INTEGRATING COMPLEMENTARY THERAPIES WITH COUNSELING:
A QUALITATIVE STUDY OF PRACTICING
COUNSELORS’ APPROACHES TO WELLNESS

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Abstract
There is a growing interest in the United States in complementary therapies (CT) to address the health needs and hopes of individuals. Research in the medical and allied health communities has reflected the expanding interest, however, the counseling profession has limited literature focusing on CT integration practices. The current study expands on existing research using a constructivist lens and grounded theory approach; a sample of 16 practicing counselors were interviewed to develop a theoretical model of CT integration in the counseling context. Scholarly literature has described CT and reasons for its use, which can be linked to counseling through professional identity, the wellness model, and ethical practice. The results of this study indicate that experience, beliefs, competence, and practice are primary factors in the integration of CT in counseling. Implications of the results on the counseling profession will be detailed in terms of practice, training, and future research.
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Chapter 1

INTRODUCTION

Health and healing in the United States has increasingly focused on the expanding interest to integrate multidisciplinary techniques to achieve optimal wellness (Astin, 1998; Chopra, Ornish, Roy, & Weil, 2009; Coulter & Willis, 2007; Eisenberg et al., 1998; Hildreth & Elman, 2007; Kiefer, Pitluk, & Klunk, 2009; Roy, 2002). This research explores how and why practicing counselors are integrating complementary therapies (CT) into counseling sessions. Often referred to as complementary and alternative therapies (CAT) or medicine (CAM), complementary therapies focus on the use of these approaches in conjunction with conventional practices (Berman & Straus, 2004). My research focus is on complementary techniques, not those used as alternatives, to illuminate the collaborative opportunity to create effective counseling practices.

In the U.S., CT are identified as those approaches that fall outside of conventional methods of addressing health, such as yoga, chiropractic, massage, and homeopathy (Institute of Medicine, 2005; National Center for Complementary and Alternative Medicine [NCCAM] 2012). Conventional or Western medicine is identified as the mainstream orientation to understanding and responding to health and healing needs. Divergent from this medical or problem focus, complementary therapies utilize a wellness or holistic perspective to health. Using counselor professional identity, the wellness model, and ethical practice as lenses informing the significance of this study, I explored complementary approaches and their integration in the counseling session. It is important to recognize the profession’s focus on responsive practices for clients. In 1962, Gilbert Wrenn, responding to rapid globalization and change, challenged
counselors to look outside of their “cocoon’s” and at the various truths that exist for individuals.

Each day we should question something that we believe but that other people of integrity may reject... The thing that we believe in deeply may be something that someone else has every right not to believe. (p. 448)

CT are approaches to health that many diverse individuals believe in and use to address a large scope of concerns. Therefore, my exploration of CT integration seeks to avoid cultural encapsulation. With little research illuminating how and why counselors are integrating complementary approaches in client sessions, my study used grounded theory methodology to explore practices by identifying categories from interviews with practicing counselors.

Statement of the Problem

Literature regarding the use of CT within the medical professions provided me with a great deal of insight into individual as well as practitioners’ perspectives and practices to address health concerns (Baumrucker, 2002; Ben-Arye, Frenkel, Klien, & Scharf, 2008; Bishop, Yardley, & Lewith, 2007, 2008; Hsiao et al., 2005; Hsiao, Ryan, Hays, Coulter, Andersen, & Wegner, 2006) including, but not limited to, chronic pain, arthritis or rheumatism, severe headaches, digestive problems, and diabetes (Astin, 1998; Berman, Bausell, & Lee, 2002; Caspi, Koithan, & Criddle, 2004; Eisenberg et al., 1998; Sirois & Gick, 2002). Within this literature, Astin (1998) and others also identified various mental health issues such as addiction, but particularly anxiety (Bishop et al., 2008; Caspi et al., 2004; Eisenberg et al., 1998) and depression (Bishop et al., 2007; Eisenberg et al., 1998) as providing motivation to pursue CT. Numerous studies outside
of counseling have also focused on complementary therapy use with individuals coping with mental health concerns (Collinge, Wentworth, & Sabo, 2005; Horowitz, 2009; Kabat-Zinn et al., 1992; Milligan, 2006; Ossebaard, 2000; Pilkington, Kirkwood, Rampes, & Richardson, 2005; Sharp, Hurford, Allison, Sparks, & Cameron, 1997; Tsang, Fung, Chan, Lee, & Chan; 2006; Weze, Leathard, Grange, Tiplady, & Stevens, 2007; Woolery, Myers, Sternlieb, & Zeltzer, 2004).

Resurgence of medical interest in psychoneuroimmunology or how psychological factors impact immune function (Kiecolt-Glaser, McGuire, Robles, & Glaser, 2002) and use of the biopsychosocial model in medical research, or how the physical, mental, and social dimensions of an individual influence health (Alonso, 2004), have challenged traditional biomedical approaches to focus on healing possibilities from holistic practices. Kaplan and Coogan (2005) also discussed application of the biopsychosocial model, but in the context of the counseling profession, signifying interest in finding approaches counselors can use to connect the various aspects (e.g., mental, physical) of an individual.

I found detailed information from the Centers for Disease Control and Prevention (Barnes, Bloom, & Nahin, 2008) on the increased use of mind–body therapies reinforced earlier research demonstrating the widespread use of CAM or CT in the U.S. Three out of the six most commonly used therapies identified by Barnes et al. were mind-body approaches (i.e., deep breathing exercises [12.7%], mediation [9.6%], yoga [6.1%]). Information is limited, however, regarding how counseling professionals, important members of the helping professions, are addressing the needs and interests of individuals. More directly, it is unclear how counselors are providing opportunities to integrate multiple therapies, particularly the increasingly utilized area of mind-body approaches, in
pursuit of effectively addressing wellness and clients diverse needs.

Research in counseling has sparse information extrapolating how and why CT are implemented in practice (Baruch-R nylon, 2009; Evans, Valadez, Burns, & Rodriguez, 2002; Lumadue, Munk, & Wooten, 2005). Although Collinge et al.’s (2005) pilot study showing client’s increased satisfaction and perceived change based on using integrative techniques (i.e., massage, acupuncture, reiki, healing touch) in a local community mental health practice, those practitioners were identified as psychotherapists, not counselors. The primary identification of complementary techniques in existing counseling literature is explored in terms of understanding indigenous practices of clients and self-care opportunities for counselors and counselors in training, outside of the counseling session (Chambers Christopher, & Maris, 2010; Chandler, Bodenhamer-Davis, Holden, Evenson, & Bratton, 2001; Chrisman, Chambers Christopher, & Lichtenstein, 2008; Constantine, Myers, Kindaichi, & Moore III, 2004; Herring, 1997; Lee & Armstrong, 1995; Lee, Oh, & Mountcastie, 1992; Lumadue, et al., 2005; Rothaupt, & Morgan, 2007; Schure, Christopher, & Christopher, 2008; Shapiro, Brown, & Biegel, 2007; Solomon & Wane, 2005; Yeh, Hunter, Madan-Bahel, Chiang, & Arora, 2004). CT is highlighted in the professional counseling literature, however, there remains limited research exploring the integration process in sessions. As a result of this absence, my questions remained unanswered regarding its current and future utility to the profession.

Information focused specifically on the integration of CT within the counseling session has been limited to a few empirical studies (Baruch-R nylon, 2009; Evans et al., 2002; Winfield, 1983). More common in the literature are brief theoretical articles and personal anecdotes and endorsements of how such therapies complement counseling
The early publications by Danskin and Walters, Henschen, and Sarnoff detailed the creative use and potential benefit of biofeedback in counseling sessions with clients based on personalities and needs. Most recently and closely related to my study, Christenson compiled the perspectives of several counselors implementing various mind-body techniques focused on assisting clients’ wellness pursuits. The literature surrounding integration uses various approaches to delineate the use of complementary modalities, but a great deal of detail is missing from their articles; it remains to be empirically understood how and why counselors have integrated CT with counseling to meet their various goals or objectives.

With only surface understanding of how complementary approaches are perceived and used in the counseling profession, my aim is to continue to explore and expand awareness of integration practices to guide approaches to training, practice, and research in counseling. Grounded theory, stemming from research intending to illuminate individuals’ experiences living with chronic illnesses, reinforces its compatibility with understanding perspectives regarding wellness approaches (Glaser & Strauss, 1967; Strauss & Corbin, 1997). To construct theory about the future utility of complementary approaches integrated with counseling, it is critical to gain a detailed understanding of current counselors’ integration practices of CT with counseling including the factors influencing them. Guided by a constructivist paradigm, employing qualitative methodology lends itself to developing understanding through the observations, interactions, and materials surrounding an issue (Charmaz, 2006; Guba & Lincoln, 2005; Hays & Wood, 2011; Patton, 2002; Ponterotto, 2005). Qualitative research allows for the
emergence of data, rather than the controlling of data through the use of specific variables (Lincoln & Guba, 1985). Without limiting the possibilities of what could be identified, qualitative methods and grounded theory methodology allow data to emerge, while systematically collecting and coding that information to ultimately develop a core category, providing an integrative theory on the topic of interest (Fassinger, 2005; Strauss & Corbin, 1998; Vogel, Epting, & Wester, 2003). A great deal of research supports why people are seeking out CT, but modest amounts of empirical research have illuminated why and how counselors are incorporating these techniques. This line of research could also inform continued exploration of the effectiveness of these techniques for clients, particularly those from diverse backgrounds for which traditional approaches may not be culturally responsive or effective.

**Research Questions**

The questions guiding my research were:

1. How are practicing counselors integrating complementary therapies (i.e., mind-body approaches) into counseling sessions?

2. How do various factors influence counselors’ knowledge, attitudes, and behaviors towards complementary therapies?

3. How do counselors perceive counseling effectiveness with clients when complementary approaches are integrated into the session?

These guiding questions permitted participants to describe and detail their experiences allowing categories to emerge and using their words as support, rather than imposing my theoretical ideas on them (Bryant & Charmaz, 2007; Charmaz, 2006; Dey, 1999; Rubin & Rubin, 2005). The broad questions allowed me to explore the counselors’ worldviews
and the potential influences on their orientation, influencing their current approach to working with clients. As a profession ascribed to holistically addressing the wellness of an individual, the veiled discussion of CT integration within the profession signals a need to explore real world practices so steps can be taken to further research, training, and practice rooted in professional standards. Acknowledging the interest of counselors and clients to find creative and effective ways to address wellness needs, I believe the profession needs to take notice of increasing trends towards integrative health care.

The use of qualitative methodology requires that before all else, as the researcher, I assess my background and assumptions related to the issue (Fassinger, 2005; Hunt, 2011; Kline, 2008; Marrow, 2005). As a counselor committed to the goals of the profession, my investment in this study stemmed from personal, professional, and academic experiences. As an individual diagnosed with a chronic illness over 14 years ago, I have explored a variety of complementary therapies (e.g., biofeedback, applied kinesiology, energy therapies, homeopathy, acupuncture, chiropractic) to meet my needs and my changing beliefs toward achieving wellness.

My illness led me to interact with other individuals coping with the same or other chronic diseases reinforcing the impact information and opportunity can have on how individuals choose to address their health. Also, as an athlete from childhood through college, I also encountered a number of individuals focused on the mind–body connection and the various techniques (e.g., imagery, breathwork, mindfulness, yoga, biofeedback) being utilized to increase physical performance. Although raised in a community and family that did not seek interventions outside of traditional Western medicine, because of interactions and information I have collected over the years,
combined with increasing interest and involvement of family and friends in complementary approaches, I have recognized the potential of these techniques for various individuals. As a counselor with personal and professional experiences with CT, I have witnessed the impact an integrated approach can have on clients with a broad range of needs.

Taking a humanistic orientation, as a practicing counselor, I have integrated the use of various complementary, mind-body therapies in sessions with several clients (i.e., biofeedback, energy therapies). My professional approach of integrating techniques stems from my personal background as well as the knowledge and skills I have gathered through formal and informal professional and academic events (e.g., conference sessions, listservs, classes, institute participation). Because of my clear support of exploring appropriate integration of complementary therapies with counseling sessions and being a member of the counseling profession, my bias provided a knowledgeable lens to the study, but required a great deal of reflexivity to minimize the limitations the bias could have posed to the conceptualization, overall design, and execution of the study (Fassinger, 2005; Hunt, 2011; Kline, 2008; Marrow, 2005). Throughout this research study, I relied on academic literature, while being reflexive of my experiences and position. This chapter provides insight into the lack of knowledge surrounding the integration of CT in counseling, the guiding questions, benefit for the counseling profession, and definition of terms for the study.

**Significance of the Study**

As the research has demonstrated, individuals in the United States have increasingly gravitated towards CT to address health concerns for various reasons
including, but not limited to, individuals’ beliefs, health status, personality, and certain socio-demographic factors (e.g., gender, education, income; Astin, 1998; Bishop, Yardley, & Lewith, 2007; Caspi, Koithan, & Criddle, 2004; Eisenberg et al., 1998; Hildreth & Elman, 2007; Sirois & Gick, 2002). The rationales for CT use distinctly overlay with the wellness approach of the counseling profession, yet there is little counseling research identifying or exploring integration in practice. Studying CT integration in the counseling session is important for several reasons. First, alignment of professional identity definitions with actual practices is critical to reinforce the wellness orientation of counseling, separating it from other mental health professionals (e.g., psychologists, psychiatrists). Thus, studying counselors applying CT in combination with counseling may help us to understand how, while using other methods, they are addressing the wellness of clients. Secondly, the wellness model has been emphasized by the profession as a way to holistically address the various areas of individuals’ lives impacting their functioning. The model focuses on counselors’ understanding clients’ diverse worldviews and the appropriateness of exploring various tools and approaches to achieve wellness. Lastly, an integral part of professional identity is practicing within an individual’s competence; the ethical standards counselors commit to following present a layer of complexity to integrating complementary therapies within the counseling session. Without understanding why and how techniques are applied, it is difficult for the profession to develop a position on the topic. Gaining information into why and how counselors integrate CT can provide insight into the responsibility and responsiveness of current practices, and demonstrate opportunities for counselors and clients in the future, by exploring the connection to counseling professional identity, the wellness model, and
ethical practice.

**Professional Identity**

Unification of counselors surrounding professional standards remains a challenge due to differences in areas such as training, philosophy, certification, and specialty (Gibson, Dollarhide, & Moss, 2010; Kaplan & Gladding, 2011). The American Counseling Association (ACA) and the Council for Accreditation of Counseling and Educational Related Programs (CACREP), however, have taken steps to bridge the divisions (Calley & Hawley, 2008; Cashwell, Kleist, & Scofield, 2009; Gale & Austin, 2003; Hanna & Bemak, 1997; Kaplan & Gladding; Mellin, Hunt, & Nichols, 2011; Myers, Sweeney, & White, 2002; Swickert, 1997). In a recent qualitative study, Mellin et al. found participants (i.e., counselors) identified themselves professionally by (a) their daily roles (e.g., teacher, consultant, supervisor, advocate) and the various approaches they use to facilitate clients making changes in their lives, (b) graduating with master’s-level training in an accredited program and earning professional credentialing or licensure (e.g., NCC, LPC) while engaging in continuing education and professional organizations, and (c) a wellness and developmental focus in their work. Part of cultivating professional identify is recognizing the impact of those three emergent themes and how personal and professional experiences influence the approach to and the practices of counseling.

The utilization of CT as self-care strategies explored within counseling programs has been shown to influence counselor-trainees perceptions of how complementary techniques could be transferred to future clients (Schure, Christopher, & Christopher, 2008). Information collected from a pilot of this study investigated counselors’
perceptions of wellness approaches and identified personal experience with complementary approaches as influential to expanding counselors’ awareness of their personal beliefs and the influence on professional disclosure or integration of such practices (Nichols, in preparation). Three of the four counselors from the focus group in the study discussed various mind-body practices they personally used or had confidence in but did not speak of professionally because of the potential negative consequences it could have (e.g., seen as “crazy,” not scholarly or empirically valid) on their professional identity. All four counselors agreed that using complementary modalities had made a significant, positive effect on their lives. These participants, however, noted attaching to various approaches outside of standard counseling practices could lead to negative perceptions of competence, labeling, and potential ostracization by other counseling professionals – powerful words supporting a need for continued research giving voice to the area. Using complementary therapies demonstrated the opportunity for counselors to better understand themselves, yet we have little understanding of how counselors are translating their knowledge and skills by using these approaches for client growth.

The Wellness Model

Responsiveness to the diverse needs of clients, regardless of their worldview, is grounded in the concept of wellness, which is a critical goal of the profession. The Indivisible-Self (IS-Wel; Meyers & Sweeney, 2008) model, uses the self as the foundation with five areas (i.e., creative, coping, physical, essential, social) infused with the self-core. The holistic focus of the model, demonstrating the interconnectedness of each component, provides insight into how many counseling professionals perceive the concept of wellness. Recognizing the uniqueness of each client, while valuing client
connections to different groups and belief systems, the wellness model links counseling to the many rationales behind the use of complementary therapies (Degges-White, Myers, Adelman, & Pastoor, 2003; Hattie, Myers, & Sweeney, 2004; Myers & Sweeney; Myers, Sweeney, & Witmer, 2000; Solomon & Wane, 2005; Witmer & Sweeney, 1992). Barnes (1996) reiterated how cultures provide a context for how health and behaviors surrounding health are defined or how culture influences each individual’s perspective of healing and wellness. The importance of counselors’ awareness of their own and client’s multicultural perspectives also reinforces the significance of multicultural competence (Constantine, Hage, Kindaichi, & Bryant, 2007) and the integration of culturally appropriate complementary therapies in the counseling process (Solomon & Wane). Applying the wellness model gives counselors another opportunity to meet the diverse needs and desires of clients while aligning with their professional orientation and standards.

**Ethical Practice**

The ACA *Code of Ethical Standards of Practice* (2005) defines the standards of practice for professional counselors. How counselors interpret and follow these standards, in relation to introducing other techniques outside of traditional counseling practices (i.e., talk therapy), has created uncertainty, particularly in the area of liability (Evans et al., 2002). The *Code of Ethical Standards of Practice* (2005) distinctly addresses professional responsibility (i.e., Section C) and the boundaries of competence or practicing within the scope of an individual’s training and expertise, but how does ACA account for the breadth of techniques used in sessions? For example, what about an individual who is trained in Reiki and uses it in conjunction with counseling; is she or he
seen as practicing with the scope of her or his abilities blending two specialties? In comparison, what of the physician trained in both medicine and mindfulness (e.g., Jon Kabat-Zinn); both could be practiced separately, but the combination of knowledge makes that physician uniquely able to treat a patient’s stress that is viewed as contributing to other ailments. Similarly to the wellness model’s attention to the cultural context of clients and what approaches might be appropriate given their worldview, ethics can also impact the approaches implemented (Arredondo & Toporek, 2004). Understanding how and why counselors are using complementary therapies in session can provide a foundation to identify how various practices of counselors are meeting the standards for the profession.

Definition of Terms

How and why practicing counselors are integrating complementary therapies into counseling sessions introduces several main terms, which will be defined for the purposes of this proposed exploration. With expansive and contested definitions, CAM/CAT/CT (e.g., energy based, mind-body practices), professional identity, and wellness will be detailed. Although some terms are generally understood within the counseling profession, the definitions listed should be applied throughout the remainder of this dissertation.

Complementary Therapies

Increasing research in the medical community has led to the most widely used term, complementary and alternative medicine (CAM), to identify holistic approaches but there is no universal definition. Throughout the literature, CAM is identified as interventions that are not embraced by conventional or Western medicine because there is
not substantial empirical evidence to support their effectiveness (Berman, & Straus, 2004; Coulter & Willis, 2007; Goldrosen & Straus, 2004). Many therapies, however, have been scientifically documented as effective, both medically and economically (Chopra et al., 2009; Roy, 2002), while others continue to confound scientific explanation and endorsement (Evans et al., 2002). Regardless of rationale, individuals more often use these approaches as supplements to other conventional or mainstream practices rather than in place of them (Phalen, 1998; Sirois & Gick, 2002), however, CAM is still the terminology most commonly used to refer to the extensive list of therapies. Terms such as integrative health or integrative medicine (Kiefer, Pitluk, & Klunk, 2009; Phalen) and whole person healing or medicine (Roy, 2002) are also synonymous with CAM.

Coulter et al. (2007) cited the definition of CAM from NCCAM as “a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine” (Institute of Medicine, 2005, p. 17). For purposes of the current literature review, CAM, which is the term widely used in research on this topic because of the medical focus, will be referred to as complementary and alternative therapies (CAT). Lumadue et al. (2005) adapted the CAM definition to focus on the mental health implications of these approaches by identifying “those therapeutic practices that fall outside of established traditional realm of medical, psychiatric, and psychological practice” (p. 13). The distinction between calling these practices therapies instead of medicine ascribes to the methods’ holistic and wellness intention, as opposed to a strictly pathological perspective. Additionally, this proposal will focus on complementary approaches, not those used as alternatives; complementary signifying the use of Eastern therapies that integrate with Western practices, alternative identifying what
is used in place of conventional treatments (Berman et al., 2004). Focusing on complementary therapies (CT) is necessary to concentrate on the collaborative and integrative approach to effective counseling practices.

NCCAM currently groups CT into four categories: natural products (e.g., herbal or botanical, vitamins, minerals), mind-body medicine or practices (e.g., meditation, acupuncture, yoga, qi gong), manipulative and body-based (e.g., chiropractic, massage), and other practices (e.g., movement therapies, traditional healers, energy fields, whole medical systems such as Ayurvedic medicine). Some therapies can be identified with multiple groups such as qi gong, Reiki, and healing touch, which are seen as energy practices but are also identified as mind-body practices (NCCAM, 2012). Counselors integrating complementary therapies within the mind-body practices (i.e., by their and NCCAM’s definition) will be the focus of this research study.

**Professional Identity**

The development of professional identity is a core issue in the counseling discipline (Gibson et al., 2010; Kaplan & Gladding, 2011). As Gibson et al. identified, the themes of professional identity, in general, surround self-imposed labels, attitudes and skills, and contextual perceptions within the professional community. Using their definition, stemming from Nugent and Jones (2009), Gibson et al. defined “counselor professional identity [as] the integration of professional training with personal attributes in the context of a professional community” (p. 21). As they described, individuals take their own values and perceptions into professional training, therefore integrating professional roles, decisions, and standards to construct an identity dictating how they will navigate their professional community. The complexity of the various identities
counselors hold, some based on the counseling environment (Kaplan & Gladding), pose a challenge to identify what roles and standards apply to whom. As the counseling literature surrounding professional identity will demonstrate, 97% of counseling organizations (i.e., all except the American School Counseling Association) ascribe to a shared vision with aims and responsibilities focused on wellness (Kaplan & Gladding).

**Wellness**

People practicing within the counseling profession identify with a wellness orientation to helping (Myers & Sweeney, 2008; Myers, Sweeney, & White, 2002; Myers et al., 2000; Myers & Willard, 2003; Roscoe, 2009). Wellness in counseling, and for the purposes of this research study, is defined as “a way of life oriented toward optimal health and well-being in which mind, body, and spirit are integrated by the individual to live more fully within the human and natural community” (Myers, Sweeney, & Whitmer, 2000, p. 252). Focused on holistically addressing health, Myers and Sweeny (2008) developed the Indivisible Self Model of Wellness (IS-Wel) using a number of components to examine the creative, coping, social, essential, and physical selves within each individual. The IS-Wel will be used to further explore the complexity of counselors adhering to the wellness of clients by integrating complementary approaches.

Through clear articulation of the terms and literature surrounding the integration of complementary approaches into counseling sessions, this research will demonstrate the need within the counseling profession to explore the details of its practice. Proclaiming a foundation in wellness, counseling lacks detailed information demonstrating how practitioners are executing this holistic orientation. Supported by data collected from a broad scope of disciplines, this study provides support for the exploration of
complementary therapy integration in the counseling profession.
Chapter 2

REVIEW OF THE LITERATURE

Ponton and Duba (2009) gave voice to understanding the purposefulness of our profession or “what is the existential need of society that has called the profession of counseling into being?” (p.118). Advocating for the welfare of clients was identified as one of the main principles needed to propel the profession into the future by the delegates from 29 of the 30 counseling organizations at the 20/20: A Vision of the Future (Kaplan & Gladding, 2011) and identifiable throughout our professional codes and actions (Arredondo & Toporek, 2004; Corey, Corey, & Callanan, 2007). In their discussion of the barriers to forming an identity in counseling, Bemak and Hanna (1998) emphasized the need for counselors to shift from a traditional, Western psychological practice of individual focus to the various relationships and communities that clients interface with and rely on (Hanna and Bemak, 1997). In other words, responsiveness to diverse needs has become synonymous with effective counseling practice and current practices do not satisfy the scope of client needs (Helms & Cook, 1999; Pedersen, 1991).

As the counseling profession continues to advance a wellness orientation, the growing interest and use of what has been widely identified in the United States as complementary and alternative medicine or therapies (CAM, CAT), or for the purposes of this research study, complementary therapies (CT), supports the need for understanding its relationship with current counseling practices (Astin, 1998; Eisenberg et al., 1998; Lumadue, Munk, & Wooten, 2005). The increased attention, interest, and use of CT in the U.S. points to a pivotal opportunity for counselors and the profession to rethink how the profession is responding to the demands of society and effectively
meeting the needs of clients. As Ponton and Duba (2009) stated, “the counseling profession continues to develop through its attention to the needs of society…Consequently, the counseling profession will also continue to alter its services and interventions” (p. 121). As previously detailed, the intention of this study is not to understand approaches used in isolation, but in conjunction with conventional approaches (e.g., traditional talk-therapy), therefore, the focus is on complementary rather than alternative techniques (Berman & Straus, 2004). Defined by its “Western” medical practices, according to the 2000 U.S. census, the population contains approximately 65 million persons belonging to ethnic and racial minorities. As immigration rates and globalization increase, the traditional beliefs and practices of these various groups, which are being adopted by individuals outside of these groups as well, need to be incorporated into, or at a minimum recognized in, mainstream practices of healthcare (Hermans & Kempen, 1998; Yeh et al., 2004).

