third of this population attempting suicide, and 3% to 4% of these committing suicide (Hazell, P, 2011).

Depression is more closely linked to nutritional habits than previously acknowledged by a conventional medical view (Jacka F et al. 2010, Freeman, MP, et al, 2008, Cott, J, 2010, Linde, K, et al, 2011, Shannon, S, and Rondeau, M, 2012). Changes in our diets have altered the ratio between omega 3 and 6 essential fatty acids, which affect brain chemistry in a number of ways. One of the ways is precipitating depression in

vulnerable individuals. Evening Primrose Oil improves the function of nerves and myelin sheath integrity, increases prostaglandins (series I - anti-inflammatory), is a source of tryptophan, and has other benefits. If high doses of GLA's are taken longer than 1-2 months, it must be balanced with EPA's (cold water fish). In August 2015, a study showing Omega-3 essential fatty acids were found safe and effective in young schizophrenics and bi-polar patients.

Drinking more than 4-5 cups of coffee a day is linked to depression, as is a low level of B6 and B complex, which affects nerve stability. Some studies have shown that depressed people are more likely to have low levels of folic acid, which in turn may lower serotonin production. Other deficiencies associated with depression are calcium, magnesium, potassium, and iron.

Two other findings associated with depression are extremes of dietary fat (either too high or too low), and food allergies. In the case of food allergies, an underlying physical problem such as *Giardia*, has been mistakenly diagnosed at least once in the literature as depression. This might be because symptoms of pain, sensitivities to food and fatigue may lead to, or mimic, depression. The key is correct diagnosis before stimulating the humoral and cell-mediated immunity to address *g.i. dysbiosis* or parasites. Otherwise, a current public fear of parasites will turn all depression cases into a search for *Giardia*, when that is only an uncommon, possible explanation for the symptoms of depression.

The fact that there is an abundance of treatments suggested for depression, plus the emerging literature interpreting different types and treatments, speaks of an almost universal concern with normal life stressors that may be pathologized as depression (Remen, RN, 1986).

Trauma – The result of experiencing, witnessing, or being confronted with actual or threatened death or serious injury to self or others, and responding with intense fear, helplessness, or horror (DSM IV-TR). In children it is more common to see disorganized behavior or agitation. This is a new diagnosis in the literature.

"What makes a negative life event traumatizing isn't the life-threatening nature of the event, but rather the degree of helplessness it engenders and one's prior history of trauma" (Scaer, R, 2006). Complex or repetitive trauma is more common than single-incident trauma.

In a sense, there is no singular "event." There is our response. We interpret, or even suppress, a memory that combines sensation, feeling, and thought. Witnesses and survivors of "one event" demonstrate unpredictability regarding details, its impact on them, and its meaning.

Subcortical responses to stressors are received in 40 milliseconds, according to some studies. It takes on average 450 milliseconds for the cortex to get oriented. Panicked people imagine they are thinking clearly yet make poor decisions, including no decision.

In contrast, highly stressed people with resilience perform remarkably well in a crisis. The optimal completion of responding to danger follows a wave of arousal/survival with parasympathetic activity, social engagement, and rest. It is this wave where treatment of any sort targets modulating extremes in favor of a new rhythm or energetic flow.

As a fact of life, trauma can be matched by natural resilience. With support, and with what complexity theory calls the "strange attractor" that is our innate capacity for self-healing, trauma may lead <u>to and through</u>:

Symptoms

- Anxiety
- Sleep disturbance
- Emotional numbness
- Intrusive thoughts
- Disassociation (ranges from healthy daydreaming to maladaptive coping)
- Physiological complaints (real yet independent of other possible cause of symptom)

If criteria for PTSD (below) are not met, there may be a diagnosis that helps hardly at all, such as Acute Stress Disorder (ASD) or Disorders of Extreme Stress Not Otherwise Specified (DES NOS).

Trauma is the opposite of empowerment; at some point, herbalists may demonstrate to a curious patient how to make one's remedies. These are not psychopharmacological pharmaceuticals; we are talking about tea blends, dream pillows, and fun ways to use herbs. Even when standardized herbs, nutraceuticals, and

other supplements form the basis for treatment, creative providers may identify safe and effective natural self-care so that interested people regain 1) some measure of control, and 2) hope for other successes.

The Role of Memory

Out of all the complex ways to comprehend trauma, two basic types of memory seem to concretize or somatize trauma in us:

1. Emotion-linked memory triggers troubling, intrusive thoughts that pull us out of the present. "I try to focus on work or go for a run but the same old worries crowd in till I'm shaky and sick."

Important for natural medicine providers: It may seem counter-intuitive, but because patients are overwhelmed, **meditation is not recommended** at the beginning. Trauma material floods and overwhelms the unprepared meditator. Play therapy, body work, and physical care that is perceived as nonthreatening (acupuncture?) creates a safe stage for ethical processing. Staying focused on doing something, however small or simple, is a good predictor of healthy recovery from shock, loss, and trauma.

Strategies herbalists can offer for all ages include coloring mandalas, drawing "power animal" cards, and spiritually neutral breathing exercises.

Herbal medicines are known to affect memory and the Neuroendocrine System. The limbic nucleus is where we evaluate emotional contents of sensory stimuli. If the incoming stimulus holds a threat, the amygdala's job is to start a cascade of arousal for survival: alert the hypothalamus – activate the sympathetic nervous system, signal adrenal neurotransmitters epinephrine and norepinephrine. There is no talking oneself down; the amygdala cannot hear soothing words. Medicinal plants may provide a wide variety of pharmacological and nonphysical benefits for patients with neuroendocrine challenges.

Quick Review (from the neck up towards the crown chakra):

- Brain stem – most primitive survival functions: breathing, blood pressure, temperature

  Also called Reptilian brain

  Speaks language of Sensation

- Diencephalon – control of appetite, sleep

  Sandwiched between Survival and Feeling

- Limbic region – instinctual emotions, sexual appetite

  Speaks language of Feelings

- Cortex – both abstract and concrete thinking

  Frontal lobe – modifies impulses, organizes learning, decision-making

  Decides when we are and are not in danger

  Function interrupted/disrupted in trauma

  Speaks language of words, thoughts, abstract symbols

Physical trauma such as brain injury is only recently beginning to be better understood. Yet a study almost twenty years ago of 279 Vietnam veterans who had head injuries showed those with frontal lobe damage were two to six times more aggressive and violent as uninjured soldiers from that war. Accidents are another cause of "neurological rage" that does not relate to the actual trigger – minor insult or mortal danger.

- Right and left hemispheres connected in midline by the fibrous corpus callosum ('information superhighway"); smaller in abused children. Healthy subjects have more fatty myelin sheathing.
- Hippocampus – role in retrieving memory; shrunk in PTSD patients yet functioning in healthy trauma survivors. Impaired ability to recall can mean traumatized patients are challenged to "re-write a healthy narrative."
- Note we aim to treat symptoms first, to achieve "mastery" later.

Longitudinal studies reveal that healthy people alter their remembered versions of past trauma. Those who vividly recall details and tell their story the same way over time are more likely to receive a diagnosis of a mental disorder such as PTSD. To survive we adapt, sometimes by creatively re-organizing how we make sense of negative experience.

"Remembering" is not re-living. The Hypothalamic-Pituitary-Adrenal axis (HPA axis) is described at length in the literature on herbal medicine mediating acute and chronic stress.

While there is still debate regarding whether thoughts are purely transmitted by neurons, or feelings mediated by peptides, mind-body medicine is revisiting cognition

(thoughts), emotion (feelings), and behavior (how we act). This is where I believe herbal medicine excels at delivering pharmacological health care as well as synergy beyond known active constituents.

Not all trauma is walled off, but often the mind tries to encapsulate the body-mind experience. This "wall," however, is permeable to stimuli so parts of the trauma seep into awareness. A theme with clinicians is to slow down the process so that, metaphorically, patients' protective defenses are respected until some time after their sense of Self and support systems are strengthened.

A nuanced interpretation of an established view, proposed by Robert Scaer, Antonio Damasio (author of *Descartes' Error* and *The Feeling of What Happens*), Daniel Stern, and others, is that the patient's lizard brain is trying to protect her from danger that is <u>not</u> current but is experienced as if it is. It is ancient survival biology: flee, fight, or if those are not options, freeze and shut down. In all of these states, enormous reserves of vital energy are summoned, though in the case of shutting down the energy may become frozen or stuck. Even stuck energy will find a way out. It may be messy or not. The trauma patient, despite everyday circumstances, is in touch with a terrifying past when she felt helpless, as if that danger is threatening her now. These episodes can be confusing and re-traumatizing: "I'd been feeling just fine; suddenly, without warning, I feel scared. I couldn't open my mouth to scream or move a muscle. Am I going crazy?"

- Tripping this switch may be:

  <u>Conscious</u> (I bring my ailing dog to the animal hospital where, years ago, my terminally sick cat died. As I park, my heart rate and sweating are all out of proportion to my dog's minor health issue) or,

  <u>Unconscious</u> (His neck stiffens painfully the moment traffic gets heavy; the car accident was so many years ago, he isn't remembering it).

The hypothesis that goes with this idea when it comes to treatment is, to "turn off" the on-off switch of the amygdala. Three ways we may down-regulate the amygdala that is stuck in the "on" position are 1) Somatic Experiencing, 2) Eye Movement Desensitization Reprocessing or EMDR (Harper M et al. 2009), and 3) Emotionally Focused Therapy (EFT, also known as Emotional Freedom Technique, tapping), more on these below. Brain integration seems to follow repetitive behaviors as simple as

eye-rolling, counting (left hemisphere) and singing, chanting, or affirmations with tapping (right hemisphere).

2. Body memory is a hard-wired, mostly unconscious response to trauma.

"The ax forgets, the tree remembers."

Maya Angelou,
Even the Stars
Look Lonesome,
1997.

In a nanosecond, jaws clench, the stomach lurches. The whole body experience can be stored for a lifetime after that. Also a primitive survival strategy, the body wants to be prepared if we ever face that danger again. This body memory can be released, just as the limbic "switch" can be re-set. Body memories that are frozen respond to non-verbal body therapies.

