



# Focus group interviews: How aromatherapists feel about changing their practice through undertaking a randomised controlled trial?

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## KEYWORDS

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Aromatherapists;  
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**Summary** In 2003/2007 a randomised controlled trial (RCT) was undertaken into the efficacy of aromatherapy in reducing levels of anxiety amongst palliative care patients. In the study patients were randomised into one of three treatment groups. The participating aromatherapists treated patients according to a strict research protocol. As the trial commenced, the therapists indicated a concern about a potential loss of their holistic principles while undertaking the trial. These genuine concerns formed the impetus to undertake a qualitative study to illuminate the aromatherapists' experience of changing their practice. Findings and discussions are through the themes that emerged. It appears that participating in a RCT does impact on aromatherapists' holistic practice but equally important is their commitment to undertake the research.

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## Introduction

Between 2003 and 2007, a multi-centred randomised controlled trial (RCT) was undertaken into the efficacy of aromatherapy in reducing levels of anxiety in palliative care patients. Results of the pilot study were published in 2006.<sup>1</sup> Patients who volunteered to participate in the study were randomised into one of three groups. Group 1 (experimental group) received a 20 min standar-

dised leg and foot massage using 1% Santalum album (sandalwood) with Sweet Almond carrier oil. Groups 2 and 3 were comparison groups and received either a 20 min leg and foot massage using Sweet Almond carrier oil only (Group 2) or using 1% Santalum album via an aromastone (Group 3). An aromastone is an electronic vaporiser, the essential oil is applied to a vaporising filter.

In order to keep interaction between aromatherapist and the patient to a minimum the same music was played throughout all interactions. Music could be considered a confounding factor but it was felt by the researchers that keeping verbal interaction with the patient to a minimum reduced

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the possibility of the therapist's voice being considered as a further therapeutic intervention. All groups were exposed to the same music.

Participants were adults of both genders. Prior to commencing the study patients were assessed against inclusion criteria for suitability. The aromatherapists completed the assessment. All participants received a patch test prior to the commencement of the study. Patients who were too unwell to receive a full leg massage, who failed the skin assessment or those with a positive patch test were unable to proceed in the trial but were still able to access aromatherapy.

Randomised controlled trial (RCT) was selected as the research approach for this study due to existing biases and weaknesses cited in previous studies.<sup>2-4</sup> It appeared from the literature that RCTs were the most appropriate way to assess the effects of aromatherapy as they demonstrate a theoretically superior 'cause and effect' relationship than quasi-experimental and observational studies. It is suggested that if aromatherapy is to be accepted by more conventional practitioners, it must be evaluated through RCTs.<sup>5</sup> Increasing calls have also been made for RCTs to be used wherever possible to provide 'gold standard' evidence of the effectiveness of complementary therapies.<sup>6</sup> However, the holistic and collaborative philosophy that underpins complementary therapies, such as aromatherapy, can create a conundrum and a challenge for aromatherapists who participate in such research.

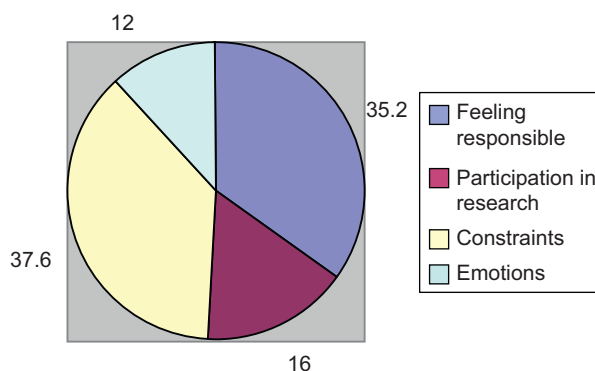
The randomisation can be seen as interfering with the process of holistic decision-making about treatment, leading Feder and Katz<sup>7</sup> to suggest that blinding and randomisation can significantly distort complementary prescribing, potentially weakening its effects. The cornerstone of all complementary therapies is holism. In the assessment of a patient, the aromatherapist has concern for the whole person rather than just the presenting symptoms.