Counseling has separated itself from the medical model, or problem focused approach (Armentrout, 1993) to managing health, and approaches issues holistically. Counseling, however, has only scratched the surface exploring the significance of the growing national trend to employ integrated approaches to healing outside of conventional practices. For example, at the American Counseling Association (ACA) Annual Conference & Exposition, in 2010 only 10 programs out of the hundreds offered appeared to mention CT. In 2011, the number of programs using specific CT terms such as yoga, biofeedback, meditation, rose slightly to 13, however there were also a number of programs that discussed spirituality and neuroscience, two components that can be coupled with CT. Additionally, I was fortunate to attend a session on treating trauma in
military families and one of the approaches briefly discussed was eye movement desensitization and reprocessing (EMDR) which is an identified complementary treatment. CT’s presence in counseling is evident by the explicit and unexpected identification of various practices in the profession’s most recent main forum.

The dominant counseling structure in the West has traditionally utilized a passive talk therapy approach to working with clients (Lee & Armstrong, 1995; Rogers, 1957; Teyber, 2006; Yeh et al., 2004). Some traditional practices in the mental health professions, and indigenous wellness approaches in general, however, support the use of creative and active approaches to working with clients (Henderson & Gladding, 1998; Lumadue et al., 2005; Parvinbenam & Barclay, 2008; Yeh et al.) and where the link with CT becomes evident. Biofeedback (Chandler et al., 2001; Danskin & Walters, 2005; Henschen, 1976; Sarnoff, 1982; Sharp, Hurford, Allison, Sparks, & Cameron, 1997; Walsh, 2010; Winfield, 1983) and particularly mindfulness (including meditation, guided imagery, yoga, and breath-work) have become increasingly acknowledged and researched topics in the counseling field as active techniques that counselors are using to understand and support their own wellness needs as well as to potentially benefit their clients (Chambers Christopher & Maris, 2010; Chrisman, Chambers Christopher, & Lichtenstein, 2009; Rothaupt & Morgan, 2007; Rybak & Deuskar, 2010; Schure, Christophe, & Christopher, 2008). These practices, however, are not recognized as mainstream in professional counseling practice (i.e., part of the required curriculum in counselor education training programs or used by the majority of professional counselors) and are not typically utilized with the same confidence or legitimacy as traditional counseling techniques (Baruch-Runyon, 2009; Lumadue et al., 2005). Despite
skepticism in the profession, CT may be what clients need or want to utilize, or discuss, in conjunction with counseling sessions (Evans, Valadez, Burns, & Rodriguez, 2002).

Counselors need to become more informed about the wellness strategies employed in the U.S. to provide a bona fide holistic approach to addressing individuals’ mental health needs. Although there has been some research investigating the beliefs that are embedded with the use of CT (Astin, 1999; Ben-Arye, et al., 2008; Bishop et al., 2007; Bishop, et al., 2008; Schure et al., 2008) and various helping professionals’ (i.e., physicians, nurses, social workers) conceptions, there has been little focus on counselors’ attitudes and behaviors related to CT as collaborative tools (Ben-Arye et al.; Dziegielewski, 2003; Hsiao et al., 2005; Hsiao et al., 2006). Counselors are increasingly discussing the mind-body connection (Christenson, 2009), but are found supplying anecdotal and descriptive information rather than empirical justification for its inclusion in counseling practice. Complementary therapies combined in accordance with the wellness approach of counseling could create an optimal opportunity to positively impact the counseling profession in terms of exploring and strengthening professional identity, understanding the application of the wellness model, and ethical practices to meet the needs of a diverse population of clients. Outside of Evans et al.’s (2002) study on practitioners’ attitudes toward brief and non-traditional approaches, however, little has been empirically studied about U.S. counselors’ attitudes and behaviors toward the growing area of complementary therapy integration.

To increase the understanding of the utility of complementary approaches in counseling practices in the U.S., counselors must be open to exploring the information surrounding these therapies. Consistent with grounded theory methodology, this study
utilizes induction, or using data collected, to form conceptual categories (Charmaz, 2006; Hays & Wood, 2011). The following review of the literature, however, comes from an a priori approach (Crabtree & Miller, 1999) to give readers a sense of the three main topics that, before conducting the study, inform how and why counselor’ attitudes and behaviors towards CT could be constructed. Having previous knowledge and experience informing the study questions is important for enhancing the trustworthiness of the study design and execution, particularly when health is a known and complex construct (Barnes, 1996; Hesse-Biber, & Piatelli, 2007).

The purpose of this review is to illuminate CT and the potential influence it can have on many areas of the counseling profession. First, an overview of CT and rationale for its current and rising use by millions of Americans will be detailed. Second, the exploration of CT outside of the counseling profession will be detailed. Third, three critical areas of the counseling profession (i.e., professional identity, the wellness model, and ethics) will illustrate the potential significance of this research study and positive impact of CT integration and synergy with counseling aims. Finally, the research that has been conducted in counseling on use and/or integration of CT in practice or training will be examined. Using the outline described, the first step in the discussion is focused on increasing counselors’ knowledge of complementary approaches.

**Complementary Therapies**

There are a wide variety of complementary practices, each subjective to the individual or group that uses it, but it is important to identify what qualifies as complementary approaches. What binds these approaches together is the aim to holistically address the health of individuals depending on their presenting concern.
(Caspi et al., 2004; Phalen, 1998; Sirois & Gick, 2002). The four categories currently distinguished by the National Center for Complementary and Alternative Medicine, a division of the National Institute of Health, are natural products, mind-body practices, manipulative and body-based practices, and other practices. From the medical perspective, Kiefer et al. (2009) identified seven different areas of CT, similar to NCCAM: (a) energy medicine, (b) herbal medicine, (c) homeopathy, (d) mind-body medicine, (e) nutrition, (f) physical medicine (i.e., body-based practices), and (g) Ayurveda, traditional Chinese medicine, and Kampo medicine. Shannon (2002) also included but does not limit to identifying approaches such as biofeedback, meditation, therapeutic touch, aromatherapy, and Ayurveda.

Since some identified complementary practices are commonly understood and used in the U.S. for health management, such as nutritional diet and exercise, CT that could be considered conventional approaches will not be included for the purposes of this study and will be discussed in further detail below as well as in Chapter 3. The National Institute of Medicine (NIM, 2005) supplied a detailed inventory of therapies, practices, and systems (go to Appendix A for more detail). Using the four categories of NCCAM (2012), a comprehensive, but not exhaustive, list is supplied.

**Categories of CT**

**Natural products.** Identified by dietary supplements primarily sold over the counter, this category encompasses vitamins, minerals, “natural products” (e.g., probiotics), and a number of herbal medicines or botanicals (NCCAM, 2012). Also identified in the past as biologically based therapies, in addition to herbal products, NIM (2005) also defined approaches including specialized diets and nonherbal products (e.g.,
fish oil). NCCAM identified the marked increase in the use of natural products, most notably fish oil/omega 3s for adults and Echinacea for children. As the NCCAM reinforced, the use of medicinal herbs can be traced back through the middle ages to original discovery in prehistoric times.

**Manipulative and body-based practices.** This category concentrates on the bones and joints, soft tissues, as well as the circulatory and lymphatic systems of the body (NCCAM, 2012). Particularly, therapies under this classification use movement or manipulation of the body, as evident by its title (NIM, 2005), however, there are more specialized movement therapies identified in the *other* category below. NCAAM divided practices into two primary therapies: spinal manipulation (e.g., chiropractic) and massage therapy. Although the approaches of these two therapies can vary dramatically, the historic use of the techniques can be traced back for thousands of years and are currently some of the top complementary and alternative techniques used in the U.S (Barnes, Bloom, & Nahin, 2008).

**Other.** NCCAM (2012) clustered movement therapies or movement based techniques developed to increase physical, mental, emotional, and spiritual well-being (e.g., Pilates, Rolfing Structural Integration, Alexander technique, Feldenkrais method), traditional healers, energy work (e.g., magnet and light therapy, qi gong, Reiki, healing touch), and whole medical systems (e.g., Ayurvedic medicine, traditional Chinese medicine, homeopathy, naturopathy). NIM (2005) originally separated alternative medical systems and energy therapies into two distinct categories. Because of the wide range of practices and components to techniques, some of those listed in this category can and will be applied to the mind-body focused on in this research (e.g., qi gong, Reiki).
**Mind-body medicine.** Ironically labeled “medicine” by NCCAM (2012), this area is focused “on the interactions among the brain, mind, body, and behavior, with the intent to use the mind to affect physical functioning and promote health.” Practices included by the NCCAM consist of, but are not limited to, meditation, yoga, hypnosis, biofeedback, group support, deep-breathing exercises, guided imagery, hypnotherapy, progressive relaxation, spirituality, qi gong, and tai chi (Sutton, 2010). Creative outlets (e.g., art, music, dance) are also encompassed in mind-body approaches. Sutton identified how patient support groups and cognitive-behavioral therapy, once considered CT, are now mainstream and no longer identified in this group. Although not identified by NCCAM, Eye Movement Desensitization and Reprocessing (EMDR) can and will be considered one of these practices for the purposes of this study since it is an approach gaining in popularity and efficacy, particularly in the area of trauma (Gunter & Bodner, 2009; Korn, 2009; Shapiro, 2002; van der Kolk, et al., 2007).

NIM (2005) defined mind-body practices as encompassing interventions focused on the mind but that impact the body and physical health, and additionally included prayer and mental healing. Biofeedback and neurofeedback (NFB), given their focus and intention on using thoughts or cognitions to self-regulate physical responses, will also be included in this category (see Chandler et al., 2001; Danskin & Walters, 2005; Gruzelier, Enger, & Vernon, 2006; Henschen, 1976; Ivey, Ivey, Zalaquett, & Quirk, 2009; Myers & Young, under review; Othmer, Pollock, & Miller, 2005; Sarnoff, 1982; Sharp, Hurford, Allison, Sparks, & Cameron, 1997; Thompson & Thompson, 2003; Walsh, 2010; Winfield, 1983). According to Ivey et al., as tools with a similar function as counseling,
biofeedback and NFB serve as a “bridge between biological and physiological processes” (p.44), in other words, they are examples of mind-body approaches to promoting health.

Mind-body practices attention on cognitions and emotions, as well as behaviors align most directly, compared to the other three areas identified, to the conventional areas of focus in counseling and will thus be the focus of the proposed study. Although many complementary approaches were identified, practices that fall within the definition of a mind-body technique will be considered. Most significantly, the holistic foci of the various mind-body approaches parallel the wellness model orientation, as previously identified, in counseling. Connecting the various aspects of an individual are a central aim of both practices to healing and health. Focusing on mind-body practices integrated into the counseling process can expand the limited knowledge in this collaborative holistic approach.

There is an increasing body of research and information on many areas of CT, particularly in the medical community (e.g., physicians, nurses, psychiatrists). Different disciplines outside of counseling have focused on looking at specific approaches under the broad scope of CT such as, but not limited to, herbal healing (Dziegielewski, 2003), yoga (Pilkington, Kirkwood, Rampes, & Richardson, 2005; Woolery, Myers, Sternlieb, & Zeltzer, 2004), mindfulness-based stress reduction (MBSR; i.e., incorporation of multiple approaches focused on mindfulness; Kabat-Zinn et al., 1992; Kabat-Zinn, Lipworth, & Burney; McCaffrey & Fowler, 2003; Shapiro, Brown, & Biegel, 2007; Shapiro, Schwartz, & Bonner, 1998), qi gong (Mannerkorpi, & Arndorw, 2004; Tsang, Fung, Chan, Lee, & Chan, 2006), gentle touch (Weze, Leathard, Grange, Tiplady, & Stevens, 2007), acupuncture (Horowitz, 2009), EMDR (Gunter & Bodner, 2009; Korn,
2009; Shapiro, 2002; Stickgold, 2002; van der Kolk, et al., 2007), biofeedback (Gilbert, & Moss, 2003; Ossebaard, 2000; Sharp et al., 1997), and neurofeedback (Gruzelier, Egner, & Vernon, 2006; Tinius, 2007). Others have focused on issues or topics (e.g., chronic illness, spirituality, healthcare reform, health decision making) that continue to facilitate an understanding of why and how CT is utilized (Astin, 1998; Bishop et al., 2007; Hök, Tishelman, Ploner, Forss, & Falkenberg, 2008; Kiefer et al., 2009; Sirois & Gick, 2002).

**Reasons for Use**

The breadth of motivations individuals have to use CT is as varied and complex as the personalities and groups from which they derive. Understanding why people use CT in the U.S. has been the topic of much speculation and research (Astin, 1998; Bazargan et al., 2008; Bishop, et al., 2007; Caspi et al., 2004; Eisenberg et al., 1998; Hildreth & Elman, 2007; Kronenberg, Cushman, Wade, Kalmuss, & Chao, 2007; Sirois & Gick, 2002). Research has shown individuals’ beliefs, health status, personality, and certain socio-demographic factors (i.e., gender, education, income) have been predictive of CT use (Astin; Sirois & Gick).

**Individual worldview.** The subjective beliefs individuals hold, such as believing in personal control or desiring proactive involvement in managing their health, have been found to be significantly associated with utilizing CT (Bishop et al., 2007; Sirois & Gick, 2002). In a national study, Astin (1998) found “having a holistic philosophy of health (e.g., “The health of my body, mind, and spirit are related, and whoever cares for my health should take that into account”) was predictive of [CT] use” (p. 1551). As Roy (2002) reiterated in his support of whole-person healing, “it is that personal experience of
effectiveness is a more reliable datum than the derivative of some theory” (p. 383).

Individuals’ past and present experiences combined with their culture will influence how they define and what they see as legitimate and useful practices for approaching their health concerns and/or issues.

**Health status.** Individuals confronted with chronic illnesses and poorer health statuses have been repeatedly found in the research as being more open to using CT (Hildreth & Elman, 2007). Cancer, chronic pain, and diabetes are three commonly identified diseases individuals address with CT, but stress and negative mental and physical health effects related to stress are also being increasingly linked with seeking integrative approaches (Bishop et al., 2007; Weze et al., 2006). In a study conducted by Bazargan et al. (2008), the use of CT for depression was explored in African American and Hispanic patients. Using interviewer-administered surveys and medical records, participants (N = 315) were found to widely utilize CT to treat their depressive symptoms. A strong correlation was found between disadvantaged (i.e., access to care is limited, not available) minority patients and CT use. Additionally, patients who were able to obtain conventional treatments still demonstrated prolific use of CT. Bazargan et al.’s study provided evidence for the potential of CT integration in both the medical and mental health professions (Lake & Spiegel, 2007). Sirois and Gick (2002) postulated, “it may be an individual’s health complaint as much as their health-related beliefs that determine choice of treatment” (p. 1027). Clearly, there are multiple factors individuals are negotiating that can foster the use of CT, but the impetus seems consistently internally derived.
**Personality.** Research is limited regarding the impact of personality on CT use, but Sirois and Gick (2002) recognized its identification across various studies. Individuals seen as “cultural creatives” or as Astin (1998) described, those valuing and having a commitment to the environment and feminism, who are self-expressive and self-actualizing, who embrace the foreign and exotic, and who are associated with non-mainstream forms of spirituality, similarly to those described by the term “New Agers,” are more likely to use CT. Hildreth and Elman (2007) found individuals who self-reported higher levels of spirituality were also associated with CT use. Additionally, less conventional and more risk-taking individuals were also seen to be more likely to pursue CT. Possessing either one or all of these character traits will clearly factor into their health care decision-making.

**Sociodemographic factors.** Research has shown mixed findings in terms of the influence of such factors as sex, race/ethnicity, and education level on the predictive use of CT. Individuals who are female, educated, and report higher incomes have been repeatedly identified as more prolific uses of CT. Besides education, Astin (1998) did not find any sociodemographic variables as significant predictors of CT use, including race and/or ethnicity, putting a greater emphasis on an individuals’ beliefs and personality. Regardless of the specific motivations, clearly there are a multitude of reasons behind an individuals’ pursuit of CT and why approaches are being increasingly sought by a wide range of Americans.

Astin (1998) suggested that research identifies, “shifting cultural paradigms, particularly with respect to recognizing the importance of spiritual factors in health” (p. 115) as a contribution to the motivation for pursuing CT. Lumadue (2005) also pointed
toward a paradigm shift in the U.S. based on emerging views of the mind-body connection and how energy and matter are being conceptualized. In other words, individuals are starting to identify with non-traditional perspectives about what impacts their health and how they can harness different options depending on their needs and beliefs. Moreover, people are increasingly putting an emphasis on looking at issues holistically. The creation of NCCAM and its educational program *Time to Talk* (see NCCAM, 2012) demonstrated the acknowledgement of CT by the medical community and the need for health care providers to communicate with patients to more effectively manage their health. Shifting and integrative conceptualizations of health and wellness (Phalen, 1998; Roy, 2002; Weil, 2000) need to be increasingly explored within the counseling field to be able to provide similar opportunities for clients using counseling to facilitate optimal wellness.

**CT Integration Among Medical and Allied Health Professionals**

Although counseling is an important member of the helping professions, literature exploring the health benefits of CT has been primarily undertaken by the medical and allied health professions. Particularly, numerous investigations have been conducted to understand the perceptions and practices of mainstream health providers toward CT. As Mildren and Stokols (2004) reiterated in their study of California physicians, although we refer to this group of practices as *complementary* therapies, they are regular practice for most other nations.

The World Health Organization estimates that 80% of the world’s population is using some form of [CT] for their primary healthcare. Thus, most of the world’s population would consider the Westernized form of medicine (allopathic) as
“complementary or “alternative,” because it represents a departure from their traditional forms of medicine. (p. 74)

Getting a sense of how those in the allopathic healthcare world perceive CT to address individual wellness, like understanding those who use CT, is complex.

Although little is known of counselors’ knowledge, attitudes, and behaviors toward CT, empirical studies, primarily in the medical community, can provide some insight into integration. National surveys published in the *Journal of the American Medical Association* demonstrating growing interest and use of CT in the public (Astin, 1998; Eisenberg et al., 1998) were closely followed by investigations of physicians orientation to CT. In their national survey of physicians (i.e., rheumatologists; N = 924), Berman et al. (2002) explored their understanding, clinical use, attitude toward, and referral of 22 more commonly used CT approaches (e.g., acupuncture, biofeedback, energetic healing, hypnotherapy). Counseling was identified as a CT technique in that study and interestingly was the most referred, most understood, and considered legitimate medical practice by those physicians surveyed, providing perspective of counseling’s journey into mainstream practices. Not surprising, the CT approaches that physicians had the least knowledge of (e.g., energetic healing, homeopathy, and music/sound) were also those that 75% of the sample had no clinical experience with (referral or use) and were not seen as legitimate practices (Berman). Was it because they had no experience that they were seen as illegitimate or did that influence their willingness to be exposed? Regardless, the research demonstrated the impact knowledge potentially can have on use and perceptions.
To gain a broader scope of understanding of knowledge, attitudes, and behaviors in the medical community, Tracy et al. (2005) conducted a national survey of critical care nurses modifying Berman et al.’s (2002). Of the 726 respondents, 98% reported use of one or more CT in their professional practice. Although perceptions of legitimacy varied among approaches, most of the participants wanted more knowledge or training on CT. Of the 22 CT approaches listed on the survey, diet, exercise, relaxation, and prayer or spiritual direction were most commonly utilized by critical care nurses. Interestingly, prayer or spiritual direction was one of the approaches physicians in Berman et al.’s survey reported no clinical use of. This difference demonstrates the various roles individuals play in attending to individuals’ health and use of different tools in those positions. Another difference is that the sample of critical care nurses was predominately women (91%) and Berman et al.’s study sample of physicians was majority male (87%). Understanding the vast practices and knowledge by those functioning within the medical model provides insight into how professions navigate the needs and demands of the individuals they serve.

In their literature review of 21 studies focused on the attitudes of health care providers toward CT, Sewitch, Cepoiu, Rigillo, and Sproule (2008) discovered few consistent findings, however, the information began to shed light on the dynamics playing into healthcare perspectives. For instance, of the physicians, nurses, social workers, public health professionals, dietitians, medical/nursing school faculty, and pharmacists surveyed, in general, physicians, compared to the rest, were less positive toward CT approaches. Across studies, lack of evidence on CT effectiveness and the potential side effects and interactions with conventional treatments were cause for
skepticism and lack of support. Interestingly, in one study reviewed, counseling and psychotherapy, along with nutrition, diet, fitness and exercise, emotional support groups, and biofeedback, were considered “legitimate medical practices” (p 147). The breadth of inquiry into understanding the attitudes and behaviors of health care providers has grown as interest and methods of evaluation have developed in CT.

Schneider, Meek, and Bell (2003) initiated their instrument development by conducting focus groups comprised of physicians and medical students at a program based in integrative medicine. Their interviews yielded concepts such as clinical importance of intuition, healing as distinct from curing or fixing, relationship-centered/patient-oriented care, and usefulness of evidence beyond randomized controlled trials. The findings were then used to create the Integrative Medicine Attitude Questionnaire (IMAQ), which was given to both conventional and integrative physicians (N = 153), eventually tailored to 29-items with a total Cronbach’s alpha of .92. The two main factors identified, openness (alpha .91) and relationships (alpha .72) reinforced driving forces shaping attitudes towards CT integration.

Other scales were developed to better understand attitudes towards CT using qualitative inquiry. Lie and Boker (2006) also looked at medical students, in addition to residents and faculty, to understand attitudes as well as use and information-seeking behavior. Their findings demonstrated that out of those three groups, faculty involved with CT approaches (i.e., teach or intend to integrate CT in their lessons) had more significant positive attitudes and used them more frequently, however, all groups showed positive attitudes toward CT. The research also gives insight into the impact exposure and knowledge of CT can have on perceptions and use. Again, more reinforcement to
understand how counseling practitioners are gaining knowledge and access to CT modalities and how it impacts their counseling work.

In their initial research to create a self-report measure to understand clinicians’ “attitudes toward and practice of merging conventional and CAM modalities” (p. 1555), Hsiao et al. (2005, 2006) looked at primary care physicians \( (N = 13) \) as well as CT practitioners (i.e., physician acupuncturists \( [N = 13] \), acupuncturists \( [N = 12] \), and chiropractors \( [N = 12] \)). Using qualitative analysis, Hsiao et al. uncovered four main categories: provider attitudes, knowledge, referral, and practice. The 10 sub-domains (e.g., practitioners’ openness, philosophical scope, methods of acquiring knowledge) shed light on the various ways participants’ conceptualized and used integration, CT, and conventional medicine. Analysis revealed feelings ranging from disapproval to approval, with the physician group less likely to be holistic and open-minded as well as have faith in integrative methods. Additionally, provider age (i.e., younger more open than older), training (i.e., integrative or conventional) and practice setting (e.g., integrative clinic/on-site, non-integrative/off-site) also impacted practitioners’ conceptualizations of integrative approaches.

Hsiao et al. (2005) then created an instrument from the detailed qualitative information. After piloting, they finalized the 30 item-instrument with five scales: a) awareness and openness to working with practitioners from other paradigms, b) readiness to refer patients to other paradigms, c) learning from alternate paradigms, d) patient-centered care, and e) safety of integrative medicine. The information collected through the interviews and scales gives insight into the various factors influencing medical
practitioners’ orientation to integration, providing a framework used to help construct this research study exploring counseling practitioners.

Navigating in opposing paradigms, the medical and counseling communities have a clear connection and purpose in helping people. Counselors have recognized the importance of building relationships with the medical community to increase important health services to individuals as well as increasing counseling’s visibility in the helping professions (Walsh & Dasenbrook, 2010). As the medical and allied health communities have opened up their awareness and exploration of CT approaches, so should counseling examine how CT is and could impact its profession.

**The Counseling Profession**

The profession of counseling is a unique yet identifiable mental health practice in U.S. culture. One of the youngest recognized mental health professions to come to fruition, the counseling profession, while growing in strength, still faces challenges (Kaplan & Gladding, 2011; Kaplan et al., 2009). When recognizing the theory behind CT and the rationale for its usage, the congruence with counseling seems to be mainly challenged by the differences in techniques. The beliefs and practices involved in the integration of CT in counseling sessions have the potential to illuminate three particular areas of the profession: identity, adherence to the wellness model, and ethical practices. The broad range of perspectives in these areas continue to fuel division, but in exploration, have the potential to guide the profession toward embracing the diversity within and approach practice, teaching, and research with a new outlook.
Professional Identity

“Counselors develop professional identities that serve as frames of reference for their counseling roles and decisions” (Auxier, Hughes, & Kline, 2003, p. 25). Even as 29 of the 30 major counseling organizations have agreed on a unified vision of the future of the profession (i.e., 20/20: A Vision for the Future of Counseling; Kaplan & Gladding, 2011), strengthening counselor identity was listed as one of the main strategic areas needing critical attention. Cashwell, Kleist, and Scofield (2009) called on counselors to “WAKE UP” (p. 60), reiterating the importance of unity and results of the 20/20 initiative. Recognizing the dynamic shift globalization has influenced in terms of population changes and information exchanges, Bemak and Hanna (1998) identified the need for the counseling profession to redefine itself to overcome existing barriers. The historical struggles with psychology have propelled many in the counseling profession to emphasize the need for a defined strength in purpose for survival (Hanna & Bemak, 1997; Ritchie, 1994). Particularly, their focus on the need to collaborate with various disciplines to provide more comprehensive care attests to the role CT integration could play in the profession’s future. Counseling as a distinct profession has been debated because of the various practices of specialties within (Hanna & Bemak), however, counseling seems to have flourished because of specialized knowledge within a single community (Kaplan & Gladding, in 2011); the potential benefit of collaborating with other approaches embracing a similar overall philosophy of helping (i.e., CT) could be a powerful way for counseling to reinforce its identity.

