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# Removing Stigma and Reducing Anxiety: Social Work Professionals Integrating Essential Oils in Mental Healthcare Services with African American and Native American Clients

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Removing Stigma and Reducing Anxiety: Social Work Professionals Integrating Essential Oils in Mental  
Healthcare Services with African American and Native American Clients

By

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University - University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

### **Abstract**

The purpose of this study was to gain insight into how mental health professionals could use essential oils with African Americans and Native Americans who may have experienced or have been diagnosed with a mental illness. Both African Americans and Native Americans have higher rates of Depression and Anxiety, but have lower rates of utilizing mental healthcare services than White Americans. How do essential oils reduce anxiety about seeking treatment for mental health and subsequently increase participation in therapy for African American and Native American clients? This project used a qualitative research design with semi- structured open – ended questions. The literature review provides key information confirming that the usage rates of mental health services in the African American and Native American communities is very low due to some of the internal and external stigma and anxiety that one could face when displaying symptoms of mental illness or seeking professional help. By using essential oils some of the signs of anxiety could be alleviated by using essential oils and possibly increase participation rates in mental health services. There is lack of research with the use of essential oils in mental healthcare, and direct services provided for African American and Native American clients.

**Key words:** African American, Native American, essential oils, anxiety, stigma, mental health

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Removing Stigma and Reducing Anxiety: Social Work Professionals Integrating Essential Oils in  
Mental Healthcare Services with African American and Native American Clients

### **Introduction**

How do essential oils reduce anxiety about seeking treatment for mental health and subsequently increase participation in therapy for African American and Native American clients? For clients of color taking the initial step to seek mental health care services can be overbearing and may cause an increased amount of anxiety and an increase in negative thoughts based on the stigma that is connected to mental health. Once these clients have attended their first session, there is a higher chance that many of these individuals will not return for a second visit. The researcher in this project investigated whether blending the use of essential oils can aid the service provider in 1) creating a more inviting and comfortable environment, 2) decreasing some of the emotions centered on stigma with seeking or receiving services, and 3) reducing some of the symptoms of anxiety about participation in therapy.

This study explored the possibilities of utilizing essential oils to aid in alleviating anxiety when participating in mental health care services for the most common mental health diagnoses linked to the African American and Native American communities. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2010) reported that the most common mental illness that have been identified in the Native community are major depression, anxiety, substance abuse and suicide. Per the National Alliance on Mental Illness (NAMI, 2016), the most common mental illnesses that have been identified with the African American community are major

depression, attention deficit hyperactivity disorder (ADHD), and suicide; both communities have a history of historical trauma which can be linked to posttraumatic stress disorders (PTSD) (Williams et al., 2016; Brockie et al., 2015).

When compared to other ethnic groups, African Americans and Native Americans have a higher percentage of factors that could increase the risk of developing poor mental health. The United States Census Bureau (2013) states that 27 percent of Native Americans and 25.8 percent of African Americans are living below the highest national poverty line. According to the office of the Surgeon General (2001), the mental health disparities are very prevalent within minority communities. The National Institute of Mental Health (2015) stated about 16.6 percent of adult Caucasians, 15.6 percent of American Indian and 8.6 percent of African Americans utilized services for their mental health needs during 2014. The U. S. Surgeon General reported that during the year of 2000, at least one in five children and adolescents would display symptoms linking to diagnoses related to mental illness (as cited in Parens & Johnston, 2008). According to the National Center for Children in Poverty (NCCP, 2010), youth from various ethnic backgrounds have a lower percentage rate of accessing mental health services. At least 31 percent of Caucasian youth had full access and utilized mental health services, whereas 13 percent of youth from various ethnic and cultural backgrounds had less access to these same health services (NCCP, 2010).

Most people who are diagnosed or exhibit symptoms of having a mental illness have a higher chance of being susceptible to and experiencing negative effects from internalizing their disorders. The negative spiral of effects can be identified in such areas such as lower academic performance levels and a decrease in social functioning that can lead to long term ramifications and psychosocial consequences in adult years (Rum, 2007). A linkage between external messages, personal assessments about self-worth and being good enough makes up a part of the internalized



stigma that is connected to each individual's schemas about self-salience (Rosenfield, 2005). Rosenfield (2005) defines self-salience as a "type of schema, which involves individual internal models of relationships and their place in those relationships" (p. 324). Stigma that is associated with having a mental illness heavily contributes to negative opinions, which in return impedes the recovery process, erodes social life, and diminishes self-esteem. These possibilities could cause a person suffering from mental illness to further internalize their symptoms or disorder, causing isolation and a delay in seeking treatment (Boyd, 2003).

Due to the barriers that these communities face, such as homelessness, exposure to violence, economic hardship, lack of knowledge about mental health, lack of education and lack of cultural specific services, it is imperative that the mental health needs of these communities are addressed.

### **Literature Review**

The purpose of this literature review is to review literature about African American and Native American clients' common diagnoses, the internal and external stigma that is faced when dealing with the possibilities of having mental health problems, and why these groups are not accessing mental health care services. This literature review will provide examples of how the use of essential oils can be beneficial in aiding with alleviating anxiety about seeking mental health services, outline regulations for use of essential oils and specific requirements needed for social work professionals. How does the use of essential oils reduce anxiety about seeking treatment for mental health diagnosis and subsequently increase participation in therapy for African American and Native American clients?

### **Criteria for Mental Health Diagnosis**

According to the DSM 5 (APA, 2013), the diagnostic criteria for Depressive Disorder is experiencing depressed moods for more of the days than not, over the course of two years for adults. Depressive Disorder is identified by subjective or witnessed by others over the duration of at least two years. At least two of these symptoms should be present 1. Decreased appetite or overeating, 2. Not sleeping or sleeping too much, 3. Low levels of energy or fatigue, 4. Low self-esteem, 5. Hard time making decisions or poor concentration and 6. Feeling hopeless. For adult clients, they must experience symptoms for more than two months at a time over the course of two years. For a large number of African American and Native American clients, they will more than likely have a diagnosis of Major Depression, which the APA (2013) described as the client having five or more of the symptoms previously listed over the course of a two-week time frame and at least one of the symptoms will be either depressed mood (most of the day or everyday) or a significant loss of interest or pleasure and activities (all or almost all). Individuals may experience a 5% weight gain or weight loss within a month. Daily interruptions in sleep patterns either insomnia or hypersomnia. These clients may also experience extreme emotions of inappropriate guilt, a decline in their ability to concentrate, indecisiveness and possible ideation of suicide.

The diagnostic criteria from the DSM 5 for Generalized Anxiety Disorder (2013 p. 222) includes excessive anxiety and worry for a duration of six months occurring more days than not centered around events or activities negatively impacting performance levels. Adults diagnosed with GAD must display three or more of the following six symptoms: 1. Restlessness or feeling on edge, 2. easily fatigued, and 3. having a hard time concentrating or experiencing a blank mind, 4. Irritability, 5. Muscle tension, 6. Disturbance in sleep pattern. The symptoms of anxiety, worry and physical symptoms can impair social and occupational functions as well as other areas of the client's life.

The diagnostic criteria from the DSM 5 for Attention-Deficit/Hyperactivity Disorder (2013 p. 59) include having a persistent sequence in hyperactivity-impulsivity or inattention that interferes with developments and functioning. 1. Overlooks or misses' details work at school or academic settings are inaccurate, 2. Has a hard time paying attention and staying on task, 3. Appears to not listen when in being spoken to, 4. Does not follow through on instructions or complete tasks (may even start something but will easily become distracted), 5. Difficulty managing and organizing tasks and activities (poor time management and not able to meet deadlines), 6. Avoids to engage in situations that require prolonged mental efforts, 7. Frequently loses things, 8. Easily distracted by outside influences, 9. Forgetful with daily activities. Six or more Symptoms must be present, for at least six months to a point where it interferes with developmental level and direct negative impact on social, academic and occupational aspects of life.

The diagnostic features for Substance Use Disorders according to the DSM 5 “is a cluster of cognitive, behavioral, and physiological symptoms indicating the individual continues using the substance despite significant substance-related problems” (p. 483) To further break down a diagnosis for a specific disorder, the client’s symptoms will need to meet specific criteria for that substance use disorder.

The proposed criteria for Suicidal Behavior Disorder, are as follows: 1. Individual has made an attempt at suicide with in the last 24 months, 2. “The act does not meet criteria for non-suicidal self-injury-that is, it does not involve feeling/cognitive state or to achieve a positive mood state, 3. the diagnosis is not applied to suicidal ideation or to preparatory acts, 4. The act was not initiated during a state of delirium or confusion, 5. The act was not undertaken solely for a political or religious objective. Suicidal Behavior Disorder is an attempt of self-initiated pattern of

behavior(s) by someone whom at the time of the event intended for the purposeful action(s) to would achieve their own death (current diagnosis must be no more than 12 months since last attempt, for early remission diagnosis must be between 12 – 24 months since last attempt) (p. 801).

