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Health Professionals' Use of Aromatherapy with Children and Adolescents with
Mental Illness

by

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MSW Clinical Research Paper

Presented to the Faculty of the School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
in Partial fulfillment of the Requirements for the Degree of

Master of Social Work

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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 explore how health professionals are using aromatherapy with children and adolescents who have exhibited or are diagnosed with the four most common mental illnesses. The four most common mental illnesses according to the Center for Disease Control and Prevention (CDC) (2013) are: ADHD as the highest mental health disorder; then behavioral or conduct problems; anxiety; and depression (part of mood disorders). This qualitative research study used an exploratory design by conducting in-depth semi-structured open-ended questions to four subjects. Themes were identified using content analysis. Subjects using aromatherapy with children and adolescents, use a mindfulness and empowerment approach. By encouraging clients to find what essential oil helps them regulate their symptoms and so they are able to return to daily living. Several subjects gave examples of effective aromatherapy has been to their clients. There has been no adverse reaction from parents or guardians of the children and adolescents who are using aromatherapy as an intervention. The only identified barrier from the subjects was the cost of essential oils. There is a lack research in this area, and research that directly interviews children and adolescents. There are no current licensure requirements in the State of Minnesota to practice aromatherapy, and a minimum amount of training courses. Besides a need for regulations of practicing aromatherapy, there needs to be regulations on the quality of essential oils.

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Introduction

Everyone has their own opinion on how to treat children and adolescents who have mental illness concerns. This study will address the most common mental health diagnoses in children and adolescents and explore a holistic approach using essential oils and aromatherapy to ease symptoms.

The four most common mental illness diagnoses seen in children and adolescents are anxiety disorders, attention deficit hyperactivity disorder, mood disorders, and behavior or conduct disorders. The Centers for Disease Control and Prevention (CDC) website reported (2013), that they collected data on children and adolescents ages three to seventeen years old, from various sources between the years 2005-2011, to determine what were the most common mental illness diagnoses. The CDC (2013) determined that ADHD was the highest mental health disorder; then behavioral or conduct problems; anxiety; and depression (part of mood disorders).

It is important to address that the amount of children and adolescents that are identifying with having symptoms or diagnosed with a mental illness is alarming. Parens & Johnston (2008), identify that the U. S. Surgeon General reported in 2000 that it was likely that one out of five children and adolescents are displaying diagnostic criteria for a mental illness each year. The United States Census Bureau estimated the percentage of the population of people under eighteen years old in 2012 at twenty-three percent. That means four point six percent of the U.S. population is experiencing signs and symptoms of a mental illness in the course of a year, if applying the U. S. Surgeon General's ratio estimate of one out of five children and adolescents with the United States Census Bureau 2012 under eighteen years old population.

It is vital to the future of mankind that mental health professionals seek to assist children and adolescents, giving them the tools and skills to be successful adults. Children and

adolescents with mental illness concerns struggle in all areas of life including academics.

McLeod, Uemura, & Rohrman, (2012), did a study comparing adolescent student's grade point average (GPA) scores. They compared students who presented with mental illness behaviors, and those with no presenting mental illness behaviors. The researchers determined that students who have mental illness behavior concerns have a lower GPA scores then those with no mental illness concerns. This study shows that it is evident that school systems need to continue to support students with mental illness concerns.

The use of aromatherapy with essential oils is another way to help treat children and adolescents that exhibit or is diagnosed with mental illness. This presents another treatment option besides traditional psychotherapy, cognitive behavior therapy, and or prescription medication. The purpose of this study was to explore how health professionals are using aromatherapy with children and adolescents who have exhibited or are diagnosed with the four most common mental illnesses.

Literature Review

The purpose of this literature review is to gather information on different treatments of children and adolescents with the four most common mental health concerns and or diagnoses. This literature review will define and explain aromatherapy and the use of essential oils, practitioner's requirements and regulations. Thus including what research has been done on the use of aromatherapy, and or essential oils.

Mental Illnesses

Anxiety Disorders

According to the criteria for generalized anxiety disorders described by the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; DSM-IV-TR; American

Psychiatric Association, 2000) (DSM-IV), symptoms of anxiety include; excessive worry regarding daily activities and events, such as school or work that persists for at least six months, and the worry is difficult to control. The next six listed symptoms, children only need to meet one in the criteria that follows to be diagnosed with an anxiety disorder, and symptoms are severe enough that they affect daily living and functioning; “restlessness or feeling keyed up or on edge, being easily fatigued, difficulty concentrating or mind going blank, irritability, muscle tension, and sleep disturbance” (p.476).

Anxiety disorders commonly occur along with other mental or physical illnesses, including alcohol or substance abuse, which may mask anxiety symptoms or make them worse. In some cases, these other illnesses need to be treated before a person will respond to treatment for the anxiety disorder. Anxiety disorders affect about forty million American adults age eighteen years and older (about eighteen percent) in a given year, National Institute of Mental Health or NIMH (2013), explains that it is pertinent that there more public knowledge of alternative ways to combat mental illness.

There has been some research on how to treat anxiety with children and adolescents, including cognitive behavioral therapy and medication. Eichstedt, Tobon, Phoenix, & Wolfe, (2010), state that cognitive behavioral therapy (CBT) for childhood anxiety includes psychoeducation about anxiety and its symptoms, learning the CBT model of treatment, developing coping skills for managing physical symptoms of anxiety (e.g., self-monitoring, relaxation training), cognitive restructuring, graduated exposure to anxiety-provoking situations, and relapse prevention strategies” (p. 226). Cartwright-Hatton, Roberts, Chitsabesan, Fothergill, & Harrington (2004), compared previous studies on the effectiveness of CBT on children and adolescents with anxiety and they concluded that there were noteworthy decreases in anxiety

symptoms when compared with those children and adolescents who did not receive CBT treatment.

Many times medications are prescribed to help with symptoms of anxiety. Selective Serotonin Reuptake Inhibitors (SSRIs), such as fluvoxamine, fluoxetine, paroxetine, and sertraline, are commonly used to treat childhood anxiety (Eichstedt et al. 2010). Eichstedt et al. (2010) purpose of clinical trial was to determine if there was a difference in effectiveness between children and adolescents with anxiety receiving SSRIs and participating in CBT treatment versus those not receiving SSRIs. Eichstedt et al. (2010) determined there was not a significant difference between the above test groups. All of the test subjects in the SSRI group had an increase in medication during the study by psychiatrists, who were not involved in the study. The researchers also noted that the disparity between the genders receiving medication and those that are not is concerning. There was an unbalanced amount of boys in the group receiving medication compared to the non-medicated group, but gender disparities did not cause an imbalance in the findings.