Regardless of similarities between the helping professions, a recent study found (Mellin et al., 2011) a developmental, prevention, and wellness orientation was endorsed
by counselors across specializations as a defining feature of their identity as professional counselors. As previously discussed, the development of a professional identity, particularly in counseling, has been contingent on some divergent standards in training, philosophy, professional organization membership, and certification, and influenced by specialty as well as personal backgrounds and values (Kaplan & Gladding; Gale & Austin, 1999; Gibson et al., 2010). As Sweeney (1995) postulated, the various specialties (i.e., those with affiliation with ACA, CACREP, or the National Board for Certified Counselors, NBCC) in counseling give the profession its dimension and strength. The development of the preceding organizations created standards in the profession with the aim of a unified professional identity. For the purposes of supporting the rationale for the proposed study, particular attention to professional identity as a result of training and philosophy will be detailed.

Training. The largest accreditation organization for counseling training, CACREP provides the standard to cultivate knowledgeable and skillful counselors who also satisfy credentialing criteria (Sweeney, 1995). Accreditation is referenced as, “the process whereby a private, non-governmental agency or association grants public recognition to an institution or program of study that meets certain established qualifications and periodic evaluations” (Sweeney, p. 117). Addressing various standards depending on specialty (i.e., addictions; career; clinical mental health; marriage, couple, and family; school; student affairs and college counseling; counselor education and supervision), CACREP, like other accreditation agencies in the profession (e.g., Council on Rehabilitation Education, CORE, instituted by the American Rehabilitation Counselors Association, of ACA, for rehabilitation counselors; Sweeney) provides a
focus on foundations, knowledge, and skills of practice, but also on how and by who information is to delivered (see CACREP Standards, 2009). Gale and Austin (2003) reinforced the importance of similar training under the same accreditation agency to create unified standards to enter into the profession. The knowledge and experience from counseling training critically impacts how counselor professional identity is developed and currently not all counseling training programs are CACREP accredited (Auxier et al., 2003; Pistole & Roberts, 2002; Zimpfer, Mohdzain, West, & Bubenzer, 1992). Even if there are nuances in training, having a common foundation of professional focus can set the stage for a collective identity in counseling.

Looking at master’s level counseling trainees, Auxier et al. (2003) conducted a grounded theory inquiry into the experiences of professional identity formation throughout the training of eight individuals at CACREP accredited programs currently in their second year. After conducting a focus group after two rounds of individual interviews, they identified a recycling identity formation process or participants’ cyclical process of identifying, clarifying, and reanalyzing their self-concepts based on their conceptual and experiential learning. Auxier et al. uncovered how the attitudes and behaviors student cultivated throughout their training experiences were influenced by the confirming and disconfirming messages from faculty, supervisors, and peers. The findings reiterated that future professionals within counseling have to support but also restrict the potential positive and effective practices of various individuals based on their own identity. Extending the results from this study to CT, for example, a counselor who utilized Reiki practices in session with a client, and the client is exhibiting a great deal of progress, is told by peers and supervisor that because Reiki is not an empirically
supported treatment, he should not use it in session. Even though the counselor feels he is being ethically and professionally competent in what he is doing, because of the disapproval of other counselors, he discontinues Reiki in session and the clients’ progress diminishes.

Similarly, Calley and Hawley (2008) identified the potential for professionals to influence the identity of other counselors, particularly the professional identity of counselor educators, because of the opportunity for them to impact counseling trainees. In their quantitative study, after recruitment from 40 randomly selected CACREP-accredited institutions, 70 counselor educators (37 females, 33 males) completed the Counselor Educators: Professional Identity & Current Trends Survey. The survey consisted of 30 items (i.e., 24 forced choice items and 6 closed-question items), and data analysis consisted of frequency counts, means, and cross tabulations of the items. Although the results of the study provided detail surrounding involvement in professional organizations and course content, the gravitation of counselor educators towards humanistic (41%) and constructivist (i.e., solution-focused and narrative; 23%) theories provided general support that professionals, and those educating the next generation of counselors, focused on similar values (i.e., emphasis on clients, therapeutic relationship/alliance, ability of client to create change). Although not empirically rigorous, the study does offer a glimpse into the eclecticism (e.g., holding multiple certifications and licensures, members of numerous professional organizations) signified by the collaborative and various practices of counselor educators. Regardless of counselors coming from similar training programs accredited under one body (i.e., CACREP), having an increased likelihood of ensuring similar qualifications in their
graduates is important. Even while continuously addressing knowledge and skills in training and practice, professional identity is shown to stem from the experiences of the individual as well as the overarching theoretical and philosophical assumptions of counseling (Gale & Austin, 1999).

**Philosophy.** Individual experiences can couple with counselor traits, reiterated by Hanna and Bemak (1997), as the factor creating the most effective therapeutic alliances. Auxier et al. (2003) acknowledged the negotiation, in developing professional identity in counseling, between the professional and personal selves. In her qualitative study of professional identity perceptions of doctoral graduates in counselor education programs in private practice, Swickert (1997) found seven significant themes among the participants, two of which speak directly to the proposed study (i.e., the uniqueness of counselors and an affinity with holistic and preventative medicine). Participants (i.e., practicing Ph.D. level counselors, N = 11) were interviewed for approximately one and one half hours linked by their uniqueness (and support of non-regimented practice) to meet their needs and those of their clients, additionally, identifying with a holistic, prevention focus. Several participants identified using “ancient techniques” and described the importance of focusing on the mind-body connection (p. 339). Although the study did not focus on the details of the final theme identified (i.e., affinity with holistic and preventative medicine), the relationship and influence on professional identity linked by Swickert demonstrated the interest professional counselors have in CT and how the differences between counselors in terms of approach can also help to strengthen the profession through diversification. In the pilot study I conducted (Nichols, in preparation) and will detail later in the chapter, however, the perceived potential of
receiving negative reactions from other counseling professionals, regarding participants personal use or philosophy connected with various CT, caused confusion and frustration between professional and personal identity. Even with those contradictory messages, the participants in both studies referenced a focus on helping people and “thinking in terms of wellness” (Swickert, p. 336).

**The Wellness Model of Counseling**

The endorsement of a wellness orientation by the counseling profession signifies an acceptance and responsibility for counselors to apply a holistic approach to helping people (Myers & Sweeney, 2008; Myers, Sweeney, & White, 2002; Myers et al., 2000; Myers & Willard, 2003; Roscoe, 2009). It appears a wellness orientation is embraced by many counselors; as previously discussed, Mellin et al. (2011) found a wellness orientation was identified as a part of counselors’ professional identity. The endorsement reaffirms the importance of continuing efforts within counseling to advance training, practice, and research that mirrors a wellness orientation (Mellin et al.). Despite the endorsement of a wellness focus, counselors continue to vacillate between a theory guiding them toward a holistic approach and practice constraints (e.g., service eligibility requirements, deficit-focused assessments) that focus on pathology and fragmented aspects of an individual (McAuliffe & Eriksen, 1999). As Hsiao et al. (2006) discovered in their research about medical provider attitudes toward integrative approaches, part of the discrepancy was resolving the conflict between the two paradigms they were trying to integrate (i.e., the “Western” view of looking at issues as separate versus the “Eastern” or holistic focus). Counseling, and the attention to a holistic approach, aligns with the integrative intent of CT. These and other factors may make it difficult for counselors to
move beyond the rhetoric celebrating wellness to actively integrating counseling with other holistic approaches or being open to the discussion of other practices in order to promote wellness among clients.

The prolific nature of CT, although varied in intention and technique, delivers a common theme from its use, which is the individuals’ beliefs in their capabilities to bolster psychological, physical, and spiritual wellness (Astin, 1998; Bishop et al., 2007; Constantine, Myers, Kindaichi, & Moore, 2004; Coulter & Willis, 2007; Goldrosen & Straus, 2004; Kelner & Welman, 1997; Lee, Oh, & Mountcastie, 1992; Yeh et al., 2004). Caspi et al. (2004) discovered the tendency for CT usage to be a result of the perception of providing holistic healing and incorporation of the mind-body-spirit. Using Myers and Sweeney’s (2008) evidence-based model of wellness, the Indivisible Self (IS-Wel), as a framework, they maintained the 17 components or life tasks and sub-tasks, reorganized from their traditional Wheel of Wellness (Myers et al., 2000), to more accurately assess and provide understanding of how the various aspects of individuals impact their overall wellness.

**The Indivisible Self Model (IS-Wel).** With the self at the core of an individual’s wellness, Myers and Sweeney (2008) provided counselors with a framework to understand the complexity of understanding and addressing wellness with clients. Ecological in design, four contexts are navigated by the self, including local (i.e., family, neighborhood, community), institutional (i.e., education, religion, government, business/industry), global (i.e., politics, culture, global events, environment, media), and lifespan or chronometrical. Organized under five factors that contribute to the total wellness of the self (i.e., Creative, Coping, Social, Essential, and Physical) there are 17
components contained throughout the five factors that counselors need to recognize their contribution to an individual’s wellness (see Figure 1).

**Creative self.** Defined as “the combination of attributes that each of us forms to make a unique place among others in our social interaction and to positively interpret our world” (Myers & Sweeney, 2008, p. 485), the creative self has five components. The first three components in particular (i.e., thinking, emotions, control) all connect with CT, particularly mind-body approaches. Thinking, or being mentally active, addresses open-mindedness, problem-solving skills, curiosity, and a propensity for creativity and experimenting. Emotions are related to an individual’s ability to identify, experience, and express both their positive and negative feelings, appropriately. Control or focus and determination to complete a specific goal set also addresses the assertiveness individuals use to meet their needs. As CT research has demonstrated, motivations for their use are largely dictated by these components. The final two factors of the creative self are work (e.g., satisfaction with) and positive humor or the ability to find the humor in challenges or mistakes that occur.

**Coping self.** The coping self can be identified as the ability of an individual to adapt to life events, particularly the negative effects of circumstances. Components of regulating an individual’s responses include leisure activities, or “having at least one activity in which...[a person loses themselves] and time stands still” (p.485), stress management, feelings of self-worth (i.e., accepting and valuing oneself), and realistic beliefs (Myers & Sweeney, 2008). CT can be identified as not only specific leisure activities, but also practices found to contribute to and intended to address all of the preceding factors. For example, mindfulness-based stress reduction (MBSR) utilizes
multiple techniques (e.g., yoga, guided imagery, meditation) to focus on breathing, movement, thoughts, and relaxation to minimize the negative effects of stress.

**Social self.** Although Myers and Sweeney (2008) defined the components of the social self as friendship and love, relational influence/support create another direct link with the use of CT. The beliefs shared and supported by the individuals in a person’s life will impact the choices he or she makes. For example, an individual who identifies as being raised in a traditional Native American Indian family will likely participate in distinctly different healing and health practices than someone who experienced life in a European American household due to the reinforcement or practices of those around them (Herring, 1997).

**Essential self.** Similar to the social self, the essential self, or how individuals make meaning for themselves, is focused on spirituality, gender, cultural identity, and self-care. CT, designated as forms of self-care stemming from individuals’ spiritual beliefs, and particularly cultural identity in the definitions provided, can clearly be related to this wellness factor. The essential self, for purposes of the current review, identifies those aspects recognized also by the broad definition of multiculturalism. Broadly or universally defined, multiculturalism is identified as the impact cultural dimensions (e.g., race, ethnicity, gender, sexual orientation, disability, religion/spirituality, socioeconomic status) have on the self (Abreu, Gim Chung, & Atkinson, 2002; Fuertes, Bartolomeo, & Nichols, 2001; Sue, Arredondo, & McDavis, 1992). With an expansive view of culture, the essential self negotiates multiple factors shaping who the individual is and how he or she views and interacts with the world.
**Physical self.** Finally, while inclusively defined as “the biological and physiological processes that compose the physical aspects of a person’s development and functioning” (Myers & Sweeney, 2008, p.485), the final factor in the IS-Wel model is concentrated on exercise and nutrition. Diet and exercise (NCCAM, 2012), regardless of their mainstream and widespread use, along with the other forms of CT demonstrate the connection with this factor by the numerous medical studies previously referenced identifying their supported health benefits. CT use linked with health status reinforces the significant impact the physical self can have on individuals’ overall well-being and how individuals negotiate options to meet their health needs.

Using the IS-Wel as the exemplar of the wellness model, it is clear that culture and context have a distinct influence on how an individual might conceptualize approaches to wellness. Embedded in wellness is multiculturalism, which is infused in CACREP training and ACA standards and has a significant influence in counseling training and practice (Das, 1995). Recognizing these areas of intersections of training (i.e., knowledge and skills) and philosophy, counselors can begin to see the relevance and connection between CT and counseling. As McAuliffe and Eriksen (1999) stated, despite the efforts and identity the counseling field has thus constructed, the profession has not necessarily fulfilled its wellness and prevention oriented developmental claims (Gale & Austin, 1999; Mellin et al., 2011). Recognizing counseling’s foundation in wellness, or holistically understanding individuals, however, reinforces the importance of continuing to understand and reinforce counselor’s openness to the various beliefs and practices to ethically meet the needs of clients in their various contexts.
Ethical Practice

The dynamic and evolving relationship between counselors’ and their surrounding culture are reflected in the ACA Code of Ethics (American Counseling Association, 2005), the professions’ proclamation of how to best serve society through integration in practice (Kocet, 2006; Ponton & Duba; 2009). Evidence of the change in society altering the landscape of the profession was the revised focus on cultural sensitivity in the 2005 ACA Code of Ethical Standards of Practice (Kaplan et al., 2009). The intention of the Code, to detail the ethical standards of practice and function of the counseling profession, provides guidance to counselors, but even in its detail, the Code leaves a great deal of the specifics of practice to the individual (Kaplan et al., 2009; Kocet; Ponton & Duba). As previously discussed, recognizing counselors’ process of identity formation, the ethical code can provide both justification as well as question regarding the integration of CT in counseling sessions. The research of Evans et al. (2002) and Lumadue et al. (2006) reinforced by additional counseling literature (Christenson, 2009; Sarnoff, 1982) detailed counselors’ concerns surrounding the appropriateness of CT use in conjunction with counseling. Therefore, knowledge of the ethical code and standards in counseling will be important to understand as counselor’s attitudes and behaviors towards the integration of CT in session are explored.

The breadth of counselors’ interpretations of the ethical code remains uncertain, but efforts have been made to detail and reinforce the evolving parameters of the Code (Kaplan et al., 2009; Kocert, 2006). Kaplan and associates (i.e., the Ethics Revision Task Force) demonstrated, in their conversations regarding the updated ACA Code of Ethical Standards of Practice (2005), the sensitivity to the emerging areas of clarification, yet the
flexibility in the code’s language for counselors to use professional judgment in order to behave in a way that benefits the client. Insight into counselor ethical principles, or criteria, from a quantitative survey conducted by Kelly (1995) indicated counselors ($N = 479$) were generalized as highly valuing diversity in others stemming from a core value focused on “holistic-humanistic empowerment for personal development and interpersonal concern” (p. 652), giving insight into the lens counselors use to interpret the professional ethics codes. Jennings, Sovereign, Bottorff, Pederson Mussell, and Vye (2005) reanalyzed qualitative data from a previous study on the characteristics of master therapists (i.e., Jennings & Skovholt, 1999), identifying nine recurring ethical principles evident in their practice. Although the study did not interview professional counselors (i.e., six psychologists, three social workers, one psychiatrist), since little recent information can be found on counselor ethical values, the study helps conceptualize what ethical ingredients come together to make an effective practitioner in the helping professions. Jennings et al. identified the following principles: (a) relational connection, (b) autonomy, (c) beneficence, (d) nonmaleficence, (e) competence, (f) humility, (g) professional growth, (h) openness to complexity and ambiguity, and (i) self-awareness as essential elements of focus for effective therapists, which are similar to the fundamental ethical principles Kitchener (1984) proposed. The values of the counseling profession exposed, after closer review (see Jennings et al.), the connection between the Code and the function and utilization of CT is apparent. The study results demonstrated how CT can ethically meet the needs of practitioners and clients, even though the basis of the findings stem from Kitchener, coming from a counseling psychology framework; it
reinforced counseling’s need to gain insight into the ethical values informing current practices and approaches with clients from their own professional orientation.

Wrapped in the complexity of professional identity, the practices of professional counselors are boundless in terms of construction, allowing for manualized or creative formats, but conducted in a way that should maintain ethical boundaries. As Ponton and Duba (2009) extrapolated from their research into the evolution of professional ethics and covenants, the development and alterations of the ACA Code of Ethical Standards of Practice reflect the changes society demands in an evolving world. For example, increased attention to diversity and cross-cultural needs has become a noticeable focus of the profession and ethical standards have been altered to reflect the metamorphosis (Kaplan et al., 2009). Similarly, the increasing interest in CT has brought attention to how integration could be viewed differently depending on a counselors’ support or disapproval of such practices. Remely stated that “some counselors get in the habit of using ethical standards to judge other people’s behaviors or professional decisions rather than simply saying, I don’t agree with you” (as cited in Shallcross, 2011, p. 32). Counselors’ perceptions’ clearly play a role into how ethical practice can validate tools and approaches used in counseling sessions.

The effective practices of practitioners are increasingly being identified by the individual characteristics, values, and experiences they bring to sessions, not necessarily theoretical frameworks and techniques (Jennings & Skovholt, 1999; Pope et al., 2002; Skovholt & Jennings, 2005; Sullivan, Skovholt, & Jennings, 2005; Vereen, Hill, & McNeal, 2008; Wampold, Mondin, Moody, Stich, Benson, & Ahn, 1997). Therefore, the practices counselors integrate into sessions due to their own beliefs and values, such as
CT, can be personally cultivated or in response to client requests or interest while adhering to professional standards of multicultural competence (Pedersen, 2000). “Clients are the primary teacher” (Skovholt & Jennings, p. 15). In their small-scale study identifying helpful experiences in counseling, Paulson, Truscott, and Stuart (1999) reinforced clients’ perceptions of effectiveness being primarily dictated by factors facilitated by a therapeutic alliance (e.g., client self-disclosure). Paulson et al. demonstrated the intimacy necessary for productive work to be done in session, and attention to the needs and worldview of clients as critical to that dynamic. Pedersen detailed the awareness and opportunity CT gives to understanding and helping the client while assisting in cultivating the therapeutic alliance. In his handbook on multicultural awareness, he devoted a chapter (see Pedersen, Chapter 3) to relating how the discussion and client use of CT can be an important part of counselors understanding their own worldviews and biases while helping to find best practices to use with diverse clients.

The needs of diverse clients are of increasingly broader complexity (e.g., the expanding importance of cultural context) and need to be addressed with cultural competency by counselors, again, identified in the Ethical Code (Atkinson, Thompson, & Grant, 1993; Arredondo, Tovar-Blank, & Parham, 2008; Arredondo et al., 1996; Constantine, 2002; Constantine et al., 2004; Constantine et al., 2007; Gilene, Fish, & Draguns, 2004; Helms & Cook, 1999; Pope-Davis et al., 2002; Sue, Arredondo, & McDavis, 1992; Sue et al., 1991). Indigenous populations and their practices as therapeutic interventions have been the focus of counseling literature shedding light on CT in the professional context (Constantine et al., 2004; Garrett, 1998; Garrett et al., 2011; Garrett & Garrett, 2002; Yeh et al., 2004). Diverse individuals with issues such as
depression and anxiety are treating themselves with and seeking out CT, as research in other disciplines has shown (Bazargan et al., 2008; Kessler et al., 2001; Pilkington et al., 2005; Weze et al., 2006), therefore the counseling profession needs to take notice and take steps to address these practices.

Although counselors are held to addressing best practices based on “rigorous research methodologies” (ACA, 2005, p. 9; Kaplan et al., 2009), increasing research and literature points to how empirically supported treatments (ESTs) are not necessarily the “gold standard” of practice as once thought (Barry, 2006; Roche & Christopher, 2008). Barry challenges the current definition of ESTs by detailing the differences between biomedical and anthropological approaches to evidence finding, particularly related to CT. Significance of ethnographic evidence of “what works” can be found related to CT (Barry) as well as applied to counseling. Although the conversation in counseling surrounding the need for theoretical or empirical support stemmed from issues surrounding sexual orientation, it is clear the addition of Section C.6.e. Scientific Bases for Treatment Modalities (see Kaplan et al.) poses a professionally driven challenge and skepticism to integrating CT into sessions due to the lack of empirical data. This research study assists in filling the gap by demonstrating evidence of theoretical symmetry between CT and counseling as well as providing empirical support for its utility to the profession.

Integration of Complementary Therapies in the Counseling Profession

There is not an extensive body of research on CT and counseling in general. In addition to studies particularly focused on counselors’ attitudes and beliefs, what has been done in conjunction with the research on wellness, multicultural competency, and
creativity in counseling, however, demonstrates a significant need for more focused research to increase counselor effectiveness (Abreu et al., 2000; Constantine, 2002; Henderson & Gladding, 1998; Lumadue et al., 2005; Myers et al., 2002; Pope-Davis et al., 2002). Current literature on CT is primarily focused on specific techniques and their direct impact on individuals or clients, which can also provide support for looking more specifically at their use and rationale in the counseling profession. Literature reviews conducted by Constantine et al. (2004) and Yeh et al. (2004) on the roles, practices, and importance of indigenous healers to assist counselors in promoting the wellness of clients, particularly minority clients, as well as counselors facilitating indigenous healing systems, provide critical insight into the importance of expanding research on CT.

Searching the scholarly literature, research related to counseling and CT will be detailed, distinguishing between quantitative and qualitative methodologies, to get a detailed understanding of how the integration of CT in the counseling profession has been explored.

**Quantitative Research**

Research in the counseling profession related to CT has largely focused on the use of a particular approach with counseling trainees as a method of self-care. Shapiro et al. (2007) focused on MBSR (mindfulness-based stress reduction) and identified its utility for counselors in training; their research demonstrates a pattern of inquiry reinforcing the idea that what can benefit the counselor could also be an effective approach for clients to utilize. Shapiro et al.’s study consisted of 54 counseling psychology master’s level students; 76.9% identified as Caucasian, while age ($M = 29.2$ yrs) and year of enrollment was the only other demographic data reported. Participants completed the 15-item
Mindful Attention Awareness Scale (Cronbach’s alpha= .79), 20-item Positive and Negative Affectivity Schedule (alpha=. 88 and alpha=. 83), 10-item Perceived Stress Scale (sample state alpha=. 95, trait alpha=. 96), and the 12-item Reflection Rumination Questionnaire (alpha=. 94) at the beginning and end of the eight week (i.e., one MBSR and two control classes) study, as well as a daily diary to track time spent performing the MBSR activities. Participants in the MBSR class were compared to the control classes and showed significant improvement in self-compassion and positive affect as well as reducing perceived stress and other negative factors. Overall, the improvements in students’ mental health signified the potential for CT to support individuals’ wellness needs by utilizing practices that attended to multiple factors of the self (i.e., essential, physical; Shapiro et al.).

Chandler et al. (2001) also utilized master’s students in a counselor training program, but focused on biofeedback-assisted relaxation training. Participants (N = 19 assigned to the treatment (i.e., biofeedback-assisted training; N = 8) or control group (N = 11) completed the Symptom Checklist-90-Revised, which the author described as demonstrating sound psychometric properties. The research provided initial evidence that over the 10-week period the biofeedback reduced somatization, psychoticism, and interpersonal sensitivity among the treatment group, which is significant because these three components can be identified within the IS-Wel model (Myers & Sweeney, 2008). Although providing support for the use and training of counselors in CT, the results are confounded by limitations including the sample size and use of one self-report measure, but provide insight into the possible ways to link CT with counseling and wellness.
The survey research conducted by Lumadue et al. (2005) on CACREP programs (N = 62) identified 54% offered courses or seminars in which CT was either the main or a covered topic, while 89% said they would support the inclusion of such topics. Additionally notable from the results was research conducted on CT by faculty (93%) and students (87%) would be supported. The support of CT research demonstrates an investment in understanding the potential of these various practices on the counseling profession. Lumadue et al. identified 34 CT approaches being utilized by programs, hypnosis being the most offered by programs (N = 10), followed by meditation (N = 8), neurolinguistic programming (N = 7), body/mind-holistic (N = 5), and Reiki (N = 4) and yoga (N = 4) rounding out the top six techniques. Of the 32 approaches listed (see Lumadue et al.), 20 could be classified as mind-body approaches reinforcing the interest and focus in counseling on this area of CT. Without knowing how each program defined the various CT offered, Lumadue et al. demonstrated the increasing interest in CT approaches in counseling as a way to reinforce wellness, reinforcing the earlier findings of Evans et al. (2002).

Healthcare reform has created a number of changes in delivering services to clients, which Evans et al. (2002) used as a basis for their study investigating the attitudes of counselors to nontraditional and brief therapy options. In their study, 151 participants completed a questionnaire containing four separate sections containing Likert-type items with the final section containing several open-ended questions. Although the first section was basic demographic information, the second contained two indices measuring practitioners’ perceptions and their perceptions of clients’ attitudes of nontraditional therapies reporting Cronbach’s alpha of .86 (p < .05) and .65 (p < .05). The third section
utilized one instrument, consisting of six items demonstrating reliable psychometric properties (i.e., Cronbach’s alpha .71, p < .05). Aiming to recruit a diverse sample of practitioners, 75% of the sample was White and female. Identifying 20 different approaches, 85% of practitioners who reported using these approaches (64% of sample) expressed a perceived positive response from clients with the use or recommendation of use of various CT approaches compared to 15% who said clients responded negatively. The researchers also discovered that 22% of practitioners interpreted clients’ interest in nontraditional techniques as due to the holistic focus on mind-body-spirit. Additionally, some practitioners specifically connected integration to cultural appropriateness for clients, lending CT to a wellness orientation. Ethical concerns such as training of counselors in the different approaches as well as the lack of scientific proof were also identified by participants in the open-ended questions. Interestingly, ethnic minority participants demonstrated significantly more positive views of CT than White participants suggesting an importance of CT within diverse cultures (Evans et al., 2002). One difficulty with the study was that the data was all self-reported as well as speculative (i.e., clients were not questioned regarding their attitudes, counselors reported their perceptions of client attitudes), but overall the study provided a more detailed understanding of how CT is being utilized in the counseling profession and the support it currently has from some practitioners to support client’s approaches to wellness.