Cultural related diagnostic information from the DSM 5 for Posttraumatic Stress Disorder (PTSD) describes that the beginning and severity of one's PTSD could vary depending on cultural background, "clinical expression of symptoms or symptoms clusters of PTSD may vary culturally, particularly with respect to avoidance and numbing symptoms, distressing dreams, and somatic symptoms (e.g. dizziness, shortness of breath, heat sensations). Cultural syndromes and idioms of distress influence the expression of PTSD and the range of comorbid disorders in different cultures by providing behavioral and cognitive templates that link traumatic exposures to specific symptoms" (p. 278).

### **Barriers to treatment**

According to Yurkovich (2011), there are roadblocks that can prevent individuals from seeking or continuing mental healthcare services. Ojelade (2011), states that cultural mistrust as well as stigma surrounding the possibility of having a mental illness can deter clients of color from seeking services. The familial, cultural and history of structural position in society can increase this perception that these communities have about the usage of mental health services (Copeland, 2011; Tighe, 2014). The connection between personal as well as communal experiences with prolonged exposure to racism and discrimination has imposed tougher barriers for these clients to overcome when seeking services (Ojelade et al., 2011). Historically, African Americans have experienced exploitation from public health providers. An example of two well-known cases of blatant racism and discrimination would be Henrietta Lacks and the Tuskegee Syphilis experiment.

Mrs. Lacks was an African American woman who was a patient of Johns Hopkins hospital. Mrs. Lacks had a cervical cancer, and she was provided with an inhumane regime of treatment. Dr. George Gey would remove cancer cells from her cervix and sell them to other facilities. Although her cells have gone on to provide cures and ongoing research in many medical facilities and educational institutions years after her death, she was not compensated. The exploitation of Mrs. Lack and her family still thrives today (Skloot, 2010). The second case largely known is the Tuskegee Syphilis experiment. This study used African American men which would withhold a cure to syphilis for the purposes of gaining knowledge about how this disease affected the body (Kennedy, 2007). The Native American community has experienced the removal of cultural practices that promoted healing and inner peace. They were also forced to live in boarding school, and subjected to various kinds of abuse and inhumane treatment, this also including forced sterilizations and medical experimentation, and locking up medicine people and other community leaders in psych hospitals to discredit them. The Native American community would only be able to rely on Western treatments which were not accommodating for Native cultural practices (Yurkovich et al., 2008). Due to these historic conditions, clients from these populations could negatively view the usage and possible treatment they may receive while in the care of mental health service providers. The over usage of Western practices and not incorporating cultural factors may be linked to not having enough qualified service providers who may not have adequate training working with diverse clientele, leading to misdiagnosis or receiving a mental health diagnosis in the later stages of illness (Schwartz, 2009). Yurkovich et al. (2008) also states that culture as well as social status can be a factor in how the provider's bias opinion (intentional or unintentional) can have a role in discrimination towards clients of color (Schwartz et al., 2009).

Hansen et al (2006), stated that at least one in five African Americans and one in four Native Americans are lacking proper insurance coverage. Clients stemming from a low economic status have limited access to quality health insurance, and not having access could have an impact on the kind of services rendered (Yurkovich et al, 2008; Hensen et al, 2006). Many of the clients residing in low income areas may also have minimal access to mental health services due to the location of potential providers (Hansen, 2006) or lack of knowledge of services they may qualify for in surrounding areas (Copeland et al. 2011).

The stigma that relates to having symptoms or being diagnosed with a mental health illness can be both overwhelming and shaming. For persons of color who utilize Western cultural mental healthcare, a deculturation of personal traditional practices can increase negative ideations centered on seeking mental health services (Grandbois, 2005).

### **Stigma with seeking mental health services**

The Mayo Clinic (2014) described stigma as a way someone can view you: In a negative way because you have a distinguishing characteristic or personal trait that's thought to be, or actually is, a disadvantage (a negative stereotype). Unfortunately, negative attitudes and beliefs toward people who have a mental health condition are common. Stigma can lead to discrimination. Discrimination may be obvious and direct, such as someone making a negative remark about having a mental illness or about participating in services associated with having a mental health problems. It could also be unintentional or subtle, such as someone avoiding you because the person assumes you could be unstable, violent or dangerous due to your mental health condition". In general, the stigma of having a mental illness can cause an individual to be reluctant in seeing or seeking mental health care services. Individuals may begin to question if others such as friends,

family, and others around them will understand what is going on with them or even provide support. When it comes to education, employment, and housing opportunities, individuals may find themselves in compromising situations due to the stigma related to mental health concerns. For many who may overcome the stigma around mental health care, there is still the barrier of whether health insurance will adequately cover services rendered. Outside of the outward stigma persons must deal with, internalized stigma could make them feel that by having a mental illness they are incapable of improving their situation or being successful in overcoming obstacles (Mayo Clinic et al., 2014). How does the use of essential oils reduce anxiety about seeking treatment for mental health diagnosis and subsequently increase participation in therapy for African American and Native American clients?

Although there have been various successful frameworks applied to treat mental illness, there is still a large number of individuals in need of services who are still not seeking or fully accessing mental health care (Corrigan., et al., 2014). Corrigan et al., (2014) also stated that stigma is a common factor that impedes usage of mental health care services and that it also includes stigma as a “complex construct that includes public, self and structural components” (p. 37). Stigma around mental health has a strong negative impact on cultural ideation on mental health, lack of education about mental illness, community resources, mental health providers and various support systems (Corrigan et al., 2014).

During the 90’s, legislators created Acts to help combat discrimination persons with mental health concerns or diagnosis may face; in 1990, the Americans with Disabilities Act was created, followed by the Mental Health Parity Act in 1996, and the Medicare Improvements for Patients and Providers Act. During the year 2010 the Affordable Care Act was created (Corrigan et al, 2014). These Acts worked well on the legislative level to stop discrimination individuals may have

to face in all aspects of their life (mental and physical health, education, relationships, housing, and employment). The State of California created a prime example at the State level to help reduce stigma that is focused on the core of mental health care services and obstacles that individuals encountered. The key highlights of California's Mental Health Services Act are various trainings, marketing to increase public awareness, (encourages participation in mental health care service) and cultural competence (Clark, 2013). In general, the ideology of these Acts is to increase knowledge about cultural aspects and social networks. For those who are contemplating seeking mental health services, there are both positive and negative impacts on whether stigma will interfere or influence the choice to seek, fully participate or ignore obtaining mental health care. For clients of color, there are cultural factors that are linked to social networks, friends and family that can directly impact increasing or decreasing the amount of stigma attached to the possibility of having a mental illness and if mental health services will be utilized.

Per Trahan (2014), racialization of people has had a profound influence on minority clients' participation in mental healthcare services. For many mental health professionals, more often than not they will be working with a client from a different racial and ethnic background than their own. For mental health providers, it is imperative that there are frameworks set in place that outline how to practice ethical decisions and acceptance of race to promote a more harmonious relationship between provider and client. How does essential oils reduce anxiety about seeking treatment for mental health diagnosis and subsequently increase participation in therapy for African American and Native American clients?

### **Stigma with seeking mental health services for African Americans**



For African Americans, coping with a diagnosis of, or the possibilities of having, a mental health illness can cause a significantly higher amount of stress on that individual due to the higher risk of economic disparities, racism, and oppression etc. that they may face. Due to the common diagnoses of Depression, Anxiety, PTSD, and ADHD with the African American population, it is quite puzzling why there is such a gap in the usage of mental health services to aid in alleviating and/or combating such harsh emotional and psychological hurdles. According to Alvidrez (2008), African Americans who suffered from Anxiety and Depression felt that they would be viewed as “crazy or weak” if they admitted to having a mental health problem. For many in the African American community, seeking mental health care services is also seen as “telling your business to an outsider”. It can also be viewed as a negative reflection on the African American family unit by admitting that there is a situation that could not be handled within the construct of that family. For the African Americans who have or are pursuing services, they hold on to the thought that due to the lack of having health care coverage or not having “good” coverage they will not receive quality care (Williams, 2011). For those that are currently participating in mental health services, there is the risk that African American clients will terminate in the early stages of treatment. Wilson (1991), states that both African American and Caucasian providers are not meeting the needs of these clients due to their educational background, and trainings are completed in White institutions with primary research that has been based on White clients. There is a lack of basic knowledge surrounding minority clients, thus creating more stigma around African Americans seeking care. Within the African American community there is a cultural component that normalizes suffering. Hamm (2012) states that during the time of slavery, persons who may have displayed signs of mental health problems would have been subjected to inhumane circumstances. Some of the harsh treatment and punishments that these enslaved persons would receive are frequent beatings and

abuse. Over a period of time, African Americans were forced to hide their issues; strength became equated with survival, and showing signs of weakness meant you have less chance of survival. Therefore, individuals started seeking solace in the comfort of the inner circle of family, kin and spirituality; this became a part of the resilient fabric of healing in the African American Community. This survival technique appears to remain in African Americans who have achieved socioeconomic security and have been able to progress on to professional levels. They are still faced with institutionalized racism and are struggling to remain “strong.” Both the African American clients and mental health providers tend to normalize negative or traumatic experiences and reactions. Having an insensitive demeanor in regards to cultural sensitivity and subconsciously assuming that strife or experiencing harsh times is to be expected and connected to the African American culture can cause providers to miss the connection that this is causing heightened negative emotion and tension that is already connected to societal institutions. This can directly affect African American clients by causing isolation to a point where they feel that they cannot trust or share personal emotions or talk about their situation to anyone, and giving the impression that it would be ideal to handle things on their own.