Choosing an aromatherapy oil is a key aspect of aromatherapy<sup>2</sup> with an emphasis on individual uniqueness; since individuals are unique, so is their treatment. This issue gives rise to a therapeutic paradox when attempting to reconcile patient uniqueness with the research protocols of a RCT.

Consequently, the decision was made to undertake a qualitative study to run concurrently with the RCT to learn how the aromatherapists felt about practice changes as a result of participating in the RCT.

## Literature review

An online literature search used the databases of, British Nursing Index, Medline, CINAHL, Cochrane



Graph 1 Percentages of identified themes.

database of systemic reviews and Google Scholar. The keywords of, therapists/aromatherapists/research/ complementary therapies and experience were used. Whilst a wide range of research undertaken by therapists was identified, the search failed to find any research on how therapists felt about participating in quantitative research such as RCT and to date, there appears to be a paucity of studies on this topic. There is some evidence that the experience of the therapist may affect treatment outcome.<sup>8</sup> In an overview of RCT designs in complementary medicine,<sup>9</sup> raised a number of issues including:

- *Randomisation*: may distort practice and create tension in the therapeutic relationship.
- *Symptoms/disease focused*: complementary therapies focus less on the disease and more on the individual assessment of the patient.
- *Standardisation and use of protocols*: therapists may be resistant to following protocols or standardisation practices.
- *Influence of the practitioner*: the subjective nature of complementary therapies are at odds with the objective detachment of a RCT.
- *Variability between the therapists*: variation between therapists due to lack of occupational standards in most complementary therapies.
- *Strict inclusion/exclusion criteria*: make it difficult to generate a homogenous subject group as such diagnostic criteria are not applied to complementary therapies.

## The study

A qualitative study using focus group interviews was undertaken with aromatherapists who had participated in the RCT. The number of therapists involved

in the RCT ranged from 14 to 19 over the research period. Focus groups were selected because of their ability to explore a specific set of issues—in this case, practising within the constraints of research. The focus groups enabled the researcher to gather rich, in-depth data through group discussion, which is not achievable through one-to-one interviews. A focus group discussion would also enable the researcher to probe any assumptions that might give rise to particular views. For example, it was apparent during the planning stage of the RCT that the therapists viewed the aromastone group negatively, stating openly that they hoped none of their patients were randomised into this treatment group. A further advantage of employing focus groups was that information would be expressed in the therapists' own words without using restricting categories often found in questionnaires. Krueger<sup>10</sup> suggests that the synergy created through active encouragement of group interaction is key to enabling a focus group method to achieve a high level of face validity.

## Data collection

Data were collected through three focus group interviews and reflective diaries kept by the aromatherapists. Each group consisted of therapists who had been involved in the RCT. Geographical locations influenced the number of group interviews conducted and those who participated with group sizes ranging from 5 to 8 participants. All participants gave consent and were offered the opportunity to withdraw at any time. Five key questions were raised in each focus group (see Table 1).

The focus group participants required little probing during the interviews as they clarified any points or misunderstandings amongst themselves. Several measures were taken by the researchers to ensure reliability and validity, often referred to in qualitative research as 'exhaustiveness' and 'trustworthiness'.<sup>11</sup> Firstly, open questions posed by the interviewer encouraged participants to interact with each other, exchanging ideas, reflecting and commenting on each others' experiences. Such group interaction is an integral component of focus group interviews. Secondly, group communication continued until the same themes that had emerged were repeated and no new themes arose. Finally, all focus groups were observed by a second researcher and field notes taken. The field notes demonstrated that all three groups were democratic in their discussions allowing time

**Table 1** Focus group questions.

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- How do you feel about giving a standardised massage in specific oil?
  - How does keeping your interaction to a minimum leave you feeling?
  - How do you feel about the aroma stone...about sitting quietly in the room with the patient?
  - In general, what does it mean to you to participate in the research?
  - What are your concerns about participating in the research?
- 

**Table 2** Points for aromatherapists to consider in their reflective journals.

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- Aromatherapy believes in the holistic approach...how do I feel about giving aromatherapy as an intervention?
  - How do I feel about giving a standardised massage?
  - How do I feel about keeping my interaction with the patient to a minimum?
  - How do I feel about sitting quietly in a room while the patient has aromatherapy via an aroma stone?
  - What has it meant to me to participate in the RCT research?
- 

for others to talk and express themselves. Similarly the focus groups appeared to find neither the topic nor the 'recording environment' difficult to cope with. In addition to these groups, each participating aromatherapist was asked to complete a reflective journal during the RCT. Table 2 summarises the points aromatherapists were asked to consider when keeping reflective journals. The focus groups were tape recorded and transcribed.

