Counseling and Complementary Therapy:
A National Survey of Counselors' Experiences

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(ABSTRACT)

There has been little research to date specifically addressing counselors' experiences with complementary therapy. The objective of this exploratory survey was to assess counselors' professional practice, knowledge and training, and personal experience with complementary therapy. The study design was a web-based, random sample survey of American Counseling Association members.

Results indicated the typical respondent was female, Caucasian, holds a Master's degree and works in a private practice/self-employed or community agency setting as an outpatient counselor. Few respondents asked about or had clients volunteer use of complementary therapy. Anxiety and depression were the most common client concerns for which respondents recommended or referred for complementary therapy. Respondents agreed that client referrals should be to licensed or certified practitioners. Respondents reported that complementary therapy provided clients with at least some positive benefits and few negative consequences.

The majority of respondents included complementary therapy in counseling during the past year and thought that complementary therapy should be included in addition to counseling. Although respondents considered themselves qualified to discuss a variety of complementary therapies, few possessed licensure or certification. The majority of respondents used informal, self-study to gain knowledge of complementary therapy. Most respondents have personally experienced at least one complementary therapy, primarily "To improve overall wellness". Respondents reported they received some to large benefits from this experience.

A number of respondents descriptors had moderately positive associations with client usage, recommendation and referral, inclusion, and knowledge factors. These descriptors were those respondents who worked in a private practice/self-employed setting, as an outpatient counselor, were licensed as an LPC, provided individual, family/couples, or alcohol/substance abuse counseling, and had a psychodynamic

orientation. There were moderately negative associations between respondents who worked in a K-12 setting, did not possess mental health licensure and were a Master's student and client usage, recommendation and referral, and inclusion factors.

The data provide support for the idea that counselors are beginning to embrace a post-modern approach, which gives consideration to complementary therapy interventions. However, the findings also suggested that the counseling profession still has a good deal of work to do before it can be considered truly holistic.

DEDICATION

I dedicate this dissertation to my family for their support throughout this long process. Thank you all for your patience and understanding of the long hours I spent working on my computer. I also wish to thank my parents for believing in me – I finally did it!

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TABLE OF CONTENTS

LIST OF TABLES

CHAPTER ONE

INTRODUCTION

Over the past few decades, the character of health care has gradually shifted toward a more inclusive or holistic model of wellness (Shannon, 2002). An important element of this conceptualization of health is an emphasis on "being well", not simply free of disease. This comprehensive model posits well being as our natural state, in stark contrast with the conventional medical view of the human being as engaged in a constant battle with a variety of insidious disease agents (i.e., germs, viruses, mutating cells) (Weil, 1997).

This recognition of our holistic nature represents a fundamental shift in how society views both illness and health. As Thomas Kuhn (1970) eloquently argued in his seminal work, *The Structure of Scientific Revolutions*, when accumulating (scientific) evidence does not readily fit into the currently accepted reality, it (the evidence) is more accurately termed a paradigm shift. This emerging trend has also been labeled as postmodern or constructivist because its challenges to present "givens" (i.e., paradigms) and skepticism about postulates that there exists a single truth or reality (Gerber & Basham, 1999). So, today, it has been asserted that underneath the observed changes in peoples' health care behaviors there are deeper currents at play, which reflect profound changes in modern society's needs and values (Jonas, 2000).

From a mental health perspective, Bassman and Uellendahl (2003) concurred that complementary and alternative therapy represents a profound paradigm shift for the practice of counseling. As they stated, "old, comfortable patterns would give way to new ones that call for more personal responsibility on the part of clients and *involve more health care options*" (p. 268; emphasis added). This ability to shift worldviews in order to meet changing needs and values is one of the most important, and difficult, challenges facing 21st century mental health caregivers (Shannon, 2002).

In striving to meet this need, the mental health profession has begun to recognize the holistic nature of psychological problems and researchers have called for a broadening of the psychotherapist's role (Miller, 1996; Pollock, 2001). Specific to counseling, is a core philosophy of wellness, which posits a positive, holistic stance toward human suffering and change (Myers, 1992). Counselors have a unique role to play

in the mental health arena by focusing on those factors, and offering more options that address the gap between wellness and lack of illness (Hermon & Hazler, 1999).

Research has shown there is an inherent and crucial connection between body, mind and spirit (Pert, 1997; Rand, 1996). Therefore, the implication of a holistic model of wellness is that effective health care, whether identified primarily as physical or psychological in origin, can no longer restrict itself to only treating part of the person, but must address multiple realms of experience (White, 2000)

Along with this emergent definition of wellness has come an increased interest in more inclusive and less invasive therapies, which work with the whole person. Thus, many age-old therapies, such as acupuncture, as well as some newer therapies (e.g., Eye Movement Desensitization Reprocessing) have become vanguards of modern health care. Likewise, counselors are also searching for integration in the practice of psychotherapy, which necessarily involves the reconciliation of different realities (Fear & Woolfe, 1996).

These “new”, integrative therapies/realties have received the title of complementary and/or alternative health care/therapy (National Center for Complementary and Alternative Medicine, 2002). Specific to a counseling perspective, complementary and alternative therapies are defined as, “therapeutic modalities other than [mainstream] psychotherapy in all its various forms and other than mainstream medical practice” (Bassman & Uellendahl, 2003, p. 264). A few examples of complementary counseling interventions are aromatherapy, exercise, guided imagery, herbs, Reiki, and Yoga. (Ernst, Rand, & Stevinson, 1998). Note: The term *complementary therapy* is used throughout this paper in lieu of complementary and alternative therapy, since less than 2% of the US population has used these therapies as an “alternative” to conventional health care (Druss & Rosenheck, 1999).

Despite a long history of animosity toward unconventional approaches, the conventional medical community has begun serious scrutiny of claims of efficacy for complementary therapeutic approaches (Diamond, 2001). In 1993, Congress established the National Center for Complementary and Alternative Medicine (NCCAM), part of the National Institutes of Health (NIH), to address many of the issues surrounding complementary therapy. Furthermore, specialized research institutes have been

established at a select group of higher education institutions to rigorously investigate complementary therapy under the auspices of the NCCAM (Marwick, 1998).

Studies have shown a substantial increase in the use of complementary therapy by the general public in recent years. Visits to complementary therapy practitioners increased by 47% between 1990 and 1997, reaching 629 million adult visits in 1997 (Eisenberg, et al., 1993, 1998). Further, 42% of the US population utilized at least one form of complementary therapy in 1997, exceeding visits to all US primary care physicians by almost 40%. In addition, payments to complementary therapy practitioners were $21 billion in 1997, with $12 billion coming out-of-pocket, exceeding expenditures for all US hospitalizations. Finally, and most importantly, these figures are expected to increase for the foreseeable future (Chez & Jonas, 1997).

Critics argue that the increased interest of the medical community reflects this inexorable trend toward the greater use of complementary therapy by consumers (Gordon, Nienstedt, & Gesler, 1998). The enormity of out-of pocket expenditures on complementary therapy alone ($27 billion in 1997, exceeding the total amount spent by consumers on all US physician services that same year), is certainly sufficient to attract the attention of those involved in conventional health care, research and policy.

Relevant research reported that an even greater percentage of the mental health population uses complementary therapy on a regular basis. Research by Knaudt, Conner, Weisler, Churchill, and Davidson (1999) found that 54% of psychiatric outpatients had used some form of complementary therapy in the past year to treat a mental health condition. Further evidence for this trend comes from research by Eisenberg, et al. (1993, 1998), which established that much of the increased use of complementary therapies was for the psychological concerns of anxiety, depression, insomnia, and (psychologically mediated) back and neck pain.

Rationale for the Study

There remains little ambiguity that mental health clients are using complementary therapy to treat both mental and physical concerns. However, Knaudt, et al. (1999) found that while over half of psychiatric outpatients had concurrent use of complementary therapy and standard mental health care, only 51% discussed this use with their psychiatrist. Interestingly, this underreporting of use was not attributed by clients to

feelings their conventional caregiver would disapprove of their use of complementary therapy (Astin, 1998). Rather, it was more likely, clients reasoned, that it was not important their caregiver know, that their caregiver did not ask or that their caregiver would not understand (Eisenberg, et al., 2001; Knaudt, et al., 1999). Surprisingly, the counseling literature is virtually silent concerning what percentage of clients discuss their use of complementary therapy with their counselors.

The dramatic increase in the use of complementary therapy produces several challenges for counselors. First, counselors need to be aware of their clients' use of complementary therapy in order to continue to provide educated and effective interventions. In addition, counselors need to be aware of the possible impact of culture on clients' use of complementary therapy. Finally, counselors have an ethical responsibility to their clients to be able to engage in competent discussions and provide knowledgeable recommendations and referrals concerning complementary therapy.

One of the goals of all forms of counseling is the empowerment of clients in the direction of self-care and regulation (Bankart, 1997; Teyber, 1997). For example, a significant predictor of complementary therapy use for women living with breast cancer was a preference for a more active and collaborative role in their treatment (Balneaves, Kristjanson, & Tataryn, 1999). Similarly, Truant and Bottroff (1999) found that a similar group of clients perceived their use of complementary therapy as means of gaining control and maintaining hope during a time of uncertainty. Therefore, the use of complementary therapy may function as a behavioral indicator and possible pathway for clients seeking self-empowerment. In essence, clients may seek out complementary therapy to take charge of their own "being" – well or not.

An additional concern relates to reported correlates between clients' use of complementary therapy and psychopathology. Several studies indicated that self-reported and professional diagnosis of mental disorders were both associated with increased client use of complementary therapy (Davidson, et al., 1998; Druss, Rohrbaugh, Kosten, Hoff, & Rosenheck, 1998; Druss & Rosenheck, 2000). These findings point out the need for counselors to be aware that clients' use of complementary treatments may be associated with mental illness. As a result, several researchers have strongly recommended that practitioners of conventional and complementary therapy increase their collaboration

concerning mental health care (Kessler et al., 2001; Ngoma, Prince, & Mann, 2003; Unutzer, et al., 2000; White, 2000).

Due to cultural norms, complementary therapy may also serve as the primary health care system for some clients (Bodeker & Kronenberg, 2002; Lee, Lin, Wrensch, Adler, & Eisenberg, 2000; Wilkinson, 1987). In fact, the World Health Organization (2002) reported that up to 80% of the population in several developing countries uses traditional or complementary therapy as the primary means to meet their health care needs. Closer to home, Brown and Segal (1996) found that African Americans residing in North Florida were almost three times more likely to use home remedies as compared to their white counterparts, controlling for all other factors. They also found that lower educational level, along with having a poverty status, was a significant predictor of use, regardless of ethnicity.

Further, Bassman and Uellendahl (2003) asserted that complementary therapy could be "important and useful to expand treatment opportunities for those individuals, who for reason of culture or worldview, easily accept the mind-body-spirit connection and who may not respond to allopathic approaches" (p. 269). Other researchers have emphasized the importance of clinicians making a conscious effort to understand the critical role that cultural values and beliefs can play in shaping clients' health information seeking behaviors (Kakai, Maskarinec, Shumay, Tatsumura, & Taskai, 2003). These cultural influences affect clients' quality of life and, perhaps, even their survival. Therefore, it is crucial that counselors have an awareness and working knowledge of culturally mediated complementary therapy.

Informed consent concerns require that counselors are aware of relevant evidence for the use of any intervention, complementary or not, and are able to assess risk-benefits and competently discuss these options with their clients (Adams, Cohen, Eisenberg, & Jonsen, 2002). In fact, it could be reasonably argued that counselors have an ethical obligation to raise and discuss complementary therapies that have been shown to be clinically efficacious.

This dilemma is further compounded by the fact that while clients are only partly informing their health providers about their use of complementary therapy, their providers lack accurate knowledge concerning this realm of interventions. Pollock (2001)

asserted that most psychotherapists, regardless of professional discipline, lack adequate knowledge and training in complementary therapy to discuss or deliver these therapies effectively. Further, this lack of expertise could be due in part to psychotherapists' lack of belief in the usefulness of these therapies, regardless of their research base. For many psychotherapists, complementary therapy simply lies too far outside the "normal" realm of what constitutes the practice of psychotherapy.

Presently, counselors need to be able to provide referrals for additional psychological testing and/or a medical evaluation when necessary. Likewise, counselors should be familiar enough with complementary therapy to provide appropriate recommendations and referrals. Much like the interactions that regularly occur between psychiatrists and other non-medical mental health care workers, counselors need to be in communication with complementary therapy practitioners and have an established referral network (Greub & McNamara, 2000).

Unfortunately, there is little guidance available for those psychotherapists who wish to use or suggest complementary therapies for their clients in an ethical and competent manner (Greub & McNamara, 2000). Simply keeping abreast of the far-flung landscape that makes up complementary therapy is in itself a daunting task (Kaptchuk & Eisenberg, 2001).

In reaction to this deficiency, there has been a recent upsurge of interest in increasing educational opportunities for conventional health care professionals concerning complementary therapy (Marcus, 2001; Wetzel, Kaptchuk, Haramati, & Eisenberg, 2003). Specifically, over 82 medical schools currently offer some form of education in complementary therapy (Wetzel, et al., 2003).

Encouragingly, psychotherapists have expressed a strong interest in knowing more about complementary therapy (Berman, et al., 1995; Sikand & Laken, 1998; Verhoff & Sutherland, 1995). Along the same lines, many professionals are advocating for the integration of complementary therapy into the practice of mainstream health care and psychotherapy (Astin, Marie, Pelletier, Hansen, & Haskel, 1998; Frenkel & Borkan, 2003; Shannon, 2002). However, there has been little movement within the clinical and counselor education communities toward educating counselors about complementary therapy (White, 2000).

In fact, a thorough review of the literature indicated there is little ongoing research related to counseling and complementary therapy. A search for articles on "complementary and alternative medicine and/or therapy" yielded limited citations from the well-known counseling databases PSYCLIT and ERIC, or the ancillary databases of Education Full-text and Sociological Abstracts. Only 20% of articles concerned with any aspect of complementary therapy were cited in counseling related journals. Echoing this dearth of information, several authors have recommended the mental health profession immediately begin its own investigations related to all aspects of complementary therapy (Bassmen & Uellendahl, 2003; Knaudt, et al., 1999; White, 2000; Yager, Siefried, & DiMatteo, 1999).

In contrast, the medical literature is replete with articles, editorials, and reviews dedicated to the many issues surrounding complementary therapy. A recent systematic literature search found over 1500 article additions located in the mainstream medical literature concerned with complementary and alternative medicine indexed per annum (equal to 0.4% of all article additions indexed per annum) between 1986 and 1996 (Barnes, Abbot, Harkness, & Ernst, 1999).

Statement of the Problem

It has been established that: (a) clients' use of complementary therapy has increased to the point that it has become an important consideration in mental health care, (b) this use is underreported, (c) counselors need to be aware and knowledgeable of their clients' use of complementary therapy in order to provide learned and effective interventions, enhance cultural sensitivity, engage in competent discussions and provide informed recommendations and referrals, (d) counselors lack adequate knowledge and training in complementary therapy to discuss or deliver these therapies effectively, (e) existing guidelines are inadequate for counselors who wish to use or suggest complementary therapy for their clients in an ethical and competent manner, and (f) there is little ongoing research related to counseling and complementary therapy.

The problem is that despite a significant increase in clients' use of complementary therapy over the last decade, counselors' knowledge, training, personal and professional experience with complementary therapy is mostly unknown. The goal of this study is to help fill this information void.

Purpose of the Study

The purpose of the present study was to gather information from counselors regarding: clients' disclosure of complementary therapy use, recommendation and referral patterns for complementary therapy, inclusion of complementary therapy within clinical practice, counselors' knowledge and training in complementary therapy and counselors' personal experience with complementary therapy. In addition, demographic information was collected from respondents.

Research Questions

I. Professional Practice variables

1. What do counselors ask, and their clients disclose, concerning clients' use of complementary therapy?
2. What are counselors' recommendation and referral patterns for complementary therapy?
3. Do counselors include complementary therapy in their practice of counseling? If so, how is it included?

II. Knowledge and training variables

4. What are counselors' knowledge and training in complementary therapy?

III. Personal experience variables

5. What are counselors' personal experiences with complementary therapy?

IV. Demographic variables

6. Do counselors differ across demographic variables (i.e., gender, age, race/ethnicity, income, degree, mental health license, years practicing, clients/week, current position, work setting, services provided, theoretical orientation) with regards to professional practice variables, knowledge and training variables, and personal experience variables?

Significance of the Study

The current study has importance for research, policy, education, and practice in counseling. It begins the process of understanding the experiences of counselors with regard to complementary therapy. This research supports the counseling profession in furthering its commitment to mental health from a holistic perspective of wellness across the lifespan.

Specifically, this study will help facilitate an increase in counselors' awareness of the need to be knowledgeable of clients' use of complementary therapy, enhance sensitivity to the cultural context of complementary therapy, and highlight the importance of being able to engage in competent discussions and provide informed recommendations and referrals. In addition, counselor education programs may wish to use this information to develop and enhance curricula to more accurately reflect changing paradigms, as manifest in the "real world" of counseling practice.

Most importantly, the present study offers support to the counseling profession as it strives to honor its holistic roots in the midst of the currently restrictive environment of managed health care. Finally, as this field of research is still relatively new, the present study will hopefully provide both inspiration and support for future counseling researchers.

Methodology

This was an exploratory survey of mental health counselors utilizing a web-based survey methodology. The survey sample included individuals who were members of the American Counseling Association (ACA) and who volunteered to complete the web-based survey. Therefore, all respondents were required to have an email address and access to the Internet.

The survey instrument was designed based on a thorough review of the literature, extensive feedback from committee members and a pilot study of the instrument. The resulting survey was posted on a designated Virginia Tech server and made available for approximately three weeks to respondents. Implementation of the survey closely followed the proven *Tailored Design Method* developed by Dillman (2000).

The survey addressed four specific areas of interest, including, professional practice, knowledge and training, personal experience and demographic variables. Data analysis and reporting included computing descriptive statistics for each area of interest and investigation of associations between variables.

Definition of Terms

Allopathic medicine – also called Conventional medicine. Refers to the Western, biologically-based, mainstream practice of medicine that focuses on disease processes and subsequently employs interventions to combat them (Muehsam, Eskinazi, Park, &

Daly, 1997). Interventions within allopathic medicine may be roughly grouped into the categories of medication and surgery.

Alternative therapy – operationally speaking, alternative therapy refers to interventions used as a substitute or complete alternative to conventional health care (Trachtenberg, 2002).

Complementary therapy – operationally speaking, complementary therapy refers to interventions used as an adjunct to conventional health care (Trachtenberg, 2002).

Conventional healthcare – the generally acknowledged practices of the dominant health care model (Eisenberg, et al., 1998). Weil (1997) proposed that orthodox health care represented a more accurate definition.

Integrative healthcare – refers to a holistic approach in which the patient, not the disease, is the focus of the healing practice (Diamond, 2001). The clients' physical, mental and spiritual well being are all given attention in order to realize the greatest healing possible (which does not necessarily correlate with a cure). Integrative medicine is also used to describe the practice of combining conventional and complementary approaches.

Counselor – relative to this study, refers to any individual who classified themselves as a counselor, regardless of employment setting or client population (i.e., school, community agency, private practice, student, etc.). Counselors are further defined as those respondents who currently possess or are in the process of obtaining the educational and experiential requirements for licensure as a counselor in their state or jurisdiction.

Traditional healthcare – used to denote the indigenous health practices of the world (World Health Organization, 2002).

Unconventional healthcare – an umbrella term, used to refer to alternative and/or complementary therapies (Trachtenberg, 2002).

Delimitations and Limitations

The present study was designed to be exploratory in nature. Therefore, it was not expected to provide definitive answers to the current issues surrounding counseling and complementary therapy. Rather, the goal was to provide a baseline of data to guide future research.

At present, web-based survey research methodology is still considered limited with regards to generalizability (Dillman, 2000). For that reason, the results of this study

cannot be considered representative of the general population of counselors. However, the sampling approach may provide representation of a specific subset of counselors (i.e., counselors who are members of ACA, with an email address and access to the Internet) (Kaye & Johnson, 1999). It was also assumed that those counselors who responded have at least a passing interest in complementary therapy.

Summary

Chapter One began with an introduction to complementary therapy and its significance for the counseling profession. Rationales for the study were then discussed. These revolved around the importance of counselors being aware and knowledgeable of their clients' use of complementary therapy in order to provide learned and effective interventions, enhance sensitivity to cultural issues, engage in informed and competent discussions, and provide knowledgeable recommendations and referrals for complementary therapy.

The statement of the problem noted that there has been little, if any, research concerning clients' disclosure of complementary therapy use, counselors' recommendation and referral patterns for complementary therapy, inclusion of complementary therapy within the practice of counseling, counselors' knowledge and training in complementary therapy, and counselors' personal use of complementary therapy. Four specific areas of interest to be researched were outlined, including, professional practice variables, knowledge and training variables, personal experience variables and demographic variables. Next, an overview of research methodology was presented. Definitions of crucial terms were provided. Finally, limitations and delimitations were discussed.

CHAPTER TWO

REVIEW OF THE LITERATURE

High utilization rates, underreported usage, as well as a growing body of evidence indicating the effectiveness of some complementary therapies for mental health related problems, all call for a response from the counseling profession on the role of complementary therapy. White (2000) cautioned that the field of psychology has done little to explore this connection, despite the fact that complementary therapies usually care for the mind, as well as the body. If this reproof holds true for psychology, then the paucity of counseling literature related to complementary therapy highlights an even greater need for counselors to investigate the opportunities and challenges surrounding complementary therapy within their distinct domain.

As pointed out in chapter one, the medical profession has conducted the majority of research on complementary therapy to date. Underscoring the importance given to this area of health care, the American Medical Association recently devoted an entire issue of its preeminent journal to complementary medicine (Fontanarosa & Lundberg, 1998b). While there are some extant guidelines regarding complementary therapy and mental health care, these are limited in scope. Expanding on White's (2000) recommendations for psychologists, the counseling profession needs to develop, "mechanisms for educators, students, researchers and practitioners to investigate CAM [complementary and alternative medicine/therapy] in an unbiased manner as *these fields relate to all aspects* of [counseling]" (p. 679; emphasis added).

In this spirit, chapter two investigates several areas of the literature related to complementary therapy. First, a look at the changing paradigm of mental health care, which underlies the increased interest in complementary therapy, provides a context for discussions specific to counseling and complementary therapy. Next, a brief overview of efforts to define and categorize the diverse spectrum of complementary therapy is offered. Then, given the rapid growth in popularity of complementary therapy, an overview of utilization trends is presented. A discussion of the experiences of mental health consumers with complementary therapy gives insights into the variety of meanings and functions these interventions can hold for counseling clients. Included is research on mental health consumers' usage of complementary therapy, as well as a discussion of

caregivers' perceptions of this use. Then, a review of the emergent roles of mental health care providers regarding complementary therapy is offered. This includes discussion of referral, recommendation and inclusion issues surrounding complementary therapy. The literature concerning education and training in complementary therapy is reviewed. Finally, insights into psychotherapists' knowledge and personal experience with complementary therapy are discussed. Multicultural, legal, and ethical concerns are included as appropriate.

The Shifting Paradigm of Complementary Therapy

"*Cogito ergo sum – I think, therefore I am"*. With this indubitable proposition, René Descartes defined the dualism of mind and body for the next three centuries of Western thought. To make the matter even more fractious, Descartes was not referring to a mere superficial division between the material (body) and the non-material (mind)[1], he insisted that, for all intents and purposes, they have *little or no interaction* (Earle, 1992).

Demasio (1994) makes this point clear:

> This is Descartes' error: the abyssal separation between body and mind, between the sizable, dimensioned, mechanically operated, infinitely divisible, body stuff, on the one hand, and the unsizable, undimensioned, un-pushpullable, nondivisible mind stuff; the suggestion that reasoning, and moral judgement, and the suffering that come from physical pain or emotional upheaval might exist separately from the body. Specifically, the separation of the most refined operations of the mind from the structure and operation of a biological organism. (pp. 249-50)

This argument for the separation of mind from body is often called "Cartesianism". Its tenets can be summarized as follows: "I can think; Bodies cannot think – Therefore, I am not a body", and "I cannot doubt that I have a mind (… that is, something that thinks…); I can doubt that I have a body – Therefore, my mind and body are not identical" (Earle, 1992, p. 104).

