

AROMATHERAPY FOR THE MEDICAL PROFESSION A USEFUL THERAPY, BUT TRAINING QUALITY AND SAFETY STANDARDS ARE A LOTTERY

Significant inroads into the mainstream clinical environment have been made in recent years by various forms of complementary medicine including aromatherapy (1). Therefore is the time not overdue for the medical professions and regulators to critically evaluate the **quality** of education provision, as well as examine the trades true ability to self regulate?

The UK Ministry of Education, Department of Health and Department of Trade and Industry have all been involved in discussions with the aromatherapy and essential oils supply trade organisations. Yet, the very people these Civil servants are having discussions with, are the ones responsible for oiling the trades hype machine over many years. Examining in detail if what their therapists are being taught is accurate always takes second place to establishing fallacious standards of conduct, ethics, procedures, etc. All the procedural niceties in the world are useless, if what some therapists may be doing (due to bad training) is dangerous or unhelpful to the conditions being treated.

Once trained, the methods of information provision to individual therapists has mainly been via trade journals and organisations (2). Any journal that relies on advertising revenue will of course not publish anything that their advertising customers will not like. Also **rarely will they publish anything that challenges the knowledge base of the trades teachers**. Such reluctance to publish controversial articles or letters, has resulted in an almost complete suppression of discussion on fundamental principles, education quality and trading practices. Only with the less censored medium of the Internet, have a small body of people started challenging accepted trade norms. **Note: The later has been overtaken by the numerous awful quality Internet blogs.**

Over the years, huge efforts have been made to try and make some of the leading therapies and their leaders look respectable (3). The tendency has been for individual therapies to form themselves into centralised bodies who then supposedly "set standards" for training, codes of ethics, etc. However, adequate analysis of the effectiveness and quality of education provision seems to have taken second place to empire building and political manoeuvring.

Since the medical profession revolves around numerous so-called 'professional' organisations (4), the complementary world has been forced down that same road. Once these trade organisations became established the medical and education establishment seemed quite happy to accept they were capable of regulating their respective trades and setting standards - NOT SO. The lack of effectiveness of trade self regulation has been recently brought into question over the UK General Medical Council and its perceived weaknesses. In addition, in the UK, a 'Health Which' report (February 2001 pp 18-20) exposed the trades inability to police the sale of fake and misleading essential oils.

Trade associations (with a few exceptions), have rarely been a significant force for setting adequate standards of quality of education and trading practices. Because of that consumer LAW has become increasingly used in recent years. However, health care officials seem happy to **assume** that because a particular aromatherapist, or even nurse aromatherapist, is a member of the respective trade body, that they must be adequately trained and safe to practice - NOT SO.

Below are some examples of malpractice and misinformation propagated by different aromatherapy trade associations and their leading lights over recent years.

1. Therapeutic attributes of the essential oils.

(a) Many of the therapeutic properties attributed by aromatherapy authors to essential oils, are a corruption of the activity attributed to the herbal preparation. For those that do not know, an

aqueous or alcoholic herbal preparation contains a significantly different mixture of chemicals to those in the same plants essential oil. Indeed, the water soluble chemicals responsible for a range of known therapeutic activities of herbs, do NOT occur in most essential oils at all. An example is the difference between peppermint oil and peppermint tea. The former is an acknowledged stimulant of the CNS, whereas tests have shown that the later has an initial excitant action followed by a long lasting sedative effect [\(5\)](#).

(b) Few (if any) of the early aromatherapy writers had knowledge on the differences between the oil phase and the water phase of a plant. Therefore, when they came to write their books they were packed with totally incorrect therapeutic actions and numerous other errors. This information has been proliferated ad infinitum by numerous subsequent authors. **The majority of aromatherapy training courses still recommend students to use such books as "recommended reading"** [\(6\)](#).

2. Safety.

Despite there being publications on the market containing researched safety data [\(7\)](#), many aromatherapy suppliers continue to sell dangerous essential oils without adequate warnings. We even have a few here in the UK selling with illegal medicinal claims. Therefore, if you come across a UK website with explicit medicinal claims please report them via the Medicines and Health Regulation web site: <http://www.mhra.gov.uk/>

Despite the clear evidence of certain oils having harmful effects, the IFA (which says it represents well-trained therapists), published articles promoting very hazardous oils. For example, **in the Autumn 1999 edition, it carried an article promoting the use of Verbena essential oil.** The author a well-known figure in the trade, states that this oil "used sensibly is safe". This advice flies in the face of all well-documented evidence proving this oil should never be applied to the skin. The International Fragrance Research Association (IFRA) who advise the International fragrance trade on safety issues say: **"(1998-12-18) Verbena oil should not be used as a fragrance ingredient based on test results showing sensitising and phototoxic potential" There are many other references in safety publications on the dangers of this oil.**

In the Summer 2000 edition of the IFA journal, there is an article written by one of their teachers, promoting the use of Tibetan Acorus Calamus oil. She even recommends this oil is used as a gargle. Yet what do the The International Fragrance Research Association (IFRA) say: **"(1998-12-18). Essential oils containing cis and trans-Asarone (e.g. calamus oils) should not be used at a level such that a total concentration exceeds 0.01% in consumer products"**. Calamus oil can contain up to 80% of asarone's but the oil in question is believed to contain around **40%** of these potentially carcinogenic chemicals [\(8\)](#).