## Data analysis

Data analysis was undertaken using a framework analysis.<sup>12</sup> The stages used in data analysis in the framework method can be found in Table 3.

Data were analysed independently by the researchers to extract key themes by immersing themselves in the data. To ensure rigour the researchers then compared their identified themes with each other and agreed that themes

**Table 3** Framework data analysis (from Ritchie and Spencer<sup>12</sup>).

There are five stages to the framework method:

- Familiarisation and immersion in data
- Identifying a thematic framework
- Indexing
- Charting
- Mapping and interpretation

**Table 4** Questions used to analyse group processes.<sup>13,14</sup>

- What were the contradictions in the focus group discussion?
- What common experiences were expressed?
- Was a particular member or viewpoint silenced?
- Was a particular viewpoint dominant?
- How did the group resolve contradictions?
- What themes produced consensus?

identified could be clustered into four domains. These were:

- Constraints.
- Emotions.
- Participation.
- Responsibility.

Some attributes were found to overlap themes, an example of which can be seen in the following quote from one focus group where their issue overlapped between the themes of 'constraints' and 'emotions':

I was more worried about the massage than anything else and getting it right. I think some of the anxiety is passed on to the patient.

The reflective journals were analysed to determine if they identified additional themes, but none emerged. The primary attributes that were identified from journal analysis was generally related to individual anxieties. This is discussed under the domain, 'emotions'. In addition, field notes written by the observers in each group were used to analyse internal group processes (see Table 4).<sup>13,14</sup>

An independent researcher then identified the thematic framework and coded the transcripts in the margins using codes identified in the thematic framework. A total of 125 individual statements were identified and coded (from transcripts, field notes and reflective journal accounts). These were assimilated under themes and sub-themes in the thematic framework and associations and relationships between these were extrapolated. Table 5 shows the coding framework that was drawn up during analysis of the qualitative data.

## Results

The analysis shows that constraints as a result of the research and *feeling responsible* for the

research were two of the most commonly stated themes arising from the data (Graph 1).

## Constraints

Of 125 statements analysed from the data, 47 (37.6%) identified perceived constraints to their practice as a result of participating in the RCT.

Within this theme, frustration about lack of treatment choice imposed by the RCT and a requirement to limit interaction with patients were perceived as key constraints for practitioners. However, 23 of the 47 comments about constraints (49%) indicated a positive interpretation to some of these constraints. For example, listening to music replaced chatter and allowed greater time spent upon the aromatherapy treatment.

## Feeling responsible for the research

A second major theme that emerged from the analysis was a sense of feeling 'responsible for the research'. Of 125 statements analysed, 44 (35.2%) were related to the way in which the aromatherapists felt responsible for correct conduct of the research. Of these statement about feeling responsible for the research, 17 of the 44 comments (39%) were related to concerns about recruiting sufficient patients to the study and 11 of the 44 (25%) were related to practitioners perceived responsibility for carrying out the treatment correctly by ensuring treatments were carried out to time as stated in the research protocol, and a sense of responsibility in ensuring research was sufficiently explained to patients.

The two other themes identified during analysis were categorised as: *emotions of the practitioners*, and *practitioners' participation in the research*.