These studies demonstrated the vast opportunity within the profession to understand the significance of linking and integrating CT with counseling. The majority of empirical inquiry comes from the medical community as evidenced by the hundreds of studies conducted on not only beliefs and attitudes of practitioners and patients, but on
the biomedical effects of CT on individuals’ health outcomes. As some exploratory mental health research has demonstrated, there are identifiable health benefits and a wellness focus when collaborating with CT practices and practitioners (Collinge, Wentworth, & Sabo, 2005).

**Qualitative Research**

Similar to Shapiro et al. (2007), in their study of 33 counseling graduate students taking an elective course utilizing Hatha yoga, meditation, and qi gong, or MSBR, Schure et al. (2008) found the 15-week experience produced five notable themes among the participants including physical, emotional, attitudinal or mental, and interpersonal changes, as well as spiritual awareness. Using qualitative research methods, the narrative responses from the students uncovered rich detail about the impact of CT including statements like “I am opening myself up to see beyond the grind toward alternative ways of living and thinking” (p. 50). As Schure et al. noted, not only were students’ spiritual beliefs and awareness challenged, but personally experiencing the mind-body connection seemed to “significantly affect many students’ attitudes and ideas about counseling” (p. 52). Students discussed incorporating different practices into counseling sessions and overall being more open to their own attitudes’ and beliefs, but also being more empathetic and compassionate towards clients. The limitations of self-report and self-selection bias, while impactful, do not overshadow the powerful detail uncovered in the study; CT use has the potential to influence future counselors’ conceptualizations about the counseling process and their own worldviews by exploring the various components of their essential self.
Utilizing counseling master’s students from the same elective course as Schure et al. (2008), but focused specifically on qigong, Chrisman et al. (2009) recruited 31 participants over a three-year period. Unfortunately, with only limited demographic data reported regarding the participants (i.e., students), researchers collected opened ended, written responses about their perceptions before and after class. Researchers applied a constant comparative approach to analyze the data. Adhering to grounded theory methodology (Charmaz, 2006), Chrisman et al. coded the data for themes and found three main themes across the duration of the course (i.e., physical, emotional, and mental changes) and two additional themes at the completion of the course (i.e., familiarity or routine and group awareness or consciousness). In vivo citations reinforced the mind-body-spirit connection that the counseling trainees experienced and provided them with an opportunity to utilize a holistic approach to wellness for their own and their clients self-care consistent with Schure et al. and Shapiro et al. (2007). As previously discussed, the personal and professional selves create an overall professional identity and this study offers a glimpse into the impact previous experience and knowledge can have on the potential integration of CT techniques and approaches counselors use with clients.

Adjusting the focus to counselors and counselor educators, Rothaupt and Morgan (2007) looked at how six participants incorporated mindfulness into their lives. Using semi-structured interviews, the researchers identified themes focusing on emphasizing the present moment, the mindful practices participants incorporated into daily life, and the effects of these wellness activities on the individuals and those around them. One theme in particular, inviting others to mindful living, showed particular connection to the importance of counselor knowledge and awareness of different approaches stating: “It’s
not our job to be the source of healing; it’s just our job to assist people into its path… We are reflections or conduits of awareness and that predisposes strongly towards growth and expansion” (Rothaupt & Morgan, p. 50). Overall, the study acknowledged and reinforced the positive potential effects that mindfulness practice can have for individuals, particularly those in the counseling profession; but the study also demonstrated how exposure to non-traditional tools could also be a powerful factor for sharing and accepting integrative approaches to wellness. Similarly to the previous study, Rothaupt and Morgan detailed the integration of selves (i.e., personal and professional) and how positive personal experiences of CT can facilitate endorsement of such practices, and for some, provide a rationale for potential integration with client sessions.

Other qualitative studies, such as the information detailed by Baruch-Runyon (2009), highlight the skepticism that surrounds complementary approaches and research; there is a desire and openness by some towards CT, but a disinterest by those who have a more traditional and positivist stance. In her narrative study of nine practitioners and teacher-practitioners of various disciplines, Baruch-Runyon detailed some of the distinctions between psychotherapy and complementary practices. Looking at the areas of tensions and commonalities she described (see Figure 1 in Baruch-Runyon), it is clear that counseling aligns with the complementary practice of holistically focusing on wellness rather than the conventional medical model of psychotherapy. Although Baruch-Runyon identified complementary practice as incorporating or using CT, her research signaled that counseling itself might fall under the definition of CT and would therefore have even more reason to embrace the various practices that define it. This study sheds light on the parallel between the philosophical approach of counseling and
applied techniques of CT, reinforcing the rationale for integration of CT in counseling sessions.

To continue to understand the reasons for CT integration in counseling, I conducted a pilot study of individual and focus group interviews in April of 2010 at a large northeastern university to inform the development of this research study, including a semi-structured guided interview schedule. The pilot sample consisted of four Caucasian, one Vietnamese-American, and one Mexican-American females between the ages of 23-31 years (N = 6). All of the participants attended the same university; two of the participants were earning their master’s level counseling degrees, three were enrolled in the doctoral-level counselor education program, and one had recently graduated with her Ph.D. from the same program. After individual interviews with the two master’s students and a focus group with the remaining participants, themes surrounding professionalism, personal experiences, and cultural contexts were identified as impacting how these counselors navigated their personal and professional attitudes and behaviors towards CT. Overall, participants had practiced CT in their personal lives, knowingly or unknowingly, but had not integrated such practices in their professional work. Although all participants expressed an interest in CT, individuals with more knowledge of CT expressed significant reservation with letting their interest be known by other counselors or professionals in mental health as well. Additionally, several participants from minority groups (e.g., race, ethnicity, sexual orientation) expressed that unless a specific technique was known or used by individuals in their cultural, such practices, although seen by many as similar to CT, would be viewed with a great deal of skepticism and resistance. The findings from this initial research demonstrated the impact that prior
knowledge as well as experience with and surrounding CT in many forms and contexts can influence personal and moreover professional attitudes and behaviors.

The exploratory qualitative studies identified demonstrate an interest and rationale to continue CT research in the counseling profession. Limited in number and scope, the research illuminated the positive physiological benefits users have experienced, but moreover, how exposure to CT provided an increase in awareness and context for their utilization, recognizing the holistic components needed to reinforce a wellness orientation. The studies also provided a link to the discrepancies individuals experience in terms of personal and professional selves, identified as being analogous with professional identity. A critical issue for the profession, increasing comprehension of the attitudes and behaviors behind integration of CT in counseling can assist as a springboard into understanding CT. The qualitative findings provide rich detail for understanding subjective perspectives, while the quantitative research focused attention on a specific topics, aiming for more general comprehension of the effects of integrative practices.
**Figure 1.** The Indivisible Self Model of Wellness (IS-Wel) taken from Myers, J. E. & Sweeney, T. J. (2008). Wellness counseling: The evidence base for practice. *Journal of Counseling and Development, 86*, 482-493. Permission gained to reprint model from authors on September 6, 2011.
Chapter 3

METHODOLOGY

Complementary therapies are increasingly visible and viable options individuals in the U.S. are using to address their wellness needs (Astin, 1998; Bishop, Yardley, & Lewith, 2007; Coulter & Willis, 2007; Eisenberg et al., 1998). Complementary approaches, similar to counseling in terms of their holistic focus, are still largely unexplored in relation to their role in the counseling profession. The discussion of integration of CT in counseling is imperative as individuals try to find healthcare options that meet their needs and align with their belief systems. As a developing profession advocating and ascribing to a wellness orientation, counseling has the opportunity to use complementary approaches to understand and meet the needs of a diverse population of clients. The following research design details this qualitative study exploring the collaborative potential of integrating CT with counseling by detailing a theoretical framework, guiding methodology, and methods of inquiry.

Research Lens

Influence of the Researcher

As a former practicing counselor, my professional and personal worldviews are critical to disclose as they influenced my role in conducting this study. My perspective was detailed prior to the description of the study and will be continue to be referenced since it is an important influence on the research process (Hunt, 2011). Throughout this study, researcher transparency is highlighted, focusing the readers’ attention on the potential biases and assumptions that may have influenced my data collection and analysis. Because I am not only the researcher, but an instrument of the study (Flynn &
Black, 2011; Hunt; Morrow, 2005), providing as much detail as possible of my history related to CT and its role in my life is imperative.

As previously discussed, my background using CT in professional and personal contexts has influenced my assumptions regarding the utility of integration in counseling sessions. After designing my counseling internship in my doctoral program to focus on CT, assisting with an academic course focused on learning about complementary approaches (i.e., WF ED 497C: The Science and Art of Healing: Sustaining Healthy Living), delivering four presentations focused on CT and its utility in counseling (i.e., ACES; Institute for Complementary, Alternative, and Integrative Approaches; NARACES; Penn State Achievement Conference), integrating CT in several publications, and assisting in one and conducting two CT related research studies, my current and future investment in this area is evident. In addition to my interest and experience, as previously noted, existing literature supports the need to discern professional identity and practices. Conducting a study focused on recognizing the worldviews of the researcher and participants who are members of the same professional community (i.e., counseling) provides an opportunity for rich understanding of the integration of complementary approaches in counseling.

**Applying a Constructivist Worldview**

Attempting to understand perspectives and positions on healthcare approaches, researchers have demonstrated the impact experiences of using CT can have on individuals’ decision making (Caspi, Koithan, & Criddle, 2004; Rothaupt & Morgan, 2007; Schure, Christopher, & Christopher, 2008; Sirois & Glick, 2002). A constructivist worldview also recognizes realities are constructed by individuals and those perspectives
affect choices (Charmaz, 2006; Creswell, 2007; Patton, 2002), making it the lens of this study. Pertinent to qualitative methodologies, constructivism seeks to understand people’s beliefs, so perceptions are therefore relative to the individual (Hammersley, 2002). For example, in their study focused on the implications of reducing tracking in a racially mixed school, Wells, Hirshberg, Lipton, and Oakes (1995) found a constructivist approach allowed them to get all of the sides of the issue. Similarly, Gibson, Dollarhide, and Moss (2010) used a constructivist approach allowing participants’ (i.e., counselors in training) experiences to guide the development of a more comprehensive understanding of how transformational tasks influence the development of professional identity. In other words, the researchers were able to view the differences in participants’ interpretations of the issue depending on their role in the school or their experiences in training, therefore, truth was relative to their perspective (Crabtree & Miller, 1999).

Similarly, in this study, hearing the various perspectives of counselors in the field, which are tied to diverse factors, the contrasting views of how and why CT is integrated into sessions can be used to develop strategies to increase the openness and awareness of the counseling profession to meet the wellness needs of all clients.

Numerous scholars (Creswell, 2007; Lincoln & Guba, 1985) reinforced Charmaz’s (2006) constructivist perspective of “emphasizing diverse local worlds, multiple realities, and the complexities of particular worlds, views, and actions” (p. 65). Using this interpretivist or naturalistic approach to inquiry (Crabtree & Miller, 1999; Lincoln & Guba), as the researcher, I also negotiated my own perspective while discovering “hidden networks, situations, and relationships…focusing on the views, values, beliefs, feelings, assumptions, and ideologies of the individuals” (Creswell, p. 65).
while planning, conducting, and now presenting the findings from the study. A constructivist approach also utilizes a priori understanding or theory, which is malleable (Crabtree & Miller); for example, I had some ideas regarding what factors influence counselors’ knowledge, attitudes, and behaviors towards CT (i.e., exposure to CT influencing professional identity, application of the wellness model, and ethical practices), but this study explores those categories and highlights the perspectives of practicing counselors. Even with some conceptualization of how the integration of CT can be influential in the counseling profession, the significance of employing a qualitative methodology allowed factors to emerge regardless of preexisting information.

**Research Design: Grounded Theory**

Research in the counseling profession has lacked substantial inquiry into CT, particularly the attitudes and behaviors surrounding their use (Evans et al., 2002). The limited number of empirical studies published by individuals in the counseling profession have primarily focused on CT usage by graduate level counselor trainees for self-care (Chambers Christopher & Maris, 2010; Chandler et al., 2001; Chrisman et al., 2009; Schure et al., 2008). Of these studies, all used qualitative methods to explore the experiences of participants.

Qualitative research is used to gain in depth information from individuals and, applying a constructivist approach, understand information from each person’s subjective viewpoint (Charmaz, 2006; Patton, 2002). The goal of qualitative research is to provide “a coherent and illuminating description of and perspective of a situation” (Schofield, 2002, p. 174). With its roots in the social sciences, the aim of grounded theory is to develop classifications and theory about a particular phenomenon grounded in the
information collected utilizing systematic procedures (e.g., open, axial, and selective coding; Corbin & Strauss, 2008; Glaser & Strauss, 1967; Strauss & Corbin, 1998).

As Charmaz (2006) and others have reiterated, the nature of qualitative inquiry is inductive or approaching the research with questions, but in an attempt to develop theory, rather than using the data collected to test a theory (i.e., deductive). The process of conducting a grounded theory study is not linear but rather a back and forth procedure consisting of comparing, contrasting, and adjusting data, while simultaneously seeking out more information to support the emerging patterns (Merriam, 2002). Bryant and Charmaz (as cited in Bryant & Charmaz, 2007) reinforced this abductive method or approach to “considering all possible theoretical explanations for the data, forming hypotheses for each possible explanation, checking them empirically by examining data, and pursuing the most plausible explanation” (p. 16). Grounded theory is embodied by the constant comparative approach or the detailed collection and coding of the data, in refining levels of analysis that derive a theoretical interpretation of what has been acquired (Bryant & Charmaz; Crabtree & Miller, 1999; Glaser, 1978).

Throughout the description of the study will be markers of grounded theory methodology and how I constructed categories and eventually a theory, keeping in mind my current and past experiences (personally and professionally) with CT, the participants, and procedures to explore my current questions (Charmaz, 2006). The research questions were closely modeled on research conducted on CT in the fields of medicine (see Hsiao et al., 2005, 2006) and counseling (see Evans et al., 2002). Particularly, the study was significantly shaped by the findings from my pilot study uncovering counselors’ perceptions of CT approaches (Nichols, in preparation). The data
assisted in adjusting the recruitment and interview procedures and data analysis methods to best explore the main questions surrounding integrating CT in counseling sessions. The research design, guided by the research questions and supporting literature, including the study sample, data collection methods, trustworthiness, and process for analyzing and reporting the data are described in detail. Again, the previously addressed overarching questions that directed the study are:

1. How are practicing counselors integrating complementary therapies (i.e., mind-body approaches) into counseling sessions?
2. How do various factors influence counselors’ knowledge, attitudes, and behaviors towards complementary therapies?
3. How do counselors perceive counseling effectiveness with clients when complementary approaches are integrated into the session?

Procedures

Participants

Counselors who completed at least a master’s degree in counseling, regardless of emphasis (e.g., rehabilitation, community mental health, school), were currently seeing clients, and integrated mind-body techniques in session were identified using purposeful sampling techniques (Crabtree & Miller, 1999; Creswell, 2007; Patton, 2002). Purposeful sampling is the intentional selection of individuals based on the focus of the study to gather the most details regarding the phenomenon. Professional counselors were used as participants because graduation with a master’s degree in the counseling profession signifies the attainment of professional membership (i.e., C.4.f.; ACA Code of Ethics, 2005). Males and females were equally desired as well as individuals of various
ages, races, and ethnicities who meet the selection criteria above, however, only two males agreed to participate in the study. A diverse sample of counselors in terms of age, sex, ethnicity, religious and/or spiritual beliefs, sexual orientation, disability, and education/training background, as well as counselors working with a diverse client population were recruited.

A total of 17 individuals were interviewed, however, 16 participants were included in the study. During the interview process, although one individual indicated on her demographic form that she completed her master’s in counseling, I discovered she was trained in counseling psychology and identified as a psychologist (was applying for doctoral programs) so she was not included in the study. Participants primarily identified as Caucasian or White ($n = 15$) with one individual not completing that answer on the demographic form. Locations of practices ranged from the northeast ($n = 6$), mid-Atlantic ($n = 2$), southeast ($n = 3$), and mountain west ($n = 5$) regions. Settings included rural ($n = 7$), suburban ($n = 3$), and urban ($n = 5$) areas. Age of participants ranged from 29 to 73 years old ($M = 52$). With an open response item to identify religious and/or spiritual orientation, or absence of, participants identified: none ($n = 4$), with one identifying leaning toward spirituality), spiritual/non-religious ($n = 3$), Roman Catholic ($n = 2$), Jewish/spiritually open ($n = 1$), Christian & spiritual ($n = 1$), Christian with respect and awareness for other religions ($n = 1$), Lutheran ($n = 1$), Christian ($n = 1$), Generalist ($n = 1$), and Buddhist orientation ($n = 1$). Sexual orientation included heterosexual ($n = 11$), hetero/bisexual ($n = 1$), bisexual ($n = 1$), and homosexual ($n = 3$). Although only three individuals identified having a disability (e.g., physical limitations, chronic illness) including diabetes, asthma, lower back pain, and Fibromyalgia, during
the interviews an additional four participants expressed past or current physical health concerns.

Participants cited a wide range of specialties (i.e., marriage & family, community, mental health, couples, group, trauma and/or disaster resolution, grief & loss, rehabilitation, eating disorders, dissociative identity disorder, addictions, college) and certifications (i.e., EMDR; addictions; clinical supervisor; internal family systems; Gestalt; hypnotherapy; yoga therapy; trainer, educator, and practitioner of psychodrama; sociometry and group psychotherapy (TEP); holistic nurse; registered nurse). Only one of the 16 participants was not a licensed counselor (i.e., LPC, LMHC, LMFT). In addition to their master’s degrees, three participants earned post-master’s credits and six hold Ph.D.s. Of the master’s programs participants attended, 12 were CACREP accredited and four were not (although one of those programs became CACREP since the individual graduated). Participants’ experience working with clients (post-master’s) ranged from 4 to 35 years ($M = 18.4$).

**Recruitment.** A snowball technique, or collecting participant referrals from other counselors throughout the interviewing process, was used to identify counselors utilizing various mind-body techniques while working with clients in counseling sessions. Similar in intent to the research conducted by Hsiao et al. (2006), participants were asked to identify other counselors who might be willing to be interviewed who have more extreme positive or negative views regarding the integration of CT in counseling compared to themselves to provide maximum variation and saturation (Creswell, 2007; Lincoln & Guba, 1985). Saturation or redundancy is when no new information emerges from the interviews (Crabtree & Miller, 1999; Fassinger, 2005; Lincoln & Guba). Working
towards saturation, as more counselors were interviewed and asked for referrals to other counselors utilizing CT in sessions, only several stated they knew anyone else who might be willing or able to be interviewed leading to more participants. Aligning with an inductive approach, this method allowed me to use initial data collected (i.e., initial interviews) to construct theories, but continued refinement of ideas required additional information and analysis (i.e., snowball sampling to recruit more participants to fill in the gaps in the developing theory, clarifying emerging categories, as well as reinforcing data through saturation of their responses; Charmaz, 2006; Corbin & Strauss, 2008; Glaser & Strauss, 1967; Patton, 2002; Strauss & Corbin, 1998). By utilizing the described method to obtain data, I was able to gather comprehensive information (i.e., triangulation; Crabtree & Miller, 1999; Creswell, 2007; Heppner, Kivlighan, & Wampold, 1999).

Participants were initially recruited for the study in two ways. First, a recruitment announcement was posted twice on the INTEGRATIVE_COUNSELING-L@neiu.edu listserv three weeks apart (the second time was one week after the 2011 ACA Annual Conference), specifically designed for individuals interested in complementary, alternative, and integrative approaches in counseling. The group was developed by a counselor and a counselor educator. Second, participants were recruited based on previous contact with me, the principal investigator, and several were a referral or recommendation by other counselors participating or not participating in the study due to their integration of CT, specifically mind-body approaches, in counseling sessions. As previously discussed, the increasing use of mind-body approaches (e.g., meditation, yoga, biofeedback, EMDR), coupled with narrowing the focus of the study to this one area of
CT created more detailed criteria and a purposeful sample was gathered, however, many counselors used techniques from various CT categories.

In addition to sending the recruitment emails to the identified listserv (Appendix A) and individuals who I had previous knowledge of (Appendix B), I also searched for counselors using the Internet and successfully recruited more individuals. I also discussed needing participants with several faculty in the department who agreed to send my recruitment email to individuals who they thought might know practicing counselors, which yielded no participants. Additionally, at the 2011 ACA Conference, I made contact with a counseling faculty member at a university who supplied me with several names of individuals who were included in the study. At the conference I also put a flyer on the announcement board using the information from the listserv recruitment email and, although all 12 slips were taken and multiple contacts made, it yielded one participant.

The content of the initial recruitment contact gave a general description of the research and interview process as well as how and why they had been specifically contacted. When the initial (and subsequent) participants made referrals of additional counselors to interview, they were contacted (see Appendix C). Regardless of how an individual was identified or recruited for the study, deception was not utilized in these additional email recruitments, but measures (e.g., purposeful description to participants being recruited as to why they are being recruited) were taken to let them know why and how they were identified. Once interest was expressed, I sent a more detailed email including initial plans to coordinate a time and location to meet with the participants, at
their convenience as well as information on how to complete the demographic form (Appendix D).

**Sample size.** The goal of recruitment was to collect rich and sufficient data to begin identifying the convergent and divergent factors influencing counselor knowledge, attitudes, and behaviors toward CT (Charmaz, 2006). The size of the sample consisted of 16 individuals, which was determined by saturation of responses or when the categories of how and why counselors integrate CT into sessions become redundant. McLeod (2001) recommends between 8 and 20 participants, as opposed to Creswell’s (2007) specific endorsement of 20 to 30 participants for a grounded theory study. Patton (2002) advocated a sample size contingent on what the researcher wants to know (e.g., more people, less opportunity for depth). The number of participants was ultimately dictated by the saturation of responses signaling a lack of basis or need to continue seeking informants based on the data collected (Charmaz).

**Data Collection**

In an effort to develop a broader understanding of the integration practices of counselors using CT in counseling sessions, various forms of data were collected. By purposefully using multiple sources of information (i.e., triangulation) the trustworthiness of the study was reinforced (Lincoln & Guba, 1985). In addition to one-to-one interviews with participants, documents and artifacts collected provided additional context to illuminate the phenomena (i.e., brochures, business cards, websites, curriculum vitae, masked session notes of counselors and/or agencies, information on techniques used in session, demonstrations of techniques/tools, example assessments used with clients).
Individual interviews. Approval was received from the Penn State Institutional Review Board (IRB) and in-depth individual interviews were immediately scheduled with known individuals to collect detailed information in confidential settings. The pilot study I previously conducted revealed feelings of stigma attached to opening up to other counselors about factors influencing attitudes towards CT, including personal use. One participant in the focus group (who knew and identified as having positive and open relationships with all the other group members) expressed, “I feel this shroud of secrecy, like I don’t want other people to know, I don’t want to bring shame on the counseling profession [for using/supporting CT].” Considering her statement and the potential for individuals to feel restricted in their responses, individual interviews were used in the current study allowing a confidential opportunity to probe participants for detailed information regarding their experiences and attitudes (Hsiao et al., 2005; Rubin & Rubin, 2005). Overall reactions from participants in both the pilot and present study reinforced individual rather than focus group interviews to give informants the maximum opportunity to share their stories and insights as well as allow greater control of confidentiality (Morgan, 1997). The majority of my attention related to confidentiality, in addition to my ethical and IRB responsibilities, was related to developing rapport with my research participants. I reiterated my commitment to participants’ rights and comfort by providing them detailed information beginning with the initial contact I made with them regarding the study (e.g., masking identity with participant numbers and pseudonyms; see ACA Code of Ethics, 2005, Section G.2. & G.3.).

Interviewing procedures. The interviews took approximately one to one and a half hours to complete and were all audio recorded with two digital recorders. Some
participants expressed a desire to continue telling their story, with one interview lasting approximately 105 minutes. Participants, depending on their location and preference, were offered the opportunity to be interviewed in person at a location of their choice or via phone or Skype. Participants were made aware that if they selected the phone or Skype (i.e., online video communication) interview, due to the use of technology, information via the internet could not be guaranteed confidential due to potential interception by a third party. All interviews conducted in person ($N = 8$) were located at the individual’s professional work site. Before conducting the interviews, participants were asked to read through an implied consent form (Appendix E or F) and complete a brief demographic questionnaire (Appendix G) pertaining to their sex, age, ethnicity, religious/spiritual orientation, counseling area (i.e., specialty), counseling training, number of years seeing clients, licensure/certification status, and membership in professional organizations. Each participant completed the demographic form and confirmed reading the informed consent with no questions or concerns.

I followed a semi-structured guided interview schedule with specific questions and prompts listed (Appendix H). Sample questions included, but were not limited to:

- When and why did you start integrating (state mind-body practice here) into your counseling sessions?
- Define your professional identity or what values and roles you ascribe to as a counselor.
- Tell me about your introduction to and experiences with CT.

The construction of the interview questions, including the three identified research questions (see p. 67) were intended to elicit detailed information about participants’
knowledge, attitudes, and behaviors toward CT. Using a semi-structured interview protocol allowed me to have similar topical areas to address with each interviewee, but also gave the participants freedom to answer the question in a less restrictive way that might support greater insight into their response (Rubin & Rubin, 2005). As previously indicated, each interview was audio recorded and transcribed using Dragon dictate software. Participants were notified and reminded of the interview and transcription procedures at several times during the study. As a token of appreciation for their time, upon conclusion of the interview, participants received compensation of a $10 Starbucks or Target gift card. Although the majority of participants initially refused their compensation, two did not take the gift card even after my numerous attempts.

**Documents.** Artifacts proved to be an important additional source of data for the study. The 2010 and 2011 ACA Annual Conference program guides were two particular documents already identified that provided a broad context for understanding the perceptions of practicing counselors toward CT, by recognizing what professional topics are presented in the yearly exposition that could influence current members and reinforce participants statements. Planning the study, I was initially unsure of what additional artifacts would emerge, but with the assistance of participants, the additional data discovered and included enhanced and supported the theoretical findings stemming from the interviews. In one of the first interviews, a participant supplied me with one of her business cards as well as a folder containing detailed information about the agency she started and the various techniques offered by the counselors and complementary practitioners there. As a result, those individuals who were interviewed in person were asked for their business card or information that advertised them and their counseling
practices. For in-person and phone interviews, if the individual or agency where the participant worked had a website, that was also viewed, downloaded, and printed off to use as supporting data. One participant who did not have either of those resources supplied me with her curriculum vitae. Additionally, one counselor provided her masked session notes so that I could see the procedures used in neuroemotional therapy. Three other counselors supplied me with their informed consent/intake forms. Documents and other artifacts helped me to gain a broader understanding of the counselor’s practice.