Attention Deficit Hyperactivity Disorder

The DSM-IV (2000) describes attention deficit hyperactivity disorder in three different subtypes. Predominantly inattentive, which includes the following symptoms, which occur often;

Failing to give close attention to details, making careless mistakes on daily living activities, difficulty keeping attention on tasks or play activities, does not seem to listen when being spoken to directly, does not follow through on instructions and fails to finish required tasks, such as schoolwork or chores, has difficulty organizing tasks and activities, avoids, dislikes, or is reluctant to engage in tasks that require sustained mental

effort including schoolwork, loses things necessary for tasks or activities, is easily distracted by extraneous stimuli and, is often forgetful in daily activities (p. 92).

For a child to be diagnosed with attention hyperactivity disorder, the above systems have to be present for at least six months and severe enough to be obstructing normal developmental stages. A child also must have six or more of the above systems to qualify for the diagnosis.

The other named subtype is predominately hyperactive- compulsive that also includes the same diagnosing requirements, those symptoms in the DSM-IV (2000) include in;

Hyperactivity: fidgets with hands or feet and squirms in seat, leaves seat in classroom when expected to stay seated, runs around and or climbs excessively on objects in inappropriate settings such as desks at school, difficulty playing or engaging in leisure activities quietly, appears to be always moving, such as a running motor, and talks excessively.

Impulsivity: blurts out answers before questions have been completed, has difficulty waiting their turn, and interrupts or intrudes on others (p. 92).

The third subtype is combined inattentive, hyperactive and impulsivity, including symptoms of both types.

In the Harvard Mental Health Letter (10/08), there are fifty-four percent to eighty-four percent of children and adolescents with ADHD, have enough symptoms to be diagnosed with oppositional defiant disorder as a co-occurring disorder. An individual exhibiting symptoms of ADHD can also appear to also have oppositional defiant disorder because they are often unable to follow through with directions including work refusal, or excessively talking to the point of annoying others.

Multimodal treatment is recommended by the Harvard Medical School (2008), for the

most effective way of helping a child or adolescent with ADHD. This model includes using a multidisciplinary approach including a combination of psychoeducation, medication, behavioral interventions, parent training, and school support.

The American Academy of Child and Adolescent Psychiatry (AACAP) and American Academy of Pediatrics (AAP) both recommend the use of stimulant medication as the first intervention for ADHD, especially when there are no co-occurring diagnostic symptoms, according to Harvard (2008).

Behavior and Conduct Disorders

Behavior and conduct disorders include conduct disorder childhood onset, and adolescent onset and oppositional defiant disorder. The DSM IV (2000 p. 93) defines Conduct Disorder as behaviors that endanger the rights of others, go against societal norms for their age group, and rule violations that are continually occurring. There are two subtypes of conduct disorders; Childhood-Onset and Adolescent-Onset. There are also severity levels of mild, moderate and severe.

In order for conduct behavior to be diagnosed per the DSM IV, a child or adolescent must present at least three of the following behaviors in the last twelve months and one behavior in the last 6 months also causing clinically significant impairment in social, academic, or occupational functioning and present the following from DSM IV (2000, p. 98);

Aggression to people and animals: often bullies, threatens, or intimidates others, often initiates physical fights, used a weapon that can cause serious physical harm to others, physically cruel to people and animals, has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery, and forced someone into sexual activity).

Destruction of property: deliberately engaged in fire setting with the intention of causing serious damage, and deliberately destroys others' property.

Deceitfulness or theft: broken into someone else's house, building, or car, lies to obtain goods or favors or to avoid obligations, and has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)

Serious violations of rules: often stays out at night despite parental prohibitions beginning before age 13 years, has ran away from home overnight at least twice while living in parent or parental surrogate home (or once without returning for a lengthy period), and often truant from school, beginning before age 13 years (p.98).

Conduct Disorder Childhood Onset according to the DSM IV (2000), can be diagnosed if at least one of the diagnostic criteria is present prior to age ten. Adolescent Onset consists of the absence of any of the diagnostic behaviors prior to age ten. There are three levels of severity. Mild severity denotes that there are fewer conduct behaviors exhibited besides those evident to diagnose, and minor harm is done to others. Moderate severity is the middle ground between mild and severe conduct disorder. Severe conduct disorder includes multiple additional conduct behaviors besides behaviors need to diagnose conduct disorder, also behaviors cause considerable amount of harm to others.

The American Academy of Children and Adolescent Psychiatry (2013) reported from their research that is it likely for children or adolescents diagnosed with a behavior disorder will continue to struggle in school, relationships, and employment, if the individual and their family do not participate in comprehensive treatment as soon symptoms above become a pattern. With out treatment the behaviors will more than likely become more severe and the child or adolescent will behave in an anti social manner and break laws.

A treatment comprehensive plan is usually developed by a child and adolescent psychiatrist using information from other professional adults, such as teachers and medical specialists, in the individual's life, to try and determine the cause for the child or adolescent to exhibit persistent behavior disorder diagnostic criteria. Due to the characteristics of behavior disorders, it is difficult to gather information from the individual because they are exhibiting uncooperative behaviors, hence the cause for treatment development. Behavior therapy and psychotherapy are also needed, to provide the appropriate outlet to learn how to express and control the individual's anger. Medication can also be part of the treatment, especially for those with depression, or with symptoms similarly exhibited to those of ADHD.

The other behavior disorder in the DSM IV (2000), which is diagnosed in children and adolescents, is Oppositional Defiant Disorder. Diagnostic criteria for Oppositional Defiant Disorder according to the DSM IV (2000), includes exhibiting at least the following behaviors occurring often for a minimum six months and hinder social, academic, and occupational functioning including the following from the DSM IV (2000);

Losing temper, consistently arguing with adults, actively defies or refuses to comply with adults' requests or rules, purposely annoys people, blames others for his or her mistakes or behaviors, touchy or easily annoyed by others, angry and resentful, and spiteful or vindictive (p. 102).

Typically children and adolescents diagnosed with Oppositional Defiant Disorder do not exhibit aggression towards people or animals, thief, or destroy property, as those with Conduct Disorder would. American Academy of Child and Adolescent Psychiatry (2009) reports;

...girls may show the symptoms of ODD differently than boys. Girls with ODD may show their aggressiveness through words rather than actions and in other indirect ways.

For example, girls with ODD are more apt to lie and to be uncooperative while boys are more likely to lose their temper and argue with adults (p. 9).

The American Academy of Child and Adolescent Psychiatry (AACAP) (2009) recommends a combination of approaches for treating a child or adolescent with oppositional defiant disorder. The treatment consists of parent-management training programs and family therapy, which will help the family learn positive reinforcement techniques and effective discipline methods.