**Table 5** Coding framework (*N* = 125 statements).

Themes and sub-themes	Codes	Numbers of statements
<i>Theme 1: constraints</i>	1.0	
General		
Frustration about to treatment choice	1.1	1
Not assessing individual need	1.1.1	3
Feels like “cheating patients	1.1.2	1
Opposite to holistic practice	1.1.3	1
Frustration about limiting interaction with patient	1.2	
Feels “cold”	1.2.1	1
Change from normal practice/not normal/not comfortable	1.2.2	10
Practicing “parrot fashion” (following someone else’s protocol)	1.2.3	3
Positive aspect of the constraints—provides discipline	1.3	3
Listening to the music replaces chatter	1.3.1	6
Not talking leads to not rushing	1.3.2	3
Constraints—specific to aroma stone	1.4	2
Uncomfortable/difficult	1.4.1	2
Positive aspects of aromastone constraints	1.5	
Relaxing for the practitioner	1.5.1	7
Relaxing for the patient	1.5.2	3
Disheartening when patient’s condition deteriorated/unable to continue	1.5.3	1
aromatherapy		
Total statements identifying an issue of constraints		47 (37.6%)
<i>Theme 2: Emotions (of practitioners)</i>	2.0	
Anxiety	2.1	1
Frustration	2.2	1
Frightened (of responsibility)	2.3	2
Disturbing (when could not keep to time)	2.4	1
Pleasure at positive response by patients to treatment	2.5	10
Total statements identifying an issue of emotions		15 (12%)
<i>Theme 3: Participation in the research</i>	3.0	
Neutral	3.1	5
Validation of aromatherapy as a treatment	3.1.1	
Negative	3.2	5
Anger/irritation at needing an RCT to validate aromatherapy	3.2.1	
Questioning own competence to participate	3.2.2	
Positive	3.3	2
Meeting people from other hospices	3.3.1	2
Benefits of standardisation of practice	3.3.2	1
Perception of the value of the research	3.3.3	5
Total statements identifying an issue of participation in the research		20 (16%)
<i>Theme 4: Responsibility</i>	4.0	
Responsible for doing it “right” for the sake of the patient	4.1	11
Feeling responsible for being true to the research protocol	4.2	6
Responsible for keeping to time (20 min treatments)	4.3	3
Responsibility for explaining the research to patients	4.4	7
Responsibility for recruiting sufficient numbers of patients to the study	4.5	17
Total statements identifying an issue of feeling responsible		44 (35.2%)

## Emotions of the practitioners

Emotions appeared in 15 statements (12%) ranging from ‘anxiety’ and ‘frustration’ about research

constraints placed on them to a sense of being ‘frightened’ of the responsibility of participating in research or feeling ‘disturbed’ about having to keep treatments to a specific time.

## Participation in the research

Twenty (16%) of the 125 statements analysed were related to this theme with five comments offering neutral-value statements about the importance of validating aromatherapy through research. Five negative statements about participation in the research were also identified. These reflected a sense of annoyance that a RCT was needed to validate a type of treatment that was perceived by the therapists to be effective. Additionally, a small number of negative statements about participation in the research were made related to therapists' questioning their own knowledge and ability to participate in research.

Finally, 10 of the 20 statements (50%) related to participation in the RCT were positive statements about the experience. These included the benefits of meeting therapists from other hospices through the research, the positive aspects of standardising practises as required by the research protocol and the value of researching aromatherapy practice.

## Discussion

The focus group study was carried out before the results of the RCT (pilot) were published and therefore the findings of the main study have not influenced this qualitative study. All the results draw on patterns, themes and differences from the data. As with any small study there is the question as to whether the results are representative and reliable when compared to a larger study. Triangulation of the data using a multi-method of data collection reduced this problem. All data collated from this study demonstrated similar trends and patterns with the consequence that the results are considered reliable.

Arguably, the directness of questions used in both reflective journals and focus group interviews suggests that some issues may have been missed. However, the purpose of the research was to ascertain how therapists felt about partaking within the rigors quantitative research it was therefore important that this was explicit in the questions used.

This is a unique piece of research; consequently analysis and evaluation against existing research in the literature is impossible. Consequently, discussion of the findings, in the absence of any significant similar literature, is presented against the observations about RCTs made by Carter.<sup>9</sup> The strongest theme that emerged from the data

analysis was constraints of participating in quantitative research.