Most aromatherapy journals have articles promoting the use of essential oils on which there is either no safety data, or on which there is sound safety data, but the authors fail to point out hazards. Bear in mind the readers are mainly qualified therapists who will presume writers in their journals are knowledgeable and would not promote dangerous practices. Clearly not the case.

Other aromatherapy organisations promote the use of little known essential oils. Most of the information on these oils is derived from just one or two therapists mainly based in France. No adequate safety data is provided and in some cases the internal use of these oils is recommended. As the 'Health Which' February 2001 pp 18-20 article has proven, the practitioners just do not know what they are giving people with the internal use of many essential oils. The students on courses that advocate internal use of oils are free to purchase their oils from anyone. As some of us know, the most clever con artists in the trade tend to be the ones these therapists buy their oils from.

3. Skin absorption.

This is a subject which many aromatherapists are adamant about, i.e. that their oils work by being absorbed by the skin and thence to the bloodstream. Sound scientific evidence simply **is not there**

to support such a mode of action. Therefore, the claimed clinical effects on internal organs, attributed to skin absorption, cannot be justified. On the other hand, there is now a substantial body of sound scientific evidence that the vapours from essential oils do indeed get into the bloodstream, but they get there because the highly volatile gases are inhaled [\(9\)](#).

Clearly the psychological effects of fragrance can be potent [\(10\)](#), and massage can have significant physiological benefits [\(11\)](#), but that does not substantiate most of the claimed effects from dermal absorption of essential oils.

4. The supply of essential oils.

Many in this trade are well aware that a lot of so called 'essential oils' are not half as natural as the sales hype suggests [\(12\)](#). It is a sad fact, but many essential oils are low grade, adulterated, or occasionally totally synthetic. Therefore, if a perfume compound is used for certain therapeutic applications, then anticipated advantageous effects may not occur and indeed adverse effects are possible. It is known that at least one clinical trial failed because of the researcher being supplied with an adulterated oil [\(13\)](#).

This adulteration of essential oils is becoming a great concern now that we have therapists being trained on **their internal use**. If members of the medical profession attend such courses, and then purchase their essential oils from dubious sources, they are playing with fire. Such courses also teach the use of certain essential oils on which no sound adverse effects testing have ever been undertaken. For example Ravensara, Niaouli, Kanuka, Yarrow, Moroccan Chamomile, etc.

So you may ask what is the trade doing about all this? The short answer is not a lot. The trade as such have no control on what individual authors write (freedom of expression). The publishers of aromatherapy books don't care much about the accuracy of their publications, as long as they sell tens of thousands of copies. Trade organisations have little influence over competing organisations; few if any discipline their own members for breaking their own rules.

Examples of hazardous information taught to many aromatherapy students including nurses.

Benzoin essential oil.

Commonly recommended on many aromatherapy courses and in most books, as ideal for application to wounded skin.

FACT: This oil can be a powerful skin sensitiser. The I.F.R.A. has recommended member companies that the unrefined grades containing the allergens should not be used for application to the skin in cosmetic products for very many years. To compound matters, **there is no such thing as a natural essential oil of benzoin**. To make this resin pourable it must have synthetic solvents such as DPG added. This process negates the whole principle of 'naturalness' of aromatherapy.

Bergamot essential oil (expressed).

The use of the dangerous unrectified oil is still promoted in aromatherapy courses. A few aromatherapy authors still recommend its use rather than the safe FCF processed version. Nowadays the advocates say that as long as the client is not exposed to sunlight there will be no problem. However, what initiates a reaction is ultra violet light which can be strong even on dull days, and particularly at high altitudes. Not a problem maybe in the UK, but what about places around the world such as Arizona many parts of which are 7000 feet high! Also of course the problem of photosensitisation caused by sunbeds. *See separate articles*

FACT: A very powerful photosensitiser, restricted in the cosmetic and fragrance trade for many years. Espersen E. 1952. Acta. Dermatovener. 32, 91, reviewed the literature and noted that Kuske H. 1940. Dermatologica 143, 137, had found more than 100 papers published on this

subject. Extensive studies of the effects of Bergamot oil on all skin types were reported by: S. Zaynoun Et al. 1977. Cont. Derm. 3: 225-239, also S. Zaynoun 1977. Br. J. Derm. 96, 475 & S. Zaynoun Et al. 1974. Brit. J. Derm. 91: suppl. 10:14. Also Meyer. J. 1970. Bull. Soc. fr. Derm. Syph. 77, 881.

Wormseed essential oil (Chenopodium).

The sale of this essential oil (other from registered pharmaceutical premises) was prohibited under the UK 1968 Medicines Act.