Wilber (1991) asserted that the separation of mind and body is fundamental to Western culture. Until recently, this perspective has contributed to a dearth of holistic ideas about human functioning.

[1]Descartes used the term *res cogitans* meaning "thinking thing" to describe the mind, in contrast with *res extensa* or "extended thing" to describe the body.

Effects of Dualism

An unfortunate outcome of Cartesian dualism is that it leaves little room for integration and wholeness in trying to heal the mind or the body. If, as Descartes believed, the body is nothing but an automat-on/ic, matter-based, mechanism (Berman, 1990), then its influence on healing (or hindering) the mind is irrelevant. In other words, the mind is treated and/or the body is treated, but they do not affect one another. That is, the cure of the mind (or body) is possible only by way of its (already sick) self. Therefore, any sensory evidence of the body is suspect and seen to have little value in engendering psychological (i.e., mind) change (Berman). So, today we generally have a dichotomy between those that define themselves as doctors of the "mind" and others that consider themselves to be doctors of the "body" (Schlesinger & Appelbaum, 2000). Brown (2002) aptly defined the schism resulting from the encapsulation of fundamentally different paradigms as "conceptual apartheid".

Candace Pert (1997) offered a concise summary of the effect of a dualistic "mindset" on the culture at large - and, thereby science (including, the relatively young science of psychology). She made the assertion that our culture is in a state of denial about the psychosomatic nature of many illnesses. The fact that the word "psychosomatic" consists of a fusion of psyche (literally "soul") and soma (or body) is beside the point. For the majority of our culture, and positively for most of the scientific community, "bringing the mind too close to the body threatens the legitimacy of any particular illness, suggesting it may be imaginary, unreal, *unscientific*" (Pert, p.18; emphasis added).

Further, if the contribution of the psyche to physical health is suspect, the possibility that the literal interpretation of psyche as "soul" may be of any consequence to health and healing smacks of mysticism, a place "where scientists have been forbidden to tread ever since the seventeenth century" (Pert, 1997, p. 18). She continues:

> It was then that René Descartes, the philosopher and [significantly, considered] one of the founding fathers of modern medicine, was forced to make a turf deal with the Pope in order to get the human bodies that he needed for dissection. Descartes agreed that he wouldn't have anything to do with the soul, the mind, or the emotions – those aspects of human experience under the virtually exclusive jurisdiction of the church at the time – if he could claim the physical realm as his own. Alas, this bargain set the tone and direction for Western science over the

> next two centuries, dividing human experience into two distinct and separate spheres that could never overlap, creating the unbalanced situation that is mainstream science as we know it today. (p. 18)

So, psychology in its quest for legitimacy and purpose, and being a nascent area of study at the turn of the century, found itself logically embracing this mechanistic, dualistic paradigm (Schaef, 1992). Inevitably, this prevailing climate strongly influenced the development of Freud's psychological theories that incorporated an almost exclusive emphasis on mental processes. This outlook still resounds within the halls of psychology (and counselor) education and practice. As a result, "this dualistic conception of human nature became firmly entrenched in contemporary psychological theory" (Rappaport, 1975, p. 49).

It has been asserted that psychotherapists have unconsciously "embodied" these cultural norms/paradigms into their own selves and practice of therapy. "We consider ourselves - and others deem us – professionals who have opted for a quiet, reflective, contemplative life in the head, not for a lot of physical exertion or athletic prowess" (Miller, 2000, p. 442).

Paradigms "Shift"

Fortunately, through accumulating scientific advances in fields such as psychoneuroimmunology, there has been a gradual transformation in opinions regarding the possibility that realms of the mind affect realms of the body, and vice versa (Murphy, 1992; Pert, 1997). This mind-body connection has been documented in depth and has contributed to a greater understanding of the truly unitive nature of the psyche and soma (Benson, 1996; Borysenko, 1988; Ford, 1989; Kabat-Zinn, 1990; Pelletier, 1977; Rossi, 1986).

There remains little doubt at this point of the relationship between the state of health of the mind and that of the body. As Damsio (1994) aptly puts it, "… the body contributes more than life support and modulatory effects to the brain. It contributes a *content* that is part and parcel of the workings of the normal mind" (p. 226; emphasis added).

The field of neuroscience has also made significant contributions to building a bridge between old and new paradigms of health care. Specific to mental health, Winkelman (2002) documented the psychobiological effects of shamanism in terms of brain functioning, socio-cultural manifestations and the psychological correlates of altered states of consciousness as adaptive potentials for wholeness and wellness. Simply put, mental health is influenced by biological, social, cultural, psychological and spiritual processes. Therefore, to be well involves accessing multiple modes of healing which, by necessity, include complementary therapy approaches.

Further support for changing paradigms comes from research, which found that neural activity following treatment for Obsessive Compulsive Disorder (OCD) was essentially identical regardless of whether the intervention was of a cognitive-behavioral or pharmaceutical nature (Brown, 2002). Perhaps even more relevant to counseling, is the well-researched connection between physical activity (i.e., body) and an improvement in depressive symptoms (i.e., mind) (Hayes, 1999; Herman, et al., 2000).

Authors writing for the counseling field have argued that there has been a shift in worldview for counselors, paralleling the changing paradigms of conventional health care (Granello, 2000; McAuliffe & Eriksen, 1999). This "new" counseling worldview conceptualizes the existence of a fundamental unity of mind and body, and acknowledges that psychological factors play a role in the etiology and course of physical disease and vice versa (White, 2000). Within this paradigm, the multiple dimensions of biological, cultural, spiritual, social, and psychological interact and influence mental health (Roberts, Kiselica, & Fredrickson, 2002). Over a decade ago, Witmer and Sweeney (1992) extended this interaction among factors to include the far-reaching concept of "cosmic consciousness", which focused on the connections among all things.

Most importantly for counselors is "the fact that the emerging paradigm in health care stresses prevention, early intervention and *alternative methods of remediation* – strategies that are in the purview of skills of professionals in our field" (Myers, Sweeney, & Witmer, 2000, p. 251; emphasis added). For example, in outlining their program for incorporating a wellness model in a violence prevention program for adolescents, Makinson and Myers (2003) emphasized that a holistic paradigm, which by definition, includes complementary therapy, can be effective in all aspects of counseling.

This all sounds like Eastern approaches to healing, which embrace a harmonious, balanced relationship between nature and wo/man; mind and body (Teeguarden, 1987). For example, in the Taoist view, there is an inherent unity between wo/man and nature. A life well lived is one that follows the natural cycles and patterns of life, without trying to force or coerce life to meet "perceived" needs. Nature can be trusted to support growth, but not to prevent suffering.

As the great sage Lao Tzu once said,

"The right way to go easy
Is to forget the right way
And forget that the going is easy"
(Merton, 1965, p. 104).

These ancient sages, Western and Eastern, knew how to properly embrace the inherent wholeness that is our birthright. They understood that experience could be trusted (Teeguarden, 1987). They grasped (without grasping) that the wisdom of the mind and body are inextricably linked – are in fact, one and the same.

Definitions and Categories of Complementary Therapy

Many definitions and categories have been proposed for complementary therapy. However, due to rapid changes throughout society and consequently, the health care industry, attempts to define complementary therapy are currently in a state of flux (Bassman & Uellendahl, 2003; Trachtenberg, 2002). Efforts at defining complementary and alternative therapy have ranged from what it is not (Eisenberg, et al., 1993), to a variety of definitions and categories of complementary therapy (Chez & Jonas, 1997; Health Canada, 2001; Kaptchuk & Eisenberg, 2001; National Center for Complementary and Alternative Medicine, 2002; Shannon, 2002).

With regard to counseling, complementary therapy was defined earlier as "interventions outside of mainstream psychotherapy or medical practice" (Bassman & Uellendahl, 2003, p. 264). Ironically, psychotherapy itself was, and occasionally still is, considered to be "complementary" in nature.

An early functional definition of complementary therapy was "those interventions neither widely taught in medical schools nor generally available in US hospitals" (Eisenberg, et al., 1993, p. 247). This definition is now outdated, since the majority of

medical schools incorporate some education on complementary therapy in their curriculum. Others have argued that there is no such thing as complementary medicine, only "scientifically proven, evidence-based medicine, … or unproven medicine, for which evidence is lacking" (Fontanarosa & Lundberg, 1998a, p. 1618).

A more comprehensive definition was proposed by Eskinazi (1998), who described alternative medicine as a, "broad set of health care practices not readily integrated into the dominant health care model, because they pose challenges to diverse societal beliefs and practices (cultural, economic, scientific, medical, and educational)" (p. 1622). In concurring, Astin, et al. (1998) asserted that CAM is largely a political term and, as such, what is considered alternative is likely to change over time. Along the same lines, Berman, et al., (1995) reported that areas where physicians had the least amount of training were considered the most alternative (or complementary) by them.

Similar to attempts to "define" complementary therapy, classification schemes have also been fraught with controversy. Some have argued that any system of classification should be precise and avoid the use of general terms (e.g., movement, healing) to distinguish among groups of interventions (Astin, et al., 1998). This is because interventions considered complementary will continue to change over time. Nevertheless, several authors have attempted to outline a taxonomy of complementary therapies (Chez & Jonas, 1997; Health Canada, 2001; Kaptchuk & Eisenberg, 2001; National Center for Complementary and Alternative Medicine, 2002; Shannon, 2002).

Kaptchuk and Eisenberg (2001) delineated between two types of complementary interventions, those that appeal to the general public and interventions that confine themselves to a particular ethnic or religious group. Accordingly, their taxonomy reflects this bifurcation by assigning interventions to either a secular or parochial grouping.

Several authors have proposed classification schemes for complementary therapies, which are generally equivalent (Chez & Jonas, 1997; Health Canada, 2001; National Center for Complementary and Alternative Medicine, 2002; Shannon, 2002). The taxonomy of complementary therapy proposed by the National Center for Complementary and Alternative Medicine serves as an exemplar for our purposes. This classification system consists of five major domains:

1) *Alternative medical systems* - Acupuncture, Ayurveda, herbal medicine, Homeopathic medicine, and Naturopathic medicine.
2) *Mind-Body interventions* – breathwork, meditation, prayer, mental healing, mental imagery, Yoga, and the art, music and dance therapies.
3) *Biologically based therapies* – aromatherapy, herbs, food, and vitamins.
4) *Manipulative and body-based methods* – applied kinesiology, chiropractic, massage, and exercise.
5) *Energy therapies* – Healing/Therapeutic touch, Qigong, Reiki, and magnetic therapy.

The examples given are not all-inclusive and are all subject, more or less, to becoming "mainstreamed", hence non-complementary, at some point in the future.

Utilization Trends in Complementary Therapy

In a seminal series of studies, Eisenberg, et al. (1993, 1998), first documented the enormous interest in and consumption of complementary therapy by the general public. They found that the use of complementary therapy nationwide increased from 34% to 42% between 1990 and 1997. "Conservative" estimates of expenditures on complementary therapy in 1997 were $21.2 billion, more than twice the amount ($9.1 billion) spent on all US hospitalizations that same year. In addition, Americans made an estimated 629 million visits to complementary therapy practitioners versus 386 million visits to all primary care physicians in 1997. There was also a 46% probability of having visited a complementary therapy practitioner in 1997.

Certain demographic factors have been consistently associated with the use of complementary therapy. There were positive correlations across several large group studies, in which being female, Caucasian, ages 35 to 64, living in the Western part of the US, having a higher socioeconomic status and being college educated were associated with greater use of complementary therapy (Astin, 1998; Eisenberg, et al., 1993, 1998; Paramor, 1996; Unutzer et al., 2000).

The most common health-related reasons cited by clients for use of complementary therapy were anxiety and depression, followed by headaches, and chronic pain, especially neck and back problems (Bausel, Lee, & Berman, 2001; Eisenberg, et al., 1993, 1998; Kessler, et al., 2001; Unutzer et al., 2000). Broadly speaking, clients using

complementary therapy have been found to possess poorer health status, have experienced long-term, chronic conditions that affect daily life and are more frequent consumers of conventional health care (Kelner & Wellman, 1997; Richardson, Sanders, Palmer, Greisinger, & Singletary, 2000).

From a more philosophical perspective, users of complementary therapy were classified as belonging to cultural groups committed to the tenants of environmentalism, feminism, personal growth and spirituality (Astin, 1998). Kelner and Wellman (1997) termed this viewpoint an "alternative therapy ideology".

In addition, those clients who consulted with a complementary therapy practitioner tended to remain loyal to their provider, have a strong belief in the efficacy of the treatment, hold a higher "health consciousness" and were likely to have relied on a personal referral from someone they knew and trusted (Furnham & Forey, 1994). Surprisingly, dissatisfaction with conventional health care was not a predictor of greater use of complementary therapy (Eisenberg, et al., 2001).

Mental Health Consumers' Experiences with Complementary Therapy

Use of complementary therapy by consumers of mental health is even more salient. Kessler, et al. (2001) reported that a total of 56.7% of respondents with anxiety disorder and 53.6% with severe depression reported using complementary therapy to treat these conditions within the past year. When these consumers were simultaneously seeing a conventional practitioner, the probability of using complementary therapy for care of anxiety disorder or severe depression increased to 65.9% and 66.7%, respectively. However, their most striking finding was that close to nine out of ten patients with self-defined anxiety attacks, who were seeing a psychiatrist, were also pursuing complementary therapy (this ratio was more than six out of ten for depression). Similarly, Unutzer, et al. (2000) found that respondents who met the criteria for major depression and panic disorder were more likely to report use of complementary therapy. Finally, Druss and Rosenheck (2000) reported that the mental health care consumers they surveyed with an adjustment disorder had the highest prevalence of complementary therapy use. Given these findings, it is clear that consumers are using complementary therapies on a regular basis to treat commonly occurring mental illnesses.

The choice of a specific complementary therapy appears to be at least partially dependent on the presenting mental health concern. For example, among a select sample of consumers with a range of anxiety disorders, the two most popular complementary therapies were hypnotherapy and self-help therapy, accounting for 44% of responses (Graham, Franses, Kenwright, & Marks, 2001). Kessler, et al. (2001) found a similar pattern of complementary therapy use for treatment of self-defined anxiety attacks or severe depression among their survey participants. These were (in order of decreasing popularity), cognitive feedback interventions (e.g., relaxation techniques, imagery), "other" therapies (e.g., spiritual healing by others, dietary changes), physical treatments (e.g., massage, acupuncture, Yoga) and oral medications (e.g., herbs, megavitamins, homeopathy). In addition, Knaudt, et al. (1999) reported that herbal/homeopathic remedies and meditation/spiritual activities were by far the most popular complementary therapies used in the previous year by psychiatric outpatients primarily diagnosed with anxiety disorders or major depression. Finally, among patients with adjustment disorders, herbal remedies were the most commonly used complementary therapy (Druss & Rosenheck, 2000).

From a broader perspective, O'Mathuna (2001) asserted that the increased interest in complementary therapy is at least partially addressing the Western thirst for spirituality, not just obvious health concerns. Furthermore, conventional practitioners often ignore complex effects that are part of the healing process. Therefore, for many clients, their search through the complementary therapy landscape for healing is rooted in an existential search for meaning. As Yamey (2000) aptly puts it, "this huge demand suggests that it [complementary therapy] offers something of value that is not provided by orthodox medicine" (p. 5). Of import here is that many well-known theories and schools of psychotherapy have been established in response to existential concerns – this "something" of value (Bankart, 1997).

Using this framework as a starting point, reasons given by mental health consumers for their use of complementary therapy are of special interest to counselors. Knaudt, et al. (1999) found that greatest perceived advantages of complementary therapy over conventional treatment were (from most to least advantage) the "natural" aspect of interventions, fewer side effects, greater effectiveness, not requiring involvement of a

health professional, less expense and greater control. Cited disadvantages were that interventions were perceived as not scientifically proven and less effective. Interestingly, potential side effects or being too expensive were not cited as disadvantages.

Other reasons given for the attraction of complementary therapy included greater time with complementary therapy practitioners, continuity of treatment, attention to personality and unique experience, client involvement and choice in treatment, instillation of hope, "high touch", ability of practitioner to work with ill-defined symptoms and explanations of illness that made sense (Zollman & Vickers, 1999). In general, consumers of complementary therapy perceived them to be more helpful than conventional care, especially for chronic, persistent, and debilitating conditions (Astin, 1988; Eisenberg, et al., 2001). In addition, up to 89% of users of complementary therapy for mental illness reported feeling at least "a little better" as a result (Knaudt, et al., 1999). These client motives are important and relevant issues for every counselor, regardless of their individual experiences or beliefs surrounding complementary therapy.

A related area of concern was the significant discrepancy between clients' use of complementary therapy and health care providers' perceptions of this use. Overall, less than 40% of all users of complementary therapy informed their caregiver of this fact (Eisenberg, et al., 1993, 1998). Baumrucker (2002) related that oncologists tended to "wildly underestimate" their patients' usage of complementary therapies to illustrate how physicians are mostly oblivious to their patients' health care practices. *Caveat emptor* - being oblivious is definitely not considered a necessary and sufficient condition of therapeutic personality change (Rogers, 1957).

Specific to mental health consumers, the percentage of clients who disclosed their use of alternative therapy was slightly higher, but still just over 50% (Knaudt, et al., 1999). In contrast to physicians, counselors' perceptions of their clients' use of complementary therapy is unknown.

Based on these findings, White (2000) recommended that psychologists become proactive about inquiring into their clients' use of complementary therapy. She also encouraged therapists to support their clients in reporting their use of complementary therapy to their medical caregiver, as well as informing their complementary practitioner of all other treatments.

Several sources have outlined procedural steps to insure that health care providers begin a conversation with their clients concerning complementary therapy (American Academy of Pediatrics, Committee on Children with Disabilities, 2001; Eisenberg, et al., 1998; Yager, et al., 1999). In fact, Haller (2001) recommends that practitioners always ask clients about possible use of complementary therapy. Certainly, these recommendations are equally applicable to counselors.

The Emergent Role of Counselors and Complementary Therapy

Counselors are just beginning to gain an awareness of the various issues surrounding counseling and complementary therapy. Not surprisingly, counselors have conducted little research into complementary therapy. However, there is a diverse and growing quantity of literature related to the use of complementary therapies for mental health care (Beaubrun & Gray, 2000; Findling, Feeny, Stansbrey, DelPorto-Bedoya, & Demeter, 2002; Graham, et al., 2001; Kessler, et al., 2001; Knaudt, et al., 1999; Schaffer, LaSalvia, & Stein, 1997; Yager, et al., 1999). However, this research is generally by, and for, the psychiatric profession and, as a result, published almost exclusively in medical journals. Researchers have called for more psychotherapists to incorporate research concerning complementary therapy into their work (Bassmen & Uellendahl, 2003; Shannon, 2002; White, 2000).

In the interim, a small, but significant body of knowledge suggests that complementary therapy offers effective interventions for certain psychological problems (Greub & McNamara, 2000). For example, there have been greater than 1000 trials over a 25-year period concerning the efficacy of exercise in the management of depression (Ernst, et al., 1998). The research in this area forms a compelling argument that exercise should be a viable first-line treatment for mild to moderate depression. Despite these findings, few psychotherapists have integrated exercise into their treatment regimen for those clients most likely to benefit (Pollock, 2001).

In addition, Miller (1996) discussed the “substantive and compelling” research concerning the relationship between diet and mental illness and health. This author also decried the lack of existing clinical protocols addressing the integration of dietary factors into mental health treatment.

Along the same lines, the medical profession has already begun to investigate referral patterns for complementary therapy (Astin, et al., 1998; Berman, Bausell, Hartnoll, Beckner, & Bareta, 1999; Frenkel & Borkan, 2003; Sikand & Laken, 1998). Overall, more than half of surveyed physicians were willing to refer their clients to a complementary practitioner (Sikand & Laken). In addition, willingness to refer was found to be strongest for clients suffering from chronic conditions. Still, significant concern is generated by reports of the ongoing fragmentation in care between conventional and complementary practitioners (Mainous, Gill, Zoller, & Wollman, 2000).

Greub & McNamara (2000) offered helpful professional guidelines concerning consulting with a physician when employing complementary therapies in a psychological setting. However, additional information is needed concerning counselors' referral and recommendation patterns for complementary therapy in order to develop guidelines specific to counselors.

The medical literature also addresses ethical and legal issues regarding referrals for complementary therapy (Adams, et al., 2002; Studdert, et al., 1998). The good news is that physicians are unlikely to be held liable for a referral to a complementary therapy practitioner gone awry – if, they refer to credentialed practitioners (Cohen & Eisenberg, 2002). Unfortunately, counselors appear to operate without professional awareness and guidance concerning complementary therapy referrals (Greub & McNamara, 2000).

Inclusion of complementary therapy into psychotherapy is also a salient issue for counselors. In fact, the integration of divergent psychotherapeutic traditions remains a long-standing concern for the counseling profession (Fear & Woolfe, 1996).

Regrettably, neither the medical community nor the counseling profession have conducted much research on the inclusion of complementary therapy in practice. One relevant article from West (1997), documents the experiences of counselors in the U.K., whose work also included healing. Not surprisingly, the majority of the counselors studied found their attempts at inclusion extremely challenging due to lack of professional support and supervision in this area.

Training and Education in Complementary Therapy

There has been a great deal of debate in the medical community concerning the need (or not) for integration of complementary therapy into mainstream systems of care

(Caspi, Bell, Rychener, Gaudet, & Weil, 2000; Grollman, 2001; Marcus, 2001; Owen, Lewith, & Stephens, 2001; Wetzel, Eisenberg, & Kaptchuk, 1998; Wetzel, et al., 2003). Despite this controversy, most medical schools now include some form of training in complementary therapy for their students (Bhattacharya, 2000; Wetzel, et al.). However, this training is usually ancillary to the conventional biomedical curriculum and of dubious value for actually practicing any form of complementary therapy (Wetzel, et al.).

Indeed, the American Academy of Pediatrics noted this lack of expertise and concluded that pediatricians' training in biomedicine may not adequately prepare them for discussion of complementary therapies (American Academy of Pediatrics, Committee on Children with Disabilities, 2001). Furthermore, the vast majority of nurses in a recent study perceived their preparation in this area to be fair or poor (Brolinson, Price, Ditmyer & Reis, 2001). Counselors' perceptions of readiness regarding various aspects of complementary therapy remain unexplored.

Finally, Burg, Kosch, Neims, and Stoller (1998) reported that more than half of the faculty they surveyed at a major health science center engaged in the personal use of at least one type of complementary therapy. Interestingly, personal or familial use of a complementary therapy has been associated with higher referral rates for complementary therapy (Borkan, Neher, Anson, & Smoker, 1994). However, counselors' personal experiences with complementary therapy are unknown.

Summary

Chapter Two began with an overview of research issues for the counseling profession regarding complementary therapy. First, the shifting paradigm of mental health care was discussed. Next, the literature surrounding definitions and categories of complementary therapy was reviewed. Then, utilization trends in complementary therapy were discussed to provide a background for this recent, but important phenomenon. Specific coverage was given to the literature referencing mental health consumers' experiences with complementary therapy. The literature addressing the emergent roles of counselors and complementary therapy followed. Training and education issues for counselors were then discussed. Finally, consideration of counselors' personal experiences with complementary therapy concluded the literature review.

CHAPTER THREE

METHODOLOGY

The current research study investigated the experiences of counselors concerning complementary therapy. Due to the deficiency of existing information, this study was designed to be exploratory in nature.

This study is important, as there has been little research to date, which specifically addresses counselors' experiences with complementary therapy. This information is expected to add to the current knowledge base, as well as provide impetus for further research regarding counseling and complementary therapy.