Individual interviews and the documents or artifacts collected provided a rich data set. The procedures for selection, recruitment, and execution of the data collection methods described delineated a detailed and purposeful research design. The solid research design allowed me to make minimal changes, outside of needing to recruit participants in various ways than initially anticipated, but the adjustment was guided by the data collected and seeking individuals that would help me reach saturation (Lincoln & Guba, 1985). Ultimately, the details provided would reinforce the trustworthiness and rigor of this research study.

**Data Analysis**

Similarly to the debate regarding ways to establish and enhance the trustworthiness of the study, so are there various approaches to confidently conducting the analysis of the data (Welsh, 2002). Analysis was conducted concurrently with data collection, utilizing a constant comparative approach, as previously described, utilizing open, axial, and selective coding to allow categories to emerge from the interviews and allow a core theory to emerge (Charmaz, 2006; Flynn & Black, 2011; Glaser, 1978; Glaser & Straus, 1967). In other words, I listened to the interview an initial time to do
the main transcription and listened to it a second and third time to make edits and adjustments while reading through the transcript. I read through the transcripts of the interviews multiple times after participants provided their comments/edits and then begin to look for patterns to emerge, going back and forth between transcripts, my notes, and artifacts, comparing categories as they were uncovered. As Patton (2002) reinforced, “do your very best with your full intellect to fairly represent the data and communicate what the data reveals given the purpose of the study” (p. 433).

With that in mind, open, then axial, and finally selective coding were used to detail the emerging categories and allowed for larger themes to develop (Corbin & Strauss, 2008; Fassinger, 2005; Vogel et al., 2003). Specifically, individual words and phrases were identified line-by-line that related to the research questions (i.e., open coding). I created an initial hard copy codebook (see Table 1) as I went through the transcripts initially using templates from Graneheim and Lundman (2004). Comparing the general coded data and questioning their connection allowed me to begin grouping data together depending on my conceptualization of the information (i.e., axial coding). As Fassinger (2005) explained, axial coding groups categories of data “into more encompassing (key) categories, that subsume several (sub)categories, thus [putting] the fractured data back together in the form of categories and their interrelationships, the next step in generating theory” (p. 160). As the main categories started to become more evident, after using different words and eventually different phrases to represent the phenomenon, I began to draw various conceptual maps, experimenting with how the categories were impacting one another. The final step (i.e., selective coding) incorporated the main categories into a general explanation or theory of the phenomenon.
At several points, guided by the recommendation of trained qualitative researchers, I used free writing as a way to extrapolate how the subcategories related to each of the categories. The theoretical model eventually developed was compared to the codebook information analyzed to support the final figure. Using this constant comparative or thematic analysis approach (Boyatzis, 1998) of identifying and grouping patterns (Patton, 2002) provided a way to enhance understanding of the CT integrative practices of counselors practicing in the field.

**NVivo8 Software**

Initial electronic codebooks made in Word were developed primarily due to convenience. When able to access NVivo8 software, however, it was used to organize, code, and store the data confidentially and clearly, while reinforcing confirmability. Relatively simple computer software to navigate for my purposes, the program has the capability to import and create documents that can be organized into various folders for easy extraction (Welsh, 2002). The documents themselves were manipulated in one location, allowing visible coding strips and annotations for me to track their analysis. For example, in vivo statements that exemplified the emerging categories were highlighted in the electronic transcription document and placed in a file labeled with that category. Flagging words and statements so they appear in a folder focused on a specific category allowed a more simplistic way for me to navigate so many pages of data.

Computer assisted qualitative data analysis software (CAQDAS), however, like most aspects of research, has been debated. CAQDAS has been linked to a grounded theory approach in terms of its systematic approach to organizing data, lending to its
purposefulness for this study as well as the added rigor and verifiability it added to the process (Welsh, 2002). Utilizing the functions of NVivo8 or CAQDAS, while a valuable tool, were balanced and negotiated because, like most tools, there are limits to its resourcefulness. Again, while NVivo8 was used for analysis, initial and final coding was done with hard copies of the transcripts due to the difficulty accessing the software located in a room in the department that was only available Monday – Friday, 8:30am-5:00pm. Limitations also included some initial challenges navigating and understanding the various program functions and commands, including ensuring the data remained confidential to other users of the software. Overall, the blend of using Word created codebooks and NVivo8 allowed me multiple options to view and organize my data.

Trustworthiness of Research

Discussed as the validity of qualitative research by some (Creswell & Miller, 2000), Cho and Trent (2006) defined it as transactional validity in the qualitative realm, supporting the integrity of the study rests largely on demonstrating the trustworthiness of how and through what lens the study is conducted. Qualitative research criteria can be identified as: credibility, dependability, transferability, and confirmability (Creswell & Miller; Golafshani, 2003; Lincoln & Guba, 1985). What constitutes as validity, or trustworthiness, in qualitative research is contested and has been investigated by numerous scholars (Cho & Trent; Lewis, 2009; Welsh, 2002), but utilizing the aforementioned four constructs of trustworthiness provided a structured approach to addressing the factors that strengthened the study and provide elaboration of grounded theory techniques.
Credibility

The first component to trustworthiness, ensuring the credibility of the data that I collected, depended on a variety of factors including triangulation, debriefing with other trained researchers, member-checking, and negative case analysis (Lincoln & Guba, 1985). Triangulation, often primarily referring to the use of either multiple data sources or methods of data collection (Crabtree & Miller, 1999; Patton, 2002) can also include different investigators and theories (Denzin, 1978; Lincoln & Guba, 1985). Interviewing a broad range of individuals helped to obtain variation of knowledge, attitudes, and behaviors surrounding the integration CT in counseling. Using documents and artifacts also assisting in understanding the emerging categories.

Additionally, I debriefed with other researchers during initial analysis on an as needed basis (e.g., biweekly) at first then for meeting weekly while phasing from axial to selective coding. Getting feedback from others on my approach and emerging theory and conceptualization allowed me to make adjustments to what I was looking for and how I was organizing what I was doing which strengthened the study design and data analysis. In grounded theory, the constant comparative analysis of data coupled with having individuals to challenge the assumptions and categories I developed allowed me to cultivate those ideas further (Creswell & Miller, 2000).

Member-checking (Flynn & Black, 2011; Marrow, 2005) was built into the interview process by checking with participants as findings emerged from their interviews and was a critical aspect to ensure I accurately captured their stories. Every participant was emailed or sent a hard copy of their transcribed interview and asked to provide feedback to ensure accuracy of their statements. All participants returned...
feedback, although one participant did not specifically comment on the interview but confirmed reading and approving of the transcript. This opportunity was included in the informed consent process, asking participants to be willing to react to the categories constructed from their experiences and is seen as crucial to establishing credibility and also as a means of building rapport and trust with participants (Creswell & Miller, 2000; Lincoln & Guba, 2000).

My aim in being open and detailing the study in emails and the informed consent was that when the interview was conducted, participants had more comfort with me and the process. It did appear to allow me to gain rapport and collect detailed information to understand the context of their experiences. Koro-Ljungberg (2008) discussed how validation of information (i.e., member-checks) includes knowing the way participants construct their positions based on their “individual, collective, and spiritual experiences within social worlds, as well as the ways in which they engage in dialogue about their assertions with the environment” (p. 986). It would be difficult to obtain such important information without establishing a sense of trust, which must be cultivated from the start of the study (Dey, 1999). I worked on establishing trust by allowing participants to choose the location and/or format for their interview and giving them context by describing my background and interest in the topic. Finally, as I conducted interviews with the various counselors, none of the individuals seemed to contradict the emerging categories I was developing, but even if they had, they would not be eliminated but would have assisted me in refining my analysis and understand their relationship to my claims to strengthen both the credibility and dependability of the research (ACA, 2005; Lincoln & Guba; Mays & Pope, 2000).
Dependability

Utilizing purposeful sampling, particularly theoretical sampling to provide rich information to support my emerging theory (Charmaz, 2006; Corbin & Strauss, 2008; Glaser & Strauss, 1967), along with a detailed and accurate audit trail (e.g., memos and self-reflection or reflexivity; Charmaz) to address my bias in the process supports the dependability and rigor of the research I have conducted (Morse, 1998). Characteristic of all qualitative research, as the researcher, I was the primary instrument for data collection and analysis (Hunt, 2011; Merriam et al., 2002, p.5; Morrow, 2005). The constructivist lens and past experiences and beliefs that participants and I brought to the study were examined and detailed as I developed categories and theories around the data. I had to be very mindful during the process to not insert my opinion during the interview process and allow participants an open space, not interjecting my biases. Most of the time I was successful, but the wrap-up of the interviews typically stimulated a conversation with the participant surrounding my perspective and will be detailed in the discussion section. Additionally, as previously stated, all interviews were audio taped allowing for my verbatim transcription, reinforced by Ronthaupt and Morgan (2007) during their qualitative study of mindfulness practices of counselor and counselor educators as another opportunity to ensure “reliability and fidelity” (p. 44).

Confidentiality is coupled with reflexivity and how I used and will report the information collected in the upcoming chapters, particularly the interviews, maintains the ethical integrity of the study and participants (Clandinin, 2007). Since pilot data already revealed individuals’ concerns about how other professionals will view them if their knowledge, attitudes, or behaviors were known, I found a balance and relied on
debrieﬁng and member-checks to assure that conﬁdentiality was maintained. All names
and identifying information has been masked by me (e.g., if the participant did not supply
a pseudonym, I created one) or the participant. The de-identiﬁcation process was
detailed in the informed consent form as well as during the ﬁnal debrieﬁng after the
interview (ACA, 2005; Bogdan & Biklen, 2007; Heppner et al. 2008).

Dependability is also demonstrated in the presentation or reporting of the data,
organized in hardcopy, Word documents, and in NVivo8 by maintaining conﬁdentiality
of participants, providing rich detail, and clearly deﬁning its limits (e.g., researcher’s
lens, study design, methods used), which is reinforced by the ACA Code of Ethics
guide the ﬁnal preparation of the data collected and analyzed for consumption. For
example, to adhere to section G.4.a. Accurate Results, the ﬁnal study report clearly labels
the emergent categories distilled and utilizes in vivo statements throughout to
demonstrate the perspectives of participants. Rubin and Rubin (2005) also suggested
speciﬁc writing techniques (e.g., tone and style, use of quotations) that are utilized to
increase the clarity and purposefulness of the qualitative methodology. Implications from
the data for practice, training, and research are also a primary focus when applying the
ﬁndings in the discussion. Being transparent throughout the process gives readers an
understanding of how to interpret the information provided for themselves and utilize it
to support professional growth. Finally, the information reported has clearly deﬁned
limits and boundaries, recognizing the exploratory and naturalistic nature of the study and
subjective analysis.
Transferability

The use of thick description (i.e., participants, contexts, concepts and categories, behaviors, and structures and processes) provides the opportunity for possible replication for future studies and demonstrates rigor of the study (Heppner et al., 2008; Lincoln & Guba, 1985; Mays & Pope, 2000). Not concerned, or even dismissive of the generalizability of findings by some researchers, there is a growing interest in the transferability of qualitative research (Schofield, 2002). The use of open questions from a semi-structured interview guide allowed for the detail to emerge from the participants’ narratives (Flynn & Black, 2011) along with descriptions and information from the various documents collected. The information and methods described will assist in replicating the study to get a better understanding of the integration of CT in counseling that can address teaching and practice policy and standards in the counseling profession. Additionally, the richness of the data creates a context for the data, which comes from a particular perspective (i.e., the participant’s, documents; Charmaz, 2006). The voices of individuals within the profession are powerful and by uncovering patterns and consistent, or inconsistent, messages from the information collected, transferability provides powerful support for continued research and funding to better understand the integration of other holistic approaches with counseling to support client wellness.

Confirmability

Support can continue to be cultivated by addressing concerns related to the objectivity of the study with techniques such as maintaining detailed records of everything done within the confines of the study. Detailed records kept include the verbatim transcription and accompanying notes pertaining to the context of the
interviews, as well as reflective memos detailing my thoughts and decisions throughout
the process. Boyatzis (1998) affirmed that the qualitative research process is highly
subjective and therefore the researcher influences the collection, processing, and analysis
of the data, thus supporting the importance of documenting my thought process during
the study. Adhering to IRB and ethical standards (i.e., ACA, 2005), like other research,
my records are accurate and clearly stored and identified in a way that maintains
confidentiality (Heppner et al., 2008). The stored data serves as verification of the rigor
exercised throughout the study in terms of design (e.g., theoretical stance, rationale, IRB
approval) and execution (e.g., data collected including reflexive memo’s related to
coding) to reinforce the overall trustworthiness of the study.

As prefaced throughout the study description and rationale, the interest in
uncovering and increasing the understanding of how and why counselors’ integrate CT in
practice comes from an inductive and researcher developed framework. Viewing the
participants experiences from a constructivist lens and finding categories amongst
multiple realities sheds light on various perspectives regarding the role of integrating CT
in professional counseling (Lincoln & Guba, 1985). The exploratory results from this
study provide the counseling profession with data to support the continued investigation
of the integration of CT and counseling to increase practice, training, and research
options focused on achieving optimal wellness for individuals.
Table 1

Data Analysis Codebook Example

<table>
<thead>
<tr>
<th>Meaning Unit</th>
<th>Condensed Meaning</th>
<th>Interpretation</th>
<th>Subcategory</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Jul) 137, [describing her mentor] she’s been the gateway for me, the doorway, that really to explore complementary treatments and avenues</td>
<td>Exposure to integration because of exposure to respected individuals doing that work</td>
<td>Learn about CT due to exposure from trusted individuals</td>
<td>Trusted persons</td>
<td>Experience with CT</td>
</tr>
<tr>
<td>(Corey) 546, And I was interested too, from a personal aspect, for my older daughter who is on the mild end of the autistic spectrum, with a more Asperger’s presentation, so there was some interest there too because there has been a lot of research on it’s impact on that…</td>
<td>Exposure to information but following personal interests</td>
<td>Use of CT driven by personal motivation</td>
<td>Personal reasons and motivations</td>
<td>Experience with CT</td>
</tr>
<tr>
<td>(Amanda) 220, that led me to a lot of research that was going on about attachment and neuroscience, what people were finding helpful. One of the things, well two of the things, well three of the things that kept coming up were EMDR, neurofeedback and Cranial Sacral therapy…</td>
<td>Empirical support for various CT approaches</td>
<td>Using research to enhance understanding and provide effective options for treatment</td>
<td>Gathering informal knowledge</td>
<td>Development of CT Competence</td>
</tr>
<tr>
<td>(Anne) 469, I would love to do an educational session on adjunct ways that you can introduce complementary modalities…. I just would never probably submit a proposal because I just don’t see that being accepted. I was looking over the all the sessions myself when I was in New Orleans and I just didn’t see much offered…</td>
<td>Wanting to do something on the national level to talk about CT, but doesn’t seem to be a great deal of support in counseling</td>
<td>Advocacy for integration and wanting to legitimize the ethical practice</td>
<td>Opportunity for advocacy</td>
<td>Reinforcement of CT Use in Professional Practice</td>
</tr>
<tr>
<td>(Joy) 330, I really did not feel comfortable after my training… I went back and got an additional 30 hours of advanced training through a different person and I can now say that it was the training because I did feel much more prepared and in fact started using it more…</td>
<td>Proper training important for competent practice; training important for increasing confidence in approach use</td>
<td>Training instills confidence and competence with approach</td>
<td>Formal knowledge acquisition</td>
<td>Development of CT Competence</td>
</tr>
<tr>
<td>(Healer 1) 449, Reiki and healing touch are very, very related and they’re much more hands-on and I’m just so conscious of the ethical and legal liability of putting hands on clients… There will be some people who will be unethical and others who will avoid using the approaches because they can’t figure out how to use them ethically.</td>
<td>Adjusting techniques to fit professional legal and ethical standards of counseling practice.</td>
<td>Challenges integrating disciplines to meet ethical standards of counseling profession</td>
<td>Ethical understanding</td>
<td>Development of CT Competence</td>
</tr>
<tr>
<td>Meaning Unit</td>
<td>Condensed Meaning</td>
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<td>Subcategory</td>
<td>Category</td>
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<tr>
<td><strong>(Corey) 414,</strong> think it really seems like it is actually something that is really actually something that ends up being quite helpful as far as they pay attention to it, so I guess that comes into play as far as the intuitive aspect</td>
<td>Intuition can become a useful tool for counselors that pay attention to it</td>
<td>Belief in the utility of intuition</td>
<td>Intuition</td>
<td>Beliefs Creating Openness to CT</td>
</tr>
<tr>
<td><strong>(Jul) 422,</strong> here’s a diversity of responses; different pieces will work for different people… I find that there’s always some form of creativity and spirituality; I believe that every human being is creative, and I believe that every human being is spiritual and sometimes I do struggle with tapping into, or finding that, but with finding those mediums that will allow us to connect with their creativity and spirituality</td>
<td>Mixed reactions to integration of approaches, but clients have voice to use or not, but counselor’s goal is to help clients tap into creative and spiritual selves.</td>
<td>Creativity of approaches hoped to stimulate creativity of clients while aligning with their needs</td>
<td>Importance of creativity</td>
<td>Beliefs Creating Openness to CT</td>
</tr>
<tr>
<td><strong>(Bob) 809,</strong> It was so important for me in my personal life and that’s where it started. As I watched other psychodramas as a group member and saw how it positively affected other people, it really reinforced what I believed.</td>
<td>Impact of CT on personal life and becoming more involved in it professionally because of effectiveness</td>
<td>Positive experiences and awareness of CT through personal use.</td>
<td>Alignment of practitioner identities</td>
<td>Reinforcement of CT Use in Professional Practice</td>
</tr>
<tr>
<td><strong>(Janet) 85,</strong> the whole mind-body-spirit connection has always been something that I really believed in, didn’t necessarily always practice it, but believed in it.</td>
<td>Belief in mind-body-spirit connection, but not always practiced so being attune to it</td>
<td>Holistic belief in all parts of a person needing to come together for health</td>
<td>Connection of mind, body, and spirit</td>
<td>Beliefs Creating Openness to CT</td>
</tr>
<tr>
<td><strong>(Joy) 93,</strong> because if I can’t do that, then I just think that anything else I try to do, whether it be a technique or some kind of skill, I just think would be very ineffective without it; so unconditional regard and showing complete non-judgment and trust in the client with what they’re telling me what their experiences are and with what their choices are</td>
<td>Unconditional regard, non-judgment and trust is essential for counseling process and for integration process of CT</td>
<td>Therapeutic relationship significant aspect of integration counseling work</td>
<td>Cohesion with clients</td>
<td>Reinforcement of CT Use in Professional Practice</td>
</tr>
<tr>
<td><strong>(Amanda) 483,</strong> We’ve seen probably a years worth of therapy collapsed into six months when we’ve worked with folks with discrete traumas like rape, sexual assault, like one or two events not chronic I’m not talking about chronic, when there’s been discrete traumas integrated with EMDR and regular talk therapy and Cranial Sacral or energy or bodywork we’ve seen 12 months of therapy collapsed into 6 months and it’s been incredible.</td>
<td>Experiences integrating techniques expediting change of discrete client issues compared to using other therapy approaches in isolation.</td>
<td>Integration creates effective and efficient opportunities for change</td>
<td>Effectiveness and Efficiency in the process</td>
<td>Reinforcement of CT Use in Professional Practice</td>
</tr>
</tbody>
</table>

Note: Adapted from Graneheim & Lundman (2004)
Chapter 4

RESULTS

The integration of complementary therapies (CT) into counseling practice has been scarcely investigated by the profession, although my personal and professional experiences with CT provided additional support to pursue this research investigation. Realizing the implications for the profession in regards to opportunities for creative and effective tools for counseling, I wanted to understand the factors contributing to CT integration into counseling practice. This chapter will presenting the findings that emerged from the data collected in the individual interviews conducted.

Guided by my research questions, using the constant comparative approach following the principles of grounded theory and consulting with trained researchers on my methods and emergent categories, I developed and refined a conceptual model of counselor integration of CT in professional practice. Four key categories were identified: (a) *Experiences with CT*; (b) *Beliefs Creating Openness to CT*; (c) *Development of CT Competence*; and (d) *Reinforcement of CT Use in Professional Practice*, and non-recursive in nature. The order of categories is reflective of their emergence in the model. Within these main categories are a number of subcategories providing additional distinctions. Definitions and examples of each category and subsequent subcategories will be presented to frame and finally detail the theoretical model developed.

**Experience with CT**

Whether actively pursuing for various reasons or as a result of circumstance, the initial knowledge created through *Experience with CT* was an essential element to future integration in counseling. During the interviews, I asked practitioners’ to share their
accounts of their initial experiences with CT. The initial awareness they gained as a result of using CT was an essential element for all of the participants’ engagement with CT.

Recognizing my own introduction to CT, it was important for me to understand the factors that contributed to practitioners’ awareness of, and their ultimate openness to, CT. Experience with CT, or the initial knowledge or recognition of the various approaches to health and healing, were met with mixed reactions and commitments from the practitioners interviewed. For example, Laura reported while growing up in the Deep South where she was exposed to “snake oil folk,” her background made her a “huge skeptic” of CT. Regardless of early perceptions, several experiences led to the participants’ eventual exploration of CT; participants identified two contexts that facilitated their awareness to the potential of CT use: trusted persons and personal reasons and motivations. Participants recounted their entrance into CT modalities was facilitated by individuals or environments and framed in terms of trust and respect, creating optimism about the various approaches. All but one participant highlighted the pursuit of various individual motivations or interests such as navigating illness or abilities. Regardless of conditions, practitioners identified the experiences that triggered their awareness of CT, focusing them on the positive potential and igniting the inception of CT into their future practices.

**Trusted Persons**

Four practitioners described experiences where CT concepts were framed as illegitimate due to religious or cultural beliefs, the remaining participants either did not reflect any negative perceptions, had neutral perceptions, or had no awareness of CT.
Regardless of their early ignorance, skepticism, or distrust, each participant eventually had an initial encounter with CT that was facilitated by a person or persons they trusted. Trusted persons was defined by participants as mentors, colleagues, family, and friends; the category reflects the willingness of participants to expose themselves to CT because of the confidence or reliance on the integrity of the individual who was facilitating the introduction. Knowledge created as a result of awareness from experiences with trusted persons ignited openness to the potential of CT use.

Anne shared her memory of first being exposed to CT in her graduate counseling coursework by a professor who integrated various approaches didactically and experientially in the class. Her recollection of her first exposure was one example of the positive interactions with CT consistently described by participants in contexts that exhibited trust and respect. Tim shared his entre into formally learning about hypnosis facilitated by his valued field supervisor. Jul also described one of her mentors, someone who gave her important support in her academic program, as being “the gateway for me, the doorway to really explore complementary treatments and avenues.”

Janet discussed her business partner exposing her to various CT while Cristin remembered hearing about EMDR in the 1990s from a friend and colleague who worked in the Veterans Affairs system. Although not popular or accepted practice at the time, she was reintroduced to EMDR again through two current, trusted colleagues who were more recently trained. Trust was evident during exposure in formal environments and was significant for some, however, many participants described awareness coming from contact in personal settings.
Cristin, although somewhat opened to CT because of interactions with colleagues, described the dynamic of her first personal experience using CT. “Part of what I think I struggled with is that I’ve got some control stuff and then it’s not easy for me to let go and just turn it over to put my body, mind, and spirit in someone else’s hands.” Like the other participants, when she was able to trust in the person and process, she experienced positive results from her personal CT use. She elaborated on the importance of trusted persons stating, “Not that I’m closed to …[CT], I’m certainly open to it, but it would have to be the right person, someone I really trusted and respected.” Janet reiterated, “I think my introduction to…[CT] had been through people that I’ve met and learned to respect.” Identifying the interconnection and importance of trust and respect in integrative work, the opportunities for exposure came from varied interactions promoting future exploration of CT.

Similar to the way almost all of the participants described their gatekeepers to CT, I was introduced to CT by a long-term academic mentor (i.e., my advisor through my undergraduate career), and the trust that facilitated these initial positive interactions with CT was a critical factor. Reflecting on this connection, there is a synchronicity with how and why individuals were initially exposed to CT. Just as influential as the actual experience were, the motivations or interests that resulted from the interactions sometimes served as the driving forces leading participants to seek out CT.

Personal Reasons and Motivations

Although the practitioners described a broad scope of interactions that led to their initial exposure to CT, the context for those interactions was primarily forged from personal factors. Personal motivations or finding the drive or incentive to actively pursue
something fueled putting those interests and abilities (i.e., reasons) identified outside of a person’s professional focus into action. Throughout the interviews, participants described exposure to many techniques (see Table 2) but limiting those they used in practice. Recognizing their personal motivations in using certain techniques as a result of personal aptitude(s) and/or desire to increase physical and/or mental wellbeing, practitioners had or developed an openness to CT.

Throughout the interviews, interests and aptitudes guided practitioners’ motivation. Joy described her introduction to CT based on her own curiosity 10 years ago and why she ascribed to one modality over another as follows: “my interests were so much more in this yoga direction that… I do incorporate some of the concepts, but I don’t really practice hypnosis much anymore.” Individuals are not going to use or sustain using something they are not interested in. As Bob stated, “I think about various treatments and decide if they appeal to me or not.” Discovering what appeals to various practitioners seemed to align with physical and spiritual comfort. As Kathy shared, “I think that my interest in [CT]…comes from my practice and my, my own view of the world.”