Cognitive problem-solving skills training is a treatment used for all age groups that are receiving treatment for ODD. The AACAP (2009) describes cognitive problem-solving treatment as way of teaching positive ways for the individual to respond to stressful situations. This training's goal is to teach clients to be able to assess situations and respond to them appropriately, since a common criteria for a ODD diagnosis with out prior treatment is that an individual may only know how to negatively interpret and respond to real-life situations.

Social skills programs and school base programs according to AACAP (2009), help children and adolescents improve their school work, and develop more positive relationship skills to interact with their peers. This treatment has the most success if it is conducted in school, or a group setting with other peers.

There are treatment differentials for different age groups according to the American Academy of Child and Adolescent Psychiatry (2009), the best treatment for children under five years old is parent management training and education. Children ages five to twelve have the most success with a combination of individual therapy, combination of school-based intervention, parent-management training, and individual therapy. For adolescents, individual therapy along with parent-management training has been shown to be the most effective form of

treatment.

The last possible treatment suggested by the AACAP (2009) is medication, but is only recommended if the treatments listed above are on going. It has not been proven effective in treating Oppositional Definite Disorder, if used alone. Since many children or adolescents that are diagnosed with ODD, have coexisting diagnoses such as ADHD, Anxiety, and mood disorders. If the medication is successfully helping one of the coexisting disorders, it can benefit the ODD treatment by lessening the behavioral symptoms.

Mood Disorders

Mood disorders essentially include Major Depressive Disorder, Bipolar I and Bipolar II, and Dysthymic Disorder. The diagnostic criteria from the DSM IV (2000 p. 356) for Major Depressive Episode includes at least five or more of the following symptoms to occur simultaneously in the same two-week period and presents differently than the child or adolescents previous functioning. Also a child or adolescent must display at least one symptom in the depressed mood category or loss of interest or pleasure category. These following symptoms from the DSM IV (2000, p. 356) regularly occur nearly every day and can be self reported or observed by others:

Depressed mood most of the day, by either self reporting of feeling sad or empty, this area includes irritable mood for children and adolescents, markedly diminished interest or pleasure in all, or almost all, activities most of the day, significant weight loss when not dieting or weight gain (a change of more than 5% of body weight in a month), in children a failure of expected weight gains, or decrease or increase in appetite, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy feelings of worthlessness or excessive or inappropriate guilt (which may be delusional), diminished

ability to think or concentrate, or indecisiveness, and recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide (p. 356).

Additionally the above symptoms must last for longer than two months and affect social, and educational functioning. A child or adolescents thoughts are preoccupied with morbid worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation. According to the DSM IV (2000 p. 349), a Major Depressive Episode can look like in a child or adolescent is in an ornery or touchy mood, instead of sad and melancholy. It is also common for children to have somatic complaints, and social withdrawal. Adolescents are more likely than children, to experience symptoms of psychomotor retardation, hypersomnia and delusions. Children that are going through puberty can develop symptoms of Major Depressive Episodes if they have already been diagnosed with Disruptive Behavior Disorder, Attention-Deficit Disorders and Anxiety Disorders. Adolescents can also develop co-occurring disorders with Major Depressive Episodes, in addition to the ones in children, there can be an occurrence of Substance-Related Disorders, and Eating Disorders determined by the DSM IV (2000 p. 354).

A Major Depressive Episode is considered to have ended when there are two consecutive months of none of the above symptoms. In order for a diagnosis of Major Depressive Disorder, a child or adolescent must meet the criteria for a Major Depressive Episode and the episodes have occurred more than once with at least a two month separation of no symptoms and the Major Depressive Episode does not turn into a Manic or Mixed Episode referenced in the DSM IV (2000).

The criteria for a Manic Episode per the DSM IV (2000 p. 362) include behaviors that last one week that are abnormally and persistently elevated, expansive, or an irritable mood that

severely hinder social activities, relationships and school functioning. During this period of altered mood, three or more of the following symptoms from the DSM IV (2000) have persisted (four if the mood is only irritable) and have been present to a significant degree:

Inflated self-esteem or grandiosity, decreased need for sleep, more talkative than usual or pressure to keep talking, flight of ideas or subjective experience that thoughts are racing, distractibility, increase in goal-directed activity or psychomotor agitation, and excessive involvement in pleasurable activities that have a high potential for painful consequences, such as impulsivity which shopping, or sexual indiscretions (p. 362).

Manic episodes are the most commonly occur in a person's early twenty's on the rare occasion it occurs in an adolescent it would present it self with psychotic features associated with school truancy or failure, antisocial behavior, or substance use, per the DSM IV (2000 p. 360).

A Mixed Episode is a person who meets the criteria for a Manic Episode and a Major Depressive Episode. A Hypomanic Episode meets the same criteria for a Manic Episode without the delusions or hallucinations, and is not severe enough to effect daily functioning.

Bipolar I Disorder has several categories depending on differential types of episodes. The first Bipolar I Disorder listed in the DSM IV (2000) is Single Manic Episode. This entails of only one Manic Episode and no past Major Depressive Episodes. Bipolar I Disorder with most recent episode Hypomanic includes, having at least one Manic Episode or Mixed Episode and currently in a Hypomanic state that is causing dysfunction in social and educational settings. Bipolar I with most recent Manic Episode includes individual exhibiting at least one Major Depressive Episode, Manic Episode, or Mixed Episode. Bipolar I Disorder with most recent Mixed Episode, includes at least one Major Depressive Episode. Bipolar I Disorder with most recent episode Depressed includes the most recent episode to be a Major Depressive Episode,

and there has been at least one Manic Episode or Mixed Episode. The last Bipolar I diagnosis is an Unspecified Episode, where as the criteria for any of the types of episodes are met except the duration of the present episode is not met. There also has to be a history of at least one Manic or Mixed Episode.

Bipolar II Disorder per the DSM IV (2000) diagnostic criteria requires a history of a Major Depressive Episode and at least one Hypomanic Episode. There never has been a Manic Episode or Mixed Episode, and the individual's mood disturbances are severe enough to affect school and social relationship, and life functioning. Bipolar II consists of depressed moods and no heightened behaviors such as feeling superior as one in a Manic Episode might exhibit. (Bipolar disease in children and teens (easy to read), n.d.), indicates that the children and adolescents diagnosed with bipolar usually receive the same treatments as adults. They recommend different types of psychotherapy, or "talk" therapy. Therapy can help children and adolescents reduce symptoms and gain more skills in creating successful routines. National Institute of Mental Health also recommends that the parents or guardians of children or adolescents with bipolar should participate in the therapy sessions as needed, and follow recommendations by the mental health professionals involved with their child's treatment. There are different kinds of medications to treat bipolar, however due to the chemical make up a person, children and adolescents may react differently to different medications. It is important to have an informed psychiatrist to help the child or adolescent with finding the best medication to treat their complex symptoms.