I had to ask the patient that we did not talk; this felt uncomfortable for the first couple of sessions.

It was hard...some patients would not receive any massage when we know the need was there. I found it difficult to keep to that standardised massage...you automatically want to follow your own...intuition.

The theme of constraints further supports concerns raised by Carter<sup>9</sup> who suggested therapists may be resistant to following protocols or standardising their practice as a result of research. Objective detachment is a considerable departure from the subjective nature of aromatherapy and there is no easy way to overcome this concern within the RCT design. However, the sense of responsibility that the aromatherapists felt about undertaking the RCT appears to almost outweigh their concerns about possible constraints. Standardisation of the massage was a concern but therapists were also able to see the positive attributes of a standard massage.

Standardised massage means you can hand over to somebody else to follow on the next week or the week after...it makes no difference to the patient.

I was OK with the standardised massage because I knew it was for a particular purpose....I wanted it all to work.

The research further suggests that restricting the therapist's conversation through the use of music may have actually been perceived as being more therapeutic because it keeps the practitioners' focus on the aromatherapy.

The minute you put on the tape everything goes quiet and there is no conversation.

When the music goes on patients tend to close their eyes.

The music is very much to do with shutting down and relaxing...not feeling that you have to talk.

Music helps get you into the right frame of mind.

The need for the therapists to ensure their practice of aromatherapy is evidence-based and not built on unsubstantiated claims may account for their strong sense of responsibility and their perception of the value of the research. It is perhaps the lack of both robust research and appropriate methodology for aromatherapy that drove the aromatherapists to take responsibility for the research, i.e., the overwhelming need to convince sceptics.

We thought this would be a wonderful opportunity to prove [through research] what we, as aromatherapists, felt about aromatherapy and its benefits.

This sense of the responsibility of participating in a RCT is a positive attribute unsupported by the challenges to RCT design.<sup>9</sup> One aromatherapist described participating in the research as 'very exciting'.

Because I was involved in a research trial I knew it was critical that I did not show any reference for any of the treatments as this might affect the data...

Interestingly, the focus group discussions did not voice an opinion on the inclusion/exclusion criteria being a constraint to their practice.

The positive accounts of the aromastone intervention suggest that preconceived ideas can change through undertaking research and that the therapists' previous negative views did not influence the outcome of the intervention.<sup>1</sup>

My first one was in the aromastone and... ✕ because I sat there thinking, 'oh no, this poor man'...because he spends a lot of time on his own at home listening to music...and I'm thinking, 'I've asked him to sit there and listen to this music for 20 min and he could do this at home', and I thought it was going to be terrible. But he came in the next week and said, 'Oh, I'm really looking forward to this. I felt so good and all my friends have told me how well I look and that I am much more relaxed after this'. So of course I enjoyed it as well'. I thought, 'this is great!'.

The research process and the use of reflective diaries promoted reflective practice by the therapists. It is therefore surprising that so few of the therapists did not reflect on the emotional journey the RCT had started because of a higher than initially anticipated (60%) attrition rate amongst palliative care patients. This has meant that the RCT has taken much longer than initially planned.

## Conclusion

This study supports the contention that aromatherapists may initially perceive RCTs as a constraint to their holistic practice. However, in this study, aromatherapists' commitment to influencing the body of evidence on the efficacy of aromatherapy overrode their initial perception that their holistic principles were being sacrificed.

Furthermore, it is interesting that aromatherapists felt that the RCT protocols enabled them to re-examine their own practice and reflect on the benefits that these protocols can impose on practice. In summary, therapists found therapy standardisation and involvement in a research study to be a positive experience both in terms of personal practice and with regard to enhancing the body of knowledge known about aromatherapy in clinical practice.

The purpose of any clinical RCT is to provide 'gold standard' evidence for improving practice. However, an RCT does not capture the experiences of those who participate in the process of a complementary therapy RCT, uniquely, this study has done this. What appears to be emerging is the need for a new research paradigm for complementary therapies. Such an approach would encompass both qualitative and quantitative methods providing robust evidence but without restricting the holistic nature that is the cornerstone of any complementary therapy.

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