Seeing the influence of worldview on Experiences with CT, Lizzy specifically described some of her motivation in CT, and recounted “… it’s always self interest, isn’t it!” Her personal motivation was also enhanced by a particular ability to hypnotize others at an early age, reinforcing her interest. Several other practitioners identified specific aptitudes toward applying various CT modalities. Tim described how after learning hypnosis that he could better understand different situations he had experienced in his past. “I was holding back a power, and I don’t think the word was power back
then, but holding back something from me that could’ve come into play had I let it to bring something more to the person that was in the counseling room and was receiving counseling.” The distinct connections or aptitudes particular individuals identified during their experiences with CT personify personal motivations.

Coping with their own chronic illnesses was the main or additional motivator described by over half of the participants. Just as I was initially directed to CT as a way to combat deteriorating health in my late adolescence, exposure to various techniques allowed me to learn more about myself and realize my connection to the CT paradigm. Many times, such as in the case of Laura, a personal health crisis challenged participants’ initial beliefs surrounding CT. “How I got into the complementary, and I have to say that I was a very reluctant come to… but my introduction to it was when I thought I had a mole on my breast that was cancerous.” She described after reading about a particular modality and seeing a flyer for a workshop and given her possible diagnosis how the openness she developed allowed her to realize the benefits of CT.

Joy discussed overcoming clinical insomnia and narcolepsy as a result of integrating CT as a tool. “I guess how it was for me personally seeing not only people in my…[research] study being affected by it, but also knowing how it affected me and along with that insomnia.” Also looking for opportunities to address physical and simultaneously emotional health, Sandy described what led her to explore CT use:

When I was in my 20s I was having some health problems and I had gone to a bunch of conventional doctors who ran a bunch of tests and found nothing and told me that it must all be in my head since they couldn’t figure it out and I thought that was extremely arrogant and premature. So I started kind of looking
around for some other alternative treatments that I could try and one of those that I found that I wanted to try was with a kinesiology chiropractor, so a chiropractor that uses muscle testing, and who also used a lot of nutritional supplements and… a whole bunch of alternative techniques.

The thoughts and emotions in conjunction with the physical issues participants were trying to cope with stimulated the personal motivation to pursue CT use. For a number of participants, CT provided an avenue of hope and opportunity that traditional approaches were not offering.

From initial exposures through pivotal personal and professional experiences, the knowledge cultivated through Experience with CT served as the catalyst to the future integrative work of each of the counselors; it spurred their interest to learn more about the various practices. Participants routinely made statements demonstrating the significance of trusted persons and personal reasons and motivations to instigate the use of CT in counseling. After these experiences, while some practitioners focused on building their skills through additional training and knowledge building, others focused on processing and better understanding their beliefs coupled with CT.

Beliefs Creating Openness to CT

Just as experience emerged as an important force in the process of CT integration into counseling, beliefs were also an important factor. Beliefs are defined as ideas developed and believed as important and true. Participant beliefs influenced experiences with CT as well as the process of integration and continued exploration and evolution of those ideas. Particularly, intuition; connection of mind, body, and spirit; and importance of creativity were beliefs that emerged.
**Intuition**

The majority of the participants talked about the role of intuition, or their belief in individuals’ ability to be attuned to self, others, and the world around them. Intuition was essentially described as a sixth sense, another way for the practitioner to collect valuable information. This belief in intuition helped build the connection practitioners had with CT regardless of early negative or skeptical perceptions because of the insight intuition created. Tim described the importance of this kind of awareness, particularly in the case of identifying what the individual needs by providing numerous examples of how intuition guides his work. Recognizing the physical cues that manifest, he described intuition as the way a person translates and makes sense of this internal awareness.

Anne, in discussing the importance of intuition noted that it is:

…a pivotal component of the work that I do. And I think of all counselors, the degree to which they or that they are going to admit to this or not, [they] have an intuitive sense of who this [client] is and what their experience is and checking for the accuracy of it.

The acknowledgement of intuition and particularly its function and importance in the counseling process was rooted in these beliefs.

For many participants, intuition was described as an invaluable and essential role in constructing knowledge. Cristin explained her belief in intuition and its presence:

I think it comes from a connectedness and it comes from experience and the combination of all of that and again it goes back to this self-awareness thing. That you have to have some awareness of what’s going on internally and in reaction and response to the world. I don’t know how people would do therapy without
it… even if you got people out there who say, “oh, I don’t believe in that intuition stuff, it’s all crap;” I don’t know how you could do…[counseling] successfully without having some access to whatever that is, I’m not even sure how I would even define it but the gut!

Joy also identified the role of intuition as she explained, “I do really feel like that our bodies really hold a lot of information, and I know that I’m always telling my clients it sounds so cliché, but I asked them what is your gut tell you… I think intuition is a very significant part of this whole picture.” Focus on the body described by participants’ conceptualizations of intuition details their belief in its function, in general, but also in the helping process. Intuition creates an attunement to something bigger than the self and its contribution to openness to CT use aligns with a belief in the self or the connection of mind, body, and spirit.

**Connection of Mind, Body, and Spirit**

Regardless of how closely each individual ascribed to the formal definitions of wellness, there was recognition that an individual’s health is made up of multiple facets. Connection of mind, body, and spirit means that the cognitive, emotional, and physical qualities of an individual all influence each other. Having a holistic view of health and the interconnections of mind, body, and spirit of an individual were evident in all of the interviews. One participant, Anne, exemplified the investment in holistically approaching health through her professional roles as both a licensed counselor and a registered and board certified nurse consistently linking physical and mental health including the identification and processing of spirituality. Attempting to understand the knowledge base of practitioners, I specifically questioned them about their
conceptualizations of mind-body approaches. Jul shared, “if you connect your body it helps your mind. I believe that completely and absolutely with every fiber of my being. Our bodies are truth tellers.” She too interwove how spirituality is an important influence on how the mind and body function.

The belief in the connection of mind, body, and spirit was reinforced by the need to understand the whole person. Kathy also described the importance of the mind-body connection:

There has been a trend to look at people’s parts. And not take into account the full human experience and what that is and I think complementary therapies say it’s not enough to just do one piece of a person, you have to… well you don’t have to, but it works better if you incorporate the whole person and apply the therapies that that fit the whole person…Working with …[clients] from a mental health standpoint if I don’t include some of the parts that would affect the body, that would bring down the physical reactions to stress, you’re really doing them a disservice. But if you’re incorporating yoga or biofeedback or relaxation therapies then you’re looking at the whole person.

Janet also focused on the holistic approach to health. “I don’t like that word alternative because again, in a wellness or holistic approach, what’s alternative mean? It’s a wholeness, a wellness, a totality, it is that mind-body and again, spirit.” Although belief in the connection of mind, body, and spirit was explicitly endorsed by all, one participant did not specifically use the term spirituality, however, she did speak of the importance of beliefs and values in a holistic approach to healing. The mind, body, and spirit connection to understand health needs was valued by participants and increased their
feelings of cohesion in terms of their personal beliefs about CT and how to address this connection.

**Importance of Creativity**

A final reoccurring belief that emerged amongst the participants was the role of creativity in the connection with CT. In the interviews I heard a great deal of creativity, not only in their integration work but in the individuals themselves. The importance of creativity is defined as the ability to use or apply thoughts, actions, and imagination in a new and different way, transcending traditional approaches. Hearing some of the practitioner’s backgrounds (e.g., Meredith, a long-time musician; Bob, a child thespian) and current interests (e.g., photography, drawing) the link was obvious, but for others, their creativity and its importance in their personal and professional lives was more covert.

Discussions of their integration work highlighted participants’ connection with creativity and the value they placed in it. Sandy discussed how CT reinforces the importance of creativity. “There’s a lot of creativity in helping the client draw that information out so they can get that information and then framing that information.” Anne also identified the importance of creativity as she reflected on her initial exposure to CT integration in a counseling course. “That class really planted the idea in my mind that you can be creative and… there are many ways to work with clients and to assist your clients and that are also personally [rewarding].” Listening to the descriptions of how the counselors creatively presented information, tailored their practices, discovered information, and wove these various aspects together, I could not help but feel and see the significance of the artistry in their approaches.
With many CT approaches developed in various time periods and cultures, the counselors’ openness and willingness to explore the opportunities within these non-traditional approaches exemplified their beliefs in the power of creativity. Participants throughout the interviews discussed the evolution of their beliefs, that through working with clients, mostly prior to integrating CT, they started to recognize the importance of creativity. Reflecting on my own beliefs, much of my own motivation for pursuing the study was grounded in my belief of CT illustrating the wellness approach of counseling while providing clients with meaningful techniques to address their concerns. Upon exposure to CT, the counselors were sometimes confronted with their beliefs and could see the connection with different practices and that encouraged many of them to learn more about these modalities.

**Development of CT Competence**

The exploration of *Beliefs Creating Openness to CT*, while stimulated by *Experience with CT*, also cultivated interests in learning more about particular techniques. The *Development of CT Competence* for some created an opportunity to explore their beliefs surrounding CT and increase their openness. Competence, defined as valuing the knowledge and ability necessary to appropriately use a skill, was evident throughout the majority of the interviews. Having extended knowledge of CT was a key piece of being competent to use CT in counseling sessions for many participants in this study. Acquiring competence builds the skills needed for integration. Corey, an experienced practitioner with a background in community and private practice settings, explained the importance of knowledge in the process of integration. “I’ve been much more exposed to and have a pretty good working knowledge of what…[CT] are and what
they do…. which helps you determine what could be helpful for someone or not.”

Specifically, the knowledge of CT from various sources, formal and informal, shaped each counselor’s integration story. Formal knowledge acquisition, gathering informal knowledge, and ethical understanding emerged as the subcategories for the Development of CT Competence.

**Formal Knowledge Acquisition**

Gaining understanding and skills regarding CT involved more formal opportunities to explore the details of various CT techniques and concepts. Formal knowledge acquisition is conceptualized as information gained in a way that it could be applied towards licensure or certification, although not necessarily the only reason to participate in such training. Formal environments where CT was taught were counseling focused contexts, aimed at counseling licensure, but some were also solely learning about a specific CT modality for the purpose of future certification in that technique. Most of the participants had participated in various amounts of training to develop their abilities and knowledge base regarding CT. All participants identified exposure to CT through more formal outlets or settings including academia and workshops or continuing education.

Coursework, internships, supervision, and mentorship from faculty provided exposure to CT or opportunities to explore its relationship to counseling. Anne reflected on content she experienced in a graduate school class in the early 80s that she identified as complementary therapies, “[the professor] would talk about… art therapy and other unique modalities, and not just talk about it, but we would work with and learn them; dance therapy, expressive therapies…” Several practitioners also touched on impactful
moments as students, particularly during their experiential internships. Meredith, who has been a CT practitioner on and off for approximately 15 years, described her neurofeedback training through a prescribed internship while participating in another academic discipline before landing in a counseling program. Like Anne, in the classroom environment, Meredith had the opportunity for hands-on use of CT in conjunction with her academic work and developed her competence.

Connected to both internship and classroom experiences, the information and opportunities mentors and supervisors provided were cited by many of the participants. Identified earlier, Tim attributed his entre and continued learning about hypnosis to his field supervisor. The support that many described from mentors and supervisors to pursue their non-traditional interests and topics or tools in their counseling work was important to development of these practitioners. For participants who were not just exposed to but had the chance to learn more about various CT in academic settings, continued education focused on the intricacies of various practices was a next step.

Short-term trainings provided outside of academic programs on specific topics or techniques were an important place that practitioners developed their competence in CT. Particularly, training was cited by all as a means to reinforce and demonstrate competence while many participants identified their certification(s) in various CT modalities as a result of their training. While discussing her extensive training, Amanda said, “I do believe in certification,” signaling the belief in standards of practice. Sandy alluded to the importance of knowing what you are doing, with or without certification in her description or her advanced training, but with a focus on competence. Although most participants can present formal certificates or recite in detail the settings, organizations,
and instructors where they received their training in their chosen CT approach or approaches, not all participants were so thorough in their professional training. Jul described her lack of formal training but discussed developing enough skill to implement some various CT and focusing on the areas of her competence. Although training in some form was a component for all participants, the structure and formality of that training varied.

Focusing on developing CT competence, Janet described wanting “to have a better understanding of it but even professionally be able to say to somebody, ‘hey, I’ve done it.’ It’s one of those things that people call woo woo, well what do they do is…” to be able to provide clients with more detailed information. Many other practitioners discussed how competency increased through their practice in formal trainings and firsthand seeing the “shifts” in clients. In many cases, professional networks developed as a result of taking part in trainings. Trainings gave people the opportunity to learn new information and to find support and connections that allowed knowledge to be transferred, including joining professional organizations. Formal knowledge acquisition to develop understanding of CT by counselors who integrate it into their practice is a prominent feature of the integration model, however, there are other important ways of cultivating competence.

**Gathering Informal Knowledge**

Competence was not synonymous with formal training for all participants. Learning more about CT through interactions not directed towards licensure or certification was an important way to increase CT knowledge and practitioner competence. Some participants had a strong sense of skepticism while others approached
CT with a great deal of openness, therefore having diverse sources of knowledge was important to reinforce Development of CT Competence. Finding opportunities to diversify their knowledge, participants described accessing research and literature as well as information gathered through various interpersonal interactions and personal use.

To pursue trustworthy information, the majority of participants described utilizing published empirical and scholarly literature to develop competence surrounding CT strategies and techniques. Amanda explained how she, “read a lot on Cranial Sacral therapy and other energy therapies and I really started thinking, wow, there’s a whole world out there that I as a therapist, if I’m really treating the whole person, I’m not doing a very good job of that.”

Not all of the participants felt as strongly about needing published research to validate their confidence and competence to use CT. The effective results found in all of their practices were not dismissed due to lack of empirical support, but rather participants explicitly or covertly implied that to be seen as competent in their professional work, there had to be scholarly literature validating their approaches. While many of the participants sought out empirical support for the techniques they use, most of them expressed their frustration with research. They identified research being lacking, or if they found a modality that worked for clients, they were not able to use it in certain instances (i.e., with insurance clients) because of minimal research that has been performed on it. As a result, several of the participants conducted some of their own research studies focused on CT. Although several participants expressed interested in pursuing and conducting more research, time and financing to support such research has been limited if not non-existent for most of them. Research and literature provided an
avenue to information with broader access to various forms of CT, cultivating more attention and understanding, building confidence in the modalities, but practitioners highlighted the power of less formal opportunities to gain knowledge.

Learning through informal communication and relationships with family, friends, peers, community, and culture was another form of gathering informal knowledge. With interpersonal interactions, the intentionality of pursuing information was usually not there, rather the focus was on spontaneity in learning. Peggy shared her awareness and initial learning of CT due to her sister’s professional involvement, and the majority of participants spoke a great deal about friends as gatekeepers to understanding and learning about CT. Corey reflected, “I think at least half of the things I had never heard of like Jin Shin Jyutsu and counter string, so the bulk of my exposure and introduction to specific complementary therapies have been through my association with [peers at current agency].” Peers provided positive reinforcement to learn more about CT to all of the participants in some way.

Conversely, some of the study volunteers were also challenged by peers. Joy recounted her only negative interaction surrounding her CT integration with teaching colleagues and balancing that with supportive interactions:

Some of [my teaching colleagues] think that [specific CT] is kind of hokey because it’s not cognitive behavioral therapy, but for the most part, people support it. My colleagues where I live, and meaning my counseling colleagues where I live, are very intrigued by it and interested and that I have never heard anything negative. Some of my teaching colleagues do see it as not fully credible, but they
also really don’t really see a lot of or any of the complementary treatments as credible. Although not the only participant to touch on a negative interaction, the majority of participants described primarily positive or neutral interactions with individuals who knew of their integrative work.

Local communities also gave insight into the possible utility of integrating CT in the counseling process, giving counselors continued opportunities to learn how they could be more effective in their work. Sandy explained, “I think at this point people are kind of interested whenever they hear energy psychology. I think there is a large segment of the population that’s kind of intrigued rather than, oh, that’s some weird New Aged freak.” Other practitioners discussed information gathered through interactions with individuals throughout the community who focused on the integration of CT fostering hope and the need to develop competent practitioners who can meet their interests.

Responsiveness to cultural norms was also discussed with regard to learning about how to competently develop CT in professional work. Kathy reflected on changing attitudes towards CT approaches through her lived professional and personal experiences in the last 20 years as a vegetarian. From what she described as negative and ignorant responses she confronted at 17 years old, to the neutral and normalized reactions she now experiences in her 50s, she identified a “shift” that led to her developing her confidence (from feeling support from the shift) to learn more and therefore be more competent in her work. Personal experience in various settings was an important opportunity for Development of CT Competence.
Gaining knowledge through personal use was another key component to learning about CT and developing skills. Opportunities to use various CT have already been touched on, particularly in terms of using various modalities in training, however, the aim of CT use for personal, not professional growth, even though that could be a side effect, is the focus. As previously discussed, while the experiences of all of the practitioners is what led to their openness to CT, their continued personal use of the various modalities strengthens their insight into the approaches.

Participants reiterated throughout their accounts of how their personal journeys with CT developed their knowledge base and ultimately their competence. Healer 1 described, “the more I use it, the more I learn what it can be useful for.” Many practitioners described their own positive experiences with CT, opening the door to offer it to clients. Janet discussed “being exposed to when I was sitting on the other side of the fence” and seeing the change it made for her. All of the practitioners were open about their continued use of CT outside of professional settings reinforcing their investment and continued understanding of the utility of CT. Personal use appeared to transcend every other method of gaining knowledge and connecting participants to their professional work. Participant after participant shared their personal experiences with CT and the learning about the techniques and themselves that resulted. Reflecting on the development of my own competence surrounding CT, the connection made with learning through personal use is parallel to how counselors who seek their own counseling work gain greater awareness of what it is like for a client. The interconnection between formal and informal knowledge sources is evident with how they work together to facilitate the skills needed for counselors to be competent in their work.
**Ethical Understanding**

The culmination of formal knowledge acquisition and gathering informal knowledge are the foundation for ethical understanding. Ethical understanding is the knowledge of the standards for appropriate conduct, particularly those upheld in the counseling profession. Reinforcing the *Development of CT Competence*, Anne stated, “certainly knowledge of and training in these modalities would be necessary and important for…[counselors who] work with certain clients, but there still are rules and boundaries you have to respect of course, respect ethics.” She also expressed being, “very careful and mindful of making sure that I have the training and comfort level and knowledge level… to be effective at what I am introducing or bringing into the session.”

The practitioners’ stories demonstrated the impact knowledge and exposure can have on counselors and counseling trainees in their application of ethical standards when integrating CT.

In many cases, membership in professional organizations or groups that provide information (e.g., standards and descriptions of practices) and opportunities based on a particular focus or topic highlighted practitioners’ awareness of the importance of ethical understanding. The majority of participants discussed membership in at least one professional group or network. Participants also discussed the resources and reinforcement that professional organizations can provide in the *Development of CT Competence*. Anne, a member of several professional organizations, discussed the appropriateness of integration of CT in counseling guided by organizations ethical codes. “If you are trained and properly knowledgeable about it, that’s your guideline, in addition of course to all ACA and ethical guidelines.” She went on to talk about counseling
colleagues and that they, “may not feel that their [main] professional organization has the support or encouragement of that integration, you know, you’ve got to go with whatever the big wave in counseling is.” Having opportunities to understand how to ethically integrate CT into counseling was a consistent topic, particularly when questioned about challenges to integration.

Guided by professional standards, practitioners focused on finding the best evidence to guide decisions to incorporate techniques with clients. Healer 1, like other participants, specifically identified the ethical and legal liability with integrating CT in a professional setting and the need to be conscious of such implications. She recognized the possibility of unethical practices in addition to “others who will avoid using the approaches because they can’t figure out how to use them ethically. I hope that there will at some point be a forum for counselors–within ACA–to discuss the ethical application of the approaches.” Professional organizations provide counselors with important information surrounding ethical understanding, defining roles and practices, and while participants discussed both the impact of the counseling and psychological associations, it was apparent that the growing organization of CT specific groups also provided credibility to their interests.

The access to knowledge gained from various sources allowed practitioners to develop ethical understanding and gain the competency needed to integrate techniques. As with my experiences, although currently I am not formally certified in any particular modality, I was attuned to the understanding and training I needed to be able to competently use a particular approach with a client. Having experienced individuals in the past who integrated or promoted CT in ways I felt were incongruent with their ethical
responsibilities as counselors, hearing the breadth of experiences that contribute to the Development of CT Competence was helpful. For all practitioners, regardless of time invested, competence facilitated the positive professional use of CT.

**Reinforcement of CT Use in Professional Practice**

The selection and application of techniques and approaches participants used in their professional work was the main focus of the study; my goal was to shed light on a wide range of counselors to see the common threads of practice. Participants used a variety of CT techniques that interconnected with their experiences, beliefs, and knowledge surrounding CT approaches. Reinforcement of CT Use in Professional Practice or products of the counseling session that occurred in conjunction with integrating CT providing support for counselors investment in using various CT approaches was reflected in four subcategories: (a) alignment of practitioner identities, (b) cohesion with clients, (c) effectiveness and efficiency in the process, and (d) opportunities for advocacy.

**Alignment of Practitioner identities**

Practitioners described the synergy between their personal and professional beliefs when they were able to integrate CT into their counseling practices as well as the positive benefits they experienced as a result of their alignment of identities. As Joy explained, integrating CT in her counseling practice “feels more professionally and personally right for me.” Healer 1 discussed her reaction while listening to a client’s story. “I started to getting tearful and so without thinking, I started tapping [using EFT] and she looks at me and says what are you doing? And that has never happened before
and that shows how much I’m integrating… [CT] into my life…” Her unintentional introduction to the technique in session exemplifies alignment of practitioner identities.

When asked if there were techniques or approaches that she personally uses that she doesn’t integrate into the session, Kathy said, “nope…if I find it’s working, I want to share!” Amanda also stated, “I’m a firm believer of you have to practice what you preach and you only take people to that level of healing if you’ve been there yourself.”

In her role as counseling faculty, Joy described:

I always tell students that you have to find your fit of your approach based on your true nature based on who you really are and that your approaches complement that and I feel like this truly complements who I am as a person so when we talk about being genuine in therapy, this is truly me being the most genuine I can be.

Alignment of practitioner identities provided investment and transparency in their work, a reoccurring theme participants attributed to helping them connect with clients. Just as any counselor aligns with a theory or techniques, the majority of participants identified the importance of personal connection with their counseling work. The alignment of practitioner identities created the openness needed for the development of a strong therapeutic alliance.

**Cohesion with Clients**

Throughout the interviews, the practices used by the participants were connected with the needs expressed by the client in conjunction with their professional knowledge and awareness of the individual. The cohesion, or establishing therapeutic relationships, with clients was an important focus of the practitioners. Cohesion with clients was
accomplished through understanding their backgrounds, assessing needs, and maintaining awareness of language used in the session that reinforced the use of CT in counseling.

Participants were attuned to the diverse individuals walking through their doors, recognizing their similarities and differences. Knowing some clients were specifically seeking them out for CT use while others were skeptical of going beyond traditional talk therapy, practitioners worked with each individual to make sure they were, as Julie stated, “availing themselves” to all resources. What resonated for participants was the ability to meet the needs of clients because of the variability and breadth of approaches available to address their current state (e.g., if walked into session angry or sad) and provide change in the present and into the future. For example, Jul describing starting off with yoga poses when a client came in very angry and she knew the client was not going to be able to connect cognitively until her body was calm.

Describing how the integration process evolved with a client, from informed consent to psychoeducation, Amanda talked about the importance of understanding where clients are coming from and providing them with information to meet them where they are. Healer 1 discussed her initial interactions with clients. “I’m introducing [CT]…as a tool for clients. For folks who are willing and interested in trying it.” She continued to say, “it depends on the client and it depends on what they seem open to and it depends on what they’re dealing with.” Although integration of CT for many is a part of every session in different ways (e.g., playing bilateral music in background, aromatherapy options at beginning of every session), across the board, either formally or informally, practitioners assessed the needs of clients to make sure next steps in the counseling process were best suited for clients’ growth and change.
Assessment, in various forms, was present in all descriptions of client interactions, making sure the CT approaches chosen were tailored to the clients’ needs. As Kathy stated, “I’m really look at people’s… what they eat and what they, how to exercise or how they take care of their physical self…” Many practitioners discussed using “mini assessments” or informal inventories either cognitively or on paper to develop a treatment plan. Or using formal assessments counselors were also able to gain information and many participants noted how cohesion with clients impacted the use of language in CT integration.

How practitioners explained or framed CT approaches depending on their audience demonstrated their knowledge of the techniques and clients. Like others, Sandy described the importance of talking about CT approaches in ways that clients can understand. For example:

I can tell people, “listen, it’s really important that you consider how your mind and body are affecting one another” and people can just think of that as a bunch of New Age mumbo-jumbo, if they want to. But if I’m telling them, “listen, there are chemicals that are released by your brain into your body when you’re experiencing emotions and it has this, this, and this effect on your functioning… then that means that you can’t just consider your emotions without considering your body.” And people will go, “oh, okay.” And I felt like it gave me a really effective framework for teaching people about the realities of how they just can’t separate their mind from the body.

Kathy also described how “sometimes we end up doing the work and it just has different words [and gives example of mindfulness, focusing].” She explained, “I don’t want
Integrating counseling and CT, the change that many of the practitioners experienced on a consistent basis fueled their continued work. The cohesion with clients that developed as a result of navigating the integration process gave participants an opportunity to build the therapeutic relationship therefore increasing the potential effectiveness and efficiency of the counseling session.

**Effectiveness and Efficiency in the Process**

The effectiveness and efficiency of their integrative work, or realizing the intended results of implementing the various techniques and approaches in a timely manner as reported by clients and practitioners, reinforced their use and/or availability. Using and becoming invested in integrative work appeared to be primarily motivated by the positive outcomes participants experienced. Amanda reported, “I jumped in completely because it was really helpful to many of my clients.” For each participant, it was an evolution—putting together their knowledge, beliefs, and skills to create a productive approach. Most participants discussed continuing to seek out opportunities to learn and try new techniques in cultivating their professional practices. Tim shared, “I have been fortunate in the last 26 years of trying [hypnosis]...and trying it and trying it and trying and trying... it’s been change producing, it has answered everybody’s question over and over and over and over and over and over again.”