Herbalists may teach self-care that empowers, for instance, massaging specific herb extracts in certain areas (temples, nape of neck, inner wrists) in a certain order. This ritual is the herbal therapy the patient continues on her/his own as self-care. Follow-up on our part includes asking how, or if, this is helping.

As with memory that is emotionally based, body memory gets activated without the actual old danger. For example, one year about the time that schools start up in the fall and the stores stock notebooks and early Halloween items, Gina's mother was killed in a drive-by. She and her remaining family members could not move away; she felt trapped attending school with kids related to the older gang members probably involved (case unsolved). Her loss, complicated by a perception of helplessness, leaves Gina fearful that any one she loves may die. The next fall, she dreads school so profoundly that her body manifests dizziness, headaches, and vomiting. Halloween equals nightmares – including dream fragments in which Gina is wrongfully imprisoned for her mother's death by an unsympathetic justice system.

Younger trauma patients may have frightening dreams often with no recognizable content. Socioeconomically, families below the poverty line are five times more likely to experience violence. In more affluent families trauma may be harder to detect.

Being present in the "Now" is estimated to last 1-10 seconds, when we problem-solve, relate to others, and move ahead with our lives. This positive reinforcement of the present moment may best be done slowly and by degrees over time.

The herbal practitioner's goal for the patient may be that the memory is described in a safe environment (confidential office space, respectful listening, box of tissues, aromatherapy, and your best ideas) until it can be experienced without the automatic triggering of intrusive thought or body cues that re-enact the traumatic associations.

When people re-live their trauma, PET scans show there is less activity in higher cortical areas (verbal language and executive functioning), while all the action is in the limbic region (right hemisphere). They can't put what's happening into words; at best, they might talk around it. "Speaking" this brain's language may skip the talking and instead play in the sand tray, or switch to puppets, theater, even shaking "like dogs after a fright." The key is desensitization rather than "re-kindling:" getting in touch can re-traumatize us because we feel the cold/hot/sick fear if there is no safe stage set for processing feelings to completion. Retraining patients in relaxation, especially deep abdominal breathing, counteracts hyperventilation and rising CO2 levels that aggravate anxiety.

Instead of "Where do you feel the tension?" we might ask, "What are you able to notice in your body?" "Where in the body are you feeling it? Okay, go to the edge of where you feel it" (not the center). We might ask, "How would your life be different/ what would you be doing if you didn't have these symptoms/ this problem?"

Using tapping can be woven into even brief consults: "Can we try some tapping together for just two minutes? Say something in your own words like, 'Even though (name the problem, i.e., I do not like feeling this queasy/scared/angry), I (name something positive, i.e., still love myself, or am perfect in the eyes of God, or know these herbs are healing'" (see EFT below).

For Gina, her disabling grief is responding to ritual self-care: her own anxiolytic herb tea ceremony, mindful breathing, and tapping with affirmations. She begins to identify who she is each time she is (temporarily) liberated from anxiety. The duration

of healthy experiences of her Self begin to increase as negative symptoms diminish, both in duration and intensity.

One of our therapeutic goals may be to schedule each experience of feeling trapped energy in a safe arena, in order to release it, in turn resurrecting or recreating a level, or layer, of mastery of Self over trauma. A general check-up can include one to two minutes practicing abdominal breathing.

Trauma shatters the person's worldview: assumptions about oneself and one's world. Feeling overwhelmed can be reframed as a phase in a chain of events that is, *as of yet*, incomplete, offering hope. The observable outcome of healing is a newly emerging worldview that integrates experience, negative and positive, with meaning that holds value for the survivor.

PTSD –

Post-Traumatic Stress Disorder (PTSD) has a changing definition, even with the recent revision of the Diagnostic Statistical Manual (DSM-V). It is common among our potential or current patients/clients after seeing or experiencing danger or loss that is perceived or actually life-threatening (disaster, traumatic loss, or violent assault). Both young and old PTSD patients feel they re-live the event in nightmares, flashbacks and behavioral disorders including insomnia, crying and depression (Van derKolk B and Pynoos R. 2009. Proposal to include a development trauma disorder diagnosis for children and adolescents in DSM-V). A common characteristic is feeling detached, isolated, or separate from family, friends, even pets.

Diagnosis hinges on changing criteria summarized for simplicity:

- Exposure to actual or threatened death PLUS response of intense fear, helplessness, horror
- Repeatedly re-experiencing the event(s) as if in a time warp
- Numbing, inability to respond that is not present before event(s)
- Attempts to avoid thoughts, feelings, recollections, associated triggers (places, reminders)
- Symptoms of overstimulation - sleeplessness, bursts of anger, overly watchful
- Duration: Within one month of a crisis, symptoms are "acute." After one month but less than three, acute PTSD may be diagnosed. Chronic PTSD lasts three months or longer.

- Impairment or distress in functioning at home, school/occupation, or other important area of life

Many Symptoms, including:

- Hypervigilance
- Easily startled
- Anxiety
- Irritability
- Cognitive dysfunction
- Anger, violence toward self, others
- Mood changes
- Fearfulness
- Numbness
- Anhedonia (inability to experience joy or pleasure)
- Memory loss
- Avoiding triggers or areas associated with the trauma
- Substance use/abuse/ addiction is common

Protective Factors

- Healthy attachment in early life, includes *in utero*
- Familiar & trusted people, pets, places after the event(s)
- Faith
- Cultural meanings related to acknowledgement of suffering (positive examples: the Victoria Cross, the Native American Sundance, the Purple Heart)
- *Decentration – having* your emotions, not *being* them
- Sense of Self – a primary aim, perhaps for patient's first time in life

History

A new name for a historic diagnosis, PTSD was formerly battle fatigue, shell shock, survivor's guilt, and traumatic neurosis. Some researchers argue PTSD is a western-created diagnosis while others find it a universal biological response. Both causes and protective factors have been noted consistently in populations as culturally different as resilient children of color in South Africa, soldiers of several nationalities and eras, and kidnapped heiresses.

Conventional Approaches

The standard of practice for stress, depression, anxiety, "complicated grief," and PTSD changes in ways that make a comprehensive summary impractical in the scope of this presentation. The focus here is on common prescriptions and treatments; comprehensive lists are widely available in the literature and online.

Anxiety –

- Selective serotonin reuptake inhibitors (SSRIs) sertraline (Zoloft) and paroxetine (Paxil). One, and if needed, two are often combined.
- Benzodiazepines (GABA-enhancing) are added, mostly for short-term use due to potential for side effects including dependence.
- Possibly safer, Buspirone works better in people who have not taken benzodiazepines.
- Antiepileptic drugs pregabalin and tiabigine are being researched for Generalized Anxiety Disorder, though results are pending.

Panic attacks or Disorder –

- SSRIs, benzodiazepines, other antidepressants, and in many combinations.

Agitation – Assess/ Treat possible new medical issues, exacerbating factors before medications:

- Antipsychotic drugs block dopamine, risperidone (Risperdal), olanzapine (Zyprexa), quetiapine (Seroquel), aripiprazole (Abilify).
- Non-FDA approved but commonly used trazodone, buspirone, SSRIs.
- Anticonvulsants valproate

Depression – Rx grouped by presumed mechanism of action

- Norepinephrine-serotonin reuptake inhibitors amitryptaline (Elavil), duloxetine (Cymbalta), imipramine (Tofranil), venlaxafine (Effexor).
- SSRIs escitalopram (Lexapro), fluoxetine (Prozac), paroxetine (Paxil), sertraline (Zoloft).
- Selective norepinephrine reuptake inhibitors nortriptyline (Pamelor)
- Serotonin antagonist reuptake inhibitor nefazodone (Serzone).
- Dopamine-norepinephrine reuptake inhibitors bupropion (Welbutrin).
- Monoamine oxidase inhibitors (MAOIs) phenelzine (Nardil), tranylcypromine (Parnate).

Natural medicine practitioners will note that review studies strongly suggest that all antidepressants are equally effective, regardless of mechanism of action, though side effects and patients' acceptance differ (Patterson J et al. 2010). For all classes of antidepressant drugs, response and remission rates average 40-60% (ibid). Note also that altering neurotransmitters is expected to lead to side effects.

Insomnia – Treat underlying problem first (anxiety, depression, substance use/abuse)

- Treat sleep hygiene (no LCD's, TV, stimulants, patterns of circadian rhythm)
- For elderly patients avoid benzodiazepines, anticholinergic diphenhydramine
- Trazodone for 3-4 days to re-set; longer use discouraged.
- Zolpidem

Related Therapies

Conventional psychotherapy approaches to trauma are also in a decade-long (some say longer) evolution. Childhood development theory, attachment theory, psychodynamic, post-modern, and other practices seek to 1) investigate, 2) corroborate, and finally, 3) incorporate novel evidence-based methods.

Research is not always consistent with clinical care, which varies widely. Current trends include seeing neurodevelopmental issues as important at every life stage rather than being limited to early life only (Perry BD. 2001). "The pathway that is repeated is strengthened." Learning new coping skills as well as discharging trapped energy possibly alters structure as well as function.

- CBT – Cognitive Behavioral Therapy is a form of psychotherapy that seeks to challenge and change damaging self-talk or distorted thinking, use reparative visualization, and reconstruct meaning within a context of instilling new, healthy behaviors.
- EMDR - Considered to stimulate the brain bilaterally, thereby possibly acting on subcortical processes resulting in integration, without necessarily altering conscious insight.
- EFT - Tapping appears to decrease arousal in the amygdala, activating various pressure points along with positive self-affirming scripts. Using EFT mentally recreates the trauma in a context of therapeutic containment, only slightly triggering the physiological and biochemical arousal. Repeatedly, even

ritualistically, tapping sends messages that may neutralize the amygdala threat response. “Almost instantly, by holding these opposing messages the messages that decreases arousal begins to predominate. Now the person is holding the image, having the memory and the threat response is not reoccurring. That becomes the new normal.” (Feinstein D. 2012).