FACT: Until the middle 1990s this oil was offered for sale by leading UK aromatherapy suppliers. Therefore, it was being sold over 25 years after its sale to the public was banned. One supplier was a leading light in the aromatherapy trade organisations and advised them on legislation - what a joke!

Summary:

Fragrance has been proven to have wide ranging effects on the brain (14). The popularity of a good aromatherapy treatment is clear by the numbers of people practising it and their clients reporting beneficial effects. If it were more widely used by the medical profession drugs bills may well be lower and clinical results improved. A significant volume of sound scientific data exists on the known and potential uses of essential oils from plants. This is available to those that care to spend the money and time seeking it out, as well as evaluating its potential worth.

Unfortunately, Very few aromatherapy courses provide students with **such sound referenced material.**

So nurses and doctors; beware of clinical efficacy claims made by aromatherapists, **ask for references** and check those references are valid. Beware of what products are used on your patients.

Never assume that membership of trade organisations represents a stamp of quality on your therapist, IT IS NO SUCH THING. Ask any medical organisations that you have influence on not to automatically assume that leading members of the complementary medicines organisations know what they are talking about. Often these people are simply good salespeople or political animals, the true depth of their knowledge is frequently highly debatable. Certainly most aromatherapy organisations have not made a concerted attempt to ascertain if their member schools are teaching accurate information.

Finally, beware of aromatherapy books written by nurses, often they are little better than the popular novels on the subject. These nurses - who seem so well qualified - have often learnt all they know from the trades con artists.

References:

1. Comp. Therapies In Nursing journal & several reports in other nursing journals. A few reports in the Lancet, about the numbers of nurses taking aromatherapy courses.

2. International Federation of Aromatherapists. International Society of Professional Therapists. Aromatherapy Today. International Journal of Aromatherapy, and others.

3. Various UK organisations such as the C.C.M; R.I.C.M; B.C.C.M; I.C.M; A.T.C; A.O.C; I.S.P.A; R.Q.A; I.F.A; IFPA; The Aromatherapy Consortium, etc. Plus overseas organisations.

4. Royal colleges of: Physicians-Midwives-Nurses-Obstetrics-Gynaecologists-Surgeons-Psicians, etc.

5. Della R. et al. 1989. Fitoterapia. V.LXI. No. 3. 215-21.

6. **ITEC**. Recommended reading: Julia Lawless. The Encyclopaedia of essential oils and Patricia Davies. Aromatherapy An A-Z.

The IFA. Recommended: The Complete Guide to Aromatherapy by Salvatore Battaglia.

College courses recommend these and other trade novels!

Beauty organisations recommend a similar range of the trades novels!

7. Essential Oil Safety by Tisserand and Balacs. Churchill Livingstone.

8 (a). Chromosome damage - Abel G. 1987. Planta Medica. Pp 251-253.

8 (b). Carcinogenicity-Habermann RT. 1971. Report to the FDA June 16, 1971.

8 (c). Many additional references in the W.H.O. Toxicological evaluation of food additives reports 1981. No A.D.I. was allocated due to concerns over adverse effects of calamus oil from many animal studies.

9. Absorption of d-limonene by inhalation in humans . Falk-Filipsson A. 1993. J. Toxicol. Environ. Health. 38: 77-88. & 1,8-cineole was detected in the blood of mice, following inhalation. Kovar K. Et al. 1987. Planta Medica 53. p.315.

10. (a) Jasmine fragrance was tested for its effects on work efficiency. Jasmine increased b -band activity suggesting mental stimulation. The study concluded that the use of lavender, orange and rose would elevate work efficiency and reduce stress levels. Sugano H. & Sato N. 1991. Chem. Senses. 16: 183-184 and same author and journal, 1989. 14(2) 303.

10. (b) Lavender oil as night time sedation. Hardy M. Kirk-Smith M. & Stretch D. 1995. The Lancet. April. Vol. 346. 701. Plus numerous other references that I have collected.

11. Increase of plasma b-endorphins in connective tissue massage. Kaada B. et al 1989. Gen.Pharmac.V.20 no. 4. pp 487-9. Plus many others are available.

12. Aromatherapy Quarterly Issues 53-54-55 and 'Health Which'. Feb. 2001. pp18-20.

13. Letter from Alan Barker in Aromatherapy Quarterly issue 54. Re failure of a clinical trial due to impure essential oil supplied.

14 (a). When the air was scented with Jasmin, a study on keypunch operators found that their errors dropped by 33%. See also lemon and lavender. Kallan C. 1991. Prevention. 32(10): 38(6).

14 (b). Lavender administered by inhalation on humans proved to have a sedative effect No effects were detectable on alertness tasks. Imberger I. Et al. 1993. Prog. Abst. 24th Symposium on Essential Oils.

14 (c). Lemon fragrance was reported to significantly improve people's perception of their health and well-being. This trial used a control of people who had no scent administered. Fewer adverse health symptoms were reported by those people who were breathing lemon oil than the control group. Knasko 1992. Chemical Senses. 17(1). 27-35.

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