It is important to add Dysthymic Disorder because it is essentially a general depression disorder. The criteria for Dysthymic Disorder per the DSM IV (2000 p. 380) "includes at least 2 years of feeling depressed more days than not." As discussed above children and adolescents

sometimes exhibit depression as irritable mood and it must last at least one year, there has not been a two-month lapse of symptoms, or qualifications for other mood disorders. The next symptoms must include two or more of the following to be diagnosed with Dysthymic Disorder from the DSM IV (2000, p. 380): "...poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions, and feelings of hopefulness."

An overwhelming amount of information documented that children and adolescents who exhibit characteristics or have been diagnosed with one mental health disorder will likely qualify for an additional mental health disorder. Thus many treatments used to assist in treating mental illness can be beneficial to targeting all mental health concerns.

Aromatherapy

Steflitsch & Steflitsch (2008) quote Buchbauer G.'s *Methods in Aromatherapy Research* (1996), as one definition of aromatherapy is "the therapeutic use of fragrances or at least of mere volatiles to cure or to mitigate or to prevent disease, infections, and indispositions only by means of inhalation" (p. 77). This definition does not address the use of essential oils in message and absorption into the skin and their effect on target organs, which is core use of the oils all over the world.

Definition. Aromatherapy is defined as:

"The use of concentrated essential oils extracted from herbs, flowers, and other plant parts to treat various diseases...more than 100 oils are used by aromatherapists...routes of administration: vapor (steam inhalations), topical (baths, lotions), or internally..."

continuation of information including lists of conditions, disorders, and diseases that it is useful in treating (Segen, J., 1995, p 22-23).

Background. Research by Steflitsch & Steflitsch (2008), supports for several thousands of years, multiple civilizations have discovered how useful aromatic plants have been to cure health problems. According to Steflitsch & Steflitsch (2008), “Phytotherapy is the name increasingly given to the use of the whole, or part, of a plant for medicinal purposes” (p. 75). Aromatherapy is a branch of phytotherapy, which uses essential oils that are produced by distillation and the citrus oils produced by expression (Steflitsch & Steflitsch, p. 75). Steflitsch & Steflitsch (2008), report, “essential and citrus oils can compete with the steroids and antibiotics used in allopathic medicine today without the body’s defense mechanism becoming exhausted or tolerance developing to them” (p. 75).

Aromatherapy is considered to be part of Complementary Alternative Medicine (CAM). The National Center for Complementary and Alternative Medicine (NCCAM) defines ““CAM” as “a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine” (Mann, Gaylord, & Norton. 2004, p 2). Other alternative medicine that is under the CAM spectrum is massage therapy, chiropractic, spiritual and energy healing, relaxation, and acupuncture.

There is a lack of information regarding parent’s feelings of using Complementary Alternative Medicine with their children or adolescents who are exhibiting mental illness characteristics or have been diagnosed with a mental illness. Gad, Al-Faris, Al-Rowis, & Al-Rubkan (2013), found in their study that parents who have used CAM in their personal treatment were six times more likely to use CAM methods on their children. This study did not include aromatherapy with essential oils and did not define why the parents are using CAM treatment with their children.

Regulations and requirements for Aromatherapists

The State of Minnesota has a statute for regulations on complementary and alternative health care (CAM). The coordinates are Chapter 146A. <https://www.revisor.mn.gov/statutes/?id=146A>. The statute denotes that the Department of Health created an Office of Unlicensed Complementary and Alternative Health Care Practice to regulate unlicensed CAM providers and investigate consumer complaints. There currently are no educational or training standards for unlicensed aromatherapists, which are under the complementary and alternative health care definition according to the State of Minnesota.

The Center for Spirituality & Healing at the University of Minnesota's website states that there is no actual licensure for aromatherapists in the United States, nor a national certification. There is a National Association For Holistic Aromatherapy (NAHA), a non-profit organization, providing education and information about aromatherapy. The NAHA has established educational guidelines for training programs. They have required that a person obtaining an aromatherapist certificate at a credited education program must complete 200 hours of training, which includes anatomy and physiology. There are two levels of standard trainings on the NAHA website. The first level is Aromatherapy Foundation I, which requires 30 hours of training and the second level is Professional Aromatherapist Certification, which incumbents the 200 hours of training at a credited educational program. The NAHA also provides information on locations for taking credited course on aromatherapy. The University of Minnesota Center for Spirituality & Healing offers a course that is credited by NAHA, to help students prepare for the Aromatherapy Registration Council (ARC) exam. The ARC provides a national exam that evaluates if individuals have obtained the core knowledge and fundamentals of essential oils and aromatherapy. An individual who passes the exam may at RATM after their name, representing

a registered aromatherapist. The benefits to being a RATM is that potential clients can search for a registered aromatherapist on Aromatherapy Registration Council website. This registration is essentially an additional credential, since the field of aromatherapy is not nationally regulated. There is only RATM in Minnesota, however there are many other practitioners that practice using aromatherapy, but have a different profession. The University of Minnesota offers a Doctor of Nursing Practice in Integrative Health and Healing, which incorporates aromatherapy, but a student of this program would only receive the aromatherapy credentials if they were to apply and take the ARC test, but would have vast knowledge of essential oil uses.

Applicable research on aromatherapy

There is limited research on the application and affects of aromatherapy and this researchers target population. Fowler (2006) conducted research using essential oils on adolescents in a residential treatment center who had been diagnosed with a mental health disorder. Adolescents had the choice of requesting the “calming blend” of oils, which included ylang ylang, sweet marjoram, and bergamot diluted with jojoba carrier oil if they felt agitated. They could choose essential oils with or with out the addition of their prescribed p.r.n. medication prescribed by the physician. If they requested the “calming blend” of essential oils and chose not to take their p.r.n. for agitation or emotional behavioral crisis and “...was not deescalating effectively, as determined through a professional nursing assessment, the necessary p.r.n. medication was administered,” according to Fowler (2006, p. 72). Some instances the use of aromatherapy alone wasn’t enough to effectively decrease an emotional and/or behavioral crisis.