12 Questions When In Doubt

In contrast to standardized scales, a mnemonic, SIGECAPS (Sounds like “SIGGY-CAPS), helps a practitioner decide when the person before them is a candidate for holistic care or needs referral to a team member (Bruzzone, D, 2007):

Look for symptom with, or negative change in:

- **S**leep
- **I**nterests
- **G**uilt
- **E**nergy
- **C**oncentration
- **A**ppetite
- **P**sychomotor symptoms
- **S**uicidality/Homicidality
    - **T**houghts
    - **I**ntent
    - **P**lans
    - **M**eans

Create or refer to team for a Safety Plan (include family and other social support, type of support, removal of weapons or means of harm, plan for increased contact and method of
contact).

Further Unpacking Herbal Therapeutics – What We May Do

A primary treatment is reaffirming that recovery is a realistic health goal.

In addition, an ethical aim is to help people feel their feelings and process these at their own rate. Many times this occurs without the patient re-telling the story in detail. Homeopaths and acupuncturists have documented positive results beyond the scope of this session. Herbal medicine is another modality that holds promise precisely because herbalists often seek a holistic, patient-centered approach.

A person whose nervous system has weathered shock and recovery is more resilient than one who has never felt stress. The rhythm of expansion followed by contraction observable in nature allows us to trust that relaxation will come, even if it is not on our preferred schedule.

The ethical care provider begins with an audit of our own instinctual responses to stressful stimuli and emotional cues. We can be alert and kind to ourselves regarding our understandable feelings of vulnerability when faced with a patient who repeats the same complaint six times in the first hour, each time louder and more intensely. If this is the discharge of pent-up energy, one's calm acceptance and support is the right remedy.

Ben Zappin, L.Ac., has described how herbs may:

- Support Patient
- Decrease effects of stress
- Decrease side effects (s/e) of Rx (as substitutes or in combination
- Treat s/e
- Treat underlying cause of an organic dysfunction (Zappin B. 2014)

Zappin further examines subjective languages used for trauma, bereavement, and loss such as:

- Western Medical Psychiatry
- Traditional Chinese Medicine
- Western & Eastern Metaphorical Classifications & Associations

  Heart – Pale, anxious person, insomnia, palpitations

  Disturbed Shen

  Liver – Irritability/ Anger

Practitioners of Ayurveda also speak to elements (earth, water, fire, air), as well as relationships between excesses and deficiencies.

In the study of these symbol-laden languages that we use to name problems and solutions, comparisons of systems reveal recognizable patterns. There may be significant differences in medical philosophies, but related concepts can be found in different schools of healing.
Drug companies are working on medicine to mimic healthy cortical function. Functional medicine, among other strategies, uses high-dose essential fatty acids to re-myelinate neurons peripherally and centrally. Psychiatrists experiment with patents by adjusting variations and doses of two or more anti-depressants, mood stabilizers, anxiolytics, low-dose "antipsychotic drugs," and/or medications for sleep. Others are using serotonin and other hormones, for instance, to reduce harmful effects of excess cortisol in acute or repetitive stress. In contrast, some researchers point out that PTSD patients have low cortisol, and so cannot modulate their biological stress response.

Differently trained talk therapists use evidence-based, short term treatments such as CBT. Talk therapies reduce symptoms (and criteria for diagnosis) yet psychotherapists observe in many of their patients that unresolved issues remain, mainly self-regulation of thinking/feeling/behaving. Common denominators in successful approaches highlight 1) safety, 2) appropriate structure (trauma patients need containment modeled for them so they find it within), and 3) **fun**.

"You can discover more about a person in an hour of play than in a year of conversation."

Plato

Every healer can be present for another in preparing for death or responding to death in ways that are meaningful. In facing our own views on grieving we allow personal growth that creates a bridge for the bereaved to find their own meaning

Have you ever felt you did not know what to say to someone who has just experienced loss? Are you quick to dispense relaxing nervines and hope the herbs rescue us from having to cope with someone who is distraught?

Goals for herbalists:

- Increasing awareness of our own emotional triggers and pitfalls.
- Attending to rapport with our Materia Medica even before establishing rapport with people. Listen to plants.
- Gaining criteria for referring people to existing support systems, encouraging their use of available resources nearest to them (geographically and psychospiritually).
- Gaining increased comfort with counseling the grief-stricken, providing compatible, manageable tools for processing loss and grief.
- Educating patients, their families, and care providers about natural remedies appropriate for death and dying as a part of living well, here and now.
- Understanding relevance of providing caregivers and families with Respite Care and authentic emotional support (see: C., Phrases Best Avoided, below). Rapport created here opens to deeper communication in right timing.

What is RESPITE Care?

R – renewal and relaxation: let primary care givers and family members take a walk, get a foot massage, getting coverage so they feel permitted to take a break that best suits them right then.

E – energy: family members cope better when they are allowed time to refuel. Not even computers run on batteries forever.

S – space: getting away from the environment of caregiving, even for a few hours, helps people rediscover a sense of purpose and "place" in the spiral of life and death.

P – pleasure: caregivers have the right to enjoy life. Terminal patients often report they want to hear laughter and experience beautiful music even if they cannot respond. The atmosphere can be as respectful to the dying as needed while still honoring life.

I – identity: family members frequently experience a shift in roles around a death. A changing sense of self can be maintained with intention and sensitivity on the part of herbalists. If appropriate, flower remedies may play a part.*

T – time: reinforcing the concept of relaxation, time away allows issues to become clear plus allowing adjustments to emerge from what may seem to be chaos.

E – engagement: social isolation is common and creates burn-out. Examples: share a lunch out, handle one's own health care appointments, window shop with a friend, play with a pet or young family members.

*This may not be the time for essential oils; consider the sensitivity of the patient and other team members.

An Alphabet of Phrases Best Avoided

A. "I know just how you feel." Made worse by: "When my ____ died….." This attempt to relate masks insensitivity by pulling the focus away from the one coping with grief and onto us. "Every person is like all others, like some others, like no other." No two people, similarities aside, "feel" the same about their life events. The person hurting may feel more alone than before and clam up. Instead, we can validate: "I can see why you feel that way."

B. "We are never given more than we can handle." Inability to cope is not necessarily tied to lack of faith or weakness of spirit. A subtle criticism of the person's coping skills, this does not offer reassurance. When grieving feels unbearable, we have one another. We can offer, "I have no words," "You are not alone," "You have people who love you," et cetera. Faith, too, can be addressed if appropriate: "I believe the love doesn't just disappear when we leave our bodies behind" (if you believe that).

C. "It's God's will." How can any of us be so sure of God's will? In cultures where religion plays a more sustaining role this view may hold other meanings. Even if you believe this now, the person you are speaking to may interpret this as you painting God to be a cruel, implacable force. Anger at God is a common reaction to loss.

D. "Call me if there is anything I can do." This may communicate, "I don't want to put myself out but I want to appear sensitive." People in crisis cannot answer this. Can you make their loved one not dead? Gently offer a specific

task you are able to do with a good will, and do not take it personally if rebuffed: "I can do your house cleaning this week, pick a relative up from the airport, answer the phone while you take a nap, weed your garden, walk the dog… if it would help you. Which day this week is better for you?"

An alternative is to halt the 25+ calls of "What can I do?" by organizing the family's congregation or community with www.Caringbridge.org, **uk**.ask.com/**Caringbridge**+Website, or www.Lotsahelpinghands.org. Further resources may be found through www.**hospiceuk**.org/ and www.**hospice**ofthecomforter.org/**caregiver-support.**

E. "She lived a good life and it was her time to die." This might be said, like other clichés, by the close family themselves but can be hurtful when offered by another. It invalidates the pain someone feels when losing a loved one, whether a five year old or someone a hundred and five.

F. "You are so brave;" "You must be strong for your children." Being strong has multiple meanings, and real grieving helps observant children more by modeling that feelings can be experienced deeply, and that this gets easier in time. Those who cry when tears come up are less likely to end up with an ulcer. Unresolved grief can be crippling for years. In contrast to surviving in denial because one "must be strong," there is the expression: "Lean into the pain." "They say, 'Feel so you can heal'."

G. "I'm sorry for your loss." An automatic response tinged with pity, this is commonly used and not always unwelcome. Yet it still begs the question: whom do the words comfort? What can the bereaved say except thank you? They may not feel thankful in any way. We may be sorry they are hurting. We may be sorry to be reminded that awful pain can come upon any of us. This phrase is used to get us off the hook. Rather, we might say, "I heard that Frank died," if we were not at the bedside or memorial service. This frees the bereaved from wondering if we know the state they may be in, and whether to explain. Then we can stay present with nonverbal empathy that feels authentic to both of us.

H. "Now it's time to get on with your life." There is no magic egg-timer for grief. Everyone has the right to move back and forth from numbness to sadness or any other natural response to loss. It may take years. With support, the grieving are more likely to find their best timing. If he isn't ready to donate her clothes to charity, we can help by not pathologizing it.

I. Writing, "Words cannot express…" Those are words – vague ones. In her 1996 Vogue article, An Etiquette for Grief, Crystal Gromer wrote that no matter how much time had passed before friends could manage a note to her, she appreciated the ones who wrote about specific memories, calling these word pictures "gifts."

J. "I didn't call because I didn't want to disturb you." Yes, you may re-open her painful wounds of grief but her pain and our embarrassment are not the worst that can happen. As an herbal practitioner, you have a professional role. As anybody, you have an opportunity to offer connection.

K. "You should…" (get a dog, lose some weight, trust God, start Pilates…).

L. "At least…" *anything*: At least he's not a vegetable. At least she didn't suffer. At least you have the other child. At least you are young enough to find another life partner. At least you have your Buddhist practice of detachment.

Perhaps you have others for letters M-Z.

When you think you want to say:	**Try:**
You are so much better today!	You appear to me to have a lot of inner strength, or fighter's attitude, or positive energy today.
I made this special meal for you!	I love you. (Food = love until Love = "food")

You are going to be fine.	I wonder; are there some things you worry about?
Don't talk like that! You can beat this!	It must be hard to come to terms with all this.
What do the doctors know? You might live forever!	Do you think the doctors are right?
There has to be something more to do.	Let's be sure we get the best treatments. I can be here with you when we have done all we can.
Please don't die. I need you.	I need you. I will miss you terribly but we will get through this.