Web-based Survey Research

The social sciences have recently experienced an explosion in the use of the Internet (i.e., web-based) for survey research (White, Carey, & Dailey, 2001). The potential to reach a vast population of groups and individuals, while spanning geographical and social borders, has clearly changed the nature of conducting survey research (Coomber, 1997).

Harris and Dersch (1999) posited that the use of the Internet as a research medium is in line with the transition to a postmodern paradigm of scientific inquiry. Under postmodernism, the concept of what constitutes research expands (Gergen & Thatchenkery, 1996). Within this model, arbitrary empiricism is deemphasized, while cultural factors governing the production and interpretation of data gains primacy. Further, the particular research methodology is seen as less important as an arbiter of "truth". In other words, as geographical and social barriers become blurred through the medium of the Internet, there is a greater likelihood of data reflecting a broader worldview (i.e., paradigm). Specific to this study, it seems appropriate to employ a postmodern approach to survey a paradigm shift in counseling.

Researchers selecting a web-based approach for obtaining survey data can expect to deal with a unique set of issues, due in large part to the dynamic nature of the Internet itself. Knowledge of these issues is critical in order to obtain reliable data, while realizing the Internet's potential as a fast, efficient and cost-effective research tool (Houston & Fiore, 1998; Kaye & Johnson, 1999). Because of the problems inherent in online

research, most notably sampling concerns, the promise of the Internet as a survey methodology often remains unrealized (Dillman, 2000).

Several researchers have offered perspectives on the use of the Internet for conducting surveys (Dillman, 2000; Harris & Dersch, 1999; Houston & Fiore, 1998; Katz, Rice, & Aspden, 2001; Kehow & Pitkow, 1996; Sills & Song, 2002; Smith, 1997; Truell, Bartlett, & Alexander, 2002). The relative advantages and disadvantages of web-based survey approaches is used to offer a balanced viewpoint.

Potential advantages of using the Internet for web-based survey research are:

1. The Internet is unparalleled in terms of accessibility of data. Geographical (and some) social barriers are of little consequence (i.e., the computer does not "care" where the data comes from, its main concern is that proper communication protocols are followed) (Houston & Fiore, 1998; Turner & Turner, 1998).
2. The Internet offers the potential for a drastic reduction in the close relationship between sample size and survey costs (Dillman, 2000). Once the initial costs of creating the survey are accomplished, the expense for each additional survey is significantly less than for any other survey method (Kehoe & Pitkow, 1996).
3. In some cases, it is possible to survey entire populations, thus eliminating or ameliorating many concerns about the coverage and representativeness of the sample (i.e., sampling error) (Sills & Song, 2002). One common compromise employed by researchers is the use of oversampling to lend more credibility to a non-random sample (Kehoe & Pitkow, 1996).
4. The design flexibility of web-based surveys far exceeds those of any other survey environment (Dillman, 2000; Sills & Song, 2002). As a result, survey designs can allow for much greater interaction between the questionnaire and the respondent. In addition, multimedia capabilities can further enhance the range of survey options (e.g., audio, video).
5. Distribution and response times for web-based surveys are significantly shorter than for traditional means of surveying (i.e., telephone, in-person). This time is measured in days, or even hours, instead of weeks (Dillman, 2000).
6. Ease of data cleaning and analysis is enhanced with web-based surveys. Advances in survey software means collected data can often be prepared for analysis

without a single minute of researcher intervention (White, et al., 2001). For example, the use of a web-based survey technology, such as software filtering, can reduce errors due to entry of erroneous or unacceptable data (Houston & Fiore, 1998). This reduces the possibility of errors resulting from manual cleaning of pre-analysis data.

7. Web-based surveys may result in more extensive and candid response quality (Bachmann, Elfrink, & Vazzana, 1996). For some people, the ability to type in a quick response instead of the having to meet the requirements for a hand-written response may produce higher quality data. In addition, the perception of increased anonymity with computerized surveys may enhance data quality (Houston & Fiore, 1998).

On the other hand, potential disadvantages of using the Internet for web-based survey research are:

1. Sampling issues abound with web-based surveys. Many households still do not own or have access to a computer connected to the Internet (Dillman, 2000; Kehoe & Pitkow, 1996). Coverage error may result as not every potential member of a survey population has an equal chance of being selected for the sample. Specifically, without access to the Internet, someone has a zero chance of selection. This results in non-random (thus non-generalizable) sampling outcomes for many web-based surveys. An exception would be the case where each member of a sample frame has an equal probability of being selected (e.g., surveying employees of a company who are all issued an email account).
2. In addition, there is no current national listing of email addresses approximating those in existence for telephone numbers (Sills & Song, 2002). Even when email lists do exist for "closed", finite populations (i.e., members of an organization with email addresses) these lists quickly become obsolete, as email addresses are prone to rapid change. This phenomenon has resulted in reports of returned or "bounced" emails as high as 28% (Smith, 1997).
3. Low response rates are another common drawback of web-based surveys. To date, methods have not been fully articulated, which consistently achieve rates comparable to those for mail surveys (Duffy, 2002; Schaefer & Dillman, 1998).

Notable are reports of substantial increases in nonresponse rates for web-based surveys (as with all types of surveys) in recent years (Cook, Heath, & Thompson, 2000). This may be due in part to increases in the incidences (and perceptions) of spamming and junk mail (Sheehan & Hoy, 1999; Sills & Song, 2002).

4. Self-selection of respondents can increase bias in web-based surveys (Houston & Fiore, 1998). Only those respondents with access to the Internet are eligible to complete the survey. In addition, respondents must posses at least a reasonable amount of technical understanding to access and complete the survey (Smith, 1997). Specifically, selection bias is related to depictions of typical web-based survey respondents as educated, white males, 26 to 30 years old (Kehoe & Pitkow, 1996).
5. Technological issues with deployment also confound web-based survey implementation (Sills & Song, 2002). Transmission rates and questionnaire image quality are interrelated concerns for all survey designers (Dillman, 2000). In practice, not every user will necessarily have the technology to easily access a web-based survey, especially if it employs multimedia elements, such as video clips. In addition, there are no guarantees that all software and hardware variations can be accounted for by designers to insure adequate access to the survey (White, et al., 2001). Harris and Dersch (1999) cautioned web-based survey designers to work as if all users are “thin clients” - that is, possess the minimum of computer resources.
6. Other technical issues relate to security concerns. Although unlikely, any data moving across the Internet does have the potential to be accessed. Therefore, claims of confidentiality may sometimes be easier to make than deliver (Bier, Sherblom, & Gallo, 1996). These concerns should be adequately disclosed to participants.
7. While anonymity can result in participants providing more truthful or involved responses, it may also create the situation where someone may falsify or skew information, including their identity (Kehoe & Pitkow, 1996). In addition, the submission of multiple responses can be a concern unless proper precautions are

taken to control survey accesss (Harris & Dersch, 1999; Heerwegh & Loosveldt, 2002).

It is important to note that many of these issues are presently in a pattern of rapid change, paralleling that of the Internet itself. For example, much research and debate has focused the so-called “digital divide” in access to the Internet. Despite ominous predictions, the division between those with and without Internet access has steadily narrowed over time (Novak & Hoffman, 1998; Stross, 2000).

While several features, including race and ethnicity, remain significant with regards to computer ownership and Internet access, other factors, such as socioeconomic status have become more accurate in delineating among factors restricting access (Bier, et al., 1996). It is projected that as the use of the Internet continues to grow across all segments of society, that it (the Internet) will one day represent a population of users in line with national demographics (Kehoe & Pitkow, 1996).

As discussed above, web-based research does present significant limitations at this time. However, it remains a modality with high potential and can provide quality data under certain circumstances.

Encouragingly, several leading researchers have outlined specific guidelines for conducting effective Internet surveys (Dillman, 2000; Fowler, 2002; Schonlau, Fricker, & Elliott, 2002). Specific to this research, are their recommendations for use of the Internet for data collection with populations with almost universal Internet (and email) access. While the exact percentage of counselors with online access is uncertain, some assurance comes from reports that similar groups of individuals have high rates of computer ownership and Internet access (Owen & Weikel, 1999). In fact, Greene (2003) reported that over 97% of the mental health counselors he surveyed considered themselves to have medium to high Internet competence. Furthermore, professionals, such as counselors, can be expected to have greater overall levels of Internet usage and familiarity (Watt, 1997).

Participants

The survey population for this study included individuals who are members of the American Counseling Association (ACA), who possessed an email address, had access to the Internet and volunteered to complete the web-based survey. The ACA currently lists its total membership at 43,470 (American Counseling Association, 2004). In addition, the

ACA estimates there are currently over 80,000 professional counselors who are licensed or certified in 46 states and the District of Columbia.

Representiveness

The sample was drawn from the population of counselors with membership in the ACA. As such, the sample cannot be considered to be representative of the entire group of counselors in the United States. However, the survey results may prove to be representative of a specific subset of counselors. Specifically, those counselors who are members of ACA, have an email address and access to the Internet (Kaye & Johnson, 1999). Comparisons of the sample demographic characteristics with those provided by the ACA were used to assess the representativeness of the sample (Lundberg & Cobitz, 1999).

Response Rate

There have been disparate reports regarding response rates to web-based survey (McGlothlin, 2004). However, response rates have generally been lower than those achieved via more traditional means (Swoboda, Muhlberger, Weitkunat, & Schneeweiss, 1997). Cook, et al. (2000) found a mean response rate of 34.6% in a meta-analysis of 56 web-based surveys (with no missing data). In addition, Sheehan and Hoy (1999) reported a response rate of 24% for their survey of 5000 Internet users. Nevertheless, particular consideration was given to feedback from a researcher who recently conducted a similar study, drawing from the same population (G. Lawson, personal communication, July 7, 2004). In this particular case, a response rate of 15% was achieved. In addition, consultation with several committee members supported the use of this estimate Therefore, a 15% response rate was selected as a reasonable, if somewhat conservative estimate, and was used for sample size calculation.

Sample Size

Sample size is one of the most important considerations in designing a study, while at the same time, being one of the more difficult tasks a researcher faces (Bonett, 2002; Lenth, 2001). Too large of a sample is wasteful of costly resources. On the other hand, too small of a sample results in an underpowered study and may also result in an excessively wide confidence interval.

The present study was designed to be exploratory in nature. Therefore, the emphasis was less on traditional null hypothesis significance testing (NHST). However, in line with current recommendations of several prominent researchers, the process that determined the sample size is fully elucidated (Cohen, 1994; Olejnik & Algina, 2000; Wilkinson, 1999). Accordingly, the margin of error and amount of informational confidence desired were given careful consideration (Mendoza & Stafford, 2001; Smithson, 2003). Finally, the reporting of results focused on ease of understanding, as opposed to "nth percentile accuracy" (Wilkinson, 1999).

In deciding on a sample size, several key criteria are important to consider (Cumming & Finch, 2001). First, a margin of error needs to be chosen. This is usually based on either convention (i.e., Cohen's effect sizes) or results from previous studies. The latter approach is preferred and also promotes the use of meta-analytic thinking (Thompson, 2002b).

The margin of error (also called the confidence interval) is the amount of error in the result that the researcher determines to be tolerable. For instance, given a margin of error of 3%, it can be assumed that if 50% of a sample picked an answer, then between 47% and 53% (i.e., +/- 3%) of the corresponding population would pick the same answer. In general, narrower (conservative) intervals are preferred over wider (liberal) intervals (Smithson, 2003). Narrower intervals are also considered more informative than wider ones.

The ideal situation is to design for a confidence interval that has the greatest probability of containing the true parameter value (and, therefore, the least probability of including false values). Since smaller margins of error typically require larger sample sizes, designers usually face a tradeoff of accuracy versus cost. As Delucchi (2004) stated, "In the end, the sample size must be a compromise between the competing demands of good science and available resources of time and budget" (p. 373).

Confidence level is another important criteria. The confidence level tells how sure of the results the researcher can be. For example, a confidence level of 95% means that the "true" percentage of the population who would pick an answer - within the respective margin of error - is 95% certain. A 95% confidence level is most commonly used and was adhered to in this study (Smithson, 2000). The choice of this value convention was

further confirmed by research related to the present study (Astin, 1998; Cuijpers, 1997; Druss & Rosenheck, 1999, 2000; Ernst, Rand, & Stevinson, 1998; McKendree-Smith, Floyd, & Scogin, 2003; Ngoma, Prince, & Mann, 2003; Unutzer, et al., 2000; Young, Klap, Sherbourne, & Well, 2001).

An additional consideration is the predicted distribution of responses. If the results are highly skewed (e.g., 99% of a sample picked "Yes", while 1% chose "No"), then the chances of error are inherently low (Smithson, 2003). The chances of error are much greater for results that tend to cluster in the middle (i.e., 50%). In order to account for the worst-case scenario, a response distribution of 50% was employed when calculating the sample size.

Finally, population size is another important consideration. Fortunately, population size is only a factor when working with relatively small populations. Otherwise, for large populations, (such as the members of ACA) the sample size does not change much, if any, as the population increases.

The preceding discussion of sample size brings up the ongoing controversy surrounding the use of null-hypothesis significance testing (NHST) (Cohen, 1994; Wilkinson, 1999). NHST continues to be used despite the reform of statistical practices in favor of confidence intervals. In addition, underpowered trials continue to plague scientific research (Halpern, Karlawish, & Berlin, 2002; Hoenig & Heisey, 2001). Several authors have pushed for a differentiation between statistical, practical and clinical significance (Kendall, 1999; Thompson, 2002a). This delineation among types of significance further obfuscates the usefulness of the traditional NHST.

For the purposes of the present research, the message is clear - the sample size needs to be sufficient large to adequately and accurately represent the population under consideration. Also, the results should be presented in a meaningful way, in which the magnitude of effects is communicated in diverse ways (Thompson, 2002b).

Calculation of Sample Size

The ACA currently has about 44,000 members (population size). A 95% confidence level and a 3% confidence interval (i.e., margin of error) were selected (Smithson, 2003). The response distribution was assumed to be 50%.

Given these assumptions, software calculations (Lenth, 2004) determined the needed sample size as 1046. Further, a 15% response rate was previously established as a reasonable, if conservative, goal. Therefore, if the response rate equals completed surveys/sent surveys*100%, then the number of surveys needed to be sent is 6973 (i.e., 1046/.15).

In addition, to compensate for the possibility of undeliverable email addresses, it was assumed that as many as 25% of the emails would "bounce". (G. Lawson, personal communication, July 7, 2004; Sheehan & Hoy, 1999; Smith, 1997). In other words, 75% of sent emails would be received. Therefore, the total sample size is 9057 (i.e., 6973/.75).

To summarize, a total of 9057 surveys would have to be sent in order to achieve the ideal of 1046 completed surveys. This figure assumes a 15% response rate and that 75% of sent emails are received.

However, due to limited resources, only 4000 email addresses were available to be "purchased" from the ACA. This is the equivalent of accepting a 4% margin of error (e.g., 4000*.15=600). In other words, 4000 email addresses is the approximate sample size with a 4% margin of error (Lenth, 2004), all other factors remaining the same.

(Note: The sample size was calculated using Lenth's (2004) *CI for one proportion Applet*. This test provided a sample-size determination for estimating a proportion to within a specified margin of error and for a finite population of specified size.)

Confidentiality and Informed Consent

This study was approved by the Virginia Tech Institutional Review Board (IRB) under an "Expedited" status. The identities of survey respondents remained confidential at all times. Only the researcher saw their email addresses. To further insure confidentiality and provide security against unauthorized access, data was removed from the remote server on a daily basis during the period of online collection based on several unambiguous recommendations (Harris & Dersch, 1999; White, et al., 2001).

Delimitations and Limitations

This study was exploratory in nature. As such, it was not designed to provide results generalizable to the entire population of counselors.

Counselors who responded to the survey by default must have possessed an email address and access to the Internet. Information could not be gathered from counselors

who could not receive solicitation for the survey via email or did not use the Internet. Lack of experience or comfort with the Internet may also have been a source of nonresponse error. For some counselors the subject of complementary therapy itself may simply have lacked sufficient salience for them to take the time and energy required to participate. On the other hand, counselors with strong computer skills and/or interest in complementary therapy may have been more likely to respond. Response bias is to be expected in these instances.

It was further assumed that respondents who completed the survey provided factual information about themselves and their experiences. While providing misleading or incorrect information is unlikely, misrepresentation remains a significant concern for online surveys (Harris & Dersch, 1999; Kehoe & Pitkow, 1996). More realistic concerns about data reliability related to the possibility of someone coming upon the survey accidentally when browsing the Internet. Providing a link to the survey website, along with a requirement that all respondents must provide a password before they can access the survey, is generally considered sufficient to ameliorate these concerns (Heerwegh & Loosveldt, 2002).

An additional limitation is the fact that the collection of data was restricted to a period of approximately three weeks, in keeping with recommendations for web-based surveys (Dillman, 2000). Once again, only those respondents who had access to and responded to the survey within this temporal window could contribute to the data. Finally, some counselors may have made a faulty assumption that the first contact, an email used to recruit subjects, was either junk or Spam (Sills & Song, 2002). Researchers must realize that unsolicited email may be seen a breach of “Netiquitte”.

Research Questions

The purpose of the study was to gather information from counselors regarding: clients’ disclosure of complementary therapy use, recommendation and referral patterns for complementary therapy, inclusion of complementary therapy within clinical practice, counselors’ knowledge and training in complementary therapy and counselors’ personal experience with complementary therapy. In addition, demographic information was collected from respondents.

I. Professional Practice variables

1. What do counselors ask, and their clients disclose, concerning clients' use of complementary therapy?
2. What are counselors' recommendation and referral patterns for complementary therapy?
3. Do counselors include complementary therapy in their practice of counseling? If so, how is it included?

II. Knowledge and training variables

4. What are counselors' knowledge and training in complementary therapy?

III. Personal experience variables

5. What are counselors' personal experiences with complementary therapy?

IV. Demographic variables

7. Do counselors differ across demographic variables (i.e., gender, age, race/ethnicity, income, degree, mental health license, years practicing, clients/week, current position, work setting, services provided, theoretical orientation) with regards to professional practice variables, knowledge and training variables, and personal experience variables?

Instrumentation

The survey instrument was developed by the researcher after a thorough review of the literature. In addition, the face and content validity of the instrument were appraised by the researcher's dissertation committee. The survey instrument was then pilot tested with a diverse group of 17 counselors. Changes were implemented as recommended by the dissertation validation committee and pilot. Modifications to the instrument were mainly changing the wording of items to increase understandability, adjusting the order of questions and determining the content of the complementary therapy list. The final version of the instrument is found in Appendix A.

The writing of questions was based on the recommendations of several researchers (Dillman, 2000; Fowler, 2002; Schonlau, et al., 2002). This resulted in the employment of a short-list of general criteria for assessing each question's appropriateness for the proposed study. Issues of question structure and wording were deliberated with appropriate regard given to social exchange theory, which is discussed in detail in the next section. For example, providing time referents provided a temporal

"anchor" to respondents and eased their "cognitive cost". Another example was the use of cognitive design techniques to improve information recall over a sequence of questions.

The construction of the questionnaire was also strongly influenced by recommended guidelines (Dillman, 2000; Fowler, 2002; Schonlau, et al., 2002). Careful attention was given to key principles that guided the design, format and layout of the questionnaire. These principles included, manipulation of size, brightness, figure/ground, simplicity and regularity. Salience is also an important issue, and the selection of an appealing first question was given careful consideration.

Dillman (2000) discussed the two overall objectives of questionnaire construction as reducing errors of both nonresponse and measurement (i.e., bias). In other words, the overall goal is the design of a respondent-friendly questionnaire, which is easily and consistently understood and thoroughly completed. For example, a very practical and effective technique to help meet these goals is to provide the respondents with some indication of survey progress as they proceed through the questionnaire (e.g., "You are halfway done") (Schonlau, et al., 2002).

Dillman (2000) cautioned that specific consideration needs to be given to the design of web-based surveys, over and above those of other mediums. Not only is questionnaire logic important, special attention needs to be given to "computer logic". This means that designers may need to provide web-based survey respondents with specific computer related instructions and assistance. This is done in order to avoid assumptions about respondents' computer skills and, correspondingly, reduce social costs. For example, it may seem overly simplistic, but prove necessary, to provide instructions to respondents to click on the "Submit" button when the survey is completed (Mathai, 2002).

Finally, there may be differences between what the designer sees on his or her computer and the image that results once the questionnaire has passed through the respondent's hardware and software. For example, disparities may occur among colors, text, and horizontal and vertical layout of the questionnaire. Other authors have put forth the recommendation that designers adopt a worst-case stance with regards to respondents' technological savvy and installed hardware and software. In proposing this

design principle, Harris and Dersch (1999) coined the term “the thin client” to indicate this type of respondent.

The questionnaire was deployed via the “Survey Maker” programming environment at Virginia Tech. The questionnaire and all collected data was stored on a dedicated Virginia Tech server. As an additional benefit, the Survey Maker program has been shown to be compatible with all currently used browsers, thus eliminating some concerns related to “thin clients”.

Data Collection Procedures

The implementation of the survey closely followed the proven *Tailored Design Method* developed by Dillman (2000). Over time, this method has been proven to provide consistently high response rates and quality data – as long as it is precisely followed. While initially developed for telephone surveys and implemented successfully within that milieu for several decades (Dillman, Christenson, Carpenter, & Brooks, 1977), the tailored design method has since been adapted to e-mail (Schaefer & Dillman, 1998) and, more recently, web-based surveys (Dillman, 2000).

One of the crucial elements in the success of the tailored design method is its utilization of social exchange theory (Dillman, 2000). Social exchange theory posits that the decisions people make concerning a request to give of themselves in some way (i.e., complete a survey), depends to a large degree on their perceptions of both the costs and rewards of the request. In addition, respondents need to know that they can trust these perceptions. Specific to this research, the costs of taking the time and energy to complete the survey with accuracy and thoroughness, must be offset by a “trusted” perception of adequate reward.

Rewards may take a tangible form such as cash or other substantial incentives for completing a survey. For example, a commitment to send the results of the study may be a sufficient and valuable incentive for some responders (Dillman, 2000). In addition, less substantive means, such as showing positive regard, saying thank you, asking for advice, making the questionnaire compelling or the simple promise of contributing to the greater good can be effective rewards.

On the other hand, the researcher must somehow convey to the respondent that the social costs (i.e., completing a survey) are, on balance, reasonable. Some means of

reducing costs include, minimizing inconvenience for the respondent, keeping questionnaires (to at least appear) short and simple, and minimizing personal information inquiries (Dillman, 2000). Reducing social costs can also involve taking care to avoid subordinating or embarrassing language,

In addition, the researcher needs to be able to communicate trust. Specifically, respondents need to know that the social costs are limited to those explicitly (or implicitly) given, that the survey is what it purports to be and that any promised rewards will be conveyed. Trust can be engendered through such means as using official letterheads to show legitimate authority, making the task appear important, invoking other exchange associations (e.g., contributing to the greater good) or providing a token incentive to respond to the survey - in advance (Dillman, 2000). Unfortunately, one of the significant drawbacks of online surveys is the lack of a mechanism to easily provide an incentive to respondents, such as putting a dollar bill in an envelope. In summary, use of the tailored design method involves invoking social exchange theory throughout the survey design and implementation process in order to most effectively increase rewards, reduce costs and engender trust.

The approach of Dillman (2000) was further utilized to structure the collection of data. Despite the attention given to the design of the questions and construction of the questionnaire, these are not the main determinants of response rates to surveys.

In fact, the area of survey implementation is clearly the most important factor in improving response rates (Dillman, 2000). Specifically, the principal influence on response rates has been found to be the employment of a survey implementation structure that employs multiple contacts (Dillman, 1991). Further, the use of a precontact or prenotification that a survey would soon be arriving, effectively functioned to increase response rates across a meta-analysis of 68 web-based surveys. (Cook, et al., 2000). In addition, the employment of a token incentive - in advance - has been found to result in slightly higher rates of response and less variability in data. Personalized contacts have also been associated with higher response rates in electronic surveys. Finally, the salience of the survey subject matter, while a somewhat “intangible” factor, can have a significant influence on response rates (Dillman, 2000). Interestingly, the social costs of survey

length or having to login with a password have not been found to correlate with decreased response rates (Cook, et al.).