### **Stigma with seeking services for Native Americans**

For Native Americans, coping with a diagnosis of, or the possibilities of having a, mental health illness can cause a significantly higher amount of stress due the higher risk of economic disparities, racism, and oppression they also experience. The common diagnoses of Depression, Anxiety, PTSD, substance abuse and suicide in the Native American population raise the question as to why there appears to be a gap in the use of mental health services that can aid in alleviating and/or combating such harsh emotional and psychological hurdles. Grandbois, et al. (2005) stated that there are four areas that can have a negative effect on Native Americans, 1. Socioeconomic

status, educational level, and living below the poverty line 2. Current and past trust factors with the US, 3. Health disparities with in the Native American community and 4. Limited access to health care. By the Native American population already having barriers in place and finding ways to cope with these daily stressors the thought of having mental illness can be overbearing. The heavy weight of possibly having a mental illness can deter individuals from seeking or using mental health services due to the stigma attached to having mental illness. For Native Americans who may want to pursue or explore mental health care, the stigma attached to receiving a diagnosis can be closely correlated with the emotion of losing traditional ways as well as feeling like personal culture is being lost. Grandbois, et al. (2005) continued that the diversity within the Native American population (tribal affiliation) can make it challenging to discern stigma. There has been evidence that some Native American Tribes do not focus much on the stigma of having a mental health problem due to the lack of distinction between the physical and mental symptoms. For most Native Americans, the connection with mental illness was “a form of supernatural possession; an imbalance and disharmony with the inner and outer natural forces in the world and the expression of a special gift” (p. 1006). During 1889, a mental hospital was created for Native Americans. The hospital was named “The Hiawatha Asylum for Insane Indians” (Ness, 2016). During this time frame, it was illegal for Native Americans to hold or participate in any kind of cultural practices. Native Americans were forced to use Western medicine and doctrines for their mental health disorders. Due to the historic maltreatment Native Americans received, they began to blend contextual, spiritual, physical and psychological aspects together to promote a peace and balance within. Stigma with mental health care services appears to become prevalent within this population when clinicians only utilize Western criteria for diagnosing and treating Native Americans.

Mental health providers must take into consideration when using essential oils that 50% of the work is going to be the use of the essential oils and the other 50% is going to be about the experience that is organic to each individual client (Jodie Baglien, personal communication, date, 2016). Preferably the provider would consult with the client before making an oil selection and give detailed information about essential oils prior to use. The sense of smell can not only trigger positive experiences, it can also trigger past negative or traumatic experiences for individuals. Ideally the provider would present oils to clients and ask about what may come up when they smell that scent and follow the client's lead in which oil is pleasant for them. One of the key purposes of using essential oils with clients is that it can help create an environment that feels safe, comfortable, make connections to the inner soul, nurture, provide a sense of control and to promote good mental health. These factors alone can create a more inviting environment that can aid a client with continuing mental health care services.

Although the use of essential oils cannot reduce the stigma about seeking mental health services to the external population, it may help with decreasing some internalized stigma by providing the client with an additional applicable method to use while in therapy as well as out of the office to create a sense of control. There are essential oils that are suggested for anxiety (Basil, Respiratory Blend, and Tension Blend). Basil is an oil that is used to strengthen the heart and relax the mind. It is also used when experiencing anxiety, depression, and nervousness. Respiratory blend is the breath oil and can help individuals to let go of grief and sadness; it can aid the client to let go with each breath out and receive with each breath in allowing to embrace life and fully open up. Tension Blend is an oil of relief. This oil can help the body to calm stress and relax feelings of being overwhelmed, nervous, fearful and physical pain (Modern Resource for Healing, 2014). Several websites suggest using Bergamot, Marjoram, Clary Sage, and Lavender as oil to

use for Anxiety and Depression (the oils listed above are suggestions of oils that might be used for symptoms and **not as** a reference of ways to treat mental health symptoms).

### **Cultural, ethnic protective and strength factors**

The coping mechanisms that African Americans as well as Native Americans use to navigate through various stressors are highly associated with cultural as well as “race- specific coping styles” (Blackmon, 2015. Pg.1; SAMHSA, 2010). Both African American and Native Americans seem to utilize a form of cross examining of personal/ community environment and current status that are grounding in culture practices to aid in ways to connect the cognitive and emotional state (Blackmon et al., 2015; SAMHSA., 2010).

Resiliency in both communities to have the capability to “bounce back”, persevere and adapt during harsh circumstances and stressful life events is astonishing and can be attributed to cultural strengths such as family and spirituality (Blackmon et al., 2015, Brown et al., 2008, et al. Yurkovich et al, 2008). A function of African American and Native American culture is to incorporate family (family can include persons that are a part of the internal or extended family as well as those that do not share the same genealogical make up) into decision making as well as providing an internal support system (Blackmon et al., 2015).

Spirituality in the African American and Native American community can be a form of a coping mechanism (Anthony, 2015, Lowery, 1998). When having an affiliation with a faith based community or partaking in ceremonial practices it can provide a strong outer support system, which can lead to great community support. By incorporating the client’s spiritual orientation in a treatment plan it could provide an extra added tool to aiding in recovery and reducing stigma

related to mental illness (SAMHSA, 2010; NAMI, 2016; Johnson et al., 2016; NASW, 2016; Brown et al., 2008).

### **African Americans spirituality and mental illness**

In the African American Community, there is a higher chance that those that may have or exhibit signs of mental illness may not seek mental health services (Anthony et al., 2015). Anthony et al., (2015) stated that there are links to why African Americans are not seeking official diagnosis and treatment for mental health issues: “1. A mistrust of medical professionals based on historical experiences; 2. Cultural barriers, influenced by language and value differences between the health care provider and the patient; 3. Reliance on the support of family and the religious community during periods of emotional distress” (p.118). Many studies have suggested that at least 63% of African Americans suffer from some form of depression and perceive that it is a form of weakness and will use personal faith and prayer to help with symptoms (et al. Anthony, 2015; et al. Hensen et al., 2006; et al. Ojelade et al., 2011; Yurkovich et al., 2008). At least 40% of African Americans turn to a clergy person as a resource for mental health issues and less than 10% are “being referred on to mental health specialist” (Anthony et al., 2015). For those that identify as African American, the church community has been a historical center piece providing education, religious traditions, economic help, empowerment, political knowledge and many other advancement opportunities (Anthony et al., 2015). The African American church provides many of its congregants with marital, bereavement counseling, employment options, legal issues, and chemical dependency problems etc. Many of the clergy persons that supply these are providing a mirror service that professional mental health practitioners provide. The separation between services provided from the pastor and professional practitioners could be educational and training background. “Involvement in spiritual and church based activities provides a source of support for many

African Americans” (p. 119). To meet the needs of church members, support groups or mission circles are created to provide members with a positive social support system. Members from these mission circles are often the first to notice one of the members may need to seek help from a mental health provider and/or the pastor of the church (Anthony et al., 2015).

### **Native Americans spirituality and mental illness**

The Native American community traditional view about mental health is that there is no separation. Everyone is “either in harmony or not” (p. 150) (Lettenberger-Klein, 2013). Native Americans have various ceremonies that are used to produce “healing, giving thanks, celebrating, clearing the way and blessings (p. 318) (Garrett, 201). The function associated with these ceremonies is to honor connection, relationship, and healing. Native Americans that practice cultural spirituality believe that there is a connection between the natural environment and the supernatural world creating a sense of equilibrium between the physical, emotional, spiritual and mental (Garrett, et al., 2011). Some of the physical interventions or techniques that are largely used by Native American tribes are sweat lodges and burning of sage, sweet grass, and cedar for smudging. Through personal contact with the Native American community and direct conversations with Mary I (2016) the researcher has come to understand the usage of medicinal herbs as a way to push out negative spirits and energy and a way to invite in positive spirits and energy with purpose to restore peace and balance to the person or a specific space. Sage, Cedar and Sweet Grass are the three kinds of medicinal herbs that are used and produce different outcomes. The herb Sage is commonly used get rid of negative spirits and energy, whereas Sweet Grass welcomes positive spirits and energy. Cedar is used to also attract positive spirits and remove negative ones.