Be cautious about applying your experience and possibly unquestioned perspective on normalcy to another family. Different norms in cultural backgrounds as well as ethnicities are not up for our best-intentioned overhaul. A goal is to educate (healthy grief can look like…), share information (do your homework preparing local resources – free and for fees, why a group is worth trying just three times, natural therapies safe and effective for…), and listen. Out of your depth? Refer.

There is less to "prescribe" than there is to hold in reserve until needed. *Materia Medica* in this workshop is selective and representative, not exhaustive. An overarching "case conceptualization" is to plant seeds of acceptance of what cannot be fixed. If palliative care reduces pain while affirming quality of life, let us trust our natural methods to enrich this tapestry with aroma, taste, color, and nourishment of physical form and function plus nonphysical dimensions of wellness.

What Tools Do Herbalists Have?

Herbal and other natural remedies can help ease symptoms while supporting people through the healing process (Gerbarg and Brown, 2013, Sarris, J. 2013, Ishaque, S et al. 2012).

1. Pain, possibly synergizing with medications – *Piscidia* (pain, sleep), *Valeriana* (tension), *Corydalis, Hypericum* (drug clearance, atonement?)
2. Memory & Cognition – *Salvia spp, Ginkgo biloba, Bacopa monniera, Rosmarinus, Mucuna pruriens*
3. Sleep – *Bacopa, Centella* (cognition), *Passiflora, Humulus* (irritability, appetite), *Scutellaria* (anger, cf. *Piper methysticum*/anxiety, aggression)
4. Daytime fatigue – Mints, aromatics, *Pseudowintera* in NZ
5. Depression – *Verbena officinalis,* adaptogens?
6. Anxiety – *Piper methysticum, Lavandula, Verbena officinalis, Myristica* (nutmeg)
7. Agitation, restlessness - *Humulus*
8. Shortness of breath – *Grindelia, Camellia, Theobroma, Pimpinella*
9. Nausea, vomiting, loss of appetite – *Zingiber, Filipendula*, lemon & salt
10. Muscle spasm – *Viburnums, Lobelia* (baths)
11. Constipation, from pain medication – *Psyllium, Althaea, Ulmas* gruels
12. Diarrhea – *Rubus villosus rad. et fr*. for electrolytes, flavor, *Agrimonia*
13. Dry mouth – *Zanthoxylum, Spilanthes, Echinacea*
14. Secretions – *Salvia*
15. G.I. ulceration – 2-5ml organic cabbage juice, sauerkraut if tolerated, *Glycyrrhiza, Ulmas*
16. Changes in appetite – *C. sativa* (Rx cannabinoid oil for CA well described in lit.)
17. Difficulty swallowing – "blender salads," nettle seed smoothies, Reishi soup
18. Tolerating medication, reducing side effects (tremors) – *Viburnums, Hypericum* (Note/Avoid HDI's)
19. Remedy administration through hand and foot massage, aromatherapy, Flower Essences
20. Other symptom management as needed

Categories of Botanical Actions

Seeking to improve specific symptoms as well as the non-specific terrain, herbalists may turn to a wide assortment of remedies with unique energies under broad categories of action:

- Adaptogens, for instance, *Rhodiola* for injury, immune repair,
- Alteratives, for instance, blue green algae for heavy metal detoxification,
- Analgesics, for instance PA-free *Petasites* for migraines, headaches, *Corydalis, Papaver spp*.,
- Anti-hypertensives, *Tilia, Achillea, Crataegus*,
- Anti-inflammatories, *Curcuma, Boswellia, Cerasus* (Tart Cherry) juice,
- Antispasmodics, *Viburnums, Zingiber spp,*
- Anxiolytics, *Piper methysticum, Lavender*,
- Calming digestive aids, *Humulus, Pimpinella*,
- Hepatics, *Hypericum, Taraxacum, Berberis aquifolium*,
- Hormonal normalizers (distinct from adaptogens), *Actaea, Paeonia, Vitex*,
- Hypnotics & Sedatives for improved sleep, *Passiflora, Valeriana, Pedicularis*.

To EBM or not to EBM?

Evidence based medicine has value as well as drawbacks. The use of functional foods and botanical remedies for mental health is documented, though research is characterized by being lop-sided from the point of view of the clinician. In this author's opinion, by practicing *Non Nocere* (Do No Harm), herbalists and other natural medicine professionals are not dependent on patchy or inconsistent published research. Herbalists are not seeking the next "PTSD herb" or formula to manipulate one or more neurotransmitters. Rather, like allied professionals, we attend to one patient at a time whose whole health history informs our choice of *Materia Medica*.

It is possible that we may use any herbs that positively affect the Hypothalamic-Pituitary-Adrenal axis (HPA axis) **and** that serve individuals energetically in their journeys of enriching their optimal sense of Self. If a provider prioritized according to positive research (clinical evidence) and commonly used herbs, the first ten might be:

1. Arctic Rose (*Rhodiola rosea*). (Hung SK, Perry R, Ernst E 2011, Panossian A et al 2010, Morgan and Bone 2005; Tuttle 2006, Saratikov and Krasnov, 1974)
2. Ashwaghanda (*Withania somniferum*)
3. Black cohosh (*Actaea racemosa*)
4. Brahmi (*Bacopa monniera*)
5. Gotu Kola (*Centella asiatica*)
6. Hops (*Humulus lupulus*)
7. Kava (*Piper methysticum*). A full discussion by Mathias Scmidt, PhD, is available from the American Botanical Council (Schmidt M, 2014)
8. Lavender (*Lavandula vera*) (proprietary product: Kaspar S et al, 2014)
9. St. Johnswort - *Hypericum perforatum* (Freeman, FP, et al, 2010, Cott, J, 2010, Linde, K, et al, 2011)
10. Valerian (*Valeriana officinalis*), more than 200 studies, including children (Houghton PJ, 1999; Bourin M et al 1997; Leathwood PD et al, 1982)

Brief monographs of these are in an Addendum.

Herbs are non-verbal body therapy –

One plant may affect multiple body systems. Like a psychiatrist, a professional will monitor often, change doses and combinations as indicated, and emphasize a team approach, referring out in the patient's best interest. Especially effective are other non-verbal body therapies (cited elsewhere) that create safety without the "pressure to process."

Beyond Giving Botanical Support –

There is less to say than there is to hear.

Listening to those whose lives are changed in a moment by terminal diagnoses, traumatic loss, or sudden death, we may hear, "I am afraid…"

<u>Patients may fear</u>

- Loss of control
- Loss of relationship
- Loss of privacy
- Being a burden
- Pain
- Disfigurement, Rejection

- Dying

After years of tending the dying, Ira Byock, MD, summarizes that there are **Four Things That Matter Most**:

1. Please forgive me

   Through forgiving and being forgiven we purify relationships and prepare for a journey out of the physical body.

2. I forgive you

   Forgiving presupposes remembering. And it creates a forgetting not in the natural way we forget yesterday's weather, but in the way of the great "in spite of" that says: I forget although I remember. Without this kind of forgetting no human relationship can endure healthily.

   Paul Tillich

3. Thank you

   There is more hunger for love and appreciation in this world than for bread.

   Mother Teresa

4. I love you

   What keeps us alive, what allows us to endure? I think it is the hope of loving, or being loved. Meister Eckhart, Love Poems from God

Recalling these four may be useful IF we are asked why someone who is past eating and talking is still hanging on, so families might consider if these apply.

Checklist: How to Speak with Someone Facing Death

Many of us are afraid we'll say or do something stupid. I hope by sharing what I have learned from my mistakes that you can avoid them. In the following, we may all recognize ourselves at some point in the past. But words do not matter as much as our heart's intent. Be there and listen. Allow this person, if they choose, to talk about her/his experience, good, bad, or indifferent. Before the visit, learn what you can about the person's condition. This serves two purposes: you will be less frightened by the unknown, and more importantly, the person will not have to go over it unless they choose.

- ✓ Create confidentiality as far as practical. Respect privacy even before you ask, "How are you doing right now?"
- ✓ Take off your coat, put down your bag. Show you can stay awhile.
- ✓ Keep your eyes level with your friend here; sit on a portable commode or even the bed, as long as they indicate agreement or it does not jostle them painfully.
- ✓ Keep a comfortable distance of 1-2 feet without a clipboard or laptop between you.
- ✓ Check whether the person wants to talk. Instead of launching into a hearty, rehearsed opening line, observe/ask if the person feels tired or just finished an intense conversation with someone else.
- ✓ Encourage with a nodding head, "Tell me more," "Yes, I see" (if you do). Let them interrupt, but avoid interrupting them.
- ✓ Breathe evenly when you may find yourself holding your breath or trying not to tear up. Let them be heard by you when they express feeling rotten. When we express empathy, tears may roll, even though we aim to check our trigger issues at the door. This person does not need to feel her/his grief is now burdening us. We may be able to model tolerating pain (rather than denying it on the one hand or falling to pieces on the other). A guideline for me personally is to check whether crying together leads to the patient feeling better. I have my <u>own</u> resources for self-care <u>after</u> the interview. My emotional needs can wait.
- ✓ It is okay to honestly admit, "I don't know what to say." Then **WAIT** (also used here as an acronym for **Why Am I Talking?**). Be wary of nervously chattering about what you DO think you know something about. Their feelings and thoughts are moving ahead even if no talking erupts from us.
- ✓ Non-verbal communication includes eye contact. If this is impossible for you during a painful exchange, stay open, touch a hand gently, or trust your intuition about caressing a shoulder.
- ✓ Keep your ego balanced, not suppressed. Focus on listening rather than hearing what you expect or hope for. Skip rehearsing your answers since this cuts off active listening.
- ✓ Encourage stories. When people feel they cannot cope, reminiscing allows them to reassure themselves because they coped with something else they can recount to us.