Fowler (2006), researched effective essential oils to use as aromatherapy to help adolescents in a residential treatment program and found multiple essential oils to aid in reducing

negative behaviors with clients. Another study by Lehrner, Marwinski, Lehr, Johren, & Deecke (2005), used lavender and orange odors diffused separately in a dental waiting room to determine if odor would influence the emotional state of a patient. Their clinical study proved that “patients who were exposed to orange order or lavender odor had a lower level of state anxiety, a more positive mood, and a higher level of calmness compared to the patients in the control condition” (p. 94).

Kutlu, Yilmaz, & Cecen (2008) found several articles on studies that validate the using aromatherapy in education, treating emotional problems, and giving support to children with learning difficulties (p. 125).

Conceptual Framework

The purpose of this section is to provide the reader with insight into the professional lens the researcher used while gathering literature and developing research questions to guide the study. The researcher is interested in understanding how professionals are using essential oils and aromatherapy in their work with children and adolescents who exhibit or are diagnosed with the four most common mental illnesses. This researcher is applying the mindfulness theory approach to this research.

Mindfulness can be defined as being aware of experiences in the present moment, with a nonjudgmental open mind according to Izel et al. (2011). Izel et al. (2011) includes a second definition by stating there is two-component model of mindfulness. The first component, in order to gain the most out of the experience, is attention regulation. Izel et al. (2011) reports “...the second component involves approaching one’s experiences with an orientation of curiosity, openness, and acceptance, regardless of their valence and desirability” (p 538).

This researcher will also use the biopsychosocial approach to this research.

Dziegielewski, (2004) defines biopsychosocial as

...approach to health care practice, the “bio” refers to the biological and medical aspects of an individual’s health and well-being; the “psycho” involves the individual aspects of the client, such as individual feelings of self-worth and self-esteem; and the “social” considers the larger picture and relates to the social environment that surrounds and influences the client (p. 130-131).

Children and adolescences that are diagnosed or exhibit mental illness symptoms without treatment will struggle to function effectively in the bio, psycho and social aspects of this approach. This researcher will use this approach to discover if professionals using aromatherapy are able to help children be more successful and functioning in an improved state due to their practices.

It is also important to note that biopsychosocial model of practice is “when all three areas (the bio, psycho, and social) are identified, assessed, and addressed, a biopsychosocial model of practice intervention is implemented. This approach to practice is viewed primarily as the basis for social work practice in the health care area” (p. 131). Most professionals use an assessment tool before treating a client or patient. In social work it is important to gain an understanding of a client as a whole, and what all their needs are. This approach and practice aligns with the use of aromatherapy because aromatherapy can be used many different ways for many different issues.

Methodology

Research Question

This research study proposed the following questions: How are professionals serving children and adolescents exhibiting symptoms of or are diagnosed with a mental health illness utilizing aromatherapy? What is the parental response? How is this therapy effective?

Design

The purpose of this study was to examine the professional attitudes around using aromatherapy on children and adolescents exhibiting or diagnosed with the most common mental health disorders. This researcher used an exploratory design by conducting in-depth open-ended questions to participants in a semi-structured audio-recorded interview lasting approximately 60-90 minutes (see appendix A). By using a qualitative approach to this research, the researcher attempted to get a better understanding of how aromatherapy is being used including what is an effective use and what is not effective while working with children and adolescents exhibiting symptoms of or are diagnosed the most common mental illnesses.

Sample

Data collection will be based on a semi structured qualitative design. The researcher conducted in-depth interviews with health practitioners that use aromatherapy on children and adolescents that have symptoms of or are diagnosed with the most common mental illnesses. This researcher purposed to interview at least ten professionals in order to gain knowledge in this exploratory form of research, however was only able to find four professionals fitting the participant requirements.

This research used snowball sampling in selection of mental health practitioners is based on the responses this researcher received. Snowball sampling per Marlow (1993), is defined as,

“...identifying some members of the population and then having those individuals contact others in the population” (p. 115). The sample population included social workers and psychologists that use aromatherapy on children and adolescents who present with mental health concerns or are diagnosed with the most common mental illnesses. This researcher created an informational hand out detailing the research and the volunteered commitment needed (see Appendix A). A committee member volunteered to email the informational sheet to her colleagues that use aromatherapy and to the head of her school district’s mental health staff to distribute. The committee member also volunteered to send the informational sheet to her sister who works at a hospital and uses aromatherapy, and to have her distribute it to other employees that use aromatherapy on patients.

This researcher sought to exclude professionals that do not use aromatherapy in their treatment with children or adolescents who exhibit or are diagnosed with the four most common mental illnesses, also excluding the use of aromatherapy in the treatment of individuals diagnosed in the Autism spectrum disorder. This research was exploratory to determine how essential oils and aromatherapy are being used and it’s effectiveness.

Protection of Human Rights

This researcher’s application to the Institutional Review Board (IRB) of St. Catherine University, St. Paul, MN before data collection began. All protections were taken to minimize the risks of participation to human subjects in this study. Required confidentiality measures were taken to guarantee safety to each participant throughout and after this research study. Participation in this study was voluntary, and participants were able to withdraw at any point during this study.

This researcher obtained informed consent (see Appendix B) prior to the beginning of each interview. If informed consent was not given from the participant, the interview would not have taken place. The researcher explained that confidentiality would be maintained throughout the entirety of the research study and thereafter, prior to the interview. The researcher explained that during the interview, the researcher would audio record the interview that then would be transcribed as soon as possible and the audio file will be deleted to ensure confidentiality. The researcher additionally explained that any identifying information has been omitted from the transcription. Further, the researcher explained that the information from the interview will be used in the researcher's paper; however, identifying information will not be used.

This research study and the process of the interview was explained to each participant and this researcher will reviewed the informed consent with each participant to ensure that they understand their involvement and their right to terminate their involvement at any time during and after the interview.

Data Analysis

Data was obtained though audio recorded interviews with each participant. This researcher completed a transcription verbatim from each interview. Qualitative data from each individual interview was coded and then content analysis was used to assess the data. According to Berg (2009), the definition of content analysis is “a careful, detailed, systematic examination and interpretation of a particular body of material in an effort to identify patterns, themes, biases, and means” (p. 338). This researcher had a peer review a sample of an interview transcript to code the data, and identify themes throughout the data. This process was preformed to ensure validity of data. After receiving the codes and themes from the peer reviewer, the researcher

then compared the themes and codes as a measure of validity. Once validity was confirmed then the findings of the themes were discussed.

Findings

In this study, the researcher explored how health professionals are aromatherapy with children and adolescents who present with the top four mental illnesses.

This researcher interviewed a total of four professionals. Three of them were school social workers and one was a school psychologist. All of the participants were female and had significant amounts of experience working with children and adolescents that have exhibited symptoms of at least one of the top four mental illnesses. Only one of the participants had what she perceived as formal training from a cosmetology institute. Three of the participants were learning from the first participant.