Smudging is the process of burning one of these medicinal herbs (sage or cedar in a shell or a container, sweet grass is braided and burned at one end). Smudging is generally done by individuals, in a place or on objects (before and after use). These herbs can also be put in water for consumption. The goal for usage of these medicinal herbs are to provide blessing to objects, individuals and space to give a positive flow of peace and energy (personal communication with Mary I, 2016). From personal contact with the Native American community the ritual of smudging has also been used for individuals that are experiencing negative emotions or having negative experiences. In general, this ritual is performed for spiritual cleansing of emotional, physical, spiritual and mental well-being (personal contact and conversations with Mary I 2016)

Sweat lodge is a ceremonial practice that is used for healing and transformation. The ideology behind the use of the sweat lodge is that it “ensures harmony, balance and wellness a person must participate in the ritualized cleansing of the mind, body and spirit provided through the sweat lodge ceremony” (p. 320) (Garrett et al, 2011). The symbolism of a sweat lodge has very deep rooted meanings. The shape of the sweat lodge represents the womb (mother earth) where all life begins, a pile of stones to represent the power of the Creator and a connection with the fire that is sacred used to heat the stones, each stone that is used in this ritual is to remind everyone of the healing powers of the earth (Garrett et al., 2011; personal experience, 2016; personal communication, 2016). The poles used to provide structure are made of willow branches. The willow tree represents death, rebirth and all things growing. Four willow poles are created to symbolize the elements of earth, wind, water and fire. Water represents life of all living creatures and the steam that rises from the rocks as the water is poured symbolized the prayers of everyone in the sweat going up to the Creator. Tobacco is used to make prayer ties and is a way to offer prayers in a respectful manner (Garrett et al., 2011). In sweat lodges that are being used today



“blankets or tarps are used” (p. 320) to cover the sweat lodge (Garrett et al., 2011). The door way to the lodge sits in a low position so persons that are entering the sweat must crawl in. What this symbolizes is each, individual returning to the womb of mother earth humbly and being fully immersed into darkness. When the opening to the lodge is covered a process of liberation from ignorance, darkness and egos takes place and everyone is spiritually reborn with truth, goodness and light (Garrett et al., 2016; 2016; personal experience, 2016).

### **Essential oils and aroma therapy**

During the 1980's, the use of essential oil therapy (aroma therapy) started to develop into a more structured practice that connected the mind and body by alleviating symptoms of both mental and emotional distress (Butje, 2008). Cooke (2000), described aromatherapy as the use of extracted oils derived from flowers, herbs and parts of plants, which can be used to treat diseases. The word aroma means *fragrant* and the word therapy means *treatment*, this form of therapy provides a more organic and holistic alternative purported to create healing properties to promote well-being with in the mind, body and spirit (Ali, 2015).

The application methods for essential oils can be administered in various ways. Application methods can be in small quantities like massage, inhalation, baths, lotions, and diffusers, direct application to skin, and direct inhalation from bottle. It is not often that oils are ingested (National Association for Holistic Aromatherapy, 2016; Ali et al., 2015). Bujte et al. (2008), states that the most effective way to use essential oils for decreasing symptoms of anxiety is by using a slow inhalation process ( palm of hand, inhalation from bottle, diffuser). A key fundamental function of using essential oils with aroma therapy externally or by inhalation are to rejuvenate, relieve,

regenerate and provide balance for both the mental, physical aspects of each individual ( Ali et al., 2015).

Essential oils have a history of providing aromatic fragrances that curative capacity on the mind, body and spirit. Each fragrance stems from a “very potent organic plant chemicals that make the surroundings free from disease, bacteria, virus and fungus. Their versatile character of antibacterial, antiviral, anti-inflammatory nature along with immune booster body with hormonal, glandular, emotional, circulatory, calming effect, memory and alertness” (p. 602) (Ali et al., 2015). Ali et al. (2015), provides five examples of how to utilize aromatherapy, cosmetic, message, medical, olfactory and psycho-aromatherapy. Cosmetic aromatherapy is the use of essential oils on the face, hair, body and skin. The oils can be used for moisturizing, toning, cleansing. By using oils in a foot soak or bath it can provide an effective way to feel rejuvenated and revitalized (Ali et al., 2015). Massage aromatherapy is a form of therapy that uses essential oils for a healing touch massage. Medical aromatherapy is a form of therapy that uses essential oils to treat and promote diagnosed medical conditions. Olfactory aromatherapy is when inhalation of essential oils is received through the nasal cavity and creates a state of emotional well-being, relaxation, and a calmness in an individual’s body. Psycho-aromatherapy pertains to specific moods and emotions that can be reached by the use of essential oils, creating a sense of pleasure, relaxation, pleasant memory and invigoration. While in therapy essential oils can be inhaled through direct infusion located in the same room as the client (Ali et al., 2015).

### **Requirement and regulations for practice**

The National Association for Holistic Aromatherapy (NAHA, 2016) states that there is no current regulation or license needed to practice or provide aromatherapy services. This also

includes the production of aromatherapy oils. The NAHA provides guidelines for secondary educational institutions that provide certification programs. For professionals and non-professionals that may be seeking to become or incorporate the use of essential oils in their practice there is a 200-hour training that must be completed with a credited institution. The NAHA website also list two levels of trainings; the first level is Aromatherapy Foundation, which has a 30-hour training requirement. The second level is a Professional Aroma Therapist Certification, which has a 200-hour training requirement that is completed at an accredited educational institution.

The State of Minnesota has a statute in place for unlicensed complementary and alternative health care practices (CAM). Statute number 146A.02 implements that the Department of Health is to produce an Office of Unlicensed Complementary and Alternative Health Care Practice to help regulate persons that practice these alternative methods and to investigate consumer complaints and if necessary enforce disciplinary actions if appropriate. At this juncture in time, there are no relevant standards for training and education for persons that practice aroma therapy with essential oils. The University of Minnesota Center for Spirituality & Healing offers accredited courses that prepare individuals to take the Aromatherapy Registration Council (ARC) exam. Once the ARC exam has been passed, that person's name will then be placed on a registry list where individuals can find certified providers that utilize aromatherapy. Normandale Community College also offers a certificate program that provides a foundation in aromatherapy and oils as well as two advanced options for pain and stress reduction. If providers would like to be added to a national registry, taking the courses at the University of Minnesota would be more of a suitable fit for professionals that are seeking to receive more knowledge about the use of aromatherapy and essentials oils to incorporate into their practice. Taking courses at Normandale Community College would be more

ideal for professionals that would like to gain more of a base knowledge before incorporating oils in their practice.

### **Applicable research on essential oils /aroma therapy**

There is limited research on the effects and application of essential oils and the targeted populations of this research project. Watt (2008) conducted a study on the usage of complementary and alternative medicine (CAM) in patients that experienced symptoms of Anxiety and Depression. Various CAM interventions are being used to treat anxiety and depression disorders. Some of these interventions include mindfulness-based stress reduction, meditation, herbal nutritional, physical interventions and aromatherapy. For clients with Anxiety, they received a combination of massage and Aromatherapy with essential oils. Six out of the eight clients did experience a reduction in anxiety and over an eight month time span reported an improvement in their mood. This study did not report if clients experienced positive effects due to the use of essential oils, massage or a combination of the two. This study was also restricted to a small controlled group (types of oils used were not listed). Clients with depression used essential oils (bergamot, citrus Bergama, geranium, pelargonium graveolens). This study concluded by saying that there is not enough efficacy information about the use of aromatherapy in patients with depression and that there is limited evidence that supports the use of aromatherapy used as a treatment in clients that have depression (Watt et al., 2008)

A controlled prospective study was conducted on both men and women pre and post procedural on patients that experienced anxiety before and after receiving an esophagogastroduodenoscopy or colonoscopy procedure. The experimental group received an inhalation treatment of Lavender essential oils pre and post aromatherapy and the controlled group

received a placebo of inert oil for inhalation. Although there was no significant change in the levels of anxiety in either study group it was noted that the limitations of this study lacked ample time for the experimental group to only received five minutes of inhalation aromatherapy, and study was conducted during the clinics busiest time of day. This study also noted that patients lacked access to other possible relaxation accommodations such as a private room and a quiet environment with mood lighting (Muzzarilli, 2006).

There have been studies on senior citizens' diagnosis with depression that reside in assisted living nursing facilities with daily exposure to the aroma of flowers and fruit. By having this daily access to these aromas many of the residence experienced reduce symptoms. The scent of citrus has been connected to the improvement of immune function and depression. Over the course of four to eleven weeks, residents of the assisted care facility received a continuous application of a citrus aroma. During this course of time, it was noted that the level of depression and the use of antidepressants was significantly reduced (Wolfgang, 2008).

### **Conceptual Framework**

The purpose of this segment is to provide information about how the researcher collected various literature to aid in developing a research question to direct the flow of this research project. The researcher of this project was interested in gaining perspective on how mental health service providers can incorporate the use of essential oils and aromatherapy with African American and Native American clients that may have been diagnoses with one of the four common mental illness identified with in those communities as well as experiencing anxiety about receiving mental health care services. The first theory that applied to this study was the mindfulness theory approach.

Davis (2011) describes mindfulness as a “psychological state of awareness” or a “moment by moment awareness of one’s experience without judgement” (p. 198). Mindfulness is a state of being and not a trait. It can also be attached to a form of practice or type of activity. Davis et al. (2011) goes on to state that mindfulness is a form of psychological freedom that can take place when individual focus becomes quiet, limber and requires no attachment to any specific point of view.