- ✓ Let them laugh. It is healing and deeply pleasurable for people to vent feelings with humor. Join in. Avoid any urge to lighten a somber mood with <u>your</u> jokes.
- ✓ Unless asked, try not giving advice. This presents a challenge for healers who tend to want to fix. The worst may be the over-cautious, "If I were you…" Patients report their response is, "You are NOT me;" this damages rapport. Try waiting until late in the exchange to offer, "Have you thought about…?" or "I've heard that ___ has been helpful for others." "I have researched ___ (remedy) for ___ (question), and if you want to try it, I can prepare it" (or, "I brought it with me just in case").
- ✓ Respond to dying wishes. Consider what your response would be if this person were not dying. If this is a promise you can ordinarily make, go ahead. Forgive yourself if you cannot maintain it for the rest of your life. If it contradicts your principles, do not falsely promise. I have said, "I am going to find someone else here that can be more sure than me of keeping that promise because your wishes are important to me. I'm not your best bet on this one." Find your own congruent language so this human feels respected.
- ✓ Remind your friend that death does not rob her/his life of meaning. S/he will be remembered and loved by those who survive her/him.

End of life is unpredictable. It is better to talk about love after death several weeks too early rather than to miss the chance, including sharing how knowing this person has changed you somehow.

Talking With the Traumatized Patient, the Family, and the Bereaved

<u>Family and care givers may fear:</u>

- Making decisions. Good teams share options so uncertainty lessens.
- Physical changes in patient.
- The medication may be interfering with the patient's natural process.
- The patient will "give up" when hospice is involved. Medical hospice meets criteria in addition to patient's will such that Quality of Life (QOL) is paramount, AND if health improvement occurs unexpectedly, there are protocols to honor all possible outcomes.
- Economic loss compounding loss of relationship.
- Outside interference from family or bureaucracy.

- I could be doing more (see RESPITE) or, I did not do enough. Herbalists can help recap for patients what WAS done.

Significant non-psychotherapeutic and non-pharmacological interventions are represented in the extensive literature on depression, mood disorders, trauma, and related topics, such as stress reduction. These include exercise, mindfulness, and several others such as yoga (Seligman, L, and Reichenberg, L, 2007).

Treat co-existing conditions

- Initiate mind/body approaches
- Mindfulness-Based Stress Reduction
- Breathing Exercises
- Guided Imagery
- Self-Hypnosis
- Biofeedback
- Consider craniosacral therapy for headaches that result from cranial trauma
- Consider advantages of Symptom Diary
- Is an Elimination Diet Practical and/or likely to help?
- Initiate preventive therapy (raise the threshold of triggering symptoms)
- Assess myofascial tension in neck and shoulders; refer for body work as needed

Aromatherapy - Essential Oil Blend:

Especially for tension headaches:

- Lavandula aa
- Peppermint
- Eucalyptus
- Rosmarinus

Mix in 2 oz. dark glass bottle with well-fitting cap. Apply 2-3 drops to temples, avoid eyes. For sensitive people, a diffuser or cotton ball in the room is sufficient.

For calming the heart, massage hands or feet, letting patient choose scent, if possible:

- Petitgrain often appeals though the citrus family may burn skin.
- Roman chamomile has uplifting aroma, German chamomile stains, smells more medicinal, stimulates granulation (wound healing) and is antimicrobial.

Essential oils and herbs mix in OTC Arnica gels without being too oily.
5% dilution in carrier oil (Calendula, St. Johnswort, Sweet Almond, Shea, depending on need).
If hydrotherapy, hand/foot or whole body, is practical:

- Mineral soaks (Epsom salts, $MgSO_4$, 3 lbs. dissolved per bath)

Nutrition

Many Paths, Some Studies, One Evidence-Based Supplement

To list all the foods that heal is out of the scope of this session. Research supports countless regimens and supplements. Naturally, nutrition has been found to play a role in depression (Freeman, MP, et al, 2008, Cott, J, 2010, Linde, K, et al, 2011, Shannon, S, and Rondeau, M, 2012), whether traumatic, hormonal, adolescent, post-partum, menopausal, geriatric, or other. One of the most-studied supplements is Omega-3. Changes in our diets have altered the ratio between omega 3 and 6 essential fatty acids, which affect brain chemistry in a number of ways (Cott, J, 2010, Freeman, MP, et al, 2008)). A study (n = 51) of perinatal women with diagnosed Major Depressive Disorder (MDD) randomized pregnant (2^{nd} trimester) and post-partum mothers to two groups receiving 1.9g daily of Omega-3 (EPA + DHA) or placebo. Both groups received psychotherapy. Scores on depression scales were reduced in eight weeks; authors note the baseline for essential fatty acids was low in all these women, and the low dose over the short term plus supportive psychotherapy in both groups may explain why placebo did not differ significantly from treatment (Freeman, MP, et al, 2008). Evening Primrose Oil (EPO) improves myelin sheath integrity, increases prostaglandins (series I - anti-inflammatory), provides the antidepressant amino acid tryptophan, and has other reputed benefits (Shannon, S, and Rondeau, M, 2012).

- Herbs with Fe salts or which may raise hemoglobin are: Kelp, Yellow Dock root, Nettles, Milk Thistle seed.
- Herbs with Magnesium are: Oatstraw, Nettles, Red Clover, Raspberry leaf, Chickweed.
- Potassium: bananas, Dandelion greens.
- Herbs with Potassium: Red Clover and Nettles.
- Essential fatty acids: freshly ground Flax seed, Evening Primrose seed, Purslane

Practice

Look without staring at the person before you. Watch body language. Mirror the intensity of the feelings, without having to have identical feelings. Grief affects feelings (affect, mood) and thoughts (mental function). We can choose between plants with affinities for emotions or cognitive signs and symptoms.

Bill Gottlieb outlines a 10-point framework that holds space for nutritional, botanical and allied modalities:

1. Educate yourself – what are normal versus pathological experiences
2. To heal, feel. Escapism and staying busy has survival value yet still, to feel is to initiate healing
3. Express – talk, journal, art, and more
4. Find two people to hear you, not advise.
5. Consider short or long term professional help
6. Move – because grief is physically draining; walk outside
7. Be kind – leave guilt behind. A goal may be for understanding to replace blame
8. Laugh
9. Support groups – We may help reframe for "non-joiners" that attending even a few meetings often helps faster and better than people normally expect
10. Find your faith

(www.vitality101.com/health-a-z/**grief**-and-joy-part-1, www.vitality101.com/health-a-z/**grief**-and-joy-part-2, www.**billgottlieb**health.com/).

In conclusion, dying and mourning are natural processes. Herbalists have resources for connecting people to plants in support of their unique path to resilience. The herbalist brings the qualities of attention, acknowledging facts, "unconditional positive regard" (Carl Rogers), and acceptance. We also bring Nature with us.

Giving and receiving solace and support are among the most profound human actions. If you are a human, you are enough. Please feel free to report to me where your explorations lead you.

***Materia Medica* Addendum**

For simplicity's sake, the focus here is on ten commonly used herbs, alphabetized by common name.

Arctic Rose, *Rhodiola rosea*

- Rhizome (commonly miscalled "root")
- Adaptogen
- Astringent

Rhodiola, also known as Golden Root, Arctic Rose, and Arctic Root, is in the Crassulaceae family, and grows at high altitudes, as its name suggests, in the Arctic and mountainous regions of Europe and Asia (mainly eastern Siberia, Altai Mountains). It has been used in Russia and Scandinavia in historic (Viking) periods and in more recent eras, especially for its effects on adaptation to stress, including stress-induced depression and anxiety, fatigue, anemia, impotence, infections (such as colds, influenza), cancer, nervous system disorders and headache (Morgan and Bone 2005; Tuttle 2006). In the herbal medicine community, Rhodiola is also used to increase physical endurance, resistance to the effects of long-term stress including altitude sickness (Saratikov and Krasnov, 1974), and to improve memory and attention span.

Rhizomes (underground stems) of the plant, harvested near sea cliffs and in mountain crags, has been found, so far, to contain compounds of six kinds:

1. Phenylpropanoids: rosavin, rosin, others specific to R. Rosea (not other species in the genus ("Indian Rhodiola").
2. Glycosides: salidroside aka rhodiolaside.
3. Flavane and similar compounds: rodiolin, rodionin, rodiosin, others.
4. Monoterpene essential oils, mainly geraniol (which gives rose-like fragrance to cut rhizomes), related rosiridol, rosaridin.
5. Triterpenes: beta-sitosterol, daucosterol.
6. Phenolic acids: chlorogenic, hydroxycinnamic, oxalix, citric, malic, gallic acids (tannins).

Panossian A et al (2010) define adaptogens thus:

"Adaptogens comprise a pharmacotherapeutic group of herbal preparations used to:

- Increase attention and endurance in fatigue, and
- Prevent/mitigate/reduce stress-induced impairments and disorders related to neuro-endocrine and immune systems [Panossian and Wikman, 2009a, b].
- Other definition of adaptogens are associated with physiological conditions:

Adaptogenic substances are stated to have the capacity to normalize body functions and strengthen systems compromised by stress. They are reported to have a protective effect on health against a wide veriety (sic) of environmental assults (sic) and emotional conditions EMEA/HMPC/102655/2007,
Adaptogens are compounds which could increase ''the state of non-specific resistance'' in stress [Lazarev, 1958; Lazarev et al., 1959]
Adaptogens are innocuous agents, nonspecifically increasing resistance against physically, chemically, biologically and psychologically noxious factors (''stressors''), normalizing effect independent of the nature of pathologic state [Brekhman and Dardymov, 1968].
Adaptogens are substances which elicit in an organism a state of non-specifically raised resistance allowing them to counteract stressor signals and to adapt to exceptional strain [Wagner et al., 1994]." (Pannosian A. et al, 2010).