The researcher asked participants to define aromatherapy. Participant 1 described her definition as: "...a lot of the inhalation of a really good scent and it affects your overall mood, or demeanor in a round about non-scientific way."

Participant two said her definition of aromatherapy is: "I think of using like the essential oils to calm people's mood or provide relaxation."

Participant three described her definition as: "...the use of scents, natural or manufactured to induce a sense of calming or some sort of relaxing effect on clients."

Participant four referenced her definition in accordance to how it is used on students as: "...using oils with students that they enjoy the smell of it to help calm them or give them energy or different uses depending on which oil it is."

One of the requirements of the professional participants in this study was that they worked with children or adolescents. The definition of aromatherapy used in the literature

review section of this paper uses rather specific and scientific descriptors and this researcher feels it is pertinent to get an understanding of how these professional are explaining aromatherapy to their clients.

Participant 1 defined it in the way she would explain it to the students she works with in a special education program as:

...when I'm working with kids I try and explain in really simple terms...I try to always say [where] these [oils] come from. I have this orange essential oil so I say, "this comes from the oil in the skin from oranges so these are the natural scents so these are the pure oil from the plant or the flower. From smelling these scents they sometimes trigger something in our brain or calm our body or give us energy." So I try to talk about more of the effects of it or what it's made out of. I don't call it aromatherapy with the kids...

Participant two referenced her previous answer of: ...using like essential oils to calm people's mood or provide relaxation. And then said she would:

...explain to them that it is an essential oil that can be used for a variety of ways. I would leave it open minded to them. For some people it might relax them or put them to sleep. I would just let them form their own opinion.

Participant 3 states:

"...it's just kind of taught in terms of, we practice different coping strategies and different things so it is just introduced as a strategy um something that can calm your body or your mind. It focuses your senses on a particular smell and maybe can serve as a distractor or just a centering force to help get in touch with their body and focus."

Participant 4 also referenced her previous answer of: "...they enjoy the smell of it to help calm them or give them energy or different uses depending on which oil it is." Then adds: "...and then let them pick what they want to use."

A main aspect of this research study was to explore how aromatherapy was being used with children and adolescents. This researcher asked participants if and how they use aromatherapy with children and adolescents with perceived mental illness.

Participant 1 describes how she uses it with her students:

I use it daily with every single one of my students when I have individual sessions, which I have usually, have from five to ten a day. ...They typically come in and we start our session by picking a scent to put in my aromatherapy lamp. Sometimes they know just right away, "I love lemon" you know they always like lemon or something over time. But a lot of times if it is a brand new student like today I had new kid so I say, "Oh I have this new scent. Do you like orange?" And I will kinda bring it up like, "so this is cool, this oil actually comes from the orange," and I will have them smell it and they will be like, "it smells like real orange" and I say "yeah it's real orange, it's not fake it's real stuff." So sometimes I will pick out a couple of the ones that are popular that I know the teenagers like. Cause some of them they never like, like geranium they never like...
...so I do a lot of the citrus ones or peppermint really safe ones that are familiar smells so kinda start them out with. We will do a sensory journey. I will pick out a couple of them [essential oils] have them [students] close their eyes then have them smell a couple of the scents and then I'll have them pick out the scents that they like the most and then help them kind of figure out which one they like the best. Maybe I will have them put a

couple drops in their hands and then we will take three deep breaths and maybe rub the extra on our necks. That can be one of the ways individually that I do it.

Participant one also leads groups and explains how she uses essential oils in her groups:

... during the yoga group that I run, we have scented towels that we do. I usually bring 3 to 4 per group different scents, I don't want to over whelm them with it, only the popular ones and all different ranges from lavender for calming or citrus for energizing and I will talk about "maybe your body one day likes lemon a lot because maybe you need energy, but maybe one day you don't like it and you like lavender more." It's about teaching about paying attention to their body, that mindfulness component. It's about ok what is my body telling me that I need. I'll go around and have them smell each time and which ever one they like of scents, we'll put a couple drops on their towel and that is what they use for yoga for relaxing at the beginning or end. They will put their towel on their face or behind their head like a pillow. So I adapted it to the students and how to approach it. It is little tweaked each time with each person.

Another main aspect of this research study was to discover what is effective in using aromatherapy with children and adolescents exhibiting symptoms of the top four mental illnesses. Participant one replied:

I think using familiar language to make it safe and I try to be really low key, and to make it comfortable because sometimes it is really weird to kids. I try to normalize it, that's a big thing that I try to do. And I also put it on myself too, so I show or model it first and show how the effects of it are. Then I talk about experience with them that way its kind of modeled, it's safe. Then I will talk about when I use it like maybe if I can't sleep at night or I'm anxious, or if I have a headache I will use peppermint. So that is how I find

it effective in teaching it that way by modeling it, talking about it and not pushing it. Some kids, just the first session might be a little nervous so I like having that as an option. "I have Spotify, we can listen to music, have some tea, I've got my fidget box there, the sand tray, we can play a games or do art, or the really cool scent things." And actually aromatherapy seems to be a very safe thing for them, like less anxiety producing then a lot of other things for them.

Using [essential oils] is almost like building the relationship in away, and I might say "it's very safe you don't have to talk about feelings," because you want to get that foundation [relationship], "and this is a place where you can get a break from class, we can calm their bodies and these are some skills and tools I have." I find it effective if they say that smells really bad, and then I might explain that "that one is for energy and maybe your body's not needing that or I know that these are really strong coming right out the bottle. Maybe we need to put it on a towel or sometimes it is hard to get used to strong scents, some people don't like strong smells and that's ok." You know not shaming them about it and then maybe over time I have seen a lot of kids, one girl in my yoga group, at first she thought they stunk and she is very vocal about it which always kinda makes me nervous, because then are the other kids want to follow and not like them because she doesn't? And now she loves them all, because it was just a matter of finding some different ones [fragrances], and now she has ones she loves and asks for them. Another thing for kids I say, like at the end of yoga, "Now you can take your scent if you want and put a little on your wrist and then if you're stressed through out the day you can smell it, to remind yourself of how calm your body felt in this room. Maybe if you are stressed through out the week and you want something to distract your mind or

calm your body you can ask your staff to bring you down to my office to have the oils.” I have a lot of kids knock on my door saying, “Can I have some lavender? I am really stressed out.” So teaching them to use it in addition to other skills.

There was a lack of research conducted on this topic and this researcher wanted to determine if it was do to barriers that providers were encountering with using aromatherapy with children and adolescents. To determine what obstacles were possibly hindering the use of aromatherapy, this researcher asked participants what barriers they have encountered.