With one exception, all of the above methods for improving the present survey's response rate were implemented. Unfortunately, the use of personalized contacts was woefully constrained due to the large number of solicitations mandated by the research design. In addition, the implementation of traditional pre-solicitation incentives (i.e., a dollar bill) is inherently problematic for web-based surveys. A reasonable substitute was developed, consisting of a link to an abridged list of complementary therapy resources on the web.

Finally, while the salience of the research topic will differ to some degree for each respondent, the intersection of complementary therapy and counseling is thought by several authors to be both compelling and on the "cutting edge" (Bassman & Uellendahl, 2003; Shannon, 2002; White, 2000). On the other hand, too much salience might prove to be counterproductive. Cook, et al. (2000) reported that a somewhat salient topic was associated with greater response rates than a topic deemed to be either not salient or very salient.

The final version of the survey was posted on the Internet for an approximately three-week period beginning November 1, 2004 and ending November 24, 2004. During this time, the survey was open for data collection 24 hours per day. Respondents were able to access the survey by simply clicking on a link provided in the second through fourth emails. Once respondents completed the questionnaire, they simply clicked on the "Submit" button to send their data. Once a day during the collection period, the raw data submitted by respondents was removed from the remote server and transferred to the researcher's computer. This measure was carried out to increase security and protect the confidentiality of respondents.

The data collection procedure carefully followed the established system of Dillman (2000). However, two modifications were made to this approach. First, the number of contacts was changed from a total of five to a total of four. Second, a reduction was made in the time for follow up contacts as recommended by Truell, et al. (2002). The change in the total number of contacts was partially based on the results of a meta-analysis of factors having an effect on web-based survey response rates (Cook, et

al., 2000). Their research showed that response rates peaked after the third contact, dipped slightly by the fourth, and were significantly lower by the fifth contact. In addition, Mathai (2002) reported that the incorporation of a fifth and final contact was found to be redundant. Therefore, in this study, the fourth contact (a final reminder) was combined with the fifth contact (announcing the closing of the data collection period). This strategy also reduced the possibility of inundating respondents with emails and, possibly, breaching "Netiquitte" (Sills & Song, 2002).

Contacts were broken down as follows.

a. The initial contact was a notice emailed to all potential members of the sample. This contact was used to introduce the study, explain its purposes, make an appeal for the usefulness of the survey and provide a token incentive. Potential respondents were informed they would be receiving a follow up email in approximately three (3) days, which would include a link to the survey (see Appendix B).
b. A second contact was made via an email sent once more to all potential respondents. In this email, respondents were informed of the specific request of them, a statement was provided regarding why they were selected, the usefulness of the survey was again emphasized, confidentiality issues were addressed, the provision of a token was reiterated and contact information for the researcher was provided for any questions or concerns. A link to the questionnaire itself was included, along with instructions on how to use the link. The period when the survey would be open for data collection was also given. Finally, a password was provided, which was identical for all participants (see Appendix C).
c. A third contact was made one week after the survey opened for data collection. This email included a thank you to respondents who had already completed the survey and a reminder to those who had not yet taken the opportunity to contribute to the research. Respondents were prompted that if they have already completed the survey, to simply ignore this message (see Appendix D).
d. A fourth contact, and final contact, was made one week later. This email again expressed appreciation to respondents who had already completed the survey. It also included a "stronger" reminder to those who had not yet taken the

opportunity to respond. Respondents were once more prompted that if they have already completed the survey, to ignore this message. Finally, this email announced that the data collection period would end in approximately three days (see Appendix E).

Data Analysis

The first step in the analysis of the data was to import the raw data into a Microsoft Excel spreadsheet. The Virginia Tech Survey Maker program has this capability built in, making for a straightforward procedure. The data was then "cleaned up" as necessary to catch "rogue" or blank data, and insure a consistent data format. Finally, the data was imported into SPSS 12.0 from Excel for further analysis.

Once the data was in SPSS format, it was modified as necessary through recoding (into same and new variables), restructuring and regrouping of variables. This was done to enhance, augment and simplify analysis.

Univariate descriptive statistics were calculated for all demographic variables and reported in text format, as well as in tables, as recommended by Wilkinson, 1999. The representativeness of the sample was then assessed through comparison with equivalent ACA categories, using chi-square based statistical analysis.

Descriptive results were delineated and reported as above for all remaining variables. This information was used to answer research questions one through five.

Finally, contingency tables (or crosstabulations) were used to answer question six. The various demographic categories served as independent variables, with professional practice, knowledge and training, and personal experience factors functioning as dependent variables. The results of these analyses were reported in both text and table format.

Summary

Chapter Three outlined the methodology used to collect data on counselors' experiences with complementary therapy. First, an overview of web-based survey research was provided and included an overview of possible advantages and limitations. Next, the rationale for selection of the sample frame from which participants were recruited was discussed. A summary of confidentiality issues and delimitations and limitations was provided. The research questions were then reiterated. Next, the

reasoning, which governed the design of the survey instrument, was covered in depth. Then, the details of the data collection procedure were examined. Finally, data analysis methods were described.

CHAPTER FOUR

RESULTS

This exploratory research study gathered data on counselors' experiences with complementary therapy (CT). This chapter reports the results of the research. First, an overview of respondent demographics corresponding to those of the American Counseling Association (ACA) is offered. Then chi-square based comparison with ACA demographics was conducted to assess the representativeness of the sample. Additional respondent demographics beyond the ACA categories are then presented. Statistical procedures, including descriptive results and crosstabulations are used to answer each research question.

An initial email announcing the study and soliciting respondents was sent to 4000 randomly selected members of the American Counseling Association (ACA). Out of this original group, 959 email address were ultimately determined to be undeliverable for a variety of reasons. The undeliverable email rate was therefore 24% (i.e., 959/4000 *100%). This frequency is in line with data on undeliverable rates (Smith, 1997). Of the remaining total of 3041 viable email addresses, 657 completed responses were obtained. This resulted in a survey response rate of 21.6% (i.e., 657/3041 *100%). The decline rate was less than 0.1% as only three of the 3041 possible respondents requested removal from involvement in the survey.

Due in part to the exploratory nature of this study, all data was either in the form of categorical (i.e., nominal) or rank ordered (i.e., ordinal) data. For nominal data, descriptive statistics are calculated and reported in table form. In the case of ordinal data, the mean, median, mode and standard deviation (SD) are also calculated and reported.

Technically speaking, central tendency measures for ordinal data should be reported in the form of median values (Rea & Parker, 1992). This is primarily due to the fact that it cannot be assumed that there are equal distances/values between each ordinal data subcategory, as with interval data. Ordinality only grants authorization to rank (i.e., order) the data, not manipulate the data mathematically. However, it has been argued that the reporting of mean values with ordinal data provides more detailed and powerful information, which tends to "far outweigh the costs associated with relaxing these

technicalities" (Rea & Parker, p. 176). In this spirit, arithmetic means are provided for all ordinal data.

Demographic Data Corresponding to ACA Categories

The demographic characteristics of the sample corresponding to ACA categories were collected through a number of survey questions. Question numbers precede each respective category. The results are summarized in Table1.

The majority of the 657 respondents were female (78%, n=509). In terms of race/ethnicity, most respondents were "Caucasian" (86%, n=555), while "Native American" was the least reported race/ethnicity (0.5%, n=3).

Because of the small frequencies for all subcategories of race/ethnicity, except Caucasian, the race/ethnicity data was combined and then divided into either "Caucasian" (n=555, 86%) or "Other" (n=78. 11.9%) subcategories. This reassignment also enhanced follow up analysis by limiting the number of low cell frequencies. See the category *Race/Ethnicity-Recoded* in Table 1.

The income category consisted of five subcategories reported on a Likert (ordinal) scale. The ordered values of 1 to 5 for each subcategory are listed after its respective label. The mean for this category was 2.82, signifying that the average income for respondents is slightly below $25,000 per year from counseling related activities. The mean value's proximity to the median value of 3.0 indicates that the center of the distribution is close to the median, but with a slight negative skew (i.e., more results at the high end of the scale).

With regard to income from counseling related activities, more than one quarter of respondents (25.4%, n=167) reported earning less than $12,500 annually, while an annual income of $12,500 to 24,999 accounted for less that ten percent of responses (9.3%, n=51). By combining subcategories, it was established that nearly 41% (40.8%, n=268) of respondents earned $25,000 to $59,999 per year from counseling related activities. Not surprisingly, the income category had the greatest number of respondents (11.9%, n=78) who preferred not to disclose the requested information (i.e., income).

The majority of respondents (61.8%, n=406) reported a "Master's" as their highest earned degree, with the "Educational Specialist" degree achieving the lowest response rate (4%, n=26). Further, the low number of respondents for the "Educational

Specialist" degree, led to its inclusion within the "Other" degree category. See the category *Highest Earned Degree - Recoded* in Table 1. Again, this reassignment supported analysis by reducing the number of cells with low expected frequencies.

In terms of current position, the majority of respondents (36.8%, n=242) reported working as an "Outpatient counselor". On the other hand, "Inpatient counselor" had the lowest response rate for current position (4.9%, n=32). Responses to this question were in the form of "check all that apply". As a result, the total number of responses is greater than the total number of respondents.

Most respondents reported working in a "Private practice/self-employed setting" (27.7%, n=182), closely followed by either a "Community agency" (24.7%, n=163) or "College/university" work setting (24.2%, n=159). Respondents were least likely (2.6%, n=17) to report employment in a "Psychiatric facility" work setting. Again, responses to this question were in the form of "check all that apply". As a result, the total number of responses is greater than the total number of respondents.

Table 1

Demographic Data Corresponding to ACA Categories

Category	Frequency	Percent
35) Gender (n=657)		
Male	136	20.7
Female	509	77.5
Prefer not to disclose	8	1.2
Missing	4	0.6
37) Race/Ethnicity (n=657)		
African American	31	4.7
Asian	11	1.7
Caucasian	555	84.5
Hispanic/Latino	17	2.6
Native American	3	0.5
Other	16	2.4
Prefer not to disclose	16	2.4

Missing	8	1.2
Race/Ethnicity- Recoded (n=657)		
Caucasian	555	84.5
Other	78	11.9
Prefer not to disclose	16	2.4
Missing	8	1.2
38) Income from Counseling Related Activities (n=657)		
$0 – 12,499 (1)	167	25.4
$12,500 – 24,499 (2)	61	9.3
$25,000 – 39,999 (3)	129	19.6
$40,000 – 59,999 (4)	139	21.2
$60,000 and above (5)	76	11.6
Prefer not to disclose	78	11.9
Missing	7	1.1
Mean = 2.82, Median = 3.0, Mode = 1, SD = 1.421		
25) Highest Earned Degree (n=657)		
Bachelor's	95	14.5
Master's	406	61.8
Educational Specialist	26	4.0
Doctorate	78	11.9
Other	40	6.1
Missing	12	1.8
Highest Earned Degree- Recoded (n=657)		
Bachelor's	95	14.5
Master's	406	61.8
Doctorate	78	11.9
Other	66	10.0
Missing	12	1.8
*31) Current Position**		
Administrator	49	7.5
Inpatient counselor	32	4.9

Outpatient counselor	242	36.8
School counselor	99	15.1
Counselor educator	67	10.2
Counselor supervisor	63	9.6
Graduate student (Master's)	157	23.9
Graduate student (Doctoral)	56	8.5
Retired	11	1.7
Other	110	16.7
Missing	4	0.6
*32) Work Setting**		
Business/Industry	23	3.5
College/university	159	24.2
Community agency	163	24.7
Government setting	31	4.7
Hospital	28	4.3
K-12 setting	105	16.0
Private practice/ self-employed	182	27.7
Psychiatric facility	17	2.6
Other	92	14.0
Missing	7	1.1

* Responses to this question were in the form of "check all that apply". As a result, the total number of responses is greater than the total number of respondents.

Representativeness of Sample

The representativeness of the sample was assessed through comparison of the demographic characteristics of the sample with those provided by ACA. Chi-square based goodness-of-fit tests were used to compare highest degree, gender, salary, race/ethnicity, work setting and position to determine the correspondence of the sample to ACA demographic characteristics. The hypothesized (i.e., weighted) proportions for each Chi-square based test were obtained from an ACA membership report dated 5/3/04. Note that the "Expected N" column values (and percentages) refers to the ACA provided (i.e., hypothesized) proportions.

The sample and ACA categories were recoded and combined in order to be equivalent. In the case of salary, the first three subcategories of the sample (i.e., $0-12,499; $12,500-24,999; $25,000-39,999) were combined into $0 to 39,999 to match the first two ACA subcategories. For the ACA subcategory of highest degree, their Associate/Certificate subcategory was combined with their Other subcategory to match the sample. With regard to work setting, the sample subcategories of "Hospital" and "Psychiatric facility" were combined with the sample "Other" subcategory, since ACA did not provide these equivalent subcategories. Similarly, the sample current position category combined "School counselor", "Inpatient counselor" and "Outpatient counselor" into one Counselor subcategory, also to match ACA. Further, the sample "Undergraduate", "Master's" and "Doctoral" student subcategories were merged into a single Student subcategory to be equivalent to ACA. Moreover, "Retired", was included under the sample "Other" subcategory. Please note: N for each category and the Observed frequency (f) were adjusted to reflect the omission of "Prefer not to disclose" and "Missing" sample data (see Table 1 for this information).

As shown in Table 2, the results were significant for all comparisons, except race/ethnicity. Overall, these results suggest that the sample is not representative of ACA membership with respect to highest degree, gender, salary, work setting and position. However, the sample is representative of ACA membership in terms of race/ethnicity. Recall that responses to the work setting and position questions were in the form of "check all that apply". As a result, the total number of responses is greater than the total number of respondents.

Table 2

Representativeness of Sample with Chi-square Output

Category	Observed N (f)	Expected N (f)	Residual
Gender (n=645)			
Male	136 (21.1%)	171.6 (26.6%)	-35.6
Female	509 (78.9%)	473.4 (73.4%)	35.6
Chi-Square (1, N=645) = 10.047, p = .002			
Race/Ethnicity(n=633)			

African American	31 (4.9%)	37.3 (5.9%)	-6.3
Asian	11 (1.7%)	9.5 (1.5%)	1.5
Caucasian	555 (87.7%)	548.2 (86.6%)	6.8
Hispanic/Latino	17 (2.7%)	21.5 (3.4%)	-4.5
Native American	3 (0.5%)	7.0 (1.1%)	-4.0
Other	16 (2.5)	9.5 (1.5)	6.5
Chi-Square (5, N=633) = 9.064, p = .107			
Income (n=572)			
$0 – 39,999	357 (62.4%)	312.9 (54.7%)	44.1
$40,000 – 59,999	139 (24.3%)	168.7 (29.5%)	-29.7
$60,000 and above	76 (13.3%)	90.4 (15.8%)	-14.4
Chi-Square (2, N=572) = 13.749, p = .001			
Highest Earned Degree (n=645)			
Bachelor's	95 (14.7%)	42.5 (6.6%)	52.5
Master's	406 (63.0%)	457.3 (71.0%)	-51.3
Educational Specialist	26 (4.0%)	20.0 (3.1%)	6.0
Doctorate	78 (12.1%)	119.1 (18.5%)	-41.1
Other	40 (6.2%)	6.1 (0.95%)	33.9
Chi-Square (4, N=645) = 274.237, p = .000			
Current Position			
Administrator	49 (7.5%)	42.6 (4.7%)	6.4
Counselor	373 (57.1%)	535.0 (59.0%)	-162.0
Counselor educator	67 (10.3%)	68.0 (7.5%)	-1.0
Counselor supervisor	63 (9.6%)	35.4 (3.9%)	27.6
Student	213 (32.6%)	127.0 (14%)	86.0
Other	121 (18.5%)	78.0 (10.6%)	43.0
Chi-Square (5, N=653) = 153.665, p = .000			
Work Setting			
Business/Industry	23 (3.5%)	19.6 (2.5%)	3.4
College/university	159 (24.5%)	150.1 (19.1%)	8.9
Community agency	163 (25.1%)	110.8 (14.1%)	51.2

Government setting	31 (4.8%)	51.9 (6.6%)	-20.9
K-12 setting	105 (16.2%)	150.8 (19.2%)	-45.8
Private practice/ self-employed	182 (28.0%)	256.1 (32.6%)	-74.1
Other	137 (21.1%)	59.7 (7.6%)	77.3
Chi-Square: (6, N=650) = 168.613, p = .000			

Additional Demographic Data

The age category consisted of six subcategories reported on a Likert (ordinal) scale. The ordered values of 1 to 6 for each subcategory are listed after its respective label. The mean for this category was 3.32, indicating that the average age of respondents was slightly above 45 years old. In addition, the mean value indicates that the central tendency is located close to the median value of 3.0, but weighted with a slight positive skew (i.e., more values at the low end of the scale).

Respondents between the ages of 45 and 54 formed the largest age subcategory (27.9%, n=183), while those ages 65 and above made up the lowest rate of response (2.7%, n=18). Further, combining the three age groups, which make up the ages ranging from 25 to 54, accounted for nearly three quarters (72.6%, n=477) of survey respondents. Only about 10% (9.5%, n=71) of respondents are in the age ranges of either 25 or less, or 65 or older.

Because of the small frequencies for the 18 to 24 and 65 and above subcategories of age, this data was combined and recoded into 18 to 34 (n=204, 31.1%) and 55 and above (n=127, 19.3%) subcategories, respectively. This reassignment was also especially useful for further analysis (i.e., limiting the number of low cell frequencies). See the category *Age-Recoded* in Table 3.

Nearly half of all respondents (49.6%, n=326) did not posses a mental health license. On the other hand, the majority of respondents (39.7%, n=261) that are licensed hold an LPC (or equivalent). Responses to this question were in the form of “check all that apply”. As a result, the total number of responses is greater than the total number of respondents. Finally, most respondents (64.7%, n=425) did not possess the National Counselor Certification (NCC).

The years practicing category consisted of four subcategories reported on a Likert (ordinal) scale. The ordered values of 1 to 4 for each subcategory are listed after its label. The mean for this category is 1.76, which indicates that respondents average slightly less than six years practicing as a counselor. The median value of 1.0 indicates that the distribution is positively skewed. In this case, the median provides a better representation of the central tendency of the distribution, which is zero to six years practicing as a counselor.

Specifically, the majority of respondents (59.2%, n=389) have practiced less than six years as a counselor. However, only 9.9% of respondents reported practicing as a counselor from 13 to 19 years.

The average number of clients seen per week category consisted of four subcategories reported on a Likert (ordinal) scale. The ordered values of 1 to 4 for each subcategory are listed after its label. The mean for this category is 2.24, indicating that respondents saw slightly more than seven clients per week, on average, during the past year. The mean value's close correspondence with the median value of 2.0 indicates that the center of the distribution is close to the median, but slightly skewed toward the positive dimension.

In terms of the average number of clients seen per week, between one and six clients was the most common response (28.9%, n=190). Respondents reported seeing 13 to 19 clients with the least frequency (15.5%, n=102). Just over half of respondents' saw one to 12 clients, on average, per week (50.2%, n=330).

"Individual therapy" was the most often provided mental health service (70.2%, n=461). On the other hand, "Alcohol/substance abuse counseling" was cited by slightly more than one quarter of respondents (26.6%, n=175). However, it should be noted that less than 15% of respondents did not provide any mental health services (14.6%, n=96). Responses to this question were in the form of "check all that apply". As a result, the total number of responses is greater than the total number of respondents.

With regard to theoretical orientation, "Cognitive/behavioral" was indicated by the majority of respondents (70.3%, n=462). This was followed by "Person-centered" (53.9%, n=354) and "Solution focused" (44.6%, n=293) theoretical orientations, respectively. Finally, the equivocal category of "Other", was the least frequently cited

(16.6%, n=109) theoretical orientation, lending credence to this question's validity. Responses to this question were in the form of "check all that apply". As a result, the total number of responses is greater than the total number of respondents.

Table 3 shows the frequencies for these additional demographics. As before, survey question numbers precede each respective category.

Table 3

Additional Demographic Data

Category	Frequency	Percent
36) Age (n=657)		
18-24 (1)	45	6.8
25-34 (2)	159	24.2
35-44 (3)	135	20.5
45-54 (4)	183	27.9
55-64 (5)	109	16.6
65 and above (6)	18	2.7
Prefer not to disclose	6	0.9
Missing	2	0.3
Mean = 3.32, Median = 3.0, Mode = 4, SD = 1.276		
36) Age- Recoded (n=657)		
18-34	204	31.1
35-44	135	20.5
45-54	183	27.9
55 and above	127	19.3
Prefer not to disclose	6	0.9
Missing	2	0.3
*26) Mental Health License**		
None	326	49.6
LPC (or LMHC, LCPC, CPC, LPCC)	261	39.7
LMFT	16	2.4

MFCC	2	0.3
Other	91	13.9
Missing	3	0.5
27) Nationally Certified Counselor (NCC) (n=657)		
Yes	229	34.9
No	425	64.7
Missing	3	0.5
28) Years Practicing as a Counselor (n=657)		
0-6 years (1)	389	59.2
7-12 years (2)	115	17.5
13-19 years (3)	65	9.9
20+ years (4)	84	12.8
Missing	4	0.6
Mean = 1.76, Median = 1.0, Mode = 1, SD = 1.074		
29) Average number of clients seen per week (n=657)		
None	111	16.9
1-6 clients/week (1)	190	28.9
7-12 clients/week (2)	140	21.3
13-19 clients/week (3)	102	15.5
20+ clients/week (4)	108	16.4
Missing	6	0.9
Mean = 2.24, Median = 2.00, Mode = 1, SD = 1.134		
*30) Mental health services provided**		
None	96	14.6
Child/adolescent therapy	315	47.9
Individual therapy	461	70.2
Family/couples therapy	277	42.2
Group therapy	275	41.9
Alcohol/Substance abuse counseling	175	26.6
Missing	5	0.8

*33) Theoretical orientation**

Behavioral	152	23.1
Cognitive/behavioral	462	70.3
Family systems	285	43.4
Person-centered	354	53.9
Psychodynamic	134	20.4
Reality	164	25.0
Solution focused	293	44.6
Other	109	16.6
Missing	1	0.2

* Responses to this question were in the form of "check all that apply". As a result, the total number of responses is greater than the total number of respondents.

Results of Research Questions

This section provides results for each research question. The six research questions are further grouped into four categories. These are professional practice factors, knowledge and training factors, personal experience factors and demographic factors.

I. Professional Practice Factors

Research Question 1: What do counselors' ask and their clients' disclose concerning clients' use of complementary therapy?

Research question one asked respondents for the approximate number of clients whom they specifically asked about their use of complementary therapy, the number of clients who voluntarily brought up their use of complementary therapy with respondents, the complementary therapies that clients reported using, and any positive and negative benefits respondents attributed to clients' use of complementary therapy. Table 4 provides results for research question one.

Respondents most frequently (28.2%, n=185) asked less than one-third of their clients specifically about clients' use of complementary therapy during the past year. Respondents reported asking between one-third and two-thirds of clients specifically about their use of complementary therapy at just over half of this rate (15.7%, n=103).

This question consisted of four subcategories reported on a Likert (ordinal) scale. The ranked values of 1 to 4 for each subcategory are listed after its label. The mean for

this category was 2.38, indicating that, on average, just over one-third of respondents asked their clients about clients' use of complementary therapy. Further, the mean value's close correspondence with the median value of 2.0 indicates that the center of the distribution is close to the median, but slightly skewed in a positive direction.

Likewise, respondents reported that less than one-third of their clients' voluntarily brought up their use of CAT (41.9%, n=275). On the other hand, only a small proportion of clients' voluntarily brought up their use of complementary therapy with two-thirds or more of respondents (6.5%, n=43).