The examples of effectiveness of approaches were extensive. Cristin expressed “I was watching really incredible things happen with people... just the shift alone, the shift [in clients] is why I have done this for this many years.” Reinforcing the effectiveness
experienced with clients, she discussed being validated by a skeptical colleague/friend who was seeing a mutual client and ultimately attributed the clients’ positive and expedited change to CT integration. Whether seeing the benefits first-hand or second-hand, the effectiveness of approaches was consistently identified.

Word of mouth between clients also demonstrated the effectiveness of CT integrative work. Kathy described her experience working with clients who then often referred friends. When I asked about her client’s motivation to refer friends she stated, “I see for my clients, that they heal. And they grow and they get better. And I will hear from them, some of them, that they have been to this counselor, they have been to that counselor… nothing has worked.” Anne also described her experience:

I think that it’s very gratifying to get referrals from physicians and get referrals from other therapists [pause] and get referrals from clients who refer somebody they know, you know, I’ve worked with [participant’s name] and this was so helpful, so from their friends.

She confided, “I think clinicians are using complementary techniques because they’re seeing the efficacy and they are using it and out there, they’re talking.” Although primarily supportive of CT effectiveness, all participants acknowledged the limitations of any approach. Particularly, Jul discussed the significance of awareness, but questioned the limits and lasting effectiveness of CT. “I think people gain a lot of awareness through creativity and spirituality and alternative methods… although people can increase their awareness, I don’t know how much lasting change there is.” With this, the practitioners focused on the benefits of integration practices found in their anecdotal work and surveyed responses of clients experiencing the effectiveness and efficiency of their work.
All of the practitioners touched on the efficiency in the process of integration for the majority of clients. Amanda, referencing in her agency, said that when integrating CT “we’ve seen probably a years worth of therapy collapsed into six months when we’ve worked with folks with discrete traumas.” More specifically focused on support for her successful work, she described seeing more clients “graduate” from therapy and in less time reinforcing her perception that “integration absolutely speeds up the therapeutic process, it speeds up the healing process.”

Healer 1 identified that when a client was ready and integration was appropriate, she felt it was her responsibility to provide integrative work:

It’s like if I had the secret of the hammer and people were only using the screwdriver, it would be doing people a disservice to just say, to not mention that there’s tool called the hammer, if you want to drive in the nail, but you’ve been using that screw driver, I’m telling you this is a faster more efficient way to do it.

Repeatedly in the interviews, the participants described how integrating CT into the counseling session allowed the healing work to be done and there was efficiency in the process unlike any traditional approach they had used. Recognizing the impact created through this expedited and effective change, practitioners’ stories touched how integration empowered them and their clients.

**Opportunities for Advocacy**

The preceding factors providing *Reinforcement of CT Use in Professional Practice* set the stage for advocacy or finding ways to actively support a concept, individual, or group. With each participant there was a sense of advocacy in using CT in their work and taking risks to do what was in the clients’ best interest. When talking
about direct advocacy for CT in the counseling profession, Healer 1 spoke about the challenges conducting research and submitting presentations on CT. “I’m doing it anyway and at this point, I don’t really care that those decision-makers aren’t accepting [presentations and research on CT], I’m doing it anyway because I’m seeing the results on the level that I’m working.” Similarly Anne discussed seeing CT as being undervalued and dismissed in the profession, particularly on a the national level, but she is continuing to seek opportunities to bring awareness due to the positive results she’s found:

I just didn’t see much offered in complementary modalities [at the American Counseling Association Conference in New Orleans], there were several workshops, and I think there is a wellness division within ACA, maybe they would be really receptive to promoting …[CT information], but I don’t know. Maybe I’ll write up a proposal and just see if that would be something that ACA would say, huh, this it’s kind of different and new and some basic knowledge that counselors could put in their toolbox.

Frustrated by the poor training that others have given or wanting to educate others, the opportunity for advocacy as a result of the benefits of CT use was present. Healer 1 talked about the importance of bringing awareness about CT through activism, but how challenging it can be. “This has been my struggle, because of how I grew up, that this has had to be a secret and that I can only use it in certain environments. But because now I teach a class and now have…[an organized opportunity with professionals] I’m taking more risks.” She echoed the feeling amongst many of the participants of a grassroots
movement of CT integration in counseling being stimulated by a growing interest and openness of counseling students.

Providing information about CT to clients to inform and empower them with healing options is part of opportunities for advocacy. Sandy described using “brochures that I bought from the … [specific CT] people that has a really nice way of describing the whole thing, so I’ll give them the brochure or I have the print out of the text that’s from my website.” Amanda stated, “and the way that we’re doing things empowers the client to be able to begin to heal themselves.” Anne described integrating yoga with a client and how grounding and empowering the practice can be as well as the ability to incorporate it in their lives outside of session.

Whether it was advocating on a professional or one-to-one level, practitioners were inspired to seek out and support best practices in their professional role. From the opportunities for advocacy beginning with the alignment of practitioner identities, use of CT in the counseling session was overwhelmingly reinforced. Exploring the various words and definitions to encapsulate the influential experiences of the participants, I began to see how interconnected and influential each was to the other. My memos reflected the ongoing process to distinguish between the many connections to resources, self, and others until consistent demonstration of the importance of the navigations within and between the categories (i.e., *Experiences with CT, Beliefs Creating Openness to CT, Approaches to Develop CT Knowledge, Reinforcement of CT Use in Professional Practice*) became the framework to better understand the integration of CT in counseling.
Theoretical Model for Integration of CT in Counseling

Throughout the exploration of integration practices, the categories that emerged from the interviews and artifacts guided the development of a theoretical model to conceptualize the use of CT in counseling. Expanding on the limited understanding of CT use in counseling, the analysis process uncovered significant overlap between the surfacing categories, making them difficult to distinguish until I realized the implications of these links. The experiences cultivating initial knowledge of CT laid the foundation for understanding use by counseling practitioners. As participants shared their stories, I became more aware of the mutual influence of the categories. Through ongoing analysis and consultation with other researchers, a model of CT integration in counseling practices emerged. Integration occurred when practitioners gained the awareness, openness, and skills necessary to develop competence to implement CT with a client.

As I have previously detailed in my expansion of the categories, counselors navigated CT integration in a similar pattern and the process was typically initiated by participants’ Experience with CT. As a result of interactions with trusted persons and in response to personal reasons and motivations, the experiences encountered by practitioners gave them the opportunity to gain awareness of CT and how it could address various physical, mental, and spiritual interests. From the experiences described by participants, cultivating knowledge about CT came from practitioners’ increasing openness to learn more about the techniques and/or the beliefs surrounding them.

Experience with CT developed understanding, affecting the individuals’ Beliefs Creating Openness to CT. Those beliefs, however, could also predate and ultimately influence those experiences. Focusing on beliefs gave practitioners the opportunity to see
how the use of CT in counseling connected with their ideas surrounding intuition, connection of mind, body, and spirit, and importance of creativity. As a result of this interaction between Experience with CT and Beliefs Creating Openness to CT, individuals were able to move towards the Development of CT Competence.

The Development of CT Competence through formal knowledge acquisition, gathering informal knowledge, and ethical understanding continued to influence participants’ experiences and beliefs surrounding CT. The non-recursive relationship signifies that on-going training and education surrounding CT continued to shape the perceptions of the practitioners. Similarly, as a result of the Development of CT Competence there is a Reinforcement of CT Use in Professional Practice, which also creates a non-recursive connection. The alignment of practitioner identities, cohesion with clients, effectiveness of approaches, efficiency in the process, and opportunities for advocacy demonstrate the utility of CT integration in counseling practice. This Reinforcement motivates practitioners to continue their Development of CT Competency to produce even better outcomes in their counseling work.

The theoretical model developed provides insight into the CT integration practices of practicing counselors. The model organizes the subjective and diverse experiences of the participants as they developed their approach toward integration of CT into their professional counseling practice. How and why CT is integrated in the counseling process was illuminated through the development of the four main categories and corresponding subcategories signifying the key areas of focus. Reflecting on the rationale to explore the various approaches to achieving wellness by integrating CT into
the counseling session, there are noticeable implications for the profession not only in terms of practice, but also teaching and future research in counseling.
Table 2

Mind-Body Complementary Therapies Discussed by Counselors

<table>
<thead>
<tr>
<th>Type of Approach Identified</th>
<th>No. Participants Stated Using with Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>1</td>
</tr>
<tr>
<td>Aromatherapy</td>
<td>1</td>
</tr>
<tr>
<td>Arts Therapy (e.g., drawing genograms, mandalas, photography)</td>
<td>5</td>
</tr>
<tr>
<td>Biofeedback</td>
<td></td>
</tr>
<tr>
<td>Body talk</td>
<td>1</td>
</tr>
<tr>
<td>Brainspotting</td>
<td>1</td>
</tr>
<tr>
<td>Breath work</td>
<td>1</td>
</tr>
<tr>
<td>Chakra and meridian systems</td>
<td>2</td>
</tr>
<tr>
<td>Dance</td>
<td></td>
</tr>
<tr>
<td>Emotional Freedom Technique (EFT)</td>
<td>2</td>
</tr>
<tr>
<td>Eye Movement Desensitization Reprocessing (EMDR)</td>
<td>8</td>
</tr>
<tr>
<td>Guided Imagery/visualization</td>
<td>3</td>
</tr>
<tr>
<td>Holistic Memory Reprocessing</td>
<td>1</td>
</tr>
<tr>
<td>Hypnotherapy</td>
<td>3</td>
</tr>
<tr>
<td>Jin Shin Jyutsu</td>
<td>2</td>
</tr>
<tr>
<td>Internal Family Systems (IFS)</td>
<td>2</td>
</tr>
<tr>
<td>Meditation</td>
<td>4</td>
</tr>
<tr>
<td>Mindfulness</td>
<td>1</td>
</tr>
<tr>
<td>Music</td>
<td>2</td>
</tr>
<tr>
<td>Native American mantras</td>
<td>1</td>
</tr>
<tr>
<td>Neurofeedback</td>
<td>3</td>
</tr>
<tr>
<td>Neurolinguistics or Neuro-linguistic Programming (NLP)</td>
<td>2</td>
</tr>
<tr>
<td>Neuroemotional therapy (NET)</td>
<td>1</td>
</tr>
<tr>
<td>Progressive Muscle Relaxation</td>
<td>1</td>
</tr>
<tr>
<td>Psychodrama</td>
<td>1</td>
</tr>
<tr>
<td>Sociometry</td>
<td>1</td>
</tr>
<tr>
<td>Somatic Experiencing</td>
<td>2</td>
</tr>
<tr>
<td>Somato Neuro Release</td>
<td></td>
</tr>
<tr>
<td>Spirituality</td>
<td>15</td>
</tr>
<tr>
<td>Splankna</td>
<td></td>
</tr>
<tr>
<td>Tai Chi</td>
<td></td>
</tr>
<tr>
<td>Thought Field Therapy</td>
<td>1</td>
</tr>
<tr>
<td>Yoga (one specified Kundalini)</td>
<td>4</td>
</tr>
</tbody>
</table>

Note. Based on categories from Sutton, A. L. (Ed.). (2010). Complementary and alternative medicine sourcebook (4th ed.). United States: Omnigraphics, Inc. CT approaches identified, but categorized in Manipulative and Body-based Therapies (i.e., chiropractic, cranial sacral therapy, applied kinesiology, massage, muscle testing, Healing Touch, Rolfing); Energy-Based Therapies (i.e., Biogenesis, Reiki); Alternative Medicine Systems (i.e., Acupuncture/acupressure [Tapas Acupressure Technique –TAT], Chinese medicine, Ayurvedic, Homeopathy, Pranic healing); and Dietary Supplements (i.e., Nutritional/herbal supplements).
Experience with CT
- Trusted persons
- Personal reasons and motivations

Development of CT Competence
- Formal knowledge acquisition
- Gathering informal knowledge
- Ethical understanding

Beliefs Creating Openness to CT
- Intuition
- Connection of mind, body, and spirit
- Importance of creativity

Reinforcement of CT Use in Professional Practice
- Alignment of practitioner identities
- Cohesion with clients
- Effectiveness and efficiency in the process
- Opportunity for advocacy

*Figure 2. Theoretical Model for Integration of CT in Counseling.*
Chapter 5

DISCUSSION

“Creativity requires the courage to let go of certainties.” – Erich Fromm

The purpose of this research study was to explore practicing counselors’ approaches to wellness, specifically how and why complementary therapy (CT) is integrated into their sessions. Although CT integration practices have been studied in other professions, counseling has little empirical understanding behind the use by current practitioners in the field. The importance of creativity highlighted in the profession (Henderson & Gladding, 1998; Lumadue et al., 2005), mainstream counseling standards are challenged by the increasing popularity of CT in the U.S., undeterred by the empirical uncertainties CT integration presents.

The Theoretical Model of Integration of CT in Counseling (figure 2), developed from the sixteen participants in this study, demonstrates a strong interest in CT by these counselors as a means to effectively and creatively provide for the diverse mental health needs of clients. Containing similar components as the systems model of clinical preventative care by Walsh and McPhee (1992) in the medical field (e.g., motivation, beliefs, knowledge, skills), the process of integration framed by the current model reinforces its alignment with counseling and its preventative focus (Mellin et al., 2011). The model provides a framework to better understand how experience, beliefs, competence, and practices define the integration process in the counseling setting and influence the counseling profession. Although within counseling there is a wide spectrum of reactions to CT integration, giving a voice to those who have invested themselves in these practices was an important goal to understand this growing practice
in the field. Recognizing the context of the findings, I will first review the limitations of the study and then reflect on the findings and implications of the current research on the counseling profession.

**Limitations of the Study**

Even while including components in the four areas (i.e., credibility, dependability, transferability, and confirmability) identified to establish the trustworthiness of the current study (Lincoln & Guba, 1985, 2000; Morrow, 2005; Creswell & Miller, 2000), some limitations were present. There are four primary limitations to this study. First, the proposed study focused on one of the four categories of CT (i.e., mind-body) identified by U.S. National Institutes of Health [NIH], National Center of Complementary and Alternative Medicine (NCCAM; 2012). The findings for why and how counselors integrate mind-body therapies in session may not reflect perspectives or approaches for integration of the other three categories. Throughout the descriptions of their experiences, however, many of the practitioners were exposed to and used techniques from multiple NIH categories. Although overlapping use was present, by intentionally focusing on one category, the developed model is more dependable by focusing on a common group of practices. Additional research should be conducted to examine the approaches of counselors using other forms of CT.

A second limitation arises with the purposeful sampling techniques employed; using specific criteria for the study participants, the goal of obtaining a diverse representation of counselors and clients was hampered by the use of snowball sampling. My knowledge of diverse counselors employing CT in client sessions was limited, with the majority of potential study participants’ demographics consisting of White women in
the eastern United States. An announcement for the study was posted on a listserv targeted at counselors interested in CT, followed by a general posting at the 2011 ACA conference and chance meetings with individuals with an interest in integration produced some diversity. Primarily geographic, there was no diversity in terms of self-identified ethnicity despite my best efforts. The sample was surprising given the research by Evans et al. (2002) finding ethnic minority group members significantly more likely to have favorable attitudes toward nontraditional approaches, however, that study was focused on attitudes, not practices. The current study sample brought up interesting questions regarding the demographics of counselors implementing CT in their practices and how ethnicity, and other factors such as sexual orientation (31% of the current study’s sample identified as sexual minority) might influence the decision to use such practices with clients or willingness to discuss such practices and will be examined in the section on future research.

A third limitation surrounding the study design was the use of only individual interviews. As evident in the methodology section (i.e., Chapter Three), while individual interviews were purposefully used, focus groups could have allowed participants the opportunity to reflect on the comments of others, assisting in developing their own insights (Bogdan & Biklen, 2007; Gibson et al., 2010; Marshall & Rossman, 2006). Discussion in a group could have uncovered various perspectives, through interaction, promoting additional discourse (Bogdan & Biklen; Morgan, 1997), which could not occur with an isolated interviewee. Due to the detail of the interviews, however, the participants’ responses provided rich and sufficient data for analysis (Charmaz et al., 2006). Future research replicating the questions from the current study, but using focus
groups, would provide additional information to confirm or challenge the current theoretical model of integration.

A fourth and final limitation is the reliance on self-reported data (i.e., counselors reporting perceptions of integration effectiveness with clients). Due to the scope of the present study, additional research would be important to understand the experiences of clients integrating CT in counseling sessions. Because of the detail provided in this study as a result of the descriptive interviews, transferability is evident, reinforcing the trustworthiness of the research (Charmaz et al., 2006; Crabtree & Miller, 1999; Creswell, 2007). Regardless of the limitations presented, the information gathered supports the continued exploration of the integration of nontraditional approaches like CT into counseling practice and training due to the perceived positive results experienced by both client and counselor.

**Findings and Implications for Counseling Profession**

Although there has been some investigation of the knowledge, attitudes, and behaviors of health care providers who use CT in practice, there has been little focus on this area in conjunction with professional counselors. Scholars in the medical and allied health professions have brought attention to the importance of practitioners’ conceptualizations of the integrative process when working with patients (Hsiao et al., 2005; Hsiao et al., 2006; Schneider et al., 2003; Sewitch et al., 2008). This study expands the work first done by Evans et al. (2002) who explored counseling practitioners’ attitudes of brief and nontraditional approaches, by specifically examining how and why practicing counselors integrate CT into the counseling session. The findings of this study extend the research by reinforcing the role that experience, beliefs,
competence, and practices have on the integration process in counseling. The CACREP Standards (2009) currently identify knowledge, skills, and practices in particular as areas necessary for competent counseling training. Recognizing the synergy with the CACREP framework, the developed model demonstrates the congruence CT integration shares with traditional counseling practice and the opportunity for it to be part of the mainstream process.

**Experience**

The first category detailed in the model, *Experience with CT*, focuses on experience, identifying the initial avenues by which participants gained awareness and knowledge of CT. As with developing attitudes in general, with increased exposure to something (i.e., CT), the more likely it is individuals’ beliefs and values will withstand the influence of others (Evans et al., 2002; Pomerantz, Chaiken, & Tordesillas, 1995; Nichols, in preparation). This was apparent in the current study as participants expressed feelings of marginalization due to their practices and interests, but continued to pursue their work due to their exposure through trusted persons and as a result of personal reasons and motivations. Similar to Evans et al. (2002) findings regarding minority participants having a more favorable view of nontraditional (i.e., CT) approaches because of their own positive personal exposure, a similar trend was found in this study, emphasizing the importance of experience.

Theoretical and empirical discussions that focused on the influence exposure to CT- whether in personal practice, vicarious practice or information (e.g., literature, videos, presentations) - has on individuals’ awareness and openness to the various approaches (Dziegielewski, 2003; Eisenberg et al., 1998) are reinforced by the present
study. Research related to the use of CT with counseling graduate students demonstrated the power exposure and use of these practices can have on the self. As a number of participants in the Schure et al. (2008) study described, the changes and increase in awareness they experienced, as a result of the mindfulness training, could also be utilized by their clients, solidifying the possibility of using CT as a tool in session. Current study findings also revealed how personal use of CT by counselors was a main source of knowledge, influencing their practices as well as the effective and efficient experiences of integration with clients. Literature in counseling, such as Mulligan (2006) and Adams and Puig (2008), reinforced CT collaboration with counseling. As the current findings demonstrate, there can be noteworthy and significant wellness benefits to discussing CT in counseling sessions as well as utilizing practices in sessions just as there was in training programs (Baruch-Runyon, 2009; Chandler et al., 2001; Chrisman et al., 2009; Christenson, 2009; Evans et al., 2002; Schure et al., 2008; Shapiro et al., 2007). The findings from this research study illuminate the potential knowledge counseling trainees could benefit from through learning about CT and the integration process including a potential asset to their future practices, reinforcing the need for additional research.

Experience gave the study participants the opportunity to begin learning about additional therapeutic interventions while also exploring their own beliefs, another important aspect of CT integration in counseling.

**Beliefs**

In the current model, *Beliefs Creating Openness to CT* highlighted the factors contributing to participating counselors positive attitudes toward CT, compared to the identification of attitudes towards CT integration found by Evans et al. (2002) and Hsiao
et al. (2006). Although the current study focused on beliefs rather than attitudes, since all practitioners demonstrated a favorable attitude towards CT, as evident by their integration work, the extrapolation of specific beliefs expands the literature detailing the process. Scholarship focused on multicultural counseling competencies reflects the interconnection between attitudes and beliefs (Arredondo et al., 1996; Sue et al., 1992) or how dispositions and ideas affect the other. Medical practitioners in the Hsiao et al. study showed, similar to the current study, how attitudes along with knowledge influence the interest and investment in using integrative approaches in health care. Just as Evans et al. affirmed the significance attitudes have on the selection of treatment approaches applied by practitioners, the current study uncovered details supporting their attitudes (i.e., beliefs) and how they are constructed by counselors to lead them to integrate CT into professional practice.

The belief and value clients had on the “body, mind, and spirit connection” (p. 325) in the Evans et al. (2002) study was also found in the current study, and provides support for how integration translates into a wellness approach. The connection of the mind, body, and spirit found in the current study model clearly aligns with the professional focus on the wellness model (Mellin et al., 2011; Myers & Sweeney, 2008; Myers, Sweeney, & Whitmer, 2000; Roscoe, 2009). For example, there is a connection between current study participants’ beliefs in the importance of creativity and the Creative Self category of the Indivisible Self Model of Wellness (IS-Wel), similar to how intuition could be connected with the concept of the Essential Self from the same model (see Myers & Sweeney, 2008). The belief of the use of intuition and its influence on decision-making found in the current study is reinforced by the early work by Gelatt
(1989) emphasizing the importance of using multiple forms of knowledge to guide choices. Therefore, the effective results experienced as a result of using intuition (and creativity), along with rational information, to make treatment choices can allow counselors and clients the opportunity to benefit from the holistic approach of CT integration. The beliefs identified in the current model, particularly the connection of mind, body, and spirit, reinforce the argument by Kaplan and Coogan (2005) for applying the biopsychosocial model in counseling. Although there is no spiritual component, there is the recognition of various dimensions influencing individuals and the need to address that in the counseling context.

Much of counseling training is focused on examining counselor’s backgrounds, biases, and worldviews to allow them to provide an empathic and open space for all clients to challenge their issues (Rothaupt & Morgan, 2007). Ultimately, how they translate their knowledge and beliefs into the counseling session, regardless of the topic, will have an impact on the counseling environment and alliance (Abreu et al., 2000; Constantine et al., 2004; Myers & Willard, 2003; Orlinsky, Grave, & Parks, 1994; Pope-Davis et al., 2002; Souza, 2002; Yeh et al., 2004). With CT becoming more prominent in healthcare, there is a need for counselors to be aware of the various healing modalities clients may be using as well as approaches that may best serve the client. The current study identifies how counselors who have exposure to a number of different therapies have other options and opportunities to develop an effective treatment plan while exploring or as a result of their worldviews and beliefs.

For example, spirituality has become an important dimension of counseling and is recognized by various cultures as integral to health and healing; it is the responsibility of
counselors to be open to the spiritual views of their clients in order to holistically and ethically address their needs (Watts, 2001). Spirituality was specifically identified by all but two participants and competence was a universal topic of awareness in the current study. Particularly, the various CT approaches either connected individuals with their spirituality due to the nature of the technique or as a result of using or going through the steps of a technique, individuals felt more “in touch” with their spirituality. Competency models have been developed and endorsed by ACA for counselors to address both their spiritual and multicultural attitudes (Arredondo et al., 1996; Fukuyama & Sevig, 1999; “Summit Results,” 1995) reinforcing their significance to the standards in professional practice for counselors to understand their beliefs and those of their clients. Discussion of various CT approaches that might be familiar or unfamiliar can be an opportunity to explore competency models with counseling trainees, facilitating students’ attention to ways various individuals and cultures approach health and healing. Faculty as well as peers can provide ways for trainees to positively explore their own beliefs and counseling identity while being introduced to potential effective practices they can align with (Auxier et al., 2003; Baruch-Runyon, 2009). The beliefs identified in the current study (i.e., use of intuition; connection of mind, body, spirit; importance of creativity) contributed to a need to strive for continuous self and professional development by participants to understand their various roles and to be more confident in them and with their identity as a counselor.

**Competence**

The *Development of CT Competence* reflects the various knowledge counselors developed to reinforce their commitment to professional ethics. Concern over the
competence of counselors integrating CT in the counseling session is a reoccurring topic in the literature (Baruch-Runyon, 2009; Christenson, 2009; Evans et al., 2002). The current findings were similar to the Hsiao et al. (2006) study where medical practitioners’ knowledge, along with attitudes, affected the interest and investment they had in integrative approaches to health care; the greater the knowledge of CT the more likely the practitioner was to have a positive attitude towards CT integration. Participants in the current study searched out more opportunities for learning in various forms, therefore developing and/or reinforcing their positive attitudes. Although some participants were more formal and intentional in their pursuits, all touched on the role of the Development of CT Competence in the integration process. Only one participant, the youngest and only non-licensed (but is NCC working towards LPC), did not disclose detailed training experiences to learn the techniques she employed with clients.

Ethical understanding was a specific subcategory of competence development as participants consistently addressed the gray area that comes with applying the ACA Code of Ethical Standards (2005) to any counseling approach. Although the standards do not directly refer to CT integration practices, the findings of the current study suggest, at least this sample of counselors, use professional (e.g., ACA, APA) directives to inform practices and reinforce their competence. Findings in this study reinforced the ethical concerns identified by Evans et al. (2002) such as “appropriate training” (p. 326), empirical evidence, and significance of knowledge for competent integration practices (Lumadue et al., 2005). Descriptions of how the process of integration meets ethical practice standards while effectively meeting the needs of clients can help shed light on various interpretations of the ACA Code. There is an ambiguity in the ethical codes of
what defines competence and how it can be decided if certification and licensure are not required for CT use (although several approaches identified offer such credentials) just as they are not required for cognitive behavioral therapy and other conventionally used approaches. The emphasis of the current research reinforces counselors’ ability to be competent in their professional work using integrative practices to provide the most appropriate and effective treatment possible to their clients.