The second theory applied to this study was the biopsychosocial approach. The biopsychosocial theory was developed by a psychiatrist named George Engel. Engel believed that the importance of comprehending both the health and illness of a person essential when trying to systematically connect the complexities of the biological, behavioral, psychological and social interactions to gain a better perspective of each client’s individual state of health or illness to provide supreme services (MacDonald, 2009; “Urmc. Rochester,” n.d.). Biological components include individuals’ genetics, family history, age, medical conditions, race and sex, etc. *Behavioral* refers to personal health status, diet, adherence to medications as well as daily behaviors that can have an impact on each client’s well-being and health. *Psychological* consists of variables that can either positively or negatively impact mental health. Environmental components play an essential part in piecing together the complete puzzle of the client’s mental health. Social networks, employment, family, income and housing are all environmental factors that can aid in the quality of each client’s individual physical and mental health (Somjee, n.d.).

African American and Native American clients who exhibit symptoms of or have been diagnosed with a mental illness, without proper treatment will grapple with finding a balance between the biological, psychological and social components of this framework. Once the biological, psychological and social areas have been assessed and identified, the biopsychosocial

framework can then be implemented. Using this approach can enhance the beginning stages of mental health services provided. BPS can also provide ample time to inquire about the client's personal history and gain perspective on clients' insight in to their situation. (MacDonald et al., 2009). For the African American and Native American clients, this could create a space that will validate and allow the clients to narrate their stories. By using the Biopsychosocial approach, it can assist with unveiling if the usage of essential oils can aid in creating a more functional relationship and environment with mental health care services as well as improve some of the symptoms experienced that are inhibiting the overall quality and functioning of the client's life.

## **Methodology**

### **Research Question**

Does essential oils reduce anxiety about seeking treatment for mental health diagnosis and subsequently increase participation in therapy for African American and Native American clients?

### **Design**

The goal of this research was to gain insight about how the use of essential oils can be used with African American and Native American clients that have been diagnosed or display symptoms of mental health illnesses. The researcher used open-ended questions in a semi-structured interview with professionals that were currently incorporating the use of essential oils in there practice. Each interview lasted about 60 to 90 minutes (see appendix C) in length and recorded. The researcher also utilize a qualitative approach with this study. By using this approach it helped shed insight about how the basic use of essential oils can be used by professionals to help

clients alleviate symptoms and encourage use of mental health services. To create a stronger research project, the researcher interviewed professionals that are currently incorporating essential oils in their practice.

### **Sample**

All of the data collected will be centered on a semi structured qualitative design. The researcher of this project will conduct in-depth interviews with various professionals that use essential oils in their practice with clients that may have experienced symptoms or have been diagnoses with a mental illness. The purpose of interviewing four to fifteen professionals will be to provide a solid based foundation in understanding how the use of essential oils can have an impact on general mental health and services.

A snowball sample was used in the selection process of choosing professionals. Atkinsons (2001) defines snowball sampling as “a technique for finding research subjects. One subject gives the researcher the name of another subject, who in turn provides the name of a third, and so on” (p. 1). By using snowball sampling it can provide a way to overcome potential barriers of locating possible candidates to interview for this study.

The sampling method is based on the thought that the primary sample will have a connection to a secondary sample of other professionals within the same target population thus creating an easy flow of referrals made within a “circle of acquaintances” (Atkinson et al., 2001) (p. 1). The ideal sample population included professionals such as Aroma therapist, Nurses and Social workers that were currently using essential oils on clients that may have concerns about their mental health or have been diagnosed with a mental illness. An informational hand out was provided to interviewees outlining an explanation of research and that participation in this research



project was voluntary (see appendix B). To maintain validity of this project the research will exclude professionals that do not use essential oils in their practice. The goal of this research was to examine and make a connection on if the use of essential oils can be effective in a mental health care setting.

### **Confidentiality and protection of rights**

The researcher has applied to the Institutional Review Board of St. Catherine University located in St. Paul, MN. The application process was completed and approved before any data collection began. The researcher followed guidelines to minimize any possible risk while participating in this study. Appropriate confidentiality steps were taken to keep all personal information safe; however, anonymity cannot be guaranteed due to direct contact with interviewee. Researcher insured the safety of each professional participating in this study both during and after research was completed. Any person participating in this research project did so on a voluntary basis, and had the option to reserve the right to withdraw at any given time during the interview process.

### **Collection of data**

Data obtained from interviewees was be done so by audio recording of each participant. Interviews were conducted in one 60 to 90 minuet session on professionals over the age of 18. A post interview transcription of each recording was completed (Appendix C). Researcher analyzed data using the grounded theory approach to assess all data obtained from each participant and mirror data to reflect everyone's information (Berg, 2012). Post interview researcher did a transcription of all data for review and identify recurring codes that where categorized into themes.

## **Findings**

The overall purpose of this research project was to explore if the use of essential oils with African American and Native American clients could decrease symptoms of anxiety and encourage higher participation rates in mental healthcare services for these specific populations. To answer this question, I interviewed three professionals, a rehabilitative massage Aroma therapist, medical social worker and a clinical aroma therapist nurse. All parties interviewed for this project have had a significant amount of experience working with essential oils.

The hypothetical inquiry for this project was to find the answer to this research question, can essential oils reduce anxiety about seeking treatment for mental health diagnosis and subsequently increase participation in therapy for African American and Native American clients? To gain a broader perspective of this theory, a series of questions was constructed as a guide to find answers to the research question. There were four themes that were identified after all three interviews and transcription were completed. The four themes include positive effects and mental health, training, holistic methods and integrative psychotherapy, and time and consent.

### **Positive Effects and Mental Health**

Essential oils can have a positive effect on client's mental health. Participants were asked their thoughts about the possible partnership of incorporating the use of essential oils with mental health and if it could increase usage rates of services with individuals from one or both of these communities. Consensus of all participants confirms that yes, the use of essential can be very beneficial for persons that are experiencing anxiety by decreasing those symptoms. It was also noted that the use of oils can have a positive influence on a person's overall mood by boosting energy, natural sleep aid as well as decreasing an individual's mental health symptoms. "I have

seen repeatedly, in my own personal experience, with family members and friends, and on a weekly basis for the past 5 years with hundreds of clients, that yes, essential oils absolutely do have a powerful, deeply soothing effect on the nervous system and a remarkable balancing effect on the mental/emotional/physical processes that trigger chemicals in the body that we experience as the feeling that we call “anxiety. So, yes, I would say I absolutely believe that pure, therapeutic grade essential oils, when used properly, have a great potential to help reduce the anxiety experienced by clients seeking mental health services”. Regardless of an individual’s ethnicity, and cultural practice the use of oils will still transfer its therapeutic effects.

### **Training**

Prior to using essential oils, professional should complete some sort of training program. Each person interviewed for this project stressed the importance of taking and completing some kind of training or educational program before incorporating essential oils in there practice. All interviewees expressed the reason why gaining knowledge about oils prior to use with clients can have a negative impact if used improperly by making of their symptoms worsen. When using oils it is not a one size fits all method simply because each individual is different and oils can have a different impact each person’s reactions. “The nurses are trained about essential oils using a 1 hour e-learning module. Once they have completed the training, nurses are allowed to offer essential oils to their patients”. “Everyone reacts differently to different aromas. For instance, if you’re working with someone who has PTSD, and they experienced significant trauma as a child (locked in a closet that smelled like cedar), they most likely won’t want to be smelling cedarwood and lemon coming from a diffuser. Likewise for the person who maybe had chemo, and was given lemon or peppermint to smell for nausea. They now associate those with the scent memory of

getting chemo, etc. Where another person in the waiting room maybe had their fondest memories of their grandparent's cedarwood closet and their grandmother's lemon candy dish".

### **Holistic Methods and Integrative Psychotherapy**

Each professional interviewed incorporated a form of holistic methodologies and or integrative psychotherapy in their practice in addition to the use of essential oils. For professionals that are practicing it is ideal to focus on each individual client rather than only focusing on their symptoms. It is also essential to link the function, behavior as well as cognitive levels of the client, but using essential oils as a bridge between holistic methods and integrative therapy this can give a sense of completion to treatment methods. "Yes, besides aromatherapy, I teach relaxation breathing, mindfulness, meditation, guided imagery, massage, neurolinguistic programming and motivational coaching". "I was an outpatient mental health therapist, I utilized elements of horticultural therapy, prayer, and meditation with clients". By merging an additional method to therapy and essential oils it can provide the client with an additional tool to practice as it can furthermore empower and provide a sense of control when symptoms arise; an example of that may be a combination of a breathing exercise or imagery while taking a moment to use an inhalation of an essential oil of choice.