Again, this question consisted of four subcategories reported on a Likert (ordinal) scale. The ranked value of 1 to 4 for each subcategory are listed after its label. The mean for this category is 2.13, indicating that just over one-third of clients, on average, voluntarily brought up their use of complementary therapy with respondents. Further, the mean value's proximity to the median value of 2.0 indicates that the center of the distribution is close to the median, but again slightly skewed toward the positive dimension.

Respondents reported that their clients' most often used the complementary therapy modalities of "Exercise" (60.1%, n=395), "Prayer" (51.8%, n=340) and "Diet" (45.8%, n=301). Respondents least frequently reported that their clients' used the complementary therapy modalities of "Ayurveda" (2%, n=13), "Qigong" (2.6%, n=17) and "Magnetic Therapy" (3%, n=20). Responses to this question were in the form of "check all that apply". As a result, the total number of responses is greater than the total number of respondents.

Respondents attributed "Some positive effects to clients' use of complementary therapy" in almost half of cases (45.1%, n=296). Interestingly, respondents attributed "No positive effects to clients' use of complementary therapy" in zero cases.

This category consisted of five subcategories reported on a Likert (ordinal) scale. The scale was recoded in order for the subcategory of "Not sure of positive effects" to effectively form the center, or neutral point, of the distribution. The ranked values of 1 to 5 for each subcategory are listed after its label. The mean for this category is 4.05, indicating that on average, respondents reported some positive effects from their clients' complementary therapy use. Further, the close correspondence between the mean and the

median value of 4.0 indicates that the center of the positive effects distribution is close to the median value, but with a very slight positive skew.

On the other hand, respondents most frequently (48.2%, n=317) attributed "No negative effects to clients' use of complementary therapy". Along the same lines as no positive effects above, respondents attributed "Great negative effects" to their clients' use of complementary therapy in only one client (0.2%).

This category consisted of five subcategories reported on a Likert (ordinal) scale. The scale was also recoded so that the subcategory of "Not sure of negative effects" effectively formed the center, or neutral point, of the distribution. The ranked values of 1 to 5 for each subcategory are listed after its label. The mean for this category is 1.50, indicating that, on average, respondents reported between no and only slight negative effects from their clients' use of complementary therapy. The divergence between the mean value and the median value of 1.0 indicates that this distribution is positively skewed. In this instance, the median provides a better interpretation of the central tendency of the distribution, which is no negative effects.

Table 4

Professional Practice Factors: Research Question One

Category	Frequency	Percent
1) Asked clients specifically about their use of complementary therapy (n=657)		
No clients seen in past year	86	13.1
None (1)	130	19.8
Less than one-third (2)	185	28.2
One-third to two-thirds (3)	103	15.7
More than two-thirds (4)	115	17.5
Missing	38	5.8
Mean = 2.38, Median = 2.00, Mode = 2, SD = 1.076		
2) Clients' voluntarily brought up their use of complementary therapy (n=657)		
No clients seen in past year	86	13.1
None (1)	114	17.4
Less than one-third (2)	275	41.9

One-third to two-thirds (3)	97	14.8
More than two-thirds (4)	43	6.5
Missing	42	6.4
Mean = 2.13, Median = 2.00, Mode = 2, SD = .842		
*3) Complementary therapies clients reported using**		
No clients seen in past year	86	13.1
None	67	10.2
Acupuncture	43	6.5
Aromatherapy	90	13.7
Art Therapy	164	25.0
Ayurveda	13	2.0
Breathwork	174	26.5
Dance/Movement Therapy	70	10.7
Diet	301	45.8
Exercise	395	60.1
Guided Imagery	202	30.7
Healing/Therapeutic Touch	73	11.1
Herbs	112	17.0
Homeopathy	79	12.0
Magnetic Therapy	20	3.0
Massage	201	30.6
Meditation	244	37.1
Music Therapy	97	14.8
Naturopathy	38	5.8
Prayer	340	51.8
Qigong	17	2.6
Reiki	61	9.3
Vitamins	181	27.5
Yoga	192	29.2
Other	48	7.3
Missing	40	6.1

4) Positive effects attributed to clients use of complementary therapy (n=657)

No clients seen in past year	86	13.1
No clients' reported use of CAT	66	10.0
No positive effects (1)	0	0.0
Only slight positive effects (2)	26	4.0
Not sure of positive effects (3)	35	5.3
Some positive effects (4)	296	45.1
Great positive effects (5)	109	16.6
Missing	39	5.9

Mean = 3.33, Median = 3.00, Mode = 3, SD = .695

5) Negative effects attributed to clients use of complementary therapy (n=657)

No clients seen in past year	86	13.1
No clients' reported use of CAT	71	10.8
No negative effects (1)	317	48.2
Only slight negative effects (2)	69	10.5
Not sure of negative effects (3)	60	9.1
Some negative effects (4)	13	2.0
Great negative effects (5)	1	0.2
Missing	40	6.1

Mean = 1.73, Median = 1.00, Mode = 1, SD = 1.354

* Responses to this question were in the form of "check all that apply". As a result, the total number of responses is greater than the total number of respondents.

Research Question 2: What are counselors' recommendation and referral patterns for complementary therapy?

Research question two sought to discover respondents' patterns of complementary therapy recommendation and referral. Survey questions addressed how many clients specifically requested a recommendation or referral for complementary therapy from respondents, the frequency of respondents' recommendations for complementary therapy, without providing a specific referral, how often specific referrals were made for complementary therapy, what client concerns led to recommending or referring for complementary therapy, the reasons, if any, for not referring or recommending for

complementary therapy, and the importance that referrals are to licensed or certified complementary therapy practitioners. Table 5 shows the results for research question two.

It was most common (46.4%, n=305) for no clients to specifically request a recommendation or referral for complementary therapy from respondents. Least common (2%, n=13), was the case where more than two-thirds of clients specifically requested a recommendation or referral for complementary therapy from respondents.

This category consisted of four subcategories reported on a Likert (ordinal) scale. The ordered values of 1 to 4 for each subcategory are listed after its label. The mean for this category is 1.53, indicating that between none and one-third of clients specifically requested a recommendation or referral for complementary therapy from respondents. The difference between the mean value and the median value of 1.0 indicates that the distribution is positively skewed. In this instance, the median provides a better interpretation of the central tendency of the distribution, which is that no clients specifically requested a recommendation or referral for complementary therapy from respondents

Most often, less than one-third of respondents (n=218, 33.4%) recommended complementary therapy to a client, without providing a specific referral. On the other hand, respondents were least likely (2.1%, n=14) to recommended complementary therapy to a client, without providing a specific referral for two-thirds or more of clients.

This category consisted of four subcategories reported on a Likert (ordinal) scale. The ordered values of 1 to 4 for each subcategory are listed after its label. The mean for this category is 2.03, indicating that indicating that less than one-third of the time respondents recommended complementary therapy for a client without providing a specific referral. Further, the mean value's close correspondence with the median value of 2.0 indicates that the center of the distribution is very close to the median.

When asked how often they provided clients with a specific referral for complementary therapy, the greatest percentage of respondents answered "Never" (38.5%, n=253). Only a few respondents (2.1%, n=14) provided more than two-thirds of clients with a specific referral for complementary therapy.

Again, this category consisted of four subcategories reported on a Likert (ordinal) scale. The ordered values of 1 to 4 for each subcategory are listed after its label. The

mean for this category is 1.67, indicating that less than one-third of the time respondents provided clients with a specific referral for complementary therapy. The difference between the mean value and the median value of 1.0 indicates that the center of the income distribution is negatively skewed. In this instance, the median provides a better interpretation of the central tendency of the distribution, which is that respondents never provided clients with a specific referral for complementary therapy.

The most common client concerns for which respondents provided complementary therapy recommendations or referrals were “Anxiety” (52.7%, n=346), followed closely by “Depression” (51.6%, n=339). The least common client concern for which respondents provided a complementary therapy recommendation or referral was “Personality disorder” (9.4%, n=62). Note that the ubiquitous “Other” category of client concerns actually resulted in only a 7% (n=46) recommendation or referral rate. Responses to this question were in the form of “check all that apply”. As a result, the total number of responses is greater than the total number of respondents.

The most common reasons for not referring or recommending complementary therapy to clients were “Not having it come up as a client concern” (32.4%, n=213), followed closely by “Client discomfort with complementary therapy” (28.6%, n=188), “Lack of knowledge and/or training in complementary therapy” (26.6%, n=175) and “Not sure who to refer to” (26.2%, n=172). Least frequently cited reasons for not referring or recommending complementary therapy to clients were “Incongruence with beliefs about client change” (2.1%, n=14) and “Poor acceptance by counseling profession” (3%, n=20). Again, responses to this question were in the form of “check all that apply”. As a result, the total number of responses is greater than the total number of respondents.

Almost half of respondents (46.4%, n=305) reported that it was “Very important” that any referrals they provide are to licensed or certified complementary therapy practitioners. Not surprisingly, only a small percentage of respondents (2.7%, n=18) stated that it was “Not important at all” that referrals were to licensed or certified complementary therapy practitioners.

Lastly, this category consisted of four subcategories reported on a Likert (ordinal) scale. The scale was recoded so that the subcategory of “Not sure of importance” effectively formed the center, or neutral point, of the distribution. The ordered values of 1

to 5 for each subcategory are listed after its label. The mean for this category is 4.25, indicating that it is between somewhat and very important that counselors' referrals are to licensed or certified complementary therapy practitioners. The difference between the mean value and the median value of 5.0 indicates that the distribution is negatively skewed (i.e., toward the high end). In this instance, the median provides a better interpretation of the central tendency of the distribution, which is that it is very important that referrals are to licensed or certified complementary therapy practitioners.

Table 5

Professional Practice Factors: Research Question Two

Category	Frequency	Percent
19) Clients' specifically requested a recommendation or referral for complementary therapy (n=657)		
No clients seen in past year	95	14.5
None (1)	305	46.4
Less than one-third (2)	181	27.5
One-third to two-thirds (3)	30	4.6
More than two-thirds (4)	13	2.0
Missing	33	5.0
Mean = 1.53, Median = 1.00, Mode = 1, SD = .715		
20) Recommended complementary therapy without providing a specific referral (n=657)		
No clients seen in past year	95	14.5
Never (1)	168	25.6
Less than one-third (2)	218	33.2
One-third to two-thirds (3)	98	14.9
More than two-thirds (4)	44	6.7
Missing	34	5.2
Mean = 2.03, Median = 2.00, Mode = 2, SD = .915		
21) Provided client with a specific referral for complementary therapy (n=657)		
No clients seen in past year	95	14.5
Never (1)	253	38.5

Less than one-third (2)	207	31.5
One-third to two-thirds (3)	51	7.8
More than two-thirds (4)	14	2.1
Missing	33	5.0
Mean = 1.67, Median = 2.00, Mode = 1, SD = .760		

*22) Client concerns for which provided a recommendation or referral for complementary therapy**

No clients seen in past year	95	14.5
None	129	19.6
ADHD	111	16.9
Alcohol or substance abuse	138	21.0
Anxiety	346	52.7
Depression	339	51.6
Eating disorder	82	12.5
Medical concern	123	18.7
Personality disorder	62	9.4
Somatic problems	127	19.3
Trauma/PTSD	178	27.1
Other	46	7.0
Missing	33	5.0

*23) Reasons for NOT having recommended or referred for complementary therapy (CT)**

No clients seen in past year	95	14.5
Client discomfort with CT	188	28.6
Ethical/scope of practice issues	100	15.2
Has not come up as a client concern	213	32.4
Incongruence w/beliefs about client change	14	2.1
Lack of knowledge and/or training in CT	175	26.6
Lack of research supporting CT	40	6.1
Not sure what to recommend	98	14.9

Not sure who to refer to	172	26.2
Poor acceptance by profession	20	3.0
Other	53	8.1
Missing	43	6.5

24) Importance that client referrals for complementary therapy be to licensed or certified practitioners (n=657)

No clients seen in past year	95	14.5
Not important at all (1)	18	2.7
Only slightly important (2)	37	5.6
Not sure of importance (3)	43	6.5
Somewhat important (4)	123	18.7
Very important (5)	305	46.4
Missing	36	5.5

Mean = 3.6, Median = 4.00, Mode = 4, SD = .866

* Responses to this question were in the form of "check all that apply". As a result, the total number of responses is greater than the total number of respondents.

Research Question 3: Do counselors include complementary therapy in their practice of counseling? If so, how is it included?

In attempting to satisfy research question 3, the respective survey questions asked respondents for their experiences and opinions on the inclusion of complementary therapy in the practice of counseling. These questions addressed how often respondents included complementary therapy, in some form, in their practice of counseling, how often clients' requested that complementary therapy be included, in some form, in their counseling, complementary therapies included in counseling, reasons for the inclusion of complementary therapy in counseling, and beliefs about the inclusion of complementary therapy in counseling. Table 6 shows the frequencies for research question three.

The frequency of respondents' inclusion of complementary therapy in counseling category consisted of four subcategories reported on a Likert (ordinal) scale. The ranked values of 1 to 4 for each subcategory are listed after its respective label. The mean for this category was 2.37, indicating that respondents included complementary therapy, in some form, in counseling with less than one-third of their clients. Also, the mean value's close

correspondence with the median value of 2.0 indicates that the center of the distribution is close to the median, but somewhat skewed in a positive direction (i.e., more results at the low end of the scale).

Over one-third of respondents (34.7%, n=228) included complementary therapy, in some form, in their counseling with just one-third or less of clients. Only 12.5% (n=82) of respondents included complementary therapy, in some form, with two-thirds or more of their clients.

The frequency of clients' requesting the inclusion of complementary therapy in their counseling category consisted of four subcategories reported on a Likert (ordinal) scale. The values of 1 to 4 for each subcategory are listed after its respective label. The mean for this category was 1.83, indicating that slightly less than one-third of clients requested the inclusion of complementary therapy, in some form, in their counseling. Also, the mean value's close correspondence with the median value of 2.0 indicates that the center of the distribution is close to the median, but with a slight negative skew.

Once again, over one-third of respondents (36.2%, n=238) reported that their clients requested the inclusion of complementary therapy, in some form, in their counseling. In fact, if consideration is given the number of clients that "Never" requested the inclusion of complementary therapy, over two-thirds of clients (67.1%, n=441) made requests of this nature to their counselors less than one third of the time. Furthermore, only a small percentage of respondents (4.1%, n=27) had two-thirds or greater of their clients request the inclusion of complementary therapy in their counseling.

For respondents who included complementary therapy in their practice of counseling, "Guided Imagery" was most frequently cited (40.5%, n=266), followed closely by "Exercise" (39.3%, n=258). The least number of respondents employed the complementary therapy modalities of "Ayurveda" and "Magnetic Therapy" in counseling (0.3%, n=2, each). Responses to this question were in the form of "check all that apply". As a result, the total number of responses is greater than the total number of respondents.

The principal motivations for respondents to include complementary therapy in their practice of counseling was "Congruence with beliefs about client change" (43.2%, n=284), followed by "Personal experience with complementary therapy" (38.5%, n=253). On the other hand, respondents were least likely to be motivated to include

complementary therapy in their counseling practice because “Nothing else working” (3.8%, n=25). The familiar “Other” category was also cited infrequently (3.7%, n=24), which supports the validity of this question. Responses to this question were also in the form of “check all that apply”. As a result, the total number of responses is greater than the total number of respondents.

Finally the majority of respondents (59.5%, n=391) believed that “complementary therapy should be included in addition to counseling”. Very few respondents (0.2%, n=1) believed that “Complementary therapy should never be included in counseling”.

Table 6

Professional Practice Factors: Research Question Three

Category	Frequency	Percent
14) How often complementary therapy was included, in some form, in counseling (n=657)		
No clients seen in past year	95	14.5
Never (1)	94	14.3
Less than one-third (2)	228	34.7
One-third to two-thirds (3)	126	19.2
More than two-thirds (4)	82	12.5
Missing	32	4.9
Mean = 2.37, Median = 2.00, Mode = 2, SD = .948		
15) How often clients requested the inclusion of complementary therapy, in some form, in counseling (n=657)		
No clients seen in past year	95	14.5
Never (1)	203	30.9
Less than one-third (2)	238	36.2
One-third to two-thirds (3)	59	9.0
More than two-thirds (4)	27	4.1
Missing	35	5.3
Mean = 1.83, Median = 2.00, Mode = 2, SD = .821		
*16) Complementary therapies included in practice of counseling**		

No clients seen in past year	95	14.5
None	97	14.8
Acupuncture	6	0.9
Aromatherapy	45	6.8
Art Therapy	147	22.4
Ayurveda	2	0.3
Breathwork	193	29.4
Dance/Movement Therapy	29	4.4
Diet	199	30.3
Exercise	258	39.3
Guided Imagery	266	40.5
Healing/Therapeutic Touch	23	3.5
Herbs	23	3.5
Homeopathy	8	1.2
Magnetic Therapy	2	0.3
Massage	30	4.6
Meditation	183	27.9
Music Therapy	78	11.9
Naturopathy	8	1.2
Prayer	154	23.4
Qigong	5	0.8
Reiki	14	2.1
Vitamins	52	7.9
Yoga	39	5.9
Other	44	6.7
Missing	33	5.0

*17) Motivation to include complementary therapy (CT) in practice of counseling**

No clients seen in past year	95	14.5
Did not include CT	100	15.2
Client requested	106	16.1
Congruence with beliefs	284	43.2

about client change		
Nothing else working	25	3.8
Personal experience with CT	253	38.5
Professional climate encourages	125	19.0
Research supporting CT	129	19.6
Other	24	3.7
Missing	34	5.2

18) Beliefs about the inclusion of complementary therapy (CT) in the practice of counseling (n=657)

No clients seen in past year	95	14.5
CT should never be included in counseling	1	0.2
CT should be included in lieu of counseling	4	0.6
CT should be included in addition to counseling	391	59.5
CT should be included in lieu of and in addition to counseling	82	12.5
Not sure about the inclusion of CT in counseling	52	7.9
Missing	32	4.9

* Responses to this question were in the form of "check all that apply". As a result, the total number of responses is greater than the total number of respondents.

II. Knowledge and Training Factors

Research Question 4: What is counselors' knowledge of and training in complementary therapy?

In answering research question four, survey questions asked respondents which complementary therapies they were qualified to discuss, if they had licensure or certification in any complementary therapy modalities, sources of complementary therapy knowledge and training, and respondents' preferences for additional knowledge and training in complementary therapy. Table 7 outlines the results for research question four.

Note that this research question contained no ordinal variables and, therefore, did not make use of Likert scales.

The majority of respondents reported that they were qualified to discuss the complementary therapies of “Exercise” (46.9%, n=306), “Guided Imagery” (43.7%, n=287) and “Prayer” (39.9%, n=260). Only a few respondents declared themselves qualified to discuss the complementary therapies of “Magnetic Therapy” (1.4%, n=9), “Ayurveda (1.5%, n=10), or “Qigong” (2.1%, n=14). Interestingly, almost one-fourth of respondents (23.5%, n=153) felt they were not qualified to discuss any complementary therapy modalities. Responses to this question were in the form of “check all that apply”. As a result, the total number of responses is greater than the total number of respondents.

Regarding complementary therapy licensure or certification, almost 80 percent of respondents (79.9%, n=525) are not licensed or certified in any complementary therapy Modality. For those respondents that do possess a complementary therapy license or certification, the ubiquitous “Other” category was most frequently cited (6.1%, n=40). Otherwise, the specific complementary therapy modalities of “Reiki” (3.7%, n=24), “Guided Imagery” and “Meditation” (both 2.3%, n=15) were most common. A total of eight complementary therapy modalities did not have any respondents reporting they were either licensed or certified. These included, “Acupuncture”, “Aromatherapy”, “Herbs”, “Homeopathy”, “Magnetic Therapy”, “Music Therapy”, “Naturopathy”, and “Vitamins”. Responses to this question were in the form of “check all that apply”. As a result, the total number of responses is greater than the total number of respondents.

For most respondents (62.3%, n=409), “Books” served as a source of knowledge or training in complementary therapy. This was followed by “Personal experience with complementary therapy” as a source of knowledge or training in just less than half of respondents (47.8%, n=314). Fewer that 13 percent (12.9%, n=85) of respondents used “Video/DVD” to enhance their complementary therapy knowledge or training. The now familiar “Other” category was the least frequently cited (2.9%, n=19) source of knowledge or training in complementary therapy, furthering the validity of this question. Again, responses to this question were in the form of “check all that apply”. As a result, the total number of responses is greater than the total number of respondents.

"Art Therapy" was the complementary therapy modality, which respondents most frequently indicated (41.7%, n=274) they would like additional knowledge or training. "Guided Imagery" was cited by almost as many respondents (38.2%, n=251) as a complementary therapy modality in which they would like additional knowledge or training. On the other hand, respondents least frequently wanted additional knowledge or training in "Magnetic Therapy" (5.8%, n=38). Once again, the common "Other" category was named by the fewest respondents (4.3%, n=28) for additional knowledge or training. This adds support to the validity of the question (i.e., possesses exhaustive complementary therapy categories). Responses to this question were in the form of "check all that apply". As a result, the total number of responses is greater than the total number of respondents.

Table 7

Knowledge and Training Factors: Research Question Four

Category	Frequency	Percent
*10) Complementary therapies qualified to discuss**		
None	153	23.5
Acupuncture	53	8.1
Aromatherapy	56	8.5
Art Therapy	120	18.3
Ayurveda	10	1.5
Breathwork	154	23.6
Dance/Movement Therapy	47	7.2
Diet	232	35.3
Exercise	306	46.9
Guided Imagery	287	43.7
Healing/Therapeutic Touch	56	8.5
Herbs	40	6.1
Homeopathy	23	3.5
Magnetic Therapy	9	1.4
Massage	105	16.0

Meditation	234	35.9
Music Therapy	80	12.3
Naturopathy	19	2.9
Prayer	260	39.9
Qigong	14	2.1
Reiki	45	6.8
Vitamins	84	12.8
Yoga	101	15.4
Other	56	8.5
Missing	5	0.8

*11) Complementary therapy license or certification**

None	525	79.9
Acupuncture	0	0.0
Aromatherapy	0	0.0
Art Therapy	11	1.7
Ayurveda	2	0.3
Breathwork	7	1.1
Dance/Movement Therapy	2	0.3
Diet	6	0.9
Exercise	8	1.2
Guided Imagery	15	2.3
Healing/Therapeutic Touch	12	1.8
Herbs	0	0.0
Homeopathy	0	0.0
Magnetic Therapy	0	0.0
Massage	3	0.5
Meditation	15	2.3
Music Therapy	0	0.0
Naturopathy	0	0.0
Prayer	19	2.9
Qigong	3	0.5

Reiki	24	3.7
Vitamins	0	0.0
Yoga	8	1.2
Other	40	6.1
Missing	9	0.9

*12) Sources of knowledge and/or training in complementary therapy (CT)**

None	127	19.3
Books	409	62.3
Colleagues	283	43.1
Internet	276	42.0
Magazines/Non-refereed journals	155	23.6
Personal experience with CT	314	47.8
Refereed journals	123	18.7
Training/education program	150	22.8
Video/DVD	85	12.9
Workshops	219	33.6
Other	19	2.9
Missing	9	0.9

*13) Would like additional knowledge and/or training in complementary therapy**

None	74	11.3
Acupuncture	75	11.4
Aromatherapy	138	21.0
Art Therapy	274	41.7
Ayurveda	62	9.4
Breathwork	185	28.2
Dance/Movement Therapy	141	21.5
Diet	149	22.7
Exercise	168	25.6
Guided Imagery	251	38.2
Healing/Therapeutic Touch	135	20.5
Herbs	88	13.4

Homeopathy	71	10.8
Magnetic Therapy	38	5.8
Massage	107	16.3
Meditation	217	33.0
Music Therapy	192	29.2
Naturopathy	68	10.4
Prayer	104	15.8
Qigong	75	11.4
Reiki	84	12.8
Vitamins	81	12.3
Yoga	101	15.4
Other	28	4.3
Missing	9	1.4

* Responses to this question were in the form of "check all that apply". As a result, the total number of responses is greater than the total number of respondents.

III. Personal Experience Factors

Research Question 5: What are counselors' personal experiences with complementary therapy?