A review of clinical trials (Hung SK, Perry R, Ernst E, (2011) cite research by others in their introduction to mechanisms believed to explain, at least in part, some of the widespread popular use of Rhodiola. These include increasing bio-electrical brain activity (Khanum et al (2005), and the prolonged action of neurotransmitters in the Central Nervous System (adrenaline, dopamine, serotonin, acetylcholine) along with enzyme inhibition, these mechanisms affecting cognitive function. Rhodiola prevents stress response mediators including cortisol and nitric oxide (Panossian et al 2007). This review of eleven RCT from six countries between 2000 and 2009 concluded that Rhodiola may have benefit for people seeking improved physical and mental performance and some mental health concerns, though only five trials were rated with more than three points on the jaded scale (good methodology). The only three adverse

effects (such as headaches) were from placebo groups or in one case, one unspecified illness not attributed to either treatment or control group; none were serious.
Regarding cognitive improvement attributed to Rhodiola, a pilot study (DBRPC) of a proprietary product showed results after a single dose described as 270mg (Aslanyan G et al, 2010). The product ADAPT-232 is a standardized trio of nervine herbs often found in combination: *R. rosea*, *Schisandra chinensis* and *Eleutherococcus senticosus*. Forty healthy women between 20 and 78 years who described living with long term stress were selected and randomized into two equal groups. The women took tests of attention under stressful conditions (d2Test of Attention). Before as well as two hours after administration, researchers measured attention, accuracy (reduced errors), and speed. The results were significant for the treatment group.
Dose: 200-600 mg/day.
In Russia, Estonia, Finland, Sweden, and other countries where extracts are commonly manufactured and used, a tincture (water/alcohol mixture) of 40-70% v/v is dosed for mental health indications as low as 5-10 drops one to three times per day, increased up to 30 drops tid.
Fifteen drops of *R. rosea* extract is approximately equivalent to 150 mg of dry encapsulated root extract standardized to 3% rosavin and 1% salidroside.
"*R. rosea* extracts used in most human clinical studies were standardized to minimum 3 percent rosavins" (current biomarker) "and 0.8-1 percent salidroside" (former biomarker for purity, strength) "because the naturally occurring ratio of these compounds in *R*. *rosea* root is approximately 3:1" (Brown RP et al. 2002).
According to Panossian, who is open regarding his proprietary interests in the Swedish Herbal Institute, the manufacturer, "the adaptogenic effect of Rhodiola root SHR-5 extract have been shown in double blind, randomized controlled clinical trials Orally administrated for 2-6 weeks, dry SHR-5 extract prepared with ethanol-water (ethanol 70% (V/V) in the daily doses of 288 – 680 mg (1-4 tablets), have been shown to improve mood" (Panossian et al, 2011).

Ashwagandha, *Withania somnifera*

- Root
-
- Sweet, mild acrid

- Tonic
- Adaptogen
- Mild sedative
- Anti-inflammatory
- Immunomodulator
- Anti-anemic
- Anti-tumor (high dose)

Withania is also known by the name Winter Cherry, and belongs to the tomato family (*Solanaceae*). In the Ayurvedic tradition it is a premier tonic. One translation of its Sanskrit name is "the aroma and strength of a sweaty horse," usually by implication a stallion. In modern practice it is a complex plant: it is sometimes classed as an aphrodisiac yet is a nervine sedative used to reduce pain. Its aphrodisiac reputation may have more to do with endocrine health rather than simply stimulating libido and sperm health. It has a role in raising low thyroid function. In practice, I have not seen nor found in literature evidence that it causes over-active thyroid, and doubt this caution cited in some texts. The sedating quality (hence "*somnifera*") is useful where there is exhaustion associated with over-activity or anxiety. For this, Ashwagandha combines well with similarly acting Hops. Yet *Withania* is used in chronic fatigue for central nervous system clarity and improved cognition. Some actions are bulleted below.

Practitioners of natural and herbal medicine who treat women for hot flashes, anxiety, depression, and loss of cognitive functions – menopausal symptoms that are thought to be associated with the decline of estrogen – often relate these symptoms to a reduced ability to respond to stress. Therefore, many herbalists recommend Ashwagandha to increase the body's ability to withstand stress and improve physical energy and overall health. It also strengthens the immune system, hence its use for auto-immune patients and depleted immunity such as patients on chemotherapy and radiation.

Indications:

- Maintenance or improvement of general well-being and energy
- Nervous tension, stress and mild anxiety
- Exhaustion
- Chronic inflammation
- Convalescence

- Poor appetite, anemia, especially in children

Safety:

- AHPA 2b; 2d - May potentiate the effects of barbiturates
- Speculative? may elevate T4, is used to treat low thyroid function.
- May interact with GABA receptors; use with caution in clients on tricyclics, MAOI, antipsychotics (dose may require reduction).
- No adverse effects expected in pregnancy and lactation.

Dose:

3-6 g daily

Tea: one cup of decocted tea 1-3 times a day. There are also delicious coffee substitutes on the market that contain Ashwagandha.

Tincture: 1-3 tsp. in water per day, or in combination with other herbs.

Black Cohosh, *Actaea racemosa*

- Root
- Sedative, analgesic, antidepressant
- Peripheral vasodilator
- Acrid

Black Cohosh in low dose or in combinations may correct low estrogen states in depression. Its other therapeutic benefits (analgesic nervine relaxant) give it a role in depression due to physical disease, for example, arthritis or chronic pain.

Black cohosh is ideal for hormonal depression, in menopausal women or, according to David Winston, in grumpy old men. For women with a dragging sensation in the uterus, or uterine pain with muscle aches, this is the nervine of choice. For insomnia related to menopause, it works well with *Vitex*, *Leonurus*, *Glycyrrhiza*, and *Passiflora*. Though it is no longer thought to act exactly like a SERM, black cohosh does improve osteoblast activity, and may prevent or treat osteopenia and osteoporosis. Black cohosh is a mild oxytocic, used for post-partum pain with *Viburnum prunifolium*. The product Remifemin has been studied for safety and efficacy in women on Tamoxifen and with a history of estrogen-sensitive cancers. It appears to slightly reduce the risk of recurrence, and did not affect the pharmacokinetics of other medications.

Its main Euro American use in the 19th century was for the musculoskeletal system. With Piper methysticum and Withania, black cohosh can be used for fibromyalgia. For neuralgias it combines well with Hypericum.
Black cohosh is a peripheral vasodilator, and care should be taken to avoid symptoms such as headache or dizziness in sensitive people with normal blood pressure as well as labile or low blood pressure.
Avoid in pregnancy (except last two weeks by experienced midwives), lactation, and children (pre-puberty).
Avoid in low blood pressure.
Avoid products mixing the Chinese species, *Cimicifuga foetida*, or Sheng ma, which may be linked to the rare reports of black cohosh and liver damage. Practitioners trained in the use of Sheng ma tend not to combine it with *Actaea*.
Dose: Tea: ½ tsp. dried root, decoct 20 minutes. Take 4 fl oz. bid.
tincture: 0.5-1ml tid

Brahmi, *Bacopa monniera*

- Leaves
- Cooling, bitter, calming
- Improves memory, cognition

Sometimes called the scholar's herb because it helps mental function, brahmi has been a part of traditional Ayurvedic medicine since at least the sixth century A.D. The name *brahmi*, sometimes used for other herbs, means “god-like.” In SE Asia brahmi or Bacopa is given to people with diseases of the nervous system including epilepsy, but also for mental exhaustion and to improve memory. Meditators use it to increase comprehension, concentration and recollection. Because it increases the ability to solve problems effectively, it is often found in Ayurvedic formulas to prevent stress. The herb is traditionally used for anxiety, irritability, poor memory, Alzheimer’s syndrome, Attention Deficit Disorder and in recovery from head injuries. Bacopa offers broad benefits for cognitive health linked to three major neurosupportive

mechanisms: neurotransmitter receptor binding activity, antioxidant capacity and anti-

inflammatory activity. The herb's adaptogenic effects combine well with ginkgo and ginseng.

In 1980, Indian researchers ran an open trial with 35 adult anxiety neurosis patients. The dose was 12 g per day of the dried plant in syrup form, for four weeks. Concentration and immediate memory span improved, as well as a decrease in on-the-job mental fatigue. Other symptoms of stress such as nervousness, heart palpitations, insomnia, headache, tremors, and irritability, also improved to a greater or lesser degree among the 35 people in the 4 week study. (Singh RH and Singh L (1980).

In a double-blind, placebo controlled study, long-term administration of Bacopa extracts (300 mg) improved 'early information processing, verbal learning, and memory consolidation in humans. This clinical study investigated its effect on cognition, memory, anxiety and / or depression in healthy volunteers (either elderly or of unspecified age) or in Alzheimer's patients (Goswami S et al, 2011). Comparative studies of Bacopa's use has been studied in combination with Gotu Kola, considered the sister "Brahmi" and known as the Elixir of Life or "Manjjukaparni" in Ayurveda Medicine. The combination was shown to have a significant psychotropic action as evidenced by excessive sleep, as well as changes in brain and blood (Singh RH et al, 1975). Numerous citations exist in support of memory, focus and mood enhancements and mechanisms of action.

Dose: 300mg -4 g/ day, capsules or tea; possibly higher in syrup form.

Gotu Kola, *Centella asiatica*

- Leaf
- Cooling, bitter
- Nerve, Skin Tonic

Another herb from India with the common name of brahmi is a plant that grows in hot, wet parts of the world. Gotu Kola is the food of elephants, known for their memories and wisdom.

Long used in European and North American herbal medicine, gotu kola is considered a healing food for the nervous system. A Korean study shows that components in gotu kola show potential for treating Alzheimer's disease.

Internally and topically the anti-inflammatory properties combine with wound healing or vulnerary effects against all manner of skin damage, from autoimmune to scarring.

Since gotu kola leaf is a vegetable, the dose can be very high. Add to smoothies or take 1 Tbl of fresh juice every morning. Many products provide 1 gram per day in capsules.
Dose: 1-4 g per day, 1 Tbl juice, 1c tea

Hops, *Humulus lupulus*

- Female strobiles
- Cold, drying
- Bitter digestive tonic
- Nervine sedative
- Hypnotic
- Antispasmodic
- Antimicrobial
- Emmenagogue
- Galactagogue
- Diuretic

This climbing vine is native to temperate climates and is a fast growing perennial of the *Cannabinaceae* or Nettle leaf family. Female plants have "strobiles" - pale green papery "flowers;" stems twist clockwise. Hops prefer rich deep soil and full sun. The bitter young shoots and leaves are edible as a spring cleaning digestive tonic.
The aromatic yellow to green flowers are shaped like cones, covered with shiny oil glands and a powdery yellow hops "flour." These are collected in late July to September in flower. When dried in less than a day at low temperature with rapid air movement and tightly packed, the flowers last up to eight months. Otherwise, they commonly decompose in storage after two to four months. If flower is faded to pale yellow, bitter beyond reasonable human use, the quality is poor and should not be relied upon. The more "beery" the smell, the less active medicinally.
The calming effects of Hops is well established, and is given for tension headaches. The fresh plant and its extracts are slightly stronger than dried, though this form also

works, possibly by the bitter compounds being made in the body into sedative compounds.