**Practices**

Effectively meeting the needs of clients while adhering to ethical standards was a particular area identified in Evan et al.’s (2002) research and in the current study’s final category, *Reinforcement of CT Use in Professional Practice*. The *Code of Ethical Standards of Practice* (ACA, 2005) provides counselors with an important framework for their professional practice and was explicitly identified by many of the participants in their counseling. Similar to the use of CT in the counseling setting, traditional approaches also have the potential to be delivered in an unethical manner by the individual counselor. Although conventional approaches signify a certain attainment of empirical support, as many of the counselors shared, the integration of various CT approaches that also have significant evidence of effectiveness (e.g., EMDR) have not reached widespread acceptance, yet. This appeared as a consistent theme and some of the participants have found themselves in a position to increase the attention to and legitimacy of various techniques through their own research on their work. While effectiveness has always been a primary focus when evaluating techniques, efficiency is a critical component with the rising influence of managed care. The study highlighted
counselors accounts of positive results in less time than traditional techniques, opening up questions of continued research to explore this phenomenon.

Recognizing the potential effectiveness of integrating CT into the counseling session, the competence and enthusiasm demonstrated by the participants provides a plausible mechanism for combating counselor burnout. As with other helping professions, counseling must focus on ways that practitioners can continue to be their most productive selves while finding purpose in their work. Although all but one of the participants interviewed worked in private practice or a private agency allowing freedom to choose techniques employed, the study findings give initial insight on how CT can be a creative and self-empowering practice for counselors, allowing them to use techniques that positively influence their continued work.

*Reinforcement of CT Use* in the current study highlighted the alignment of professional identity with actual practices. Although several participants in the study were hesitant to refer to themselves as counselors, even though they hold counseling degrees and licensure as a professional counselor in their state, each participant clearly ascribed to the concept of alignment and holistic health, the focus of wellness and orientation of the profession (Mellin et al., 2011). Because of their developed interests, particularly in integrating CT into counseling practice, it appeared their role as a counselor gave them the flexibility and platform to offer such services to clients as opposed to other professions (e.g., psychology) that have a more clinical and regimented approach to working with individuals. Recognizing that current counselors partially define themselves by the services they provide (Mellin et al.), integration could be an important approach the profession uses to distinguish it from others. Striving for unity in
the counseling profession (Cashwell et al., 2009; Hanna & Bemak, 1997; Kaplan & Gladdening, 2011; Ritchie, 1994), integration provides additional support to strengthen the image of the counseling profession featuring an effective, ethical process based on a *wellness* orientation, one of the pillars of counseling professional identity (Mellin et al.). A similar concept of alignment was also found by Baruch-Runyon (2009) in her exploration of integration in counseling work by non-counseling professionals (e.g., social work, psychology, psychiatry), but reinforcing the connections within the process.

As previously detailed, cohesion with clients, another subcategory uncovered, is a critical factor in the therapeutic alliance and counseling process. As research in the field has demonstrated, counselor attitudes and behaviors have a major impact on the counseling relationship (Constantine et al., 2007; Fuertes et al., 2001; Jennings & Skovholt, 1999; Paulson, Truscott, & Stuart, 1999; Rosenberger & Hayes, 2002; Skovholt & Jennings, 2005; Sullivan, Skovholt, & Jennings, 2005; Wampold, Mondin, Moody, Stich, Benson, & Ahn, 1997). Integration of CT in the counseling process illuminated how infusing various approaches into the traditional session can allow counselors the ability to connect with clients in different and deeper ways. The significance of counselor awareness of diverse client beliefs and foundation in multicultural competence, and the broader understanding of individuals’ unique selves, are well documented in the counseling literature and delineated by the IS-Wel model (Hage, Hopson, Siegel, Payton, DeFanti, 2006; Myers & Sweeney, 2008).

Yeh et al. (2004) acknowledged traditional “Western psychological traditions [where] there are clear distinctions made between physical, mental, and spiritual existence and well-being” (p. 414) and clearly there is support by individuals to move
past the traditional. The current study identifies how counselors put these concepts into action, reinforcing similar findings from Baruch-Runyon (2009). Constantine et al. (2004) cautioned about the Western counseling tradition of “modernism” or focus on the belief of “rational thought, objectivity and the belief in a universal truth” leaving a gap between client and counselor perspectives (p. 113). The integration of CT in counseling by applying the wellness model confronts conventional perspectives of the separateness of self and highlights the importance of subjectivity. All participants embodied the wellness model through their integrative practices and approaches with clients. Recognizing the factors influencing professional practice, it is important to see how these areas can be explored in counselor training, again, giving students the opportunity to gain awareness of themselves and potential perspectives of future clients.

Finally, the opportunity for advocacy that emerged in the process provides yet another link with the aim of the counseling profession, to be an active support to the individuals we serve. Consistent connections with current counseling standards and aims from advocacy through personal and professional awareness/alignment are evident throughout the developed model of integration of CT in counseling. Distinguishing how CT integration responds to clients’ and counselors’ needs provides a context for the potential for such practices to increase counseling effectiveness, providing opportunities to enhance the profession. Recognizing the expansion of the profession, it is important to take notice of the diverse tools that when trained, knowledgeable practitioners use can provide numerous opportunities to meet the wellness needs of the individuals who walk through their doors.
Implications for Future Research

As the current research initially indicated, there is interest and synergy between CT and counseling. The range of CT and the increasing attention to holistic options reinforces the implications the practice and/or the discussion of these approaches could have on the counseling environment in relation to effective and efficient methods to meet client needs. The counseling profession is increasingly focusing on multicultural counseling competency (Worthington, Soth-McNett, & Moreno, 2007) and CT research can reinforce both the overall identity and ethical practices of counseling as well as provide empirical evidence to support the diversity of wellness approaches to increase counseling effectiveness with all clients. This study provides direction to sharpen the focus of researchers interested in examining the potential benefits of CT integration for client level outcomes. Particularly, future research can include: (a) construction of a reliable instrument that can more broadly survey counselors to understand integrative practices within the profession, (b) investigation the effectiveness and efficiency of practices with clients, (c) insight into how sexual orientation, ethnicity and factors related to culture influence decision to use and/or discuss CT in counseling sessions, and (d) exploration of CT integration practices in a variety of counseling settings (e.g., schools, residential facilities).

Developing a survey instrument is an important next step in examining the findings of the current study. Creation of a psychometrically sound instrument would test the theory of integration developed in a different and broader method. The development of an instrument would also support understanding of how these factors generalize to other groups of counselors (e.g., those who are not independently licensed, from ethnic...
minority populations). With more data to understand integrative practices in counseling, practitioners, educators, and trainees can continue to pursue more effective ways to meet client, professional (e.g., ethics), and personal (e.g., interests) goals.

Research is also needed to explore the experiences of clients who are using integrative practices (Collinge et al., 2005). Continued qualitative research, particularly narrative inquiry, can be used to gain detailed understanding of the lived experience of clients. In addition, conducting mixed method and controlled experiments can assist in better understanding the efficacy of integration practices in the counseling context. By increasing the empirical support of various CT approaches, counselors’ integration practices would gain professional legitimacy and respect giving practitioners the opportunity to use a greater variety of techniques to match clients and their needs. While several participants from this study are already collecting data from clients, the need for methodologically sound studies similar to those being conducted in other professions (e.g., medical) should also be a focus of the counseling profession to meet evolving client and managed care demands. Partnerships between practicing counselors and researchers are encouraged to specifically evaluate client level outcomes associated with CT practices.

Future mixed methods research can also elaborate our understanding of how various aspects of self and culture influence the use of particular techniques in counseling sessions. The sample of the current study reflected a significant number ($N = 5$) of females who identified as sexual minorities integrating CT into their counseling. Also, due to Evans et al. (2002) findings and the lack of participant ethnic diversity in the current study, there needs to be investigation into specific groups of counselors to explore
how personal and cultural factors affect the techniques they employ in sessions; particularly, what are nontraditional and traditional approaches within their cultures (that could be considered CT) and how do their attitudes develop regarding whether or not to use those techniques? Although research in counseling has explored indigenous practices (Constantine, Myers, Kindaichi, & Moore III, 2004; Garrett & Garrett, 2002; Garrett et al., 2011; Herring, 1997; Lee & Armstrong, 1995; Lee, Oh, & Mountcastie, 1992; Yeh, Hunter, Madan-Bahel, Chiang, & Arora, 2004), comparing and contrasting how various individuals incorporate their worldview, particularly in a U.S. context, through the professional practices they use needs to be better understood. The research could identify ways to engage and assist a more diverse and broad scope of clients as well as attract more diverse counselors as result of incorporating more CT approaches that might be more familiar or better aligned with their worldviews.

Finally, the opportunity to understand how CT is integrated into various counseling contexts needs more detailed exploration. Consisting of a broad range of specialties, particularly defined by setting, the integration process would likely look very different. By learning more about how the process is negotiated and implemented in various settings, we can better understand the overlapping and divergent factors related to integration to continue to inform more effective practices and teaching foci. The future research proposed highlights the diverse way examination of CT integrative practices can reinforce the important and creative work of counselors.

**Conclusion**

The current research demonstrates the need and benefit of exploring counselors’ experiences, beliefs, competence, and practices related to CT to potentially create more
effective treatment options for those delivering and utilizing counseling. It is also important to reiterate the increased interest in CT in society, and counselors in and entering the profession. As Joy, a participant in the current study, expressed:

Since I have the perspective of being a counselor educator, is that it’s a significantly growing interest. So, in combining traditional and complementary, it’s something that has really piqued the interest of people in the profession and people evolving in the profession that’s worthy of us continuing to explore.

The counseling profession is at an important juncture to acknowledge and gain understanding of a growing phenomena in the quest for optimal health. Although other professions have embraced the challenge that CT presents because of the potential in their diverse approaches, such as noticeable shifts in care options provided in the medical community, counseling has done little to extrapolate the implications it could have on its traditional practices. Initial research has explored utilization of CT within counseling contexts, as well as some of the factors influencing those interactions (Baruch-Runyon, 2009; Evans et al., 2002). Detailed understanding of counselor attitudes and behaviors toward integration of CT into counseling sessions and how those perceptions and practices developed, however, needs to continue to be rigorously and empirically investigated, as was done in the current study. The findings from this research detail the process of CT integration currently being implemented by some in the counseling profession and the potential utility it can have on the field. By understanding practices of current counselors, we can see opportunities for counselors to be more connected and ultimately more productive in their work. Although more research needs to be done, this
study demonstrates the positive implications integration of CT in counseling can have for the practitioner, client, and profession.

The non-recursive construction of the model demonstrates a constant theme of connection evident throughout the study as participants discussed how the exposure to CT challenged their personal and professional beliefs, knowledge, and practices. The emphasis on interconnection between experience, beliefs, competence, and practices are rooted in counseling standards (ACA, 2005; CACREP, 2009; Sue et al., 1992). The findings reinforce the importance of exposure as well as self-exploration and understanding for counselors to find practices that align with and motivate them in their professional work to be effective practitioners (Eisenberg et al., 1998; Evans et al., 2002). The anecdotal evidence supplied by the participants providing Reinforcement of CT Use in Professional Practice gives insight into promising approaches to employ with clients. With the professional focus of counseling aimed at using creativity to meet the needs of diverse clients, CT integration appears to allow counselors additional tools with which to connect with clients while processing their various concerns. The positive results reported by study participants with their clients appeared to rejuvenate them as counselors, instilling confidence in their work and motivation to continue exploration of techniques that could be beneficial to the profession and the individuals we serve to no end.
Dear Counseling Practitioners,

I want to announce the opportunity for practicing professional counselors (i.e., master’s degree in any area of counseling) to participate in my qualitative research study as I seek my Ph.D. in Counselor Education at The Pennsylvania State University. My goal is to recruit a diverse sample of counselors integrating various mind-body therapies or techniques (e.g., biofeedback, EMDR, hypnosis, Reiki, yoga, mindfulness) in counseling sessions with diverse clients.

I will be conducting individual interviews ranging from 60-90 minutes, either in person (preferable, but as able), via phone, or Skype (i.e., free on-line video calling) that will be audio recorded. To attempt to compensate their time, participants will be offered the choice of a $10 Starbucks or Target gift card upon completion of the interview.

If you are interested, please contact me at lmn183@psu.edu or if you know any practicing counselors integrating CT into sessions that might be interested, please forward this email or refer them to me at the same email address. I appreciate your potential support and interest in my research. If you have any questions regarding this study, please don’t hesitate to contact me.

Sincerely,

Lindsey M. Nichols M.Ed., NCC
Appendix B

Pre-Identified Participant Recruitment

Dear (name of individual),

I am contacting you because I am in the initial recruitment of participants for my qualitative research study exploring the use and utility of complementary therapies (CT) in the counseling profession. I am hoping to recruit practicing professional counselors (i.e., master’s degree in any area of counseling), like you, to participate in my dissertation study as I seek my Ph.D. in Counselor Education at The Pennsylvania State University. As a counselor currently integrating CT in client sessions and after personal use of CT to address and maintain health, I have a vested interest in exploring this topic. I have attached the informed consent form for your review, but my goal is to recruit a diverse sample of counselors integrating various mind-body therapies or techniques (e.g., biofeedback, EMDR, Reiki, yoga, mindfulness) in counseling sessions with diverse clients.

I will be conducting individual interviews ranging from 60-90 minutes, either in person (preferable, but as able), via phone, or Skype (i.e., free on-line video calling). Regardless of format, each interview will be audio recorded and later transcribed for analysis purposes. Participants will be asked to provide basic demographic data as well as information surrounding their professional training. This information will be masked throughout the study by use of a participant ID number and then a participant identified pseudonym. I am also interested in collecting additional data in the form of documents (e.g., brochures, newspaper articles, client consented video’s and/or recordings, training or procedural information) and making connections with counselors to potentially survey their clients for a follow-up study, that can help inform how CT is being used by counseling professionals in practice.

In an attempt to compensate your time, you will have the choice of a $10 Starbucks or Target gift card upon completion of the interview. All interviews will be masked and I will work with you to insure the information you disclose is accurate. If you are interested, please contact me at lmn183@psu.edu or, if you know any other practicing counselors integrating CT into sessions that might be interested, please forward this/my email or refer them to me at the same email address. I appreciate your potential support and interest in my research. If you have any questions regarding this study, please don’t hesitate to contact me.

Sincerely,

Lindsey Nichols
Appendix C

Example of Initial Contact to Referred Participant

Dear (name of individual),

Your name and contact information was been provided by (insert name of referring individual if appropriate) due to your potential interest in participating in a research study I am conducting for my Ph.D. in Counselor Education at The Pennsylvania State University exploring of the use and utility of complementary therapies (CT) in the counseling profession. I am contacting you because I have been told that you are currently seeing clients and integrate CT in your sessions. As a counselor currently integrating CT in client session and after personal use of CT to address and maintain health, I have a vested interest in exploring this topic. I have attached the informed consent form for your review, but my goal is to recruit a diverse sample of counselors integrating various mind-body therapies or techniques (e.g., biofeedback, imagery, Reiki, yoga, mindfulness) in counseling sessions with diverse clients.

I will be conducting individual interviews ranging from 60-90 minutes, either in person (preferable, but as able), via phone or Skype (i.e., free on-line video calling). Regardless of format, each interview will be audio recorded and later transcribed for analysis purposes. I will store data in a password-protected file and all audio recordings will be destroyed upon completion of the study. Participants will be asked to provide basic demographic data as well as information surrounding their professional training. This information will be masked throughout the study by use of a participant ID number and then a participant identified pseudonym. I am also interested in collecting additional data in the form of documents (e.g., brochures, newspaper articles, client consented video’s and/or recordings, certifications, training or procedural information) and also interviewing potential clients for a follow-up study, that can help inform how CT is being used by counseling professionals in practice.

To compensate your time, you will have the choice of a $10 Starbucks or Target gift card upon completion of the interview. All interviews will be masked and I will work with you to insure the information you disclose is accurate. I also hope that you would be able to refer additional practicing counselors, who are integrating CT, for the study.

If you are interested, please contact me at lmn183@psu.edu. Or, if you know any other practicing counselors integrating CT into sessions that might be interested, please forward this email or refer them to me at the same email address. I appreciate your potential support and interest in my research. If you have any questions regarding this study, please don’t hesitate to contact me.

Sincerely,
Lindsey Nichols
Appendix D

Detailed Information to Participant

Dear (name of individual),

Thank you for your interest in participating in my qualitative research study exploring the use and utility of complementary therapies (CT) in the counseling profession. I am contacting you in order to schedule a convenient time and discuss the interview format (i.e., in person, phone, or Skype) depending on your location and/or setting preference. If you do decide to conduct the interview over the phone or Skype, due to the nature of the communication, there is less control over confidentiality. I am happy to discuss and work out these details in person, but am also available to organize the specifics over the phone depending on your comfort.

Interviews, again, will be between 60-90 minutes (and will be audio recorded), so please keep that in mind when trying to identify availability. I will store data in a password-protected file and all audio recordings will be destroyed upon completion of the study. I am currently available (insert available times for upcoming week(s)), but if none of those dates/times work for you, we will find something that does. The interview will be tape recorded regardless of setting it is conducted in, so the more quiet the location, the better.

Once a time, date, and format/location is decided, if the interview will take place over the phone or Skype, I will send the demographic and consent form to you via email prior to the scheduled time. Your participant ID# will be (give random number to confidentially track demographic information). The demographic information can then be completed electronically or in hard copy format, but will need to be available to you during the actual interview. Upon conclusion of the interview, you will need to send me the completed demographic form (again, either in electronic form to lmn183@psu.edu or hard copy to my attention at: The Pennsylvania State University, 315 CEDAR Building, University Park, PA 16802). As stated earlier, because of this in-direct contact, confidentiality of information cannot be insured opposed to if the forms being directly collected by the researcher in person and not being transported through another medium.

Finally, you will have the choice of a $10 Starbucks or Target gift card as small token of gratitude for your time; if the interview is not conducted in person, I will send the gift card to you via the mail as soon as possible (after being provided with an address). Again, I greatly appreciate your willingness and support of my research study. I look forward to hearing from you and moving forward with setting up the interview.

Sincerely,

Lindsey
Appendix E

Individual Interview Implicit Informed Consent Form, Not in Person

**Implied Informed Consent Form for Social Science Research**
The Pennsylvania State University

**Title of Project:** Counselor Attitudes and Behaviors Toward Wellness Approaches

**Principal Investigator:** Lindsey M. Nichols, Graduate Student
315 CEDAR Building
University Park, PA 16802
(203) 801-8117, lmn183@psu.edu

**Advisor:** Dr. Elizabeth Mellin, Assistant Professor
310 CEDAR Building
University Park, PA 16802
(814) 863-2414; eam20@psu.edu

1. **Purpose of the Study:** The purpose of this research study is to explore why and how counselors integrate various mind-body approaches in counseling session with clients.

2. **Procedures to be followed:** After meeting selection criteria, you will be individually interviewed regarding your attitudes and behaviors through a series of open questions. Prior to the interview, you will be asked to complete some basic demographic data about yourself.

3. **Duration:** Completion of the demographic form will take about 5 minutes to complete. The interview will take approximately 90 minutes or 1-½ hours.

4. **Statement of Confidentiality:** Your participation in this research is confidential. Your confidentiality will be kept to the degree permitted by the technology used. No guarantees can be made regarding the interception of data sent via the Internet by any third parties. A random number will be used in place of your name and any information that would identify who the responses belong to will be masked with your approval. In the event of any publication or presentation resulting from the research, no personally identifiable information will be shared because your name is in no way linked to your responses. Your interview will be audio recorded and the recordings will transferred onto CD-ROM and deleted from the original recorders. Only the Primary Investigator will have access to the data, which will be kept in a locked file cabinet and on a password protected computer to maintain confidentiality and destroyed after 3 years.

5. **Right to Ask Questions:** Please contact Lindsey Nichols at lmn183@psu.edu or (203) 801-8117 with questions or concerns about this study.

6. **Voluntary Participation:** Your decision to be in this research is voluntary. You can stop at any time. You do not have to answer any questions you do not want to answer.
You must be 18 years of age or older to take part in this research study and meet selection criteria detailed.

Completion and return of the demographic information questionnaire and participation in the interview implies that you have read the information in this form and consent to take part in the research. Please print off and keep this form for your records and future reference. Each participant will be offered a $10 gift card at the completion of the interview as compensation for his/her time.
Appendix F

Individual Interview Implicit Informed Consent Form, In Person

Implied Informed Consent Form for Social Science Research
The Pennsylvania State University

Title of Project: Counselor Attitudes and Behaviors Toward Wellness Approaches

Principal Investigator: Lindsey M. Nichols, Graduate Student
315 CEDAR Building
University Park, PA 16802
(203) 801-8117, lmn183@psu.edu

Advisor: Dr. Elizabeth Mellin, Assistant Professor
310 CEDAR Building
University Park, PA 16802
(814) 863-2414; eam20@psu.edu

1. Purpose of the Study: The purpose of this research study is to explore why and how counselors integrate various mind-body approaches in counseling session with clients.

2. Procedures to be followed: After meeting selection criteria, you will be individually interviewed regarding your attitudes and behaviors through a series of open questions. Prior to the interview, you will be asked to complete some basic demographic data about yourself.

3. Duration: Completion of the demographic form will take about 5 minutes to complete. The interview will take approximately 90 minutes or 1½ hours.

4. Statement of Confidentiality: Your participation in this research is confidential. A random number and pseudonym will be used in place of your name and any information that would identify who the responses belong to will be masked with your approval. In the event of any publication or presentation resulting from the research, no personally identifiable information will be shared because your name is in no way linked to your responses. Your interview will be audio recorded and the recordings will transferred onto CD-ROM and deleted from the original recorders. Only the Primary Investigator will have access to the data, which will be kept in a locked file to maintain confidentiality and destroyed after 3 years.

5. Right to Ask Questions: Please contact Lindsey Nichols at lmn183@psu.edu or (203) 801-8117 with questions or concerns about this study.

6. Voluntary Participation: Your decision to be in this research is voluntary. You can stop at any time. You do not have to answer any questions you do not want to answer.

You must be 18 years of age or older to take part in this research study and meet selection
Completion and return of the demographic information questionnaire and participation in the interview implies that you have read the information in this form and consent to take part in the research. Please keep this form for your records and future reference. Each participant will be offered a $10 gift card at the completion of the interview as compensation for his/her time.
Appendix G

Demographic Form

Counselor Demographic Questionnaire

Please answer the following questions prior to the interview. If applicable, please email or mail this form back to Lindsey Nichols at the addresses provided. You will be contacted if the researchers need to clarify/follow-up on any information you provide to insure accuracy of your statements. Please make sure to circle only one answer and write as clearly as possible for the other questions. Any identifying information will be kept confidential and this questionnaire will be kept locked with the other information collected during this study.

Participant ID# (given after confirmation of interview): ______

Location and Setting of Practice (Ex. state/region in U.S., urban or rural):
_________________________________________________________________

Participant pseudonym to use for confidentiality (first name only):
_________________________________________________________________

1. Sex (circle one): Male Female

2. Ethnicity (Example: Latino/a) _____________________________________________

3. Date of Birth (day/month/year): ______________________________

4. Religious/Spiritual Orientation (please indicate if none):________________________

5. Sexual Orientation: ______________________________

6. Disabilities (example: physical limitations, chronic illness):
________________________

5. Specialty area of counseling (examples: School, Community, Marriage & Family):
___________________________________________

5. Highest Education level obtained (circle one): Master’s Post-Master’s Ph.D.

6. Completed counselor training at a CACREP certified Institution (circle one): Yes No

7. Certifications and/or Licenses (please list all current):________________________

8. Number of years working with clients (not including master’s internship): ________
Appendix H

Guided Interview Schedule for Interviews

The following statements and questions reflect topical areas surrounding the questions I will ask. Due to the nature of conducting a semi-structured interview, having guiding topics will offer the flexibility needed to pursue lines of discussion that emerge in the interview process. The interviews will commence with an initial statement, listed below, and then address the topical areas.

**Beginning of Interview:**
Thank you again for coming and taking time out of your day to speak with me. I know that you read and responded to the initial email I sent you and you have read the consent form, but I wanted to remind you again that I am trying to better understand how and why counselors are integrating complementary therapies (CT) into counseling sessions. I have a few questions to ask you that will hopefully help stimulate our conversation. Before we get started, I’ll ask you to complete this demographic form that was previously discussed in the email and consent form (pass out forms if interview is being conducted in person; previously sent if via phone or Skype) and remind you that our conversation will be audio recorded and then transcribed. Do you have any questions?

**Topical Areas for Questions**
- Brief personal background information.
- Description about how individual became a counselor.
- How define his/her professional identity, concept of wellness.
- Knowledge of and background related to CT.
- Counselor training and professional specialty interests.
- Role and responsibility counselor takes when working with clients to meet their needs.

**Main Guiding Questions:**
1. Counseling is supposed to be based on the concept of wellness, so how do you define wellness?
2. Define your professional identity or what values and roles you ascribe to as a counselor? (Follow-up question: How did you develop that identity?)
3. When you hear CT or mind-body approaches, what comes to your mind?
4. Tell me about your introduction to and experiences with CT?
5. Where and when did you learn about (state mind-body practice here).
6. When and why did you start integrating (state mind-body practice here) into your counseling sessions?
7. How do you integrate CT into sessions?
8. What are your perceptions of counseling effectiveness with clients when (state mind-body practice here) is integrated into the session?
9. What have been other professional benefits and/or challenges to integrating CT in session?
10. Do you have any last comments or do you have any other materials that may assist me in understanding why and or how you integrate CT into your counseling practice?
References


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*Counseling Today, 53,* 18-20.


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Education
Ph.D., Counselor Education & Supervision, Pennsylvania State University, May 2012
M.Ed., School Counseling, University of North Carolina at Chapel Hill, August 2006
M.A., Education – History and Social Sciences, University of Connecticut, May 2003
B.S., History, University of Connecticut, May 2002

Publications


International and National Presentations


Research Grants

Teaching Experience: Courses Taught & Co-Taught
Introduction to Counseling & Development, (Fall 2010 & Fall 2011), The Pennsylvania State University, University Park, PA.