In attempting to answer research question five, respondents were asked about complementary therapies they had personally experienced, their most recently experienced complementary therapy, the reasons for seeking out this most recent complementary therapy experience and the benefits of their most recent complementary therapy experience. Table 8 provides a summary of the results for research question five.

"Exercise" was the complementary therapy that respondents most frequently (79.8%, 524) reported personally experiencing. This was followed by a tight cluster of respondents' personal experiences with the complementary therapies of "Diet" (62.6%, n=411), "Massage" (62.3%, n=409), "Guided Imagery" (61.3%, n=403), "Prayer" (58.4%, n=384) and "Meditation" (56.3%, n=370). "Ayurveda" (5.8%, n=38), "Qigong" (7.5%, n=49) and "Magnetic Therapy" (9.3%, n=61) were the complementary therapies least likely to have been personally experienced. Interestingly, only 5.5% of respondents (n=36) reported they had not personally experienced any complementary therapies.

Responses to this question were in the form of “check all that apply”. As a result, the total number of responses is greater than the total number of respondents.

With regard to their most recent personal experience with complementary therapy, respondents most frequently reported the complementary therapies of “Prayer” (19.6%, n=129), “Exercise” (16.7%, n=110) and “Massage” (12.5%, n=82). In fact, these were the only responses attaining double digits in terms of frequency. “Magnetic Therapy” was cited by only one respondent (0.2%) as the complementary therapy they most recently experienced. Further, only two respondents (0.3%) reported most recently personally experiencing either “Homeopathy”, Qigong” or “Reiki”.

Respondents’ reason for their most recent personal experience with complementary therapy was overwhelmingly “To improve overall wellness” (70.9%, n=466). At the other end of the spectrum, “An acute medical condition” (3.7%, n=24) was the least likely reason for respondents’ most recent personal experience with complementary therapy. Responses to this question were in the form of “check all that apply”. As a result, the total number of responses is greater than the total number of respondents.

Finally, the majority of respondents (52.5%, n=345) reported “Large benefits” from their most recent use of complementary therapy. Only two respondents (0.3%) reported “No benefits” from their most recent use of complementary therapy.

This last category consisted of four subcategories reported on a Likert (ordinal) scale. The scale was recoded in order for the subcategory of “Not sure of benefits” to effectively form the center, or neutral point, of the distribution. The ordered values of 1 to 5 for each subcategory are listed after its label. The mean for this category is 4.48, indicating that respondents reported between some and large benefits from their most recent use of complementary therapy. The difference between the mean value and the median value of 5.0 indicates that the center of the distribution is close to the median, but with a negative skew (i.e., more results at the high end of the scale).

Table 8

Personal Experience Factors: Research Question Five

Category	Frequency	Percent

*6) Personally experienced complementary therapies (CT)**

No personally experienced CT's	36	5.5
Acupuncture	136	20.7
Aromatherapy	234	35.6
Art Therapy	204	31.1
Ayurveda	38	5.8
Breathwork	297	45.2
Dance/Movement Therapy	141	21.5
Diet	411	62.6
Exercise	524	79.8
Guided Imagery	403	61.3
Healing/Therapeutic Touch	180	27.4
Herbs	189	28.8
Homeopathy	119	18.1
Magnetic Therapy	61	9.3
Massage	409	62.3
Meditation	370	56.3
Music Therapy	189	28.8
Naturopathy	72	11.0
Prayer	384	58.4
Qigong	49	7.5
Reiki	96	14.6
Vitamins	333	50.7
Yoga	257	39.1
Other	79	12.0
Missing	13	2.0

7) Complementary therapy (CT) most recently personally experienced (n=657)

No personally experienced CT's	36	5.5
Acupuncture	8	1.2
Aromatherapy	8	1.2
Art Therapy	13	2.0

Ayurveda	3	0.5
Breathwork	14	2.1
Dance/Movement Therapy	4	0.6
Diet	17	2.6
Exercise	110	16.7
Guided Imagery	29	4.4
Healing/Therapeutic Touch	9	0.9
Herbs	7	1.1
Homeopathy	2	0.3
Magnetic Therapy	1	0.2
Massage	82	12.5
Meditation	33	5.0
Music Therapy	12	1.8
Naturopathy	3	0.5
Prayer	129	19.6
Qigong	2	0.3
Reiki	2	0.3
Vitamins	43	6.5
Yoga	55	8.4
Other	25	3.8
Missing	13	2.0

*8) Reasons for most recent experience with complementary therapy (CT)**

No personally experienced CT's	36	5.5
To improve overall wellness	466	70.9
A specific mental health concern	64	9.7
An acute medical condition	24	3.7
A chronic medical condition	66	10.0
Just to try it, no specific wellness, mental health or medical concern	49	7.5
Other	35	5.3
Missing	14	2.1

9) Benefit of most recent use of complementary therapy (CT) (n=657)

No personally experienced CT's	36	5.5
No benefits (1)	2	0.3
Only slight benefits (2)	16	2.4
Not sure of benefits (3)	17	2.6
Some benefits (4)	229	34.9
Large benefits (5)	345	52.5
Missing	12	1.8

Mean = 4.48, Median = 5.00, Mode = 5. SD = .709

* Responses to this question were in the form of "check all that apply". As a result, the total number of responses is greater than the total number of respondents.

IV. Demographic Factors

Research Question 6: Do counselors' differ across demographic factors with regard to professional practice factors, knowledge and training factors, and personal experience factors?

In answering this question, contingency tables or crosstabulations (crosstabs) were conducted to test the hypothesis that the row (independent) variables and column (dependent) variables (i.e., demographic x various factors) were independent. Pearson Chi-Square output was calculated for each respective crosstabulation.

While the presence of a significant value ($p<.05$) is useful to establish the existence of a statistical association, it does not provide information on the strength of this association (Kinnear & Gray, 2004). In addition, to address concerns about Type 1 errors when using crosstabs (i.e., Chi-square) with ordinal data, Spearman's rho was calculated for each crosstab (Rea & Parker, 1992). These results further confirmed the significance of all associations.

Fortunately, the Cramer's V (V) statistic provides a measure of the strength of association. The strength of associations for Cramer's V are taken from Rea and Parker (1992) and are as follows: .00 < .10 – negligible association, .10 < .20 – weak association, .20 < .40 – moderate association, .60 < .80 – strong association, and .80 to 1.0 – very strong association.

In addition, the greater the expected frequencies, especially for larger contingency tables, the more valid the results (Kinnear & Gray, 2004). The rule of thumb employed in this study was one of questioning the results if more than 20% of cells had expected counts of less than five (Green, Salkino, & Akey, 2000).

There were a total of 1127 possible associations between variables (i.e., 23 columns x 49 rows). Of this number, 275 crosstabulations were significant at the alpha less than .05 level. These significances can be further broken down as follows: $p < .001$ in 116 cases (42.2%), $p < .01$ in 72 cases (26.2%), and $p < .05$ in 87 cases (31.6%). In addition, a total of 66 crosstabulations (24% of 275 total) resulted in Cramer's V values indicative of a "moderate" strength of association. Out of these significant findings, questionable results were found to be present in 63 cases (22.9%), due to 20% or more of cells having expected counts of less than five. The result of this data sifting was that only 44 crosstabulations (4% of 1127 total cells) were found to be both significant ($p<.05$) and have a Cramer's V value indicative of a moderate strength of association ($V>.200$).

The independent variables were represented by 49 rows. With respect to significance, 41 rows or independent variables were found to contain at least one significant statistical association ($p<.05$). The independent variables of "Position-Graduate student (Doctoral)", "Position-Other", "Work setting-College/university", "Work setting-Community agency", "Work setting-Government setting", "Work setting-Other", "Services provided-Testing" and "Theoretical orientation-Behavioral" did not have any significant statistical associations.

Cramer's V was at least moderate ($V>.200$) down 18 of the independent variables/rows, including questionable associations with 20% or more of cells having expected counts of less than five. Removing these questionable associations resulted in just 10 independent variables/rows with a Cramer's V value indicative of a moderate association. These independent variables were, in order of frequency, "Work setting-Private practice/Self-employed" (n=8), "Position-Outpatient counselor" (n=7), "Services provided-Individual counseling" (n=6), "Work setting-K-12 setting" (n=5), "Services provided-Family/couples counseling" (n=5), "Mental health license-None" (n=3), "Mental health license-LPC", (n=3), "Services provided-Alcohol/Substance abuse

counseling" (n=3), "Theoretical Orientation-Psychodynamic" (n=2) and "Position-Graduate student (Master's)" (n=2).

The five most frequent independent/row variables accounted for over 70 percent (n=31) of the 44 significant and moderate strength of associations. In other words, just 10% (i.e., 5/49*100%) of the independent/row variables were present in 70% of crosstabs with both significant and moderate strength of associations.

The dependent variables were represented by 23 columns. With respect to significance, all 23 columns or dependent variables were found to contain at least one significant statistical association ($p<.05$). Cramer's V was at least moderate ($V>.200$) across 13 of the dependent variables/columns, including associations with 20% or more of cells having expected counts of less than five. Removing these questionable associations resulted in nine dependent variables/columns with a moderate strength of association.

Research question five, consisting of survey questions 6 to 9, did not have any significant and moderate strength of associations. Research question four, which was made up of survey questions 10 to 13, had only one significant and moderate strength of association (Work setting-private practice x Complementary therapy modalities qualified to discuss).

Of the 44 significant and moderate strength of associations, most frequently the dependent variable was "Counselor asked client about use of complementary therapy" (n=8), followed by "Included complementary therapy in counseling" (n=7), "Client requested inclusion of complementary therapy" (n=7), "Provided client with a specific referral for complementary therapy" (n=7), "Client voluntarily brought up use of complementary therapy" (n=5), "Client requested a recommendation or referral for complementary therapy" (n=4), "Client concerns for which recommended or referred for complementary therapy" (n=4), " Complementary therapy modalities qualified to discuss" (n=1) and "Recommended complementary therapy without providing a referral" (n=1).

The five most frequent dependent/column variables were present in over 84 percent (n=37) of the 44 significant and moderate strength of associations. In other

words, just 21% (i.e., 5/23*100%) of the dependent/column variables are present in 84% of the significant and moderate strength of associations.

Tables 9 to 17 present detailed information for all results, which indicated a significant association between variables (i.e., p<.05) and a strength of association of at least a moderate value (i.e., Cramer's V>.200). Note that three associations where p<.001 and V=.199 were also included because of their close proximity to significance criteria. Table information includes actual and expected counts, $X^{2,}$ p, df, V, as well as identifying the strength of association.

Table 9

Crosstabulation: Significant Associations for Demographics x Research Question One (#1 Counselor asked client about use of complementary therapy (CT))

Group	*State mental health license: None*	*1) Counselor asked client about use of CT (n=530)*				
		None	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	77	86	49	32	244
	Expected count	59.4	84.2	47.4	52.9	244.0
	% of Group	31.6%	35.2%	20.1%	13.1%	100%
	% of Total	14.5%	16.2%	9.2%	6.0%	46.0%
No	Count	52	97	54	83	286
	Expected count	69.6	98.8	55.6	62.1	286.0
	% of Group	18.2%	33.9%	18.9%	29.0%	%
	% of Total	9.8%	18.3%	10.2%	15.7%	54.0%
Total	Total count	129	183	103	115	530
	% of Total	24.3%	34.5%	19.4%	21.7%	100%
X^2=25.196, df=3, p=.000, V=.218, Strength of association=Moderate						
Group	*Current Position: Outpatient Counselor*	*1) Counselor asked client about use of CT (n=530)*				
		None	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	38	76	51	72	237
	Expected count	58.1	81.4	46.1	51.4	237.0
	% of Group	16.0%	32.1%	21.5%	30.4%	100%
	% of Total	7.2%	14.3%	9.6%	13.6%	44.7%
No	Count	92	106	52	43	293
	Expected count	71.9	100.6	56.9	63.6	293.0
	% of Group	31.4%	36.2%	17.7%	14.7%	100%
	% of Total	17.4%	20.0%	9.8%	14.7%	55.3%

Total	Total count	130	182	103	115	530
	% of Total	24.5%	34.3%	19.4%	21.7%	100%
X^2=29.107, df=3, p=.000, V=.234, Strength of association=Moderate						
Group	*Work Setting: K-12*	*1) Counselor asked client about use of CT (n=530)* None	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	36	32	9	7	84
	Expected count	20.4	29.2	16.2	18.2	84.0
	% of Group	42.9%	38.1%	10.7%	8.3%	100%
	% of Total	6.8%	6.0%	1.7%	8.3%	15.8%
No	Count	93	152	93	108	446
	Expected count	108.6	154.8	85.8	96.8	446.0
	% of Group	20.9%	34.1%	20.9%	24.2%	100%
	% of Total	17.5%	28.7%	17.5%	20.4%	84.2%
Total	Total count	129	184	102	115	530
	% of Total	24.3%	34.7%	19.2%	21.7%	100%
X^2=26.383, df=3, p=.000, V=.223, Strength of association=Moderate						
Group	*Work Setting: Private practice/ Self-employed*	*1) Counselor asked client about use of CT (n=530)* None	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	17	57	43	59	176
	Expected count	42.8	61.1	33.9	38.2	176.0
	% of Group	9.7%	32.4%	24.4%	33.5%	100%
	% of Total	3.2%	10.8%	8.1%	11.1%	33.2%
No	Count	112	127	59	56	354
	Expected count	86.2	122.9	68.1	76.8	354.0
	% of Group	31.6%	35.9%	16.7%	15.8%	100%
	% of Total	21.1%	24.0%	11.1%	10.6%	66.8%
Total	Total count	129	184	102	115	530
	% of Total	24.3%	34.7%	19.2%	21.7%	100%
X^2=44.408, df=3, p=.000, V=.289, Strength of association=Moderate						
Group	*Services Provided: Alcohol/ Substance abuse counseling*	*1) Counselor asked client about use of CT (n=532)* None	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	25	55	44	49	173
	Expected count	42.3	59.8	33.5	37.4	173.0
	% of Group	14.5%	31.8%	25.4%	28.3%	100%
	% of Total	4.7%	10.3%	8.3%	9.2%	32.5%
No	Count	105	129	59	66	359

	Expected count	87.7	124.2	69.5	77.6	359.0
	% of Group	29.2%	35.9%	16.4%	18.4%	100%
	% of Total	19.7%	24.2%	11.1%	12.4%	67.5%
Total	Total count	130	184	103	115	532
	Total %	24.4%	34.6%	19.4%	21.6%	100%
X^2=21.258, df=3, p=.000, V=.200, Strength of association=Moderate						
Group	*Services Provided: Family/couples counseling*	*1) Counselor asked client about use of CT (n=532)*				
		None	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	43	100	59	70	272
	Expected count	66.5	94.1	52.7	58.8	272.0
	% of Group	15.8%	36.8%	21.7%	25.7%	100%
	% of Total	8.1%	18.8%	11.1%	13.2%	51.1%
No	Count	87	84	44	45	260
	Expected count	63.5	89.9	50.3	56.2	260.0
	% of Group	33.5%	32.3%	16.9%	17.3%	100%
	% of Total	16.4%	15.8%	8.3%	8.5%	48.9%
Total	Total count	130	184	103	115	532
	% of Total	24.4%	34.6%	19.4%	21.6%	100%
X^2=23.644, df=3, p=.000, V=.211, Strength of association=Moderate						
Group	*Services Provided: Individual counseling*	*1) Counselor asked client about use of CT (n=532)*				
		None	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	94	152	92	112	450
	Expected count	110.0	155.6	87.1	97.3	450.0
	% of Group	20.9	33.8%	20.4%	24.9%	100%
	% of Total	17.7%	28.6%	17.3%	21.1%	84.6%
No	Count	36	32	11	3	82
	Expected count	20.0	28.4	15.9	17.7	82.0
	% of Group	43.9%	39.0%	13.4%	3.7%	100%
	% of Total	6.8%	6.0%	2.1%	.6%	15.4%
Total	Total count	130	184	103	115	532
	% of Total	24.4%	34.6%	19.4%	21.6%	100%
X^2=31.818, df=3, p=.000, V=.245, Strength of association=Moderate						
Group	*Theoretical Orientation: Psychodynamic*	*1) Counselor asked client about use of CT (n=533)*				
		None	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	15	33	35	32	115
	Expected count	28.0	39.9	22.2	24.8	115.0

	% of Group	13.0%	28.7%	30.4%	27.8%	100%
	% of Total	2.8%	6.2%	6.6%	6.0%	21.6%
No	Count	115	152	68	83	418
	Expected count	102.0	145.1	80.8	90.2	418.0
	% of Group	27.5%	36.4%	16.3%	19.9%	100%
	% of Total	21.6%	28.5%	12.8%	15.6%	78.4%
Total	Total count	130	185	103	115	533
	% of Total	24.4%	34.7%	19.3%	21.6%	100%
X^2=21.290, df=3, p=.000, V=.200, Strength of association=Moderate						

Table 10

Crosstabulation: Significant Associations for Demographics x Research Question One (#2 Client voluntarily brought up their use of complementary therapy with counselor)

Group	*Current Position: Outpatient Counselor*	*2) Client voluntarily brought up their use of CT (n=526)*				
		None	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	33	120	56	28	237
	Expected count	51.2	123.0	43.3	19.4	237.0
	% of Group	13.9%	50.6%	23.6%	11.8%	100%
	% of Total	6.3%	22.8%	10.6%	5.3%	45.1%
No	Count	81	153	40	15	289
	Expected count	62.6	150.0	52.7	23.6	289.0
	% of Group	28.0%	52.9%	13.8%	5.2%	100%
	% of Total	15.4%	29.1%	7.6%	2.9%	54.9%
Total	Total count	114	273	96	43	526
	% of Total	21.7%	51.9%	18.3%	8.2%	100%
X^2=25.909, df=3, p=.000, V=.222, Strength of association=Moderate						
Group	*Work Setting: K-12*	*2) Client voluntarily brought up their use of CT (n=526)*				
		None	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	34	40	8	2	84
	Expected count	18.0	43.8	15.3	6.9	84.0
	% of Group	40.5%	47.6%	9.5%	2.4%	100%
	% of Total	6.5%	7.6%	1.5%	.4%	16.0%
No	Count	79	234	88	41	442
	Expected count	95.0	230.2	80.7	36.1	442.0
	% of Group	17.9%	52.9%	19.9%	9.3%	100%
	% of Total	15.0%	44.5%	16.7%	7.8%	84.0%
Total	Total count	113	274	96	43	526

	% of Total	21.5%	52.1%	18.3%	8.2%	100%
X^2=25.447, df=3, p=.000, V=.220, Strength of association=Moderate						
Group	*Work Setting: Private practice/ Self-employed*	*2) Client voluntarily brought up their use of CT (n=526)* None	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	19	81	48	28	176
	Expected count	37.8	91.7	32.1	14.4	176.0
	% of Group	10.8%	46.0%	27.3%	15.9%	100%
	% of Total	3.6%	15.4%	9.1%	5.3%	33.5%
No	Count	94	193	48	15	350
	Expected count	75.2	182.3	63.9	28.6	350.0
	% of Group	26.9%	55.1%	13.7%	4.3%	100%
	% of Total	17.9%	36.7%	9.1%	2.9%	66.5%
Total	Total count	113	274	96	43	526
	% of Total	21.5%	52.1%	18.3%	8.2%	100%
X^2=47.083, df=3, p=.000, V=.299, Strength of association=Moderate						
Group	*Services Provided: Family/couples counseling*	*2) Client voluntarily brought up their use of CT (n=528)* None	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	38	153	52	29	272
	Expected count	58.7	141.2	50.0	22.2	272.0
	% of Group	14.0%	56.3%	19.1%	10.7%	100%
	% of Total	7.2%	29.0%	9.8%	5.5%	51.5%
No	Count	76	121	45	14	256
	Expected count	55.3	132.8	47.0	20.8	256.0
	% of Group	29.7%	47.3%	17.6%	5.5%	100%
	% of Total	14.4%	22.9%	8.5%	2.7%	48.5%
Total	Total count	114	274	97	43	528
	% of Total	21.6%	51.9%	18.4%	8.1%	100%
X^2=21.677, df=3, p=.000, V=.203, Strength of association=Moderate						
Group	*Services Provided: Individual counseling*	*2) Client voluntarily brought up their use of CT (n=526)* None	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	79	237	92	41	449
	Expected count	96.9	233	82.5	36.6	449.0
	% of Group	17.6%	52.8%	20.5%	9.1%	100%
	% of Total	15.0%	44.9%	17.4%	7.8%	85.0%
No	Count	35	37	5	2	79
	Expected count	17.1	41.0	14.5	6.4	79.0

	% of Group	44.3%	46.8%	6.3%	2.5%	100%
	% of Total	6.6%	7.0%	.9%	.4%	15.0%
Total	Total count	114	274	97	43	528
	% of Total	21.6%	51.9%	18.4%	8.1%	100%
X^2=33.581, df=3, p=.000, V=.252, Strength of association=Moderate						

Table 11

Crosstabulation: Significant Associations for Demographics x Research Question Two (#19 Client requested recommendation or referral for complementary therapy (CT))

Group	*Current Position: Master's student*	*19) Client requested recommendation or referral for CT (n=526)* None	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	79	23	1	0	103
	Expected count	59.5	35.2	5.9	2.3	103.0
	% of Group	76.7%	22.3%	1.0%	.0%	100%
	% of Total	15.0%	4.4%	.2%	.0%.	19.6%
No	Count	225	157	29	12	423
	Expected count	244.5	144.8	24.1	9.7	423.0
	% of Group	53.2%	37.1%	6.9%	2.8%	100%
	% of Total	42.8%	29.8%	5.5%	2.3%	80.4%
Total	Total count	304	180	30	12	526
	% of Total	57.8%	34.2%	5.7%	2.3%	100%
X^2=21.163, df=3, p=.000, V=.201, Strength of association=Moderate						
Group	*Current Position: Outpatient Counselor*	*19) Client requested recommendation or referral for CT (n=526)* None	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	109	96	25	8	238
	Expected count	137.6	81.4	13.6	5.4	238.0
	% of Group	45.8%	40.3%	10.5%	3.4%	100%
	% of Total	20.7%	18.3%	4.8%	1.5%	45.2%
No	Count	195	84	5	4	288
	Expected count	166.4	98.6	16.4	6.6	288.0
	% of Group	67.7%	29.2%	1.7%	1.4%	100%
	% of Total	37.1%	16.0%	1.0%	.8%	54.8%
Total	Total count	304	180	30	12	526
	% of Total	57.8%	34.2%	5.7%	2.3%	100%
X^2=35.362, df=3, p=.000, V=.259, Strength of association=Moderate						
Group	*Work Setting:*	*19) Client requested recommendation or referral for CT (n=526)*				

	Private practice/ Self-employed	None	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	77	73	17	10	177
	Expected count	102.3	60.2	10.1	4.4	177.0
	% of Group	43.5%	41.2%	9.6%	5.6%	100%
	% of Total	14.6%	13.9%	3.2%	1.9%	33.7%
No	Count	227	106	13	3	349
	Expected count	201.7	118.8	19.9	8.6	349.0
	% of Group	65.0%	30.4%	3.7%	.9%	100%
	% of Total	43.2%	20.2%	2.5%	.6%	66.3%
Total	Total count	304	179	30	13	526
	% of Total	57.8%	34.0%	5.7%	2.5%	100%
X^2=31.527, df=3, p=.000, V=.245, Strength of association=Moderate						
Group	*Services Provided: Individual counseling*	*19) Client requested recommendation or referral for CT (n=528)*				
		None	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	243	166	30	12	451
	Expected count	260.5	154.6	25.6	10.3	451.0
	% of Group	53.9%	36.8%	6.7%	2.7%	100%
	% of Total	46.0%	31.4%	5.7%	2.3%	85.4%
No	Count	62	15	0	0	77
	Expected count	44.5	26.4	4.4	1.8	77.0
	% of Group	80.5%	19.5%	.0%	.0%	100%
	% of Total	11.7%	2.8%	.0%	.0%	14.6%
Total	Total count	305	181	30	12	528
	% of Total	57.8%	34.3%	5.7%	2.3%	100%
X^2=21.011, df=3, p=.000, V=.199, Strength of association= Weak/Moderate						