It is given for insomnia as an infusion 30 minutes before bed to promote sleep. It is muscle relaxing and a mild sedative for restlessness of the mind when the body is tired. The dried flowers mixed with *Matricaria* and *Lavandula* are stuffed in small pillows and have a sleep-inducing effect through the sense of smell. For sleeplessness and agitation especially if due to pain, Hops is often given in combination of equal parts with Valerian (*Valeriana officinalis*). A classic trio for sleep is Hops, Valerian and Passion Flower (*Passiflora incarnata, P. edulis*).

Hops is specific for anxiety and hyperactivity as opposed to *Valeriana* root, usually given for stress characterized by exhaustion. Hops will not help stress and tension, where *Valeriana* and *Eleutherococcus senticosus* will. *Valeriana* will not help over-excitement, or excess activity of brain and body, whereas Hops is perfect for this.

The estrogen-like effects of Hops bring on a delayed menstrual cycle. In the Hops growing regions of Europe, it has been observed over centuries that the women hand picking the crops began to menstruate in a regular, shorter cycle together. It is given for irregular cycle associated with sluggish metabolism, for which it is stronger than Chamomile (*Matricaria recutita*). For reproductive pain and infection made worse by heavy cramping, Hops works well with the *Viburnums* or *Withania*. Hops promotes breast milk in anxious mothers who are missing their sleep and having digestive disorders. It is not used in pregnancy because it may stimulate uterine contractions when while stimulating digestive peristalsis, plus its hormonally stimulating property, though a Hops pillow in pregnancy has been found useful. It is considered by many herbalists to be too strong for babies' dream pillows, though the other flowers are great for them, even if they chew on a corner as they grow, and taste the Chamomile while teething.

Reaching back to folk use, another use of Hops is as an anti-androgen, to lessen excess male hormones. As an anaphrodisiac for men, it is given for those who cannot contain their sexual energy such as premature ejaculation, or boys and men who get over-excited mentally leading to physical sexual over-activity. It may be given to those who cannot keep it in their pants when they should perhaps look before they leap. In central Europe Hops are said to calm down the "goatishness" of men with excess libido, while making timid women frisky.

As a bitter tonic, Hops is given for nervous indigestion, anorexia and ulcers. Though bitters are usually avoided in ulcers because they stimulate hydrochloric acid

production, Hops has the unusual quality shared by *Acorus calamus* (Sweet Flag) to decrease excess stomach acid while stimulating healing of any inflammation, infection or congestion. The humulin and lupulin inhibit gram-negative bacteria, and kills staphylococcus and streptococcus on contact. Note that for life threatening intestinal or systemic infections, Hops will not replace antibiotics. For nervous indigestion, Irritable Bowel Syndrome, and menstrual irregularity including painful cramps and PMS, Hops combines well with *Valeriana* and *Glycyrrhiza*, *Citrus auranticum* (Orange peel), and *Foeniculum* (Fennel seeds).

Externally Hops is used as a poultice on infected wounds. For poorly healing leg ulcers, it combines well with *Symphytum*, *Centella* and *Calendula*.

Contra-indications: Hops may be better substituted with other nervine or digestive remedies if a woman has an estrogen-dependent growth or disease, though there is little reliable research on the whole herb's actual estrogenic effect in such women. While the books say it is possibly contra-indicated in depression, I have never seen this in practice though it is a consideration if someone has no spark of life or excitement. Women who have been depressed due to pain, chronic illness or reproductive conditions that respond well to Hops' aromatic, bitter stimulation of metabolism and estrogenic stimulation of reproductive function have benefited from its use for 6 months to two years without side effects.

In experiments using the isolated humulene, it was determined that to have a narcotic action from paralyzing the central nervous system, enormous amounts of herb would have to be taken. Like tobacco pickers, the symptoms of harvest poisoning can be serious unless gloves are worn or breaks are taken. For Hops, symptoms of excess are the opposite of its herbal effects, giving problems such as diarrhea, insomnia, rapid heartbeat, excitement.

Dose: 1/2-1 gram , up to 2 grams (1/15th oz.) for muscle relaxing action, taken one cup three times a day or as needed. For the strongest pain relieving, sedative effects, infuse 1/2-1 oz. per pint, one wineglassful repeated as needed.

Tincture: Minimum 10 drops, up to 2 1/2-5 ml., 1/2- 1 tsp., diluted in liquid, taken three times a day. For sleep, repeat highest dose every fifteen-twenty minutes as needed up to five times per night. Use less water to avoid night-time waking at the bladder's insistence. If three doses or more are needed, some morning grogginess is to be expected; this can be cleared with a pleasantly strong cup of Dandelion root and Peppermint tea. The shaken powder or "flour" of Hops flowers is quite rich in the sedative compounds. Found at the bottom of the container, this is taken in doses of

150-300 mg. as an infusion, in capsules, starch paper, or thinly disguised in a tablespoon of honey.

Kava, *Piper methysticum*

- Rhizome and roots
- Bitter, pungent, dry
- Anxiolytic
- Muscle relaxant
- Analgesic
- Sedative
- Possible anticonvulsant
- Antimicrobial (UGS), antifungal.

Kava is a Polynesian root related to Awa in the Hawaiian Islands, and other widespread species of pepper (*Piper genus*). Only *Piper methysticum* is referred to here. Home use requires standard decoction in a liquid solvent with fats such as milk, or tincturing through double maceration, for best effects. It is less an antidepressant as an anxiolyic analgesic. It has a mild antimicrobial effect in the urogenital system, and is used in other parts of the world as a first line treatment for bladder spasm, urinary tract infections, and interstitial cystitis.

This year (2014), a twelve year ban on marketing authorization for kava products has been reversed; a German administrative court ruled that, based on data, kava's risk: benefit ratio was confirmed as positive. A full discussion by Mathias Scmidt, PhD, is available from the American Botanical Council (Schmidt M, 2014).

The following in quotes is entirely from the monographs of Health Resources Unlimited Inc. (1992-2010):

"Major compounds include resin, containing alpha pyrones (Kavalactones) demethoxyyangonin, dihydrokavain, yangonin, kavain, dihydromethysticin, and methysticin. Depending on climate, soil, and season, kavalactone content varies between 3% and 20%. In Samoa where it is grown commercially for the global market, family, clan, and regional control over patches are guarded fiercely. Analysis of different chemotypes suggest that kava drinkers prefer a higher percentage of

kavain and lower percentage of dihydrokavain and dihydromethysticum (Lebot V, et al. 1992.)

Kavalactones increase GABA receptor density in specific areas of rodent brain (especially hippocampus and amygdala) suggesting GABA-a receptor mediation of the sedative effects of kava, although earlier studies did not find GABA or benzodiazepine receptor binding. German EEG studies have confirmed the limbic structures, especially the amygdylar complex, mediate the sedative effects of Kava (Holm E, et al. 1991).

Kretschmar et al found that kava extracts have "anti-strychnine" activity in rodents, acting similarly to the drug mephensin. Aqueous extracts depress spontaneous motor activity in rats without altering forced motor activity responses, according to O'Hara et al, and reduce amphetamine induced hypermotility in mice (Furgiuele et al, 1965: Kretzschmar R. 1970: and O'Hara MJ, et al. 1965).

Gleitz et al demonstrated that kava extracts are antinocioceptive in mice and directly relax muscles by fast and specific inhibition of voltage dependent Na+ channels. Kava is well known for causing muscular relaxation without CNS inhibition. However a depressant activity at cord level is suggested by the abolition of flexor reflex in cats according to research by Furgiuele (Furgiele A, et al. (1965): Gleitz J, et al (1997); Jamieson DD, Duffield PH (1990).

Other Effects: Kava has fungistatic activity but not against Candida spp. Kava extracts are neuroprotective against ischemic damage in rodents (Backhaus C, Krieglstein (1992).

Several studies have confirmed anxiolytic activity of kava extracts to be greater than placebo and equivalent to oxazepam (benzodiazopene) in potency and nature of anxiolytic action. A clinical study comparing oxazepam with Kava on psychometric tests found that kava improved performance, and oxazepam worsened it. (Munte TF, et al (1993).

AHPA Botanical Safety Rating: 2b, 2c, 2d

Long term use of large doses (in excess of 400 mg kava lactones daily) is associated with exfoliative dermopathy, reversible on cessation of consumption. This dermatitis is not uncommon among habitual aboriginal users but reports of dermopathy in the Western medical literature are lacking.

Comission E recommends duration of use not to exceed three months without medical advice but offers no explanation. There is anecdotal ethnobotanical evidence that

prolonged use of high doses of Kava may lead to tolerance and dependence. Rodent studies failed to demonstrate tolerance.

Accomodative disturbances such as enlargement of the pupils and disturbances of oculomotor equilibrium have been described after consumption of 500 ml. Kava beverage prepared in the Fijian manner (Blumenthal M, et. al. 1998; Matthews JD, et al. 1988.)

Contraindicated in pregnancy, possibly due to loss of uterine tone (De Smet PAGM, 1993; Singh, 1992.)

Contraindicated in nursing mothers due to possible passage of pyrones into milk (De Smet PAGM, 1993.)

Interactions: In rodents, hypnotic effect of alcohol and kava enhance each other. No negative multiplicative effects with alcohol were found in a placebo controlled human clinical trial, and in fact Kava countered the effects of alcohol (Herberg KW (1993); Jamieson DD, Duffield PH (1990).

Benzodiazepine activity may be enhanced due to sedative and muscle-relaxant effects of kava pyrones.