### **Time and Consent**

Prior to the use of essential oils with clients there is a process in which oils are introduced and explained to each client. A part of that introduction is to educate about what oils are, what they can be used for and how they may help with what that client is experiencing. It was highly suggested that providers complete an assessment before and after the use of oils to assess if the oils were alleviating or aggravating symptoms. Parties' interviewed also noted that providing time is

also vital to finding the oil or combination best suited for that individual client. “I do a thorough intake with each new client, take notes during our first session, and refer back to notes and observations with each new appointment they schedule”.

### **Discussion**

The responses provided by each professional interviewed correlates with the literature review for this project. Both state that there is limited data to confirm the linkage between persons that use essential oils for mental health purposes and if there is an increase in participation in mental healthcare services. There is even more restricted research confirming the usage of essential oils in African American and Native American clients. Both literature as well as data collected from interviews suggest that there is a positive impact that oils can have on the functional relationship with individual’s personal environment as well as emotions when used properly. The benefit of oils can also provide a positive pathway to feel secure and provide a sense of control when using mental healthcare services; which in return can increase attendance with mental health providers. Although African Americans and Native Americans have higher rates of suffering from mental illness there is still low rates of participating in mental healthcare services. As stated by Yurkovich (et. al, 2011) culturally persons from one of these communities may feel increased anxiety and stigma about voicing concerns with their mental health.

The barriers that these clients face from their community and societal influences could make these individuals feel incomplete and powerless. One of the themes identified was the use of a holistic approach and combining integrative psychotherapy with essential oils can provide clients with a sense of empowerment by aiding the client in reducing symptoms of anxiety and possible decreasing personalized stigma. For Native American Clients, the use of oils seems to really follow

the path of some of the cultural practices as outlined in the literature review (Grandbois et. al., 2005, Garrett et al. 2011). Native Americans use various plants and herbs to heal the mind body, spirit and to push out negative energy so positive energy can be received. It does not appear that African American's have a specific cultural practice related to plants and herbal treatments however there is a sense of feeling not in control when situations arise that are too much for one person to handle.

Given that essential oils are derived from plants and herbs this practice could also aid mental health professionals with an extra tool when working with persons from one of these communities to create an environment that feels welcoming and safe, it can also provide clients with a sense of control with their mental health symptoms. By accomplishing these basic steps, it will build a sense of trust with that provider and create cohesion that will influence higher participation rates in mental health services.

Case studies presented in the literature review (Muzzarilli et al., 2006Watt et al, 2008, Wolfgang et al., 2008) suggested that there was not enough time provided for clients to note the full possible reactions to essentials oils and in some cases the clinical setting was in a fast pace environment not allowing a full connection with oils to happen. It was mentioned by the experts interviewed that an informed consent process needs to happen to better find suitable oils for that person. The professional also expressed that it is a good idea to let the client lead in the choice of what kind of oils are working or are not working for them. The case studies only provided one oil to all clients and did not provide any alternates.

The goal of the use of essential oils is to increase participation in mental health services for African American and Native American clients and reducing symptoms of anxiety. The logic for

choosing this topic to research, was related to personal experiences with the introduction and use of essential oils. During my under grad senior year of school I was introduced to wild orange and the positive effect this oil had on boosting my energy. I enjoyed that experience and wanted to learn more about other oils and how it could have an impact on other emotions. What I learned was that there is a plethora of oils that can work in many ways whether it is mental clarity, emotional support or physical health, there is the possibility of finding an oil that can accommodate. As time progressed and I wanted to expand my knowledge I wanted to learn more about the possibility of using oils in a therapeutic setting and how this can help those that would not seek professional help for mental health problems, and increase rates of participation in mental healthcare for those clients.

### **Implications for social work practice and policy**

The information obtained during this research project suggests that essential oils with African American and Native American clients, can create a positive and supportive atmosphere that could decrease the feeling of anxiety and personal stigma and increase participation in mental healthcare services. For most of the clients residing in these communities it could be viewed as a loss of control over their situation by seeking outside communal resources. For social work professionals that are incorporating essential oils in their practice it is creating a solid partnership with their clients by providing them with a form of empowerment as well as giving them an easy tool to practice mindfulness when experiencing symptoms. Prior to using essential oils with clients, it is highly suggested that some form of education or training should be done. The purpose for getting proper training before the use of oils with individuals is to learn how essential oils can

have an effect on a person's mood, behavior as well as gaining understanding on the connections with "psychotherapeutic, olfaction and emotions" (participant three, 2017).

At this time there is no law that requires any individual to be licensed as an aroma therapist, however the State of Minnesota has very vague guidelines for professionals that practice this form of complementary alternative method. The purchase of essential oils is fairly easy and can be brought from various organizations, such as holistic and natural stores, the internet as well as individuals that sale oils. Currently the food and drug administrations does not have any set guidelines and regulations for essential oils. Before using essential oil is always best practice to research the brand oils you are interested in using and the company in which they are produced. Due to the level of contact that individuals will be having with essential oils it is always best to use a product that is 100% natural to achieve optimal results and most importantly reduce the risk of harm.

### **Implications for research**

Based off of the information obtained from this research project it is apparent that use of essential oils with in the African American and Native American community is still an area that is in need of much more research. This study did not incorporate responses of clients from either community to record if this form of intervention could work. The three professionals interviewed for this project did not have enough data on whether the use of essential oils would be beneficial in increasing participation of African American and Native American and decreasing the personal stigma related to seeking and participating in mental healthcare service. The professionals did state that regardless of an individual's ethnicity and cultural practices essential oils could have the same therapeutic effect. Each participant in this study did provide resourceful information, however



there was not enough solidified evidence to prove that the use of oils were fully effective for clients from these communities leading to a need for more research on this particular topic.

### **Strengths and limitations of research**

The general bases for this research project was conducted on the notion that essential oils could be used on all clients that were experiencing or diagnosed with a mental illness and by incorporating these specific oils it would increase participation in mental health services. During the research process the researcher has gained a clearer understanding that each client may have a different reaction to essential oils, and a process of introduction to oils should be done to prevent a negative experience. When a formal presentation is done with each client the use of oils can create a very empowering experience which in return could reduce the emotion of anxiety and personalized stigma when utilizing mental healthcare services.

Due to only having three professional to interview for this research project and that most of their practice focus was on non-African American and non-Native American clients it created very limited results proving the full effective effects that essential oils could have in these communities. All parties that were interviewed for this project were professionals from three very different backgrounds (nurse, aroma therapist and a social worker) which provides three different pathways of how the use of oils can be used as a intervention in clients in general and stating that there is still a significant amount of research that needs to be done when it comes to the usage of oils with African American and Native American clients. The researcher of this project would have been able to receive more effective results if individuals from both of these communities that were currently using mental healthcare services partnered with essential oils were interviewed for this study. The entirety of this research project was nine months, this time frame did provide enough

time to apply and receive approval from the Institutional Review Board (IRB). However for this particular topic of research additional time would have been warranted to seek approval to interview clients and develop a more valid assessment tool.

## **Conclusion**

The African American and Native American community are population that are underserved in the mental healthcare system (Hansen et al., 2006; Grandbois et al., 2005; Yurkovich et al., 2008). Both communities find empowerment with families, spirituality, resiliency and community (Anthony et al., 2015; Garrett et al., 2011). Although the research was inclusive in unveiling if the use of essential oils can reduce anxiety about seeking treatment for mental health diagnosis and subsequently increase participation in therapy for African American and Native American clients; this study suggests that there is a need for further investigation on the use of essential oils and aromatherapy with these populations. For many of the African American and Native American client that have been diagnosed or are displaying symptoms of mental illness, it can cause the emotion of feeling powerless creating a heightened state of anxiety about seeking mental health services ( Alvidrez et al., 2008; Grandbois et al., 2005; Hansen et al., 2006; Williams et al., 2011). As a social work professional by utilizing essential oils in practice it can provide clients with an assessable easy to use tool to keep on hand and practice mindfulness self-care actions should symptoms arise. It can also provide a way to reduce some anxiety by creating a warm and inviting environment where clients can express and participate more freely in therapy sessions. The purpose of this research project was to introduce the use of essential oils in a manner

that mental health professionals can explore the possibilities of incorporating the use of essential oils in practice.

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## Appendix A

### CONSENT FORM UNIVERSITY OF ST. THOMAS GRSW682 RESEARCH PROJECT

Removing Stigma and Reducing Anxiety: Social Work Professionals Integrating Essential Oils  
In Mental Health care services with African American and Native American Clients.

I am conducting a study about the use of essential oils to reduce anxiety when seeking mental health services. I invite you to participate in this research. You were selected as a possible participant because another professional suggested that you may be interested in participating in this study. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Kamara Bauman LSW, a graduate student at the School of Social Work, Catherine University/University of St. Thomas and supervised by Dr. Sarah Ferguson.

#### **Background Information:**

The purpose of this study is: determine if essential oils can reduce anxiety about seeking treatment for mental health diagnosis and subsequently increase participation in therapy for African American and Native American clients?

#### **Procedures:**

If you agree to be in this study, I will ask you to do the following things: Participate in a semi structured 60 to 90 minute interview which will be audio recorded. Data obtained from this interview will be presented in presentation. Data will also be reviewed by fellow research student to verify reliability.