Participant one said:

I haven't really experienced very many barriers, I think it's just like when it's new its like, “this is weird or I am just too scared to try it,” maybe and those I think are the biggest barriers and usually don't last very long and I think it is very normalized in our program and a lot of the kids talk about it or know about it or either kids in the group with be like I love this, or it smells so good. Or even staff will come to ask to use it. It is normalized I think, so creating that climate where it is normalized is good. I think from the get-go I didn't have any problems at all really, so that was nice and I think it's about the approaching it in a safe way using their language and by not pushing it and just saying, “I have this here and it's kinda cool.” A lot of times I don't have them put it on their selves, first I have them put a couple of drops in the lamp and see how they like it then. I've never had any staff say, not to use it and I think it's because it's natural like it's not offensive.

Participant two's response was related to the price of the oils and was attempting to get budget funding to purchase some. She also reported that she didn't run into any barriers using

aromatherapy in her current employment. Participant three's response also included that the price of oils has limited her from purchasing oils. Additionally she reported:

...I think a lack of knowledge and information about it to it seems to some kids like its out there and, "you want me to do what?" And there are kind of closed minded to it because they haven't done more holistic treatments so just opening up their minds to giving them something new to try.

This research study is based on gathering information in practice with minors, it is important to gather information on the professional's interactions with parents and legal guardians regarding permission to use aromatherapy with their child. Participant said:

Actually, we don't get any prior consent because I don't feel that there is a lot of risk with it. It's just something we do a lot of, outside of the box creative things and we're not going to try and get consent for every little thing. We do treatment plans every ninety days, so they might see that their child is in a yoga group and they'll see what we're working on, it won't say specifically aromatherapy in the treatment plan but it's working on calming strategies and we will have them sign off on that, but it's not specifically laid out at all. We have never had a complaint actually. We usually have kids go home and say how awesome [essential oils] are and parents maybe will praise us for that. That's usually all the response we will get.

Participant three similarly responded with:

We haven't gotten formal permission it is always on a voluntary basis of the students it is offered to them the same as walks or back massages or using fidgets it's just another coping strategy that is offered to them so we haven't gotten formal permission for the students. It often comes up in IEP meetings and that kind of thing when we share how

they're doing with their mental health services. And I think a couple of parents have been really interested and asked for more information. ...we haven't had any negative or adverse reactions to it at all. I think it is a gentle enough approach that is not like we're something they feel is harmful or no we haven't had any negative feedback.

All the participants gave an example of the same student, as a story of success. This is one participant's account of how successful aromatherapy and essential oils have been for a student,

...we have a girl that is very mentally ill and has to have two staff with her and her own classroom. She is very violent and has never been in groups but we decided to try her with yoga and she is very anxious being around people and very primitive kind of like an animal and will attack. Because she is so anxious, I didn't want to go around and put the scent up to her nose so what I decided is, I bring a bunch of the scents and take the caps off, and I put the mats in a circle then I put the scents in the center. And so that way everybody do the smells themselves put the scents on the towels themselves and that completely eliminated her anxiety and she comes to group everyday and stays the whole entire time and loves it. And now she has scents in her room. Now she will come to group every day and she participates. It's like a huge success story.

From the participant's responses, it can be concluded that there are not any barriers with serving children and adolescents delivering aromatherapy in the special education program that participant 1 thru 4 work in. A couple of the participants did identify purchasing the oils for their practice is a barrier because of the price. They also thought that since the population of students they work with come from families of lower income, that are deregulated, and have low

occurrences of involvement with the school, most likely are not using essential oils with their children at home.

Discussion

The purpose of this study was to explore professional's use of aromatherapy with children and adolescents who exhibit symptoms or are diagnosed with the four most common mental illnesses, which are anxiety disorders, attention deficit hyperactivity disorder, mood disorders, and behavior or conduct disorders. Since this study was about the effects of clients that are minors, it was pertinent to include the responses from their parents or legal guardians.

There were several themes that emerged with the four participants. They all use the same approach; where they allow the student to choose what essential oil they want to use, wither if it is for needed energy or to relax anxious feelings. Parents are not specifically notified of the use of aromatherapy or essential oils, as it is offered as an intervention along with taking a walk, playing a game, listening to music or guided imagery meditation on an iPad.

The participants in this study referenced the use of the mindfulness theory in approaching the use of aromatherapy and essential oils with their students. The participants encourage students to determine what essential oils they need to regulate their mental illness symptoms. The approach the social workers, and school psychologist are using with essential oils, by having the students identify their own needs, could also be identified as an empowerment approach. "Empowerment seeks to assist clients in making changes that will lead to greater life satisfaction and adjustment, and to establish an increased sense of control over their lives" (Kruger, 2000, p. 428). Kruger (2000) additionally states that psychological and physical well-being are also part of empowerment along with "increased self-knowledge, greater identification with one's own emotions, and an increased ability to exercise control and responsibility for one's life" (p. 428).

Inevitably the goal is for children and adolescents with mental illness is to be able to learn how to cope and function up to their highest potential in school and their daily life.

This researcher choose the topic of the use of aromatherapy with children and adolescents with mental health concerns because of personal experience with mental health and finding additional resources besides medication and therapy to address the biopsychosocial imbalance within. This researcher was in search of health professionals that were conducting assessments with children and adolescents, who were exhibiting or diagnosed with mental illness, and then directing the child or adolescent to use a certain category of essential oils, like prescribing medication.

Implications for social work practice

The research conducted for this paper provides evidence that aromatherapy used with gentle education speaking in a way that children and adolescents understand, can be a positive intervention for children and adolescents that attend a federal setting level four emotionally behavior disturbed program. The children and adolescents in this program have been receptive of the empowerment and mindfulness approach using essential oils. With such a positive response, the practice of aromatherapy should be integrated in other programs that work with children and adolescents with mental illness. In order for other social workers to add this intervention into their tool kit, it would be pertinent for them to go through aromatherapy training. The training should include the professionals learning about a sensory journey, which would include that they would experience the journey, themselves. A sensory journey as discussed by one of the participants is basically an exploration of inhaling different essential oils and thinking about how they make you feel. The education must include information about the

difference between natural oils and synthetic fragrances, and incorporate information on how to find quality essential oils.

Implications for social work policy

There could be potential policy issues with using aromatherapy with clients. Many businesses are now enforcing a fragrance free environment. This is due to people have allergies to fragrances, mostly synthetic fragrances that are added to lotions, perfumes, and hair products. Even though essential oils are natural, some people have allergies to natural plants, which the oil is derived from.