Table 12

Crosstabulation: Significant Associations for Demographics x Research Question Two (#20 Recommended complementary therapy (CT) without providing a referral)

Group	*Current Position: Outpatient Counselor*	*20) Recommended CT without providing a referral (n=525)*				
		None	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	56	97	52	31	236
	Expected count	75.5	97.1	44.1	19.3	236.0
	% of Group	23.7%	41.1%	22.0%	13.1%	100%
	% of Total	10.7%	18.5%	9.9%	5.9%	45.0%

No	Count	112	119	46	12	289
	Expected count	92.5	118.9	53.9	23.7	289.0
	% of Group	38.8%	41.2%	15.9%	4.2%	100%
	% of Total	21.3%	22.7%	8.8%	2.3%	55.0%
Total	Total count	168	216	98	43	525
	% of Total	32.0%	41.1%	18.7%	8.2%	100%
X^2=24.570 df=3, p=.000, V=.216, Strength of association=Moderate						

Table 13

Crosstabulation: Significant Associations for Demographics x Research Question Two (#21 Provided client with a specific referral for complementary therapy (CT))

Group	*State mental health license: None*	*21) Provided client with a specific referral for CT (n=522)* None	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	154	63	18	3	238
	Expected count	114.9	93.5	23.3	6.4	238.0
	% of Group	64.7%	26.5%	7.6%	1.3%	100%
	% of Total	29.5%	12.1%	3.4%	.6%	45.6%
No	Count	98	142	33	11	284
	Expected count	137.1	111.5	27.7	7.6	284.0
	% of Group	34.5%	50.0%	11.6%	3.9%	100%
	% of Total	18.8%	27.2%	6.3%	2.1%	54.4%
Total	Total count	252	205	51	14	522
	% of Total	48.3%	39.3%	9.8%	2.7%	100%
X^2=48.192, df=3, p=.000, V=.304, Strength of association=Moderate						
Group	*State mental health license: LPC*	*21) Provided client with a specific referral for CT (n=522)* None	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	78	112	30	10	230
	Expected count	111.0	90.3	22.5	6.2	230.0
	% of Group	33.9%	48.7%	13.0%	4.3%	100%
	% of Total	14.9%	21.5%	5.7%	1.9%	44.1%
No	Count	174	93	21	4	292
	Expected count	141.0	114.7	28.5	7.8	292.0
	% of Group	59.6%	31.8%	7.2%	1.4%	100%
	% of Total	33.3%	17.8%	4.0%	.8%	55.9%
Total	Total count	252	205	51	14	522
	% of Total	48.3%	39.3%	9.8%	2.7%	100%
X^2=35.631, df=3, p=.000, V=.261, Strength of association=Moderate						

Group	*Current Position: Master's student*	*21) Provided client with a specific referral for CT (n=522)*				
		None	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	74	21	7	0	102
	Expected count	49.2	40.1	10.0	2.7	102.0
	% of Group	72.5%	20.6%	6.9%	.0%	100%
	% of Total	14.2%	4.0%	1.3%	.0%	19.5%
No	Count	178	184	44	14	420
	Expected count	202.8	164.9	41.0	11.3	420.0
	% of Group	42.4%	43.8%	10.5%	3.3%	100%
	% of Total	34.1%	35.2%	8.4%	2.7%	80.5%
Total	Total count	252	205	51	14	522
	% of Total	48.3%	39.3%	9.8%	2.7%	100%
X^2=31.237, df=3, p=.000, V=.245, Strength of association=Moderate						
Group	*Current Position: Outpatient Counselor*	*21) Provided client with a specific referral for CT (n=522)*				
		None	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	82	112	32	10	236
	Expected count	113.9	92.7	23.1	6.3	236.0
	% of Group	34.7%	47.5%	13.6%	4.2%	100%
	% of Total	15.7%	21.5%	6.1%	1.9%	45.2%
No	Count	170	93	19	4	286
	Expected count	138.1	112.3	27.9	7.7	286.0
	% of Group	59.4%	32.5%	6.6%	1.4%	100%
	% of Total	32.6%	17.8%	3.6%	.8%	54.8%
Total	Total count	252	205	51	14	522
	% of Total	48.3%	39.3%	9.8%	2.7%	100%
X^2=33.898, df=3, p=.000, V=.255, Strength of association=Moderate						
Group	*Work Setting: K-12*	*21) Provided client with a specific referral for CT (n=522)*				
		None	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	60	22	1	1	84
	Expected count	40.6	33.1	8.0	2.3	84.0
	% of Group	71.4%	26.2%	1.2%	1.2%	100%
	% of Total	11.5%	4.2%	.2%	.2%	16.1%
No	Count	192	194	49	13	438
	Expected count	221.4	172.9	42.0	11.7	438.0
	% of Group	43.8%	42.0%	11.2%	3.0%	100%
	% of Total	36.8%	35.2%	9.4%	2.5%	83.9%

Total	Total count	252	206	50	14	522
	% of Total	48.3%	39.5%	9.6%	2.7%	100%
X^2=23.769, df=3, p=.000, V=.213, Strength of association=Moderate						
Group	*Work Setting: Private practice/Self-employed*	*21) Provided client with a specific referral for CT (n=522)*				
		None	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	50	90	26	9	175
	Expected count	84.5	69.1	16.8	4.7	175.0
	% of Group	28.6%	51.4%	14.9%	5.1%	100%
	% of Total	9.6%	17.2%	5.0%	1.7%	33.5%
No	Count	202	116	24	5	347
	Expected count	167.5	136.9	33.2	9.3	347.0
	% of Group	58.2%	33.4%	6.9%	1.4%	100%
	% of Total	38.7%	22.2%	4.6%	1.0%	66.5%
Total	Total count	252	206	50	14	522
	% of Total	48.3%	39.5%	9.6%	2.7%	100%
X^2=44.325, df=3, p=.000, V=.291, Strength of association=Moderate						
Group	*Services Provided: Family/couples counseling*	*21) Provided client with a specific referral for CT (n=524)*				
		None	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	105	128	29	10	272
	Expected count	131.3	106.9	26.5	7.3	272.0
	% of Group	38.6%	47.1%	10.7%	3.7%	100%
	% of Total	20.0%	24.4%	5.5%	1.9%	51.9%
No	Count	148	78	22	4	252
	Expected count	121.7	99.1	24.5	6.7	252.0
	% of Group	58.7%	31.0%	8.7%	1.6%	100%
	% of Total	28.2%	14.9%	4.2%	.8%	48.1%
Total	Total count	253	206	51	14	524
	% of Total	48.3%	39.3%	9.7%	2.7%	100%
X^2=22.545, df=3, p=.000, V=.206, Strength of association=Moderate						

Table 14

Crosstabulation: Significant Associations for Demographics x Research Question Two (#22 Client concerns which recommended or referred for complementary therapy (CT))

		22) Client concerns for which recommended or referred for CT					
Group	*Work Setting: K-12*	None	ADHD	Alcohol/ SA	Anxiety	Depression	Eating disorder
Yes	Count	36	29	8	41	37	6

	Expected count	15.6	13.4	16.8	42.0	41.2	10.0
	% of Group	17.6%	14.2%	3.9%	20.1%	18.1%	2.9%
	% of Total	2.2%	1.7%	.5%	2.4%	2.2%	.4%
No	Count	92	81	130	304	301	76
	Expected count	112.4	96.6	121.2	303.0	296.8	72.0
	% of Group	6.3%	5.5%	8.8%	20.7%	20.5%	5.2%
	% of Total	5.5%	4.8%	7.8%	18.2%	18.0%	4.5%
Total	Total count	128	110	138	345	338	82
	% of Total	7.6%	6.6%	8.2%	20.6%	20.2%	4.9%

Group	*Work Setting: K-12*	Medical concern	Personality disorder	Somatic problem	Trauma/ PTSD	Other	Total
Yes	Count	8	5	14	14	6	204
	Expected count	15.0	7.4	15.5	21.6	5.5	204.0
	% of Group	3.9%	2.5%	6.9%	6.9%	2.9%	100%
	% of Total	.5%	.3%	.8%	.8%	.4%	12.2%
No	Count	115	56	113	163	39	1470
	Expected count	108.0	53.6	111.5	155.4	39.5	1470.0
	% of Group	7.8%	3.8%	7.7%	11.1%	2.7%	100%
	% of Total	6.9%	3.3%	6.8%	9.7%	2.3%	87.8%
Total	Total count	123	61	127	177	45	1674
	% of Total	7.3%	3.6%	7.6%	10.6%	2.7%	100%

X^2=66.502, df=10, p=.000, V=.199, Strength of association=Weak/Moderate

Group	*Work Setting: Private practice/ Self-employed*	None	ADHD	Alcohol/ SA	Anxiety	Depression	Eating disorder
		22) Client concerns for which recommended or referred for CT					
Yes	Count	14	52	59	150	142	43
	Expected count	54.9	47.2	59.2	148.0	145.0	35.2
	% of Group	1.9%	7.2%	8.2%	20.9%	19.8%	6.0%
	% of Total	.8%	3.1%	3.5%	9.0%	8.5%	2.6%
No	Count	114	58	79	195	196	39
	Expected count	73.1	62.8	78.8	197.0	193.0	46.8
	% of Group	11.9%	6.1%	8.3%	20.4%	20.5%	4.1%
	% of Total	6.8%	3.5%	4.7%	11.6%	11.7%	2.3%
Total	Total count	128	110	138	345	338	82
	% of Total	7.6%	6.6%	8.2%	20.6%	20.2%	4.9%

Group	*Work Setting: Private practice/ Self-employed*	Medical concern	Personality disorder	Somatic problem	Trauma/ PTSD	Other	Total
Yes	Count	69	22	64	84	19	718
	Expected count	52.8	26.2	54.5	75.9	19.3	718.0
	% of Group	9.6%	3.1%	8.9%	11.7%	2.6%	100%
	% of Total	4.1%	1.3%	3.8%	5.0%	1.1%	42.9%

No	Count	54	39	63	93	26	956
	Expected count	70.2	34.8	72.5	101.1	25.7	956.0
	% of Group	5.6%	4.1%	6.6%	9.7%	2.7%	100%
	% of Total	3.2%	2.3%	3.8%	5.6%	1.6%	57.1%
Total	Total count	123	61	127	177	45	1674
	% of Total	7.3%	3.6%	7.6%	10.6%	2.7%	100%
X^2=71.777, df=10, p=.000, V=.207, Strength of association=Moderate							

Group	*Services Provided: Alcohol/ Substance abuse cnslg.*	*22) Client concerns for which recommended or referred for CT*					
		None	ADHD	Alcohol/ SA	Anxiety	Depression	Eating disorder
Yes	Count	26	37	95	126	126	39
	Expected count	51.0	43.9	54.1	136.3	133.5	32.4
	% of Group	3.9%	5.6%	14.3%	19.0%	19.0%	5.9%
	% of Total	1.5%	2.2%	5.7%	7.5%	7.5%	2.3%
No	Count	103	74	42	219	212	43
	Expected count	78.0	67.1	82.9	208.7	204.5	49.6
	% of Group	10.1%	7.3%	4.1%	21.6%	20.9%	4.2%
	% of Total	6.1%	4.4%	2.5%	13.1%	12.6%	2.6%
Total	Total count	126	111	137	345	38	82
	% of Total	7.7%	6.6%	8.2%	20.6%	20.1%	4.9%

Group	*Services Provided: Alcohol/ Substance abuse cnslg.*						
		Medical concern	Personality disorder	Somatic problem	Trauma/ PTSD	Other	Total
Yes	Count	55	27	49	72	11	663
	Expected count	48.6	24.5	50.2	70.3	18.2	663.0
	% of Group	8.3%	4.1%	7.4%	10.9%	1.7%	100%
	% of Total	3.3%	1.6%	2.9%	4.3%	.7%	39.5%
No	Count	68	35	78	106	35	1015
	Expected count	74.4	37.5	76.8	107.7	27.8	1015.0
	% of Group	6.7%	3.4%	7.7%	10.4%	3.4%	100%
	% of Total	4.1%	2.1%	4.6%	6.3%	2.1%	60.5%
Total	Total count	123	62	127	178	46	1678
	% of Total	7.3%	3.7%	7.6%	10.6%	2.7%	100%
X^2=83.838, df=10, p=.000, V=.224, Strength of association=Moderate							

Group	*Services Provided: Individual cnslg.*	*22) Client concerns for which recommended or referred for CT*					
		None	ADHD	Alcohol/ SA	Anxiety	Depression	Eating disorder
Yes	Count	93	96	127	316	310	80
	Expected count	117.1	100.7	124.3	313.1	306.8	74.4
	% of Group	6.1%	6.3%	8.3%	20.7%	20.4%	5.3%

	% of Total	5.5%	5.7%	7.6%	18.8%	18.5%	4.8%
No	Count	36	15	10	29	28	2
	Expected count	11.9	10.3	12.7	31.9	31.2	7.6
	% of Group	23.2%	9.7%	6.5%	18.7%	18.1%	1.3%
	% of Total	2.1%	.9%	.6%	1.7%	1.7%	.1%
Total	Total count	129	111	137	345	338	82
	% of Total	7.7%	6.6%	8.2%	20.6%	20.1%	4.9%

Group	*Services Provided: Individual cnslg.*	Medical concern	Personality disorder	Somatic problem	Trauma/ PTSD	Other	Total
Yes	Count	117	59	118	170	37	1523
	Expected count	111.6	56.3	115.3	161.6	41.8	1523.0
	% of Group	7.7%	3.9%	7.7%	11.2%	2.4%	100%
	% of Total	7.0%	3.5%	7.0%	10.1%	2.2%	90.8%
No	Count	6	3	9	8	9	155
	Expected count	11.4	5.7	11.7	16.4	4.2	155.0
	% of Group	3.9%	1.9%	5.8%	5.2%	5.8%	100%
	% of Total	.4%	.2%	.5%	.5%	.5%	9.2%
Total	Total count	123	62	127	178	46	1678
	% of Total	7.3%	3.7%	7.6%	10.6%	2.7%	100%
X^2=77.385, df=10, p=.000, V=.215, Strength of association=Moderate							

Table 15

Crosstabulation: Significant Associations for Demographics x Research Question Three (#14 Included complementary therapy (CT) in counseling)

Group	*State mental health license: None*	*14) Included CT in counseling (n=527)* Never	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	63	106	50	23	242
	Expected count	42.7	103.8	57.9	37.7	242.0
	% of Group	26.0%	43.8%	20.7%	9.5%	100%
	% of Total	12.0%	20.1%	9.5%	4.4%	45.9%
No	Count	30	120	76	59	285
	Expected count	50.2	122.2	68.1	44.3	285.0
	% of Group	10.5%	42.1%	26.7%	20.7%	100%
	% of Total	5.7%	22.8%	14.4%	11.2%	54.1%
Total	Total count	93	226	126	82	527
	% of Total	17.6%	42.9%	23.9%	15.6%	100%
X^2=30.441, df=3, p=.000, V=.240, Strength of association=Moderate						
		14) Included CT in counseling				

Group	*State mental health license: LPC*	*(n=527)* Never	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	26	89	67	49	231
	Expected count	40.8	99.1	55.2	35.9	231.0
	% of Group	11.3%	38.5%	29.0%	21.2%	100%
	% of Total	4.9%	16.9%	12.7%	9.3%	43.8%
No	Count	67	137	59	33	296
	Expected count	52.2	126.9	70.8	46.1	296.0
	% of Group	22.6%	46.3%	19.9%	11.1%	100%
	% of Total	12.7%	26.0%	11.2%	6.3%	56.2%
Total	Total count	93	226	126	82	527
	% of Total	17.6%	42.9%	23.9%	15.6%	100%
X^2=24.252, df=3, p=.000, V=.215, Strength of association=Moderate						

Group	*Current Position: Outpatient Counselor*	*14) Included CT in counseling (n=527)* Never	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	28	92	69	49	238
	Expected count	42.0	102.5	56.5	37.0	238.0
	% of Group	11.8%	38.7%	29.0%	20.6%	100%
	% of Total	5.3%	17.5%	13.1%	9.3%	45.2%
No	Count	65	135	56	33	289
	Expected count	51.0	124.5	68.5	45.0	289.0
	% of Group	22.5%	46.7%	19.4%	11.4%	100%
	% of Total	12.3%	25.6%	10.6%	6.3%	54.8%
Total	Total count	93	227	125	82	527
	% of Total	17.6%	43.1%	23.7%	15.6%	100%
X^2=22.615, df=3, p=.000, V=.207, Strength of association=Moderate						

Group	*Work Setting: Private practice/Self-employed*	*14) Included CT in counseling (n=527)* Never	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	10	72	54	41	177
	Expected count	31.2	76.2	42.0	27.5	177.0
	% of Group	5.6%	40.7%	30.5%	23.2%	100%
	% of Total	1.9%	13.7%	10.2%	7.8%	33.6%
No	Count	83	155	71	41	350
	Expected count	61.8	150.8	83.0	54.5	350.0
	% of Group	23.7%	44.3%	20.3%	11.7%	100%
	% of Total	15.7%	29.4%	13.5%	7.8%	66.4%
Total	Total count	93	227	125	82	527

	% of Total	17.6%	43.1%	23.7%	15.6%	100%
X^2=37.176, df=3, p=.000, V=.266, Strength of association=Moderate						
Group	*Services Provided: Alcohol/ Substance abuse counseling*	*14) Included CT in counseling (n=529)*				
		Never	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	17	66	57	32	172
	Expected count	30.6	73.8	41.0	26.7	172.0
	% of Group	9.9%	38.4%	33.1%	18.6%	100%
	% of Total	3.2%	12.5%	10.8%	6.0%	32.5%
No	Count	77	161	69	50	357
	Expected count	63.4	153.2	85.0	55.3	357.0
	% of Group	21.6%	45.1%	19.3%	14.0%	100%
	% of Total	14.6%	30.4%	13.0%	9.5%	67.5%
Total	Total count	94	227	126	82	529
	% of Total	17.8%	42.9%	23.8%	15.5%	100%
X^2=21.203, df=3, p=.000, V=.199, Strength of association=Weak/Moderate						
Group	*Services Provided: Family/couples counseling*	*14) Included CT in counseling (n=529)*				
		Never	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	29	116	76	54	275
	Expected count	48.9	118.0	65.5	42.6	275.0
	% of Group	10.5%	42.2%	27.6%	19.6%	100%
	% of Total	5.5%	21.9%	14.4%	10.2%	52.0%
No	Count	65	11	50	28	254
	Expected count	45.1	109.0	60.5	39.4	254.0
	% of Group	25.6%	43.7%	19.7%	11.0%	100%
	% of Total	12.3%	21.0%	9.5%	5.3%	48.0%
Total	Total count	94	227	126	82	529
	% of Total	17.8%	42.9%	23.8%	15.5%	100%
X^2=26.715, df=3, p=.000, V=.225, Strength of association=Moderate						
Group	*Services Provided: Individual counseling*	*Included CT in counseling (n=529)*				
		Never	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	73	183	115	81	452
	Expected count	80.3	194.0	107.7	70.1	452.0
	% of Group	16.2%	40.5%	25.4%	17.9%	100%
	% of Total	13.8%	34.6%	21.7%	15.3%	85.4%
No	Count	21	44	11	1	77
	Expected count	13.7	33.0	18.3	11.9	77.0

	% of Group	27.3%	57.1%	14.3%	1.3%	100%
	% of Total	4.0%	8.3%	2.1%	.2%	14.6%
Total	Total count	94	227	126	82	529
	% of Total	17.8%	42.9%	23.8%	15.5%	100%
X^2=23.998, df=3, p=.000, V=.213, Strength of association=Moderate						

Table 16

Crosstabulation: Significant Associations for Demographics x Research Question Three (#15 Client requested inclusion of complementary therapy (CT) in counseling)

Group	*State mental health license: LPC*	*15) Client requested inclusion of CT in counseling (n=524)*				
		Never	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	62	116	36	16	230
	Expected count	88.7	103.6	25.9	11.9	230.0
	% of Group	27.0%	50.4%	15.7%	7.0%	100%
	% of Total	11.8%	22.1%	6.9%	3.1%	43.9%
No	Count	140	120	23	11	294
	Expected count	113.3	132.4	33.1	15.1	294.0
	% of Group	47.6%	40.8%	7.8%	3.7%	100%
	% of Total	26.7%	22.9%	4.4%	2.1%	56.1%
Total	Total count	202	236	59	27	524
	% of Total	38.5%	45.0%	11.3%	5.2%	100%
X^2=22.556, df=3, p=.000, V=.225, Strength of association=Moderate						
Group	*Current Position: Outpatient Counselor*	*15) Client requested inclusion of CT in counseling (n=524)*				
		Never	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	63	119	37	18	237
	Expected count	90.9	107.2	26.7	12.2	237.0
	% of Group	26.6%	50.2%	15.6%	7.6%	100%
	% of Total	12.0%	22.7%	7.1%	3.4%	45.2%
No	Count	138	118	22	9	287
	Expected count	110.1	129.8	32.3	14.8	287.0
	% of Group	48.1%	41.1%	7.7%	3.1%	100%
	% of Total	26.3%	22.5%	4.2%	1.7%	54.8%
Total	Total count	201	237	59	27	524
	% of Total	38.4%	45.2%	11.3%	5.2%	100%
X^2=30.308, df=3, p=.000, V=.240, Strength of association=Moderate						
Group	*Work Setting: K-12*	*15) Client requested inclusion of CT in counseling (n=524)*				

		Never	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	55	24	4	1	84
	Expected count	32.4	38.0	9.3	4.3	84.0
	% of Group	65.5%	28.6%	4.8%	1.2%	100%
	% of Total	10.5%	4.6%	.8%	.2%	16.0%
No	Count	147	213	54	26	440
	Expected count	169.6	199.0	48.7	22.7	440.0
	% of Group	33.4%	48.4%	12.3%	5.9%	100%
	% of Total	28.1%	40.6%	10.3%	5.0%	84.0%
Total	Total count	202	237	58	27	524
	% of Total	38.5%	45.2%	11.1%	5.2%	100%
X^2=31.595, df=3, p=.000, V=.246, Strength of association=Moderate						
Group	*Work Setting: Private practice/Self-employed*	*15) Client requested inclusion of CT in counseling (n=524)*				
		Never	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	32	92	33	18	175
	Expected count	67.5	79.2	19.4	9.0	175.0
	% of Group	18.3%	52.6%	18.9%	10.3%	100%
	% of Total	6.1%	17.6%	6.3%	3.4%	33.4%
No	Count	170	145	25	9	349
	Expected count	134.5	157.8	38.6	18.0	349.0
	% of Group	48.7%	41.5%	7.2%	2.6%	100%
	% of Total	32.4%	27.7%	4.8%	1.7%	66.6%
Total	Total count	202	237	58	27	524
	% of Total	38.5%	45.2%	11.1%	5.2%	100%
X^2=58.955, df=3, p=.000, V=.335, Strength of association=Moderate						
Group	*Services Provided: Family/couples counseling*	*15) Client requested inclusion of CT in counseling (n=526)*				
		Never	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	74	141	40	19	274
	Expected count	105.7	123.5	30.7	14.1	274.0
	% of Group	27.0%	51.5%	14.6%	6.9%	100%
	% of Total	14.1%	26.8%	7.6%	3.6%	52.1%
No	Count	129	96	19	8	252
	Expected count	97.3	113.5	28.3	12.9	252.0
	% of Group	51.2%	38.1%	7.5%	3.2%	100%
	% of Total	24.5%	18.3%	3.6%	1.5%	47.9%
Total	Total count	203	237	59	27	526
	% of Total	38.6%	45.1%	11.2%	5.1%	100%