#### **Risks and Benefits of Being in the Study:**

The study has no inherent risks.

The study has no direct benefits.

#### **Confidentiality:**

The records of this study will be kept confidential. Research records will be kept in a locked file in my office. I will also keep the electronic copy of the transcript in a password protected file on my computer. A research partner and my research professor will see a 15-minute transcript of the interview, but will not know who you are. I will delete any identifying information from the transcript. Findings from 15 minutes of the transcript will be presented to my research class. The audiotape and transcript will be destroyed by June 1, 2019.

#### **Voluntary Nature of the Study:**

Your participation in this study is entirely voluntary. You may skip any questions you do not wish to answer and may stop the interview at any time. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University, the University of St. Thomas, or the School of



Social Work. If you decide to participate, you are free to withdraw at any time without penalty. Should you decide to withdraw, data collected about you will not be shared with any third parties.

**Contacts and Questions**

My name is Kamara Bauman LSW. You may ask any questions you have now. If you have questions later, you may contact me at 612.207.3519. Dr. Sarah Ferguson may be reached at 651. 690.6296 You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

**You will be given a copy of this form to keep for your records.**

**Statement of Consent:**

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study and to be audiotaped.

\_\_\_\_\_  
**Signature of Study Participant**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name of Study Participant**

\_\_\_\_\_  
**Signature of Researcher**

\_\_\_\_\_  
**Date**

## **Appendix B**

### Interview guide

1. What is your profession?
2. Do you use other holistic methodologies or integrative psychotherapy?
3. What exposure have you had before using essential oils with clients?
4. Do you feel by using essential oils with clients experiencing anxiety when seeking mental health services can help reduce that? Do you think that oils can help alleviate stigma?
5. Do you feel that the use of essential oils can increase participation in mental health services for African American and Native American clients?
6. How do you introduce the use of essential oils to your clients (the lobby, throughout the agency or only in meeting rooms)?
7. Do you think that essential oils can work for individuals from the African American and Native American communities?
8. What is your informative process that you use with clients before proceeding with using essential oils and can you provide examples of their response?

## Appendix C

### Partial transcripts

The researcher asked participants what is their current profession? Participant one replied that she is a “Clinical Aroma therapist I am a Registered Nurse, Board Certified in Holistic Nursing, a Board Certified Massage therapist and a Clinical Aroma therapist. I am a senior trainer for the Penny George Institute for Health and Healing so I travel and teach integrative therapies to staff. I am in charge of the Allina Health aromatherapy initiative, including 13 hospitals and 80 clinics”.

Participant two replied that she was a “? I am a LICSW. I just resigned from my job as a Medical Social Worker in Home Care (had been doing that for the past 4 years). I am in transition right now in these next few months. I am completing my training for Clinical Aromatherapy and starting my own wellness business. I have also worked as a school social worker, county targeted case manager, state social worker (D/HH population), out-patient mental health therapist, managed care telephonic case management and utilization review”.

Participant three replied that she was a “My profession is therapeutic bodywork, including Shiatsu therapy, Rehabilitative Massage Therapy, Active Isolated Stretching and Aromatherapy, working one-on-one with individual clients and customers. I also work in group settings, teaching semi-private group sessions for rehabilitative stretching techniques, as well as teaching classes on self-care using essential oils. I incorporate coaching in mindfulness with my group sessions/classes for both stretching and aromatherapy”.

Do you use other holistic methodologies or integrative psychotherapy? Participant one replied “Yes, besides aromatherapy, I teach relaxation breathing, mindfulness, meditation, guided imagery, massage, neurolinguistic programming and motivational coaching”.

Participant two replied “I was an outpatient mental health therapist, I utilized elements of horticultural therapy, prayer, and meditation with clients”.

Participant three replied “I do not have formal training in psychotherapy. However, my approach to working with clients always incorporates an assessment of how their emotional and thinking patterns are influencing the state of their muscles/joints/internal organs, sleep and overall quality of life, etc. According to Traditional Chinese Medicine, which informs Shiatsu Therapy, it’s important to be aware of one’s client’s emotional/mental tendencies to know where and how to treat. This helps us decide which meridian systems to focus on, which internal organs to work on during the abdominal massage which is usually a part of the treatment, and at what depth to work, and which techniques to use”.

What exposure have you had before using essential oils with clients? Participant one replied “I have used essential oils on clients as part of their massage therapy sessions and I have taught clients about using essential oils at home”.

Participant two replied “My father first started selling one of the major multi-level marketing company oils back in 1990. He got me my first diffuser in 1990. I had had a lot of exposure through the multi-level marketing facet over the years (never became a member/distributor much to my father’s dismay). A lot of my friends used essential oils. I only used my diffuser on and off. I did

not use them like I do now. I would not be using them with clients/patients without proper training, which is one of the reasons I went to school for it”.

Participant three replied “My personal exposure to essential oils prior to using them with clients involved using them for immune support, pain relief, digestive support, and relaxation and sleep. My mother gave me several bottles of essential oil, and taught me how to use them. She helped me to eliminate a severe mold problem in my apartment by spraying an essential oil solution on the area the mold was growing in, and this completely resolved it, it never came back despite a continual moisture issue in those areas. That convinced me these oils were extremely potent and effective substances. I also had received massages from colleagues who used essential oils and I experienced substantial pain relief and enhanced tissue repair from the essential oils, which I feel saved my own career as a bodyworker”.

Do you feel by using essential oils with clients experiencing anxiety when seeking mental health services can help reduce that? Do you think that oils can help alleviate stigma? Participant one replied “Yes, research to support that using essential oils can help reduce anxiety by 47% (see attached research). Specifically, Lavender and Sweet Marjoram can reduce anxiety by 2.73 points on a 0-10 anxiety scale and Mandarin can reduce anxiety by 2.44 points on a 0-10 anxiety scale. I do not have research on this, but my personal feeling is that yes, it could”.

Participant two replied “Absolutely, essential oils may have been possibly be used to ease some feelings of nervous tension and emotions associated with anxiety (we have to be very careful on how we word things due to the FDA). Some of the essential oils have chemical constituents and therapeutic properties that are known to be sedative, nervine, anxiolytic, etc. This is why knowing about the essential oil chemistry is important. I know that from my history of working on the side

of helping patients/clients to access mental health services that it can be a challenge to overcome anxiety of the first point of contact to actually engaging with the services. I know from my experience of working as an outpatient mental health therapist, if I had the appropriate training at the time, I would've used essential oils in some sessions. With any situation, it can be a challenge to be able to use essential oils because everyone will react differently. As far as using a diffuser in the waiting room environment to help ease overall mental health symptoms, I would disagree with that on the basis that everyone reacts differently to different aromas. For instance, if you're working with someone who has PTSD, and they experienced significant trauma as a child (locked in a closet that smelled like cedar), they most likely won't want to be smelling cedarwood and lemon coming from a diffuser. Likewise for the person who maybe had chemo, and was given lemon or peppermint to smell for nausea. They now associate those with the scent memory of getting chemo, etc. Where another person in the waiting room maybe had their fondest memories of their grandparent's cedarwood closet and their grandmother's lemon candy dish. That is one of the reasons that blends are important. But, some people could still react to that. I am conservative in this regard. So many people have Multiple Chemical Sensitivities (which actually can be triggered by essential oils regardless of how pure they are according to Tisserand & Young), and allergies as well. If I were to diffuse something in a waiting room at a mental health clinic, I would probably choose a blend and use one drop so that it is very subtle. All of these points I have brought up could be concerns in individual practice when working 1:1 with clients as well. Do you think that oils can help alleviate stigma? For me, this is a tough one. I know that with the rampant rise of the average daily consumer use of essential oils, this would lead me to guess that using essential oils as a complementary tool would help alleviate stigma. But, I think that stigma is such a larger construct and problem that just using essential oils will probably not "alleviate" it. It may in some

smaller circles, such as the stay at home mom who is struggling with post partum depression. She may find that using her essential oil diffuser (who all of her other friends in her MOMS group uses) helps to ease stress and tension. There may be more discussion amongst her and her friends about their emotional and mental struggles in regards to “which oil to use for what”. However, now that I am writing this, I am also thinking about how there may also be a reverse effect. I have witnessed a belief (among some of my friends even) that essential oils are the end all and be all. That if you diffuse non-stop, take it internally, and rub it all over your body, that you should not be feeling any emotional or mental

Participant three replied “I have seen time and time again, in my own personal experience, with family members and friends, and on a weekly basis for the past 5 years with hundreds of clients, that yes, essential oils absolutely do have a powerful, deeply soothing effect on the nervous system and a remarkable balancing effect on the mental/emotional/physical processes that trigger chemicals in the body that we experience as the feeling that we call “anxiety.” So, yes, I would say I absolutely believe that pure, therapeutic grade essential oils, when used properly, have a great potential to help reduce the anxiety experienced by clients seeking mental health services. I’m not a mental health professional, but it seems fair to say that the reason a client would be seeking this sort of therapy is because they are experiencing suffering to a degree that they need relief. And the way that they know they are suffering is through a physical sensation of discomfort in their body. This is often labelled anxiety or depression. But my understanding of those labels is that they ultimately refer to chemical imbalances in the brain/body that are caused by thinking patterns. If someone can get immediate relief from those chemicals via a therapeutic aroma from essential oils in a waiting room, or in a therapy setting, that will create positive associations with that environment. As far as stigma, again, I’m not a trained mental health professional per se. But my

understanding of any feeling of stigma is that it is a negative association. So, by creating a positive experience by directly interacting with brain chemistry through the limbic system, which is directly affected through the olfactory membrane as essential oil molecules enter the nose, yes, I believe it is possible to alleviate stigma via aromatherapy”.