Currently there are no state laws requiring an aromatherapist to be licensed. There only are general regulations from the State of Minnesota regarding unlicensed Complementary Alternative Medical professionals, which includes practitioners that are using aromatherapy. It does not include any training requirements, or qualifications. This implies that anyone can use aromatherapy and essential oils, if they purchase supplies.

Essential oils are available in many natural food stores, through direct selling companies, and other holistic type shops. This availability of oils allows anyone to purchase them. There are no guidelines or regulations, such as involvement from the Food and Drug Administration, which would require a certain level of quality of production of oils. Having regulations and standards for essential oil quality would certainly help clear out the companies that are claiming to be producing essential oils, but have large amounts of synthetic ingredients in them. Since aromatherapy is using essential oils by inhalation, direct skin application, or orally, the oils will be in contact with body systems, which is why it is important to use the highest organic quality of oils, to ensure the best possible results.

Implications for social work research

There is much needed research to be done in the use of aromatherapy with children and adolescents with mental illness. There also needs to be studies done that gather responses directly from the children and adolescents using this intervention. The participants in this study did not have enough information on parental response to this intervention, thus creating an additional need research to be conducted. In general there is a lack of qualitative research on aromatherapy with any client.

Strengths and limitations

This researcher initially thought that a health professional should choose an essential oil for a client based on their symptoms that they are presenting in a session. This research has given the researcher a new understanding of how aromatherapy can be used with clients with mental illness. The way the participants have identified using the essential oils with their clients has shown an effective way children and adolescents with mental illness can take an active empowering role in their lives.

This study was limited by only getting four participants all from the same agency. This may create some bias in results. However, this researcher spent months searching for professionals that fit the qualifications. This shows that aromatherapy with children and adolescents with mental illness, is not a common or known intervention. Additionally research on the effectiveness on children and adolescents would have been richer if this researcher was able to directly question the subjects. The allotted nine months to conduct the research for this project was feasible amount of time to gain approval from the Institutional Review Board, and to develop a valid measurement tool.

Conclusion

This research has further confirmed that the use of aromatherapy with children and adolescents with mental illness is successful if used with a mindfulness and empowerment approach. This researcher will continue exploring aromatherapy by attending classes and become a registered aromatherapist, in order to feel confident in using it in practice. The more exposure this alternative or supplemental treatment gets, the greater the chances regulations by the government will be developed, so that quality can be controlled. This research project was meant to expose aromatherapy in a way that is helpful to social workers. This project has already influenced several people this researcher has come in contact with, that are now contemplating using essential oils as an intervention for clients, and for stress relief for themselves.

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Appendix A

Explanation of Research

You are invited to participate in an exploratory research study of how you use essential oils and aromatherapy with children and adolescents exhibiting or diagnosed with the top four most common mental health disorders. This includes; ADHA, anxiety disorders, behavior/conduct disorders, and mood disorders. Requirements are that you are in the mental health field and use essential oils and aromatherapy in practice with children and adolescents with the above diagnostic criteria, to participate in this study.

Background Information The purpose of this study is to determine how mental health professionals serving children with mental health conditions or emotional behavior disorder utilize aromatherapy, how it is effective and what is the parental response.

The study is being conducted by: Emily Laconic under supervision of Lisa Kiesel, LICSW, Ph.D. from the St. Catherine University Social Work Program.

Procedures If you agree to participate in this study I will conduct a semi structured 30-minute audio-recorded interview.

Confidentiality This researcher will assure confidentiality/anonymity of participants. Participants information will be coded with a key to subject's identity locked in a separate location. The research study will be published in the St. Catherine University Library. In the research study, this researcher will not include information that will make it possible to identify you in any way. This researcher will follow confidentiality guidelines by ensuring all data is permanently destroyed after analyzed.

Voluntary Nature of the Study Your participation in the study is voluntary and you are free to withdraw at any time during the interview process.

Risks and Benefits of being in the Study No inherent risks associated with participation in this study have been identified. The benefit result of this study will contribute to better understanding the use of aromatherapy with children with anxiety and emotional behavior disorders.

Contacts and Questions The researcher conducting this study is Emily Laconic. She can be reached by email at laco9849@stthomas.edu.

Appendix B

Professional's use and methods using aromatherapy with children and adolescents with the most common mental health concerns or diagnoses**INFORMATION AND CONSENT FORM****Introduction:**

You are invited to participate in a research study investigating professionals use of aromatherapy with children and adolescents with present with or are diagnosed with the most common mental health disorders, which are anxiety, ADHD, conduct/behavior, and mood disorders. This study is being conducted by Emily Laconic a graduate student at St. Catherine University under the supervision of Lisa Kiesel, a faculty member in the Department of Graduate Social Work. You were selected as a possible participant in this research because you use aromatherapy with children and adolescents in your practice. Please read this form and ask questions before you agree to be in the study.

Background Information:

The purpose of this study is to discover how professionals are using aromatherapy with children and adolescents exhibiting symptoms or are diagnosed with the four most common mental health diagnoses, and how effective it is. Approximately 10 people are expected to participate in this research.

Procedures:

If you decide to participate, you will be asked to answer questions in a semi structured qualitative audio-recorded interview, which will last approximately 30 minutes in one session.

Risks and Benefits of being in the study:

The study has no risks.

There are no direct benefits to you for participating in this research.

Confidentiality:

Any information obtained in connection with this research study that can be identified with you will be disclosed only with your permission; your results will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented.

I will keep the research results in a locked file cabinet in my home and only I and my advisor will have access to the records while I work on this project. I will finish analyzing the data by May 24, 2014. I will then destroy all original reports and identifying information that can be linked back to you.

Voluntary nature of the study:

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with St. Catherine University in any way. If you decide to participate, you are free to stop at any time without affecting these relationships.

Contacts and questions:

If you have any questions, please feel free to contact me, Emily Laconic at 612-619-0447. You may ask questions now, or if you have any additional questions later, the faculty advisor, Lisa Kiesel at 651-690-6709, will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher, you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739.

You may keep a copy of this form for your records.

Statement of Consent:

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study at any time.

I consent to participate in the study and agree to be audio taped.

Signature of Participant

Date

Signature of Researcher

Date

Appendix C

Interview questions

1. What is your role with your current employer?
2. What is your experience working with children and adolescents exhibiting or diagnosed with the top four mental illnesses?
3. What is your definition of aromatherapy?
4. How were you trained or prepared to provide aromatherapy?
5. Do you currently use aromatherapy in your practice, if so in what ways?
6. What do you find effective about using aromatherapy when treating clients?
7. What are some barriers to using aromatherapy?
8. How do you inform parents of this form of intervention and what is their response?
9. Do you think families are doing this at home? Do you think the children are practicing aromatherapy at home?