Even though research has moved past presumptive notions that kava acted via the same manner as benzodiazepines, its mechanism of action has not yet been fully determined. According to current research, kava appears to have its primary effect on the limbic system, a part of the brain involved in regulating emotions, mood and wakefulness (Holm E, et al. 1991).

Kava is sometimes used by practitioners of natural medicine in cases where benzodiazepines might be prescribed or where a patient is attempting to wean themselves off of benzodiazepines. Individuals taking benzodiazepine class medications should not begin use of kava without first consulting their prescribing physician, preferably in collaboration with a healthcare professional trained in herbal medicine.

According to a case published in Annals of Internal Medicine a man reportedly went into a state of lethargy and disorientation after taking kava in combination with alprazolam (Xanax) or other drugs (Almeida JC et al, 1996).

Until more solid research appears, kava should not be combined with benzodiazepines without supervision by an appropriately trained healthcare professional, even though these symptoms are not uncommon as side effects of alprazolam alone.

Until more conclusive evidence is available, prudence would suggest avoiding the use of kava while taking prescription medications."

Dose: dried rhizome: 1.5 - 4 g. daily.

Tincture: (Dried 1:3) 4 - 12 ml. daily.

Standardized extract: (30% - 70% kavalactones) 100 mg 2-3 times daily

(manufacturers' preparations vary.)

Safe therapeutic dose range of kavalactones is 100-300mg daily

Standard decoction in milk, coconut milk, hemp seed milk, or similar: ¼ cup tid.

Lavender, *Lavandula vera*, L. angustifolia, *L. spica*, *L. species*

- Flowers
- Aromatic, acrid, drying
- Nervine
- Decongestant

Lavender is a nervine relaxant, mild hypotensive, and saponin-rich herb with a relaxing action on peripheral blood vessels, in contrast to a decongesting or mild stimulating effect on the respiratory and digestive systems. For depression, Lavender is traditionally given when sadness lingers chronically, despite eventual improvements in situations "causing" the depression. Lavender has paradoxical effects stimulating thought processes (aromatherapy aid for stress reduction, calming) while relaxing emotional tension. Lavender is often a main ingredient in dream pillows for insomnia. Lavender has a long history of use for mental and emotional concerns (Blumenthal M et al, 2000).

The saponins and volatile oils combine to make Lavender a mild detergent or mucolytic, especially for the respiratory system, and to a lesser extent, in the gastrointestinal tract. This is particularly indicated when grief or prolonged melancholy accompanies chronic bronchitis, pneumonia, bronchial asthma, or nonspecific nervous indigestion.

A recently introduced essential oil capsule for internal use, Silexan, has been shown in preliminary studies to compare favorably to paroxetine for anxiety (Kaspar S et al, 2014). "Silexan is produced from steam-distilled fresh flowering tops of lavender and standardized to contain approximately 70% of the compounds linalool and linalyl acetate" Keller, A, 2014, HerbClips TM, American Botanical Council). Generalized Anxiety Disorder (GAD) is associated with feelings of anxiety, tension, poor concentration, fatigue, and disruption of sleep.

This RDPCT of an essential oil product sought to measure two doses for effects compared to placebo and to paroxetine. Outcomes, based on the Hamilton Anxiety Scale (HAMA) total score, assess fourteen symptoms of anxiety on a severity scale of 1 (no symptoms) to 4 (severe symptoms). Any change after ten weeks, and a change of 50% or more (HAMA score down by 10 or more points) were the two main outcomes under investigation. The study recruited over 600 men and women (ages 18-65) from general and psychiatric practices in Germany, determined to have quantifiable symptoms without psychosis. These were given a washout period before ten weeks of treatment. The two doses of Silexan were 80mg and 160mg; the paroxetine dose was 20mg. At the beginning of the study, 2/3-3/4 of each randomized group (treatment, placebo, paroxetine) had other health problems (vascular, musculoskeletal, metabolic, or nutritional). Safety and efficacy were measured every two weeks during the study. Early withdrawals included those with adverse effects (AEs) and other problems. AEs including g.i. disorders, infections, and nervous system problems were reported in 25.0% of those in the 160 mg/d Silexan group, 34.8% of those taking 80 mg/d of Silexan, 40.9% of those taking paroxetine, and 30.9% in the placebo group.

At four weeks and later in the study, the greatest change in HAMA score compared to placebo was in the higher dose group taking 160mg/d Silexan. At six weeks, those on the lower dose of 80mg/d Silexan also had significantly greater HAMA score changes than placebo. At week six those on paroxetine versus placebo showed significant change in HAMA scores, although these were not significantly different from placebo from that point on (P=0.06). Regarding the change of symptoms equal or greater than 50%, approximately 60% of the 160mg/d patients and approximately 52% of the 80mg/d patients achieved this HAMA score, compared to approximately 38% of the placebo group. Both Silexan groups and the paroxetine group showed a higher percentage of people with “much/very much” or “moderate/marked” improvement compared to placebo. Though these results are encouraging, limitations of the study include use of questionnaires and generalized AEs reports, without routine lab biomarkers reported regarding safety. Continued study of this and other lavender formulations will be needed to gain clinical information as to what type of people, as well as what classes of symptoms, respond best.

Dose: Tea of whole or broken dried flower: 1oz. to one pint, standard infusion. Note – effective water extracts may taste soapy; use of essential oil formulations, gel caps or other dose-equivalent preparations, or glycerine extracts of recently dried flowers (1:3 in menstruum 60:40), may improve patient compliance.
Glycerite or Tincture: 1/2-1 tsp. tid.

St. Johnswort, *Hypericum perforatum*

- Dried flowering tops (infusion, tincture, standardized extract)
- Astringent, sour
- Nervine tonic (“trophorestorative”)
- Hepatic
- Anti-inflammatory (includes topical use of SJW oil)

The literature and controversy surrounding St. Johnswort (SJW) AKA St. John’s wort syn. (*Hypericum perforatum* L.) (Freeman, FP, et al, 2010, Cott, J, 2010, Linde, K, et al, 2011) may be beyond the time limits of this presentation. After all that has been, and will be, rewritten on this remedy, it remains the consensus among herbal medicine providers that St. Johnswort is a complex nervine. Recent decades have focused only on its use as an antidepressant. Herbalists tend to share a consensus regarding St. Johnswort: it is a remedy with more than antidepressant effects, though it is frequently categorized as a treatment for depressed people. This herb affects the CNS as well as having immune-benefits, possibly preventing someone with "depression" from becoming depressed immunologically, and thus, at greater risk of a vicious cycle of ill health and low mood (Cott, J, 2010).
SJW has been proven clinically effective in trials using the standard infusion of aerial parts as well as the tincture or even stronger standardized preparations (Cott, J, 2010). Traditionally, herb preparations have been thought to take eight to ten weeks to build up in a client before its mood changing properties can be experienced subjectively, or observed and measured objectively (Cott, J, 2010). Anecdotally, some patients in my practice have reported nerve relief within minutes of topical application of oil. Relief from depressive mood has occurred in as few as four days though this is not typical and may be attributed to placebo effects.

Psychopharmacology for depression, including conflicting studies on SJW, can be an unwieldy topic for many reasons. For a generation or more, paradigms of allopathic, positivist medical science have been challenged by paradigms of complexity in holistic paradigms of rigorous science (Remen, RN, 1986, Gaudiano, BA, and Herbert, JD, 2005). The "usual care" is in flux, including nutritional supplementation (Shannon & Rondeau, 2012) along with conventional and other treatments. A significantly increased incidence of stress across large sectors of the human population in recent years complicates differential diagnosis and thus treatment protocol (Seligman, L, and Reichenberg, L, 2007). This culture of care is further confused by factors such as off-label prescribing and under-reported self-prescribing. There is controversy among both professionals and consumers regarding side effects of several antidepressant medications or treatments. There may be value in comparing common methods of counseling, frequently prescribed medications, and alternatives (Bonakdar, R, 2012, Freeman, MP, et al, 2010, Cott, J, 2010). Cautions on SJW use (herb:drug interactions with cyclosporine, antiretroviral drugs, others, due to CyP450 mechanism) have been well-described in other literature.
Modern herbalists use SJW in a therapeutic range of standardized products including a 1:2 tincture, dosed at 2.5-10 ml as a single agent or in combination, diluted in water bid or tid, for one month or longer (with the caution to pulse the dose and watch for adverse effects such as photosensitivity) (McQuade Crawford, 1996).
Dose: Oil, topically, 5-25 ml daily/prn for sciatica, nerve trauma
Tea: 1 oz. dried aerial parts infused in one pint water 20 minutes, 1 cup bid/tid.
Tincture, 1/2-2 tsp. diluted in water bid or tid, 1 month or longer (pulse the dose, watch for photosensitivity).

Valerian root, *Valeriana officinalis*

- Root
- Cooling
- Sedative for anxiety, insomnia

Valerian is a relaxing herb that has a calming effect on the autonomic nervous system. It is a good short-term sedative that works best taken several nights in a row. Valerian is best for insomniacs who have trouble falling asleep because it decreases the amount of time it takes to fall asleep, but does not necessarily work on the length of sleep.

Because this is a mild herb, some patients may need five to ten capsules to get the desired result; valerian cannot be thought of like a “sleeping pill,” which is generally much stronger and just requires just one or two tablets. One or two valerian capsules or tablets may work during the day for simply for calming nerves. Because people's response is so individual, we usually start with a lower dose and work up to the desired result.

Valerian is used widely in Europe. In the past 35 years, more than 200 scientific studies have been done on valerian. In much of Europe, physicians are more likely to recommend valerian instead of pharmaceutical sleep aids. Valerian is an active ingredient in about 150 over-the-counter medicines in Germany, including some preparations for children. A few studies have shown positive effects on hyperactive children (Houghton PJ, 1999; Bourin M et al 1997; Leathwood PD et al, 1982). Nonetheless, in the U.S., some texts and supposed experts recommend that valerian not be used by children, pregnant women or nursing women, except on the advice of a health practitioner.

Dose: 1- 3 g, as necessary, up to 4 times per day, for anxiety, and up to 5 g or more, as necessary, as a dose taken 1-2 times, one hour before and just before bed.

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