Do you feel that the use of essential oils can increase participation in mental health services for African American and Native American clients? Participant one replied “Yes, based on the Penny George Research, clients who have used essential oils have found them to be beneficial. I would surmise that by reducing anxiety, clients would be more likely to participate in mental health services”.

Participant two replied “Yes, however, I have the perception of a white skinned female social worker. One of my upcoming projects will be to work with a nurse colleague of mine and her organization that serves women and their children who are court ordered to chemical dependency treatment and housing. There is a large majority of African American and Native American clients at this location, and I know that the clients that identify as Native American utilize smudging. I have not done enough research, but it would be interesting to see some research as to cultural and sociological aspects of various essential oils for the immigrant and refugee populations. I also do not think there has been any research based on the color of someone’s skin and their biophysiological reaction to essential oils. So, based on current research, one could assume that the chemical constituents of the essential oils and the therapeutic properties would remain the same regardless of skin color, cultural practice, or ethnicity. One thing that comes to mind with this is cost. Essential oil therapy can be expensive”.



Participant three replied “I would say that anything is possible. I’m not aware of any particular association with aromas that are exclusive to African or Native Americans. That’s an interesting question that I feel I would have to do more research on to answer in detail. For example, researching whether certain scents have a specific meaning in those cultures. But in general, I think any culture can be influenced positively by aromatherapy. I’ve personally observed aromatherapy working effectively with a wide variety of cultures/races including both African and Native Americans”.

How do you introduce the use of essential oils to your clients (the lobby, throughout the agency or only in meeting rooms)? Participant one replied “We use personal inhalers that clients can take home with them (they last about 3-6 months), massage oils (premixed in a 2% dilution of jojoba oil) and bath salts that are placed into a tub of water (in the post-partum area only). We do not allow diffusion of essential oils due to the fact that people cannot move away from them. There are some people that are sensitive to scents, therefore, we do not allow diffusion throughout Allina”.

Participant two replied? ” I think I have already answered this with some of my answer for #4. However to add, at NECA+WC (the acupuncture and wellness center that I am starting to work with), they use a diffuser in the common hallway. We have had some complaints about the aroma being too strong and causing headaches. I am not sure what the staff have been putting in the diffuser. I will be creating a soft blend that should be able to be used without too much irritation to people as it is in the hallway and nobody sits in the hallway for long. I have also set up a wholesale account for them with a local essential oil company that is in many co-ops. When I will be working 1:1 with clients, I will be using essential oils obviously as the main focus of our appointments will be the aromatherapy piece”.

Participant three replied “My office does have a waiting area where a diffuser is not always, but often running. There is also a diffuser usually going in the bathroom. When preparing for a session, I will assess beforehand if I feel my client would benefit from a particular essential oil being used in my diffuser in my office, and set that up accordingly. Otherwise, I apply them topically for a variety of purposes as I described before—pain relief, relaxation, digestive support, energy support, immune support, etc.”.

Do you think that essential oils can work for individuals from the African American and Native American communities? Participant one replied “Yes, the research from the Penny George Institute includes data from Abbott Northwestern Hospital, which includes a large population of African American and Native American clients”.

Participant two replied “Yes, I think that it can potentially increase mental health participation from individuals who identify as being from these communities. I also think that it would be helpful for leaders within the communities themselves to get some training and model this from within their community. With how essential oils work, I believe they have strong promise for working with trauma. Which could be taken from an individual level, to the family group, and on to the community. Regardless of what that community is.

Participant three replied “Yes, I believe essential oils when used in an informed manner, and if they are of therapeutic grade, would work very, very well for individuals from the African American and Native American communities, as I think they would work well for most individuals regardless of their background. Many studies have been done on the use of essential oils for stress management that prove they have a positive effect”.

What is your informative process that you use with clients before proceeding with using essential oils and can you provide examples of their response? Participant one replied “The nurses are trained about essential oils using a 1 hour e-learning module. Once they have completed the training, nurses are allowed to offer essential oils to their patients. The use of essential oils falls within the scope of practice of a Registered Nurse in the state of Minnesota. The nurse conducts a clinical assessment of the patient, offers aromatherapy to fit the individual need, teaches the patient about essential oils and documents the outcome. We have many anecdotal stories from patients who have loved the essential oils. One example is a gentleman who has tried to quit smoking several times without success. He was offered a tobacco cessation inhaler. On a return visit he talked about how effective the inhaler was to help him quit smoking”.

Participant two replied “I have an informed consent. As I am not currently in outpatient mental health, I have not had any responses as far as that goes. However, when I’ve used it in previous medical settings, we describe any risk involved, and basics of the essential oil use. Currently doing case studies, I review my informed consent with the client, and then I review my scope of practice with them. “As an aromatherapy practitioner I do not Dx, prevent to treat any illness, disease or any other physical or mental condition.” However, with my background and LICSW, I will be able to diagnose and treat the mental condition. Even though it will not initially be in my role description to diagnose as I am not explicitly doing psychotherapy, it may morph into that in the future. Again, by law, we have to be very careful that we don’t say “You have a diagnosis of Generalized Anxiety Disorder and Major Depressive Disorder, so I’m going to use lavender and bergamot with you in a session now to help and decrease and treat your symptoms.” Nobody has had any concerns about the informed consent process and they understand the limitations that the FDA has created around using essential oils”.

Participant three replied “I do a thorough intake with each new client, take notes during our first session, and refer back to notes and observations with each new appointment they schedule. While sometimes I simply use my knowledge of aromatherapy to choose oils based on symptoms clients describe, I often incorporate the Traditional Chinese Medicine perspective with my knowledge of aromatherapy to select oils for clients. For example, if a client is suffering from physical and mental fatigue along with stress, I know that from a TCM perspective, this is draining their Kidney energy. I might choose to apply Basil essential oil on Kidney “points” along the Kidney meridian because Basil oil is very supportive for cases of mental and physical fatigue. Or, if they happen to have low back pain, (which is also associated with the kidneys), I might apply the Basil oil directly on their low back muscles and incorporate that into massage, since Basil oil is also soothing for muscle pain. I find that this is very relaxing for clients. I could choose sedating oils to alleviate the stress such as Lavender, Vetiver or Marjoram. But these wouldn’t necessarily provide the added nuance of adrenal/kidney support that Basil does. I had a client who requested abdominal massage to detox his liver and to help alleviate some digestive issues he was having. Because I observed a pattern of restlessness and subtle anger in comments he made during our intake, and in TCM the liver is the internal organ associated with anger, I decided to use Ylang Ylang essential oil over his liver. Ylang Ylang essential oil is very soothing, relaxing and especially supportive as a mood elevator. (I call it my happy oil!) Ylang Ylang can also be soothing for the digestive system, and in TCM, digestion is closely linked to the liver. He became very relaxed after I massaged the Ylang Ylang oil into the skin, and told me later that the treatment had been very cleansing for him, which is what he wanted. I also look at other factors such as their daily activities and how they’re using their body throughout the day, and whether they’re taking time for self-care. I look at personality traits such as whether they are very talkative, confident and outgoing, or more depressed, fearful

and quiet. Are they nervous, tense, insecure, drained, overwhelmed, shy, distrustful, dealing with trauma, PTSD, ashamed, dealing with guilt, Because these emotions all have unique chemical signatures in terms of how they are felt in the body. And there are corresponding essential oils that interact with these chemical signatures, and have the effect of balancing. I use two books to inform this manner of approaching the use of essential oils with clients, one is called *Emotions & Essential Oils*, published by Enlighten Alternative Healing. I was very skeptical of this information at first, because I wondered how a person could judge that, for example, Marjoram essential oil helps someone become more trusting and open to connecting in relationships. However, when I began thinking of the wide variety of negative emotions that humans experience as simply a variety of chemicals in the body, it made perfect sense. And I've seen time and again that this book's interpretation of the emotional impact each essential oil can make on a person is spot on. The second book I reference is a standard and highly respected textbook in the aromatherapy community, called *The Complete Guide to Aromatherapy*, by Salvatore Battaglia. He discusses in great depth the function of olfaction which begins in the nasal cavity, (the olfactory system is a molecular detector that can discriminate among millions of odorants, or "smells"), and the brain, and the biology and psychology of essential oils. He explains how human behavior and mood are affected by essential oils, and the psychotherapeutic link between olfaction and emotions".