X^2=34.542, df=3, p=.000, V=.256, Strength of association=Moderate						
Group	*Services Provided: Individual counseling*	*15) Client requested inclusion of CT in counseling (n=526)*				
		Never	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	156	210	58	26	450
	Expected count	173.7	202.8	50.5	23.1	450.0
	% of Group	34.7%	46.7%	12.9%	5.8%	100%
	% of Total	29.7%	39.9%	11.0%	4.9%	85.6%
No	Count	47	27	1	1	76
	Expected count	29.3	34.2	8.5	3.9	76.0
	% of Group	61.8%	35.5%	1.3%	1.3%	100%
	% of Total	8.9%	5.1%	.2%	.2%	14.4%
Total	Total count	203	237	59	27	526
	% of Total	38.6%	45.1%	11.2%	5.1%	100%
X^2=24.518, df=3, p=.000, V=.216, Strength of association=Moderate						
Group	*Theoretical Orientation: Psychodynamic*	*15) Client requested inclusion of CT in counseling (n=527)*				
		Never	Less than one-third	One-third to two-thirds	More than two-thirds	Total
Yes	Count	23	63	22	7	115
	Expected count	44.3	51.9	12.9	5.9	115.0
	% of Group	20.0%	54.8%	19.1%	6.1%	100%
	% of Total	4.4%	12.0%	4.2%	1.3%	21.8%
No	Count	180	175	37	20	412
	Expected count	158.7	186.1	46.1	21.1	412.0
	% of Group	43.7%	42.5%	9.0%	4.9%	100%
	% of Total	34.2%	33.2%	7.0%	3.8%	78.2%
Total	Total count	203	238	59	27	527
	% of Total	38.5%	45.2%	11.2%	5.1%	100%
X^2=24.653, df=3, p=.000, V=.216, Strength of association=Moderate						

Table 17

Crosstabulation: Significant Associations for Demographics x Research Question Four (#10 Complementary therapy (CT) modalities qualified to discuss)

Group	*Work Setting: Private practice/ Self-employed*	*10) CT modalities qualified to discuss*				
		None	Acu puncture	Aroma therapy	Art Therapy	Ayurveda
Yes	Count	10	32	29	52	6
	Expected count	61.8	21.6	22.8	48.4	4.1

	% of Group	1.0%	3.1%	2.8%	5.1%	.6%
	% of Total	.4%	1.3%	1.1%	2.1%	.2%
No	Count	142	21	27	67	4
	Expected count	90.2	31.4	33.2	70.6	5.9
	% of Group	9.5%	1.4%	1.8%	4.5%	.3%
	% of Total	5.6%	.8%	1.1%	2.7%	.2%
Total	Total count	152	53	56	119	10
	% of Total	6.0%	2.1%	2.2%	4.7%	.4%
Group		Breath work	Dance Therapy	Diet	Exercise	Guided Imagery
Yes	Count	58	23	96	119	109
	Expected count	62.2	19.1	93.9	123.2	115.5
	% of Group	5.7%	2.2%	9.4%	11.6%	10.6%
	% of Total	2.3%	.9%	3.8%	4.7%	4.3%
No	Count	95	24	135	184	175
	Expected count	90.8	27.9	137.1	179.8	168.5
	% of Group	6.3%	1.6%	9.0%	12.3%	11.7%
	% of Total	3.8%	1.0%	5.4%	7.3%	6.9%
Total	Total count	153	47	231	303	284
	% of Total	6.1%	1.9%	9.2%	12.0%	11.3%
Group		Healing Touch	Herbs	Home opathy	Magnetic Therapy	Med itation
Yes	Count	32	21	14	4	94
	Expected count	22.8	16.3	9.4	3.7	93.5
	% of Group	3.1%	2.0%	1.4%	.4%	9.2%
	% of Total	1.3%	.8%	.6%	.2%	3.7%
No	Count	24	19	9	5	136
	Expected count	33.2	23.7	13.6	5.3	136.5
	% of Group	1.6%	1.3%	.6%	.3%	9.1%
	% of Total	1.0%	.8%	.4%	.2%	5.4%
Total	Total count	56	40	23	9	230
	% of Total	2.2%	1.6%	.9%	.4%	9.1%
Group		Music Therapy	Naturo pathy	Prayer	Qigong	Reiki
Yes	Count	29	10	98	8	19
	Expected count	32.1	7.7	104.1	5.7	18.3
	% of Group	2.8%	1.0%	9.6%	.8%	1.9%
	% of Total	1.1%	.4%	3.9%	.3%	.8%
No	Count	50	9	158	6	26
	Expected count	46.9	11.3	151.9	8.3	26.7
	% of Group	3.3%	.6%	10.6%	.4%	1.7%
	% of Total	2.0%	.4%	6.3%	.2%	1.0%

Total	Total count	79	19	256	14	45
	% of Total	3.1%	.8%	10.1%	.6%	1.8%
Group						
		Vitamins	Yoga	Other	Total	
Yes	Count	43	49	25	1026	
	Expected count	33.8	40.7	22.8	1026.0	
	% of Group	4.2%	4.8%	2.4%	100%	
	% of Total	1.7%	1.9%	1.0%	40.7%	
No	Count	40	51	31	1497	
	Expected count	49.2	59.3	33.2	1497.0	
	% of Group	2.7%	3.4%	2.1%	100%	
	% of Total	1.6%	2.0%	1.2%	59.3%	
Total	Total count	83	100	56	2523	
	% of Total	3.3%	4.0%	2.2%	100%	
X^2=113.732, df=23, p=.000, V=.212, Strength of association=Moderate						

To increase understanding, the strength of association values from tables 9 to 17 were condensed into one table. Table 18 provides crosstabulation values (Cramer's V, X^2, df) sorted by strength of association (primarily) and X^2 (secondarily). Examination of the crosstabulations with significant and moderate strength of associations from Table 18, indicated that the five largest strength of associations were found for "Work setting-Private practice/Self-employed" x "Client requested inclusion of complementary therapy in counseling" (V=.335), "State mental health license-None" x "Provided client with a specific referral for complementary therapy" (V=.304), "Work setting-Private practice/Self-employed" x "Client voluntarily brought up use of complementary therapy" (V=.299), "Work setting-Private practice/Self-employed" x "Provided client with a specific referral for complementary therapy" (V=.291), and "Work setting-Private practice/Self-employed" x "Counselor asked client about use of complementary therapy" (V=.289). The values in the first half of the table were deemed especially important for further consideration.

From this perspective, it is clear that the "Work setting-Private practice/Self-employed" independent variable stands out for having five out of the six largest Cramer's V values. In addition, "State mental health license-None" (V=.304 and .240, respectively) and "State mental health license-LPC" (V=.261 and .225, respectively) are notable for having two-thirds of their Cramer's V values in the top 50th percentile (i.e., largest 22 strength of associations). Continuing, the "Position-Outpatient counselor" had four of its

seven Cramer's V values in the top 50th percentile. "Services provided-Individual counseling" had only two of six Cramer's V values in the top 50th percentile, and "Work setting-K-12 setting" included Cramer's V values in top 22 Cramer's V values in just two of five cases.

Further, "Services provided-Family/couples counseling" also produced Cramer's V values in the top 50th percentile in just two of five cases, while "Services provided-Alcohol/Substance abuse counseling" only contained one of three cases in the top 22 Cramer's V values. Finally, only one of two potential values were located in the top 50th percentile for "Position-Graduate student (Master's)", while "Theoretical Orientation-Psychodynamic" had none of its two values placed in the top 50th percentile of results.

Table 18

Crosstabulation: Ordered by Strength of Association (Cramer's V)

Crosstabulation (row **X** column)***	Cramer's V	X^2	df
*Work Setting: Private practice/Self-employed **X** 15)Client requested inclusion of CT in counseling*	.335	58.955	3
*State mental health license: None **X** 21)Provided client with a specific referral for CT*	.304	48.192	3
*Work Setting: Private practice/Self-employed **X** 2)Client voluntarily brought up their use of CT*	.299	47.083	3
*Work Setting: Private practice/Self-employed **X** 21)Provided client with a specific referral for CT*	.291	44.325	3
*Work Setting: Private practice/Self-employed **X** 1)Counselor asked client about use of CT*	.289	44.408	3
*Work Setting: Private practice/Self-employed **X** 14)Included CT in counseling*	.266	37.176	3
*State mental health license: LPC **X** 21)Provided client with a specific referral for CT*	.261	35.631	3
*Current Position: Outpatient Counselor **X** 19)Client requested recommendation or referral for CT*	.259	35.362	3
*Services Provided: Family/couples counseling **X** 15)Client requested inclusion of CT in counseling*	.256	34.542	3
*Current Position: Outpatient Counselor **X** 21)Provided client with a specific referral for CT*	.255	33.898	3
*Services Provided: Individual counseling **X** 2)Client voluntarily brought up their use of CT*	.252	33.581	3
*Work Setting: K-12 **X** 15)Client requested inclusion of CT in counseling*	.246	31.595	3
*Services Provided: Individual counseling **X** 1)Counselor asked client about use of CT*	.245	31.818	3
*Work Setting: Private practice/Self-employed **X***	.245	31.527	3

19)Client requested recommendation or referral for CT			
Current Position: Master's student ***X*** *21)Provided client with a specific referral for CT*	.245	31.237	3
State mental health license: None ***X*** *14)Included CT in counseling*	.240	30.441	3
Current Position: Outpatient Counselor ***X*** *15)Client requested inclusion of CT in counseling*	.240	30.308	3
Current Position: Outpatient Counselor ***X*** *1)Counselor asked client about use of CT*	.234	29.107	3
Services Provided: Family/couples counseling ***X*** *14)Included CT in counseling*	.225	26.715	3
State mental health license: LPC ***X*** *15)Client requested inclusion of CT in counseling*	.225	22.556	3
Services Provided: Alcohol/SA counseling ***X*** *22)Client concerns for which recommended or referred for CT*	.224	83.838	10
Work Setting: K-12 ***X*** *1)Counselor asked client about use of CT*	.223	26.383	3
Current Position: Outpatient Counselor ***X*** *2)Client voluntarily brought up their use of CT*	.222	25.909	3
Work Setting: K-12 ***X*** *2)Client voluntarily brought up their use of CT*	.220	25.447	3
State mental health license: None ***X*** *1)Counselor asked client about use of CT*	.218	25.196	3
Theoretical Orientation: Psychodynamic ***X*** *15)Client requested inclusion of CT in counseling*	.216	24.653	3
Current Position: Outpatient Counselor ***X*** *20)Recommended CT without providing a referral*	.216	24.570	3
Services Provided: Individual counseling ***X*** *15)Client requested inclusion of CT in counseling*	.216	24.518	3
Services Provided: Individual counseling ***X*** *22)Client concerns for which recommended or referred for CT*	.215	77.385	10
State mental health license: LPC ***X*** *14)Included CT in counseling*	.215	24.252	3
Services Provided: Individual counseling ***X*** *14)Included CT in counseling*	.213	23.998	3
Work Setting: K-12 ***X*** *21)Provided client with a specific referral for CT*	.213	23.769	3
Work Setting: Private practice/Self-employed ***X*** *10)CT modalities qualified to discuss*	.212	113.732	23
Services Provided: Family/couples counseling ***X*** *1)Counselor asked client about use of CT*	.211	23.644	3
Work Setting: Private practice/Self-employed ***X*** *22)Client concerns for which recommended or referred for CT*	.207	71.777	10
Current Position: Outpatient Counselor ***X*** *14)Included CT in counseling*	.207	22.615	3
Services Provided: Family/couples counseling ***X***	.206	22.545	3

21)Provided client with a specific referral for CT			
*Services Provided: Family/couples counseling **X** 2)Client voluntarily brought up their use of CT*	.203	21.677	3
*Current Position: Master's student **X** 19)Client requested recommendation or referral for CT*	.201	21.163	3
*Theoretical Orientation: Psychodynamic **X** 1)Counselor asked client about use of CT*	.200	21.290	3
*Services Provided: Alcohol/Substance abuse counseling **X** 1)Counselor asked client about use of CT*	.200	21.258	3
*Work Setting: K-12 **X** 22)Client concerns for which recommended or referred for CT*	.199	66.502	10
*Services Provided: Alcohol/Substance abuse counseling **X** 14)Included CT in counseling*	.199	21.203	3
*Services Provided: Individual counseling **X** 19)Client requested recommendation or referral for CT*	.199	21.011	3

***Note: p=.000 for all results.

Summary

Chapter four summarized the results of the research study. First, an overview of the overall response rate was discussed. Then descriptive statistics were provided for demographics corresponding to ACA categories. In addition, the representativeness of the sample in comparison with ACA demographics was assessed. The remaining study demographics were then described.

Descriptive results and analysis were used to answer each research question. Arithmetic means were provided for all categories of ordinal data in order to provide additional details and information. Calculation of crosstabulations was used to assess the independence of row and column variables and provide measures of statistical association. Tables consisting of actual and expected counts and statistics of association were provided for results indicative of both a significant and moderate strength of associations. Tables were grouped according to the respective research questions.

CHAPTER FIVE

DISCUSSION AND RECOMMENDATIONS

This chapter summarizes and discusses the findings of the study. First, an overview of research participants is provided. Then, the results are discussed with respect to each research question, with implications from the literature. The limitations of the study and recommendations emerging from the study are then presented. Finally, a summary is given.

Profile of Participants

The typical respondent to the survey was female (77%), Caucasian (84%) and hold a Master's (61%) as their highest earned degree. They have an income between $40,000 and 59,999 (21%), earned from work as an outpatient counselor (37%) in a private practice/self-employed (28%) or community agency (25%) setting. Respondents may also earn below $12,500 (25%), as a master's student (24%) in a college/university (24%) setting. Somewhat fewer, but a still significant number of respondents work in K-12 setting (16%), probably as a school counselor (15%).

The external validity of the sample was examined through comparison of the survey demographics with the equivalent ACA statistics. The sample was found to closely represent ACA demographics with regards to race/ethnicity. On the other hand, the results suggest that the sample does not correspond to ACA membership according to highest degree, gender, salary, work setting and position.

Table 2 shows the differences between the sample (i.e., Observed N(f)) and the ACA population (i.e., Expected N(f)). A significant difference was there were 5.5% more females than males in the sample (78.9%) versus the ACA population (73.4%). In addition, respondents making less than $40,000 annually outnumber those reported by ACA by almost eight percentage points, while the differences at the income level of $60,000 and above were 2.5% in favor of ACA members. Over eight percent more of respondents have only a Bachelor's degree as compared to ACA membership. On the other hand, more ACA members have earned a Master's degree (71% vs. 63%) or Doctorate degree (18.5% vs. 12.1%) in comparison to respondents. Further, over 18% more survey respondents reported being a student as opposed to the ACA membership. Finally, work setting was more commonly a community agency (25.1% vs. 14.1%)

college/university (24.5% vs. 19.1%), or the now familiar “Other” setting (21.1% vs. 7.6%) when comparing respondents to the ACA population.

One possible explanation for the discrepancies between these two populations may be the greater number of students in the survey sample as compared to ACA. It seems reasonable that students have not finished their terminal (practitioner) degree, earn less income and work in a wider variety of settings.

Additional demographic data indicated that respondents are most likely to be between 45 and 54 years of age (27.9%) and hold no state mental health license (49.6%) or National Certified Counselor credential (64.7%). Respondents are relatively new (0-6 years) to counseling (59.2%), and see less than six clients per week (28.9%). Respondents reported that they most frequently provide individual therapy (70.2%), frequently from a cognitive-behavioral theoretical perspective (70.3%).

In concluding this section, it is interesting to note the congruence between respondent demographics and those factors reported in chapter two as being consistently associated with the use of complementary therapy. Studies correlating the use of complementary therapy with being female, Caucasian, ages 35 to 64, having a higher socioeconomic status and being college educated are in agreement with the typical respondent to this survey (Astin, 1998; Eisenberg, et al., 1993, 1998; Paramor, 1996; Unutzer et al., 2000). However, allowance does need to be made for the significant number of survey respondents claiming student status.

Overview of Findings

The six research questions provide a logical platform for discussion of the results of the study. Implications from the literature provide an additional context for the present research.

Research Question One

Research question one considered respondents’ inquiries and clients’ disclosures of clients’ complementary therapy use. Respondents answered in this matter via survey questions 1 to 5.

It is clear from the responses to survey question 1 that few respondents asked their clients about clients’ use of complementary therapy. In fact, almost half of respondents (46.4%) asked less than one-third of their clients specifically about their use of

complementary therapy. This included a significant number of respondents (27.5%) that asked none of their clients about clients' use of complementary therapy. These findings are congruent with the literature, which reported that broaching the subject of clients' complementary therapy use was a challenge for caregivers (Haller, 2001).

Along the same lines, the minority of clients voluntarily brought up their use of complementary therapy with respondents, according to the results of survey question 2. Almost 59% of respondents had less than one-third of their clients bring up this issue with them. The literature is clear that clients' are reluctant about sharing their complementary therapy use with their caregivers (Eisenberg, et al., 1993, 1998; Knaudt, et al., 1999). Clearly, this reticence extends to the experiences of respondents with regard to clients' volunteering their use of complementary therapy.

It is discouraging that respondents appear to be similar to other professional caregivers who tended to dramatically underestimate their clients use of complementary therapy (Baumrucker, 2002). Given that over 50% of mental health clients with common disorders reported using complementary therapy in the past year (Kessler, et al., 2001), the present study suggests that over half of respondents are unaware of their clients' complementary therapy use (i.e., 17.4% who had no clients' volunteer use and 41.9% who had less than one-third of clients' volunteer use). Counselors would be wise to question this two-way lack of communication as it is in stark contrast with professional viewpoints of client-centeredness (Glauser & Bozarth, 2001).

Respondents reported via survey question 3 that clients were most likely to have used the complementary therapies of "Exercise" (60.1%), "Prayer" (51.8%) and/or "Diet" (45.8%). These three categories were reported, on average, by over half of clients. These findings are encouraging given the substantial and compelling research supporting the efficacy of both exercise (Ernst, et al., 1998) and diet (Miller, 1996) in the treatment of mental illness.

Over 65% of respondents attributed at least "Some positive effect" to their clients' use of complementary therapy (survey question 4). On the other hand, almost as many respondents (58.7%) reported there were "No" or only "Slight negative effects" from their clients' use of complementary therapy (survey question 5). In addition, less than 4% of respondents credited complementary therapy with only a "Slight positive effect" and

no respondents cited “No positive effects”. Likewise, only 2% of respondents claimed “Slight negative effects” from their clients’ use of complementary therapy, while only one respondent reported a “Great negative effect”. In essence, respondents are reporting that for the majority of their clients complementary therapy provides at least some positive and few negative consequences.

The proportion of respondents reporting positive client responses are in line with pertinent research concerning psychiatric patients’ responses to complementary therapy (Kessler, et al., 2001; Knaudt, et al., 1999). In contrast, there was no direct corollary found in the literature addressing negative outcomes resulting from the use of complementary therapy.

Research Question Two

This research question explored respondents’ complementary therapy recommendation and referral patterns. Survey questions 19 to 24 were employed to address these concerns.

For most respondents (61.9%), less than one-third of their clients specifically requested a recommendation or referral for complementary therapy, according to survey question 19. This result is in line with research, which showed that client requests are one of the most important determinants of caregiver complementary therapy referral patterns (Berman, et al., 1999).

Similarly, 58.5% respondents recommended complementary therapy without providing a specific referral to less than one-third of their clients, according to data from survey question 20. Furthermore, the data from survey question 21 showed that less than 10% of respondents provided their clients with a specific referral for complementary therapy more than one-third of the time. The corollary to this statistic is that 70% of the time less than one-third of clients were given a specific referral for complementary therapy.

In other words, clients infrequently asked for complementary therapy recommendations or referrals, while respondents only occasionally recommended, and even less frequently, specifically provide a referral for complementary therapy. These results are interesting when compared with reports that greater than 60% of physicians made at least one complementary therapy referral in the past year (Borkan, et al., 1994).

Anxiety (52.7%) and depression (51.6%) were by far the most common client concerns which prompted respondents to recommend or refer for complementary therapy, according to survey question 22. Several researchers have reported similar frequencies for complementary therapy usage in clients with anxiety disorders and depression (Kessler, et al., 2001; Unutzer, et al., 2000). It makes sense that if, as Borkan, et al. (1994) established, referrals are generally based on client requests, then the referral patterns for client concerns in this study are in line with client usage.

Respondents' answers to survey question 23 regarding reasons for not recommending or referring complementary therapy were fairly evenly divided among "Has not come up as a client concern" (32.4%), "Client discomfort with complementary therapy" (28.6%), "Lack of knowledge and/or training in complementary therapy" (26.5%) and "Not sure who to refer to" (26.2%). It is not surprising that "Has not come up as a client concern", was the most common negative attribution for referrals, given it was previously established that the majority of clients do not bring up their complementary therapy usage. It also makes sense that clients would express "discomfort" with complementary therapy if they are not bringing this issue up and respondents are not asking. Eisenberg (1997) provided a strong admonishment against the medical profession's "don't ask, don't tell" policy that has distinguished physician-patient communication in this matter.

Concerns about "Lack of knowledge and/or training in complementary therapy" echo Berman et al.'s (1999) report that physicians were more likely to provide referrals for modalities in which they had training. It therefore seems obvious that a lack of training (or knowledge) would emerge as a primary determinant for respondents not recommending or referring clients for complementary therapy. In fact, Bassman and Uellendahl (2003) attributed much of the scarcity of therapists integrating complementary therapies into their practice to a lack of training.

The "Not sure who to refer to" category may be indicative of a "gap" between counselors and the complementary therapy community. A similar disengagement has been reported between physicians and complementary therapy practitioners (Mainous, et al., 2000).

On the other hand, it is encouraging that "Lack of research" (6.1%) and "Poor acceptance by profession" (3.0%) were not deemed significant barriers to referring clients for complementary therapy. This may indicate that respondents are more open than other caregivers to complementary interventions.

Lastly, respondents overwhelmingly reported (65.1%) in answering survey question 24 that it was somewhat to very important that client referrals for complementary therapy be to licensed or certified practitioners. This is congruent with the expectations that counselors place on their own professional credentials and identity (Glauser & Bozarth, 2001; Magnuson, 2000; McAuliffe & Eriksen, 1999).

Bassman and Uellendahl (2003) offer a succinct summary of the challenge complementary therapy referrals present for counselors. They said, "Because so few psychotherapists have training in alternative healing arts, the process of referral to qualified practitioners is crucial" (p. 267).

Research Question Three

This research question surveyed respondents concerning their inclusion patterns for complementary therapy in the practice of counseling. Survey questions 14 to 18 were employed in this informational quest. Unfortunately, few comparable studies were found in the literature corresponding to the concerns of this research question.

According to responses to survey question 14, the majority of respondents (66.6%) included complementary therapy in their practice of counseling with at least one client during the past year. However, many respondents (12.5%) included complementary therapy with greater than two-thirds of their clients. As a corollary, a survey of 1000 members of the American Psychological Association, found that indeed it was quite infrequent for practitioners to include the direct use of complementary therapy in their practice, although the researchers failed to provide specific data (Bassman & Uellendahl, 2003).

Responses to survey question 15 indicated that the majority of clients (67.1%) did not request the inclusion of complementary therapy in their counseling. Once again, it is clear that respondents and their clients often lack open communication regarding complementary therapy – whether this impasse involves issues of usage, referral or inclusion (see also research questions one and two).

Survey question 16 asked respondents to cite any complementary therapies, which they may have included in their practice of counseling. “Guided Imagery” (40.5%) and “Exercise” (39.3%) were the most frequently mentioned modalities. Following were the complementary therapies of “Diet” (30.3%), “Breathwork” (29.4%), “Meditation” (27.9%), “Prayer” (23.4%), “Art Therapy” (22.4%), and “Music Therapy” (11.9%). No other complementary therapies received double-digit mention. These numbers indicate that for those respondents that do include complementary therapies in their practice of counseling, they are incorporating a diversity of modalities. Finally, it should be noted that in terms of “Never” including or including “None” of complementary therapies in practice, questions 14 and 16 are in basic agreement (n=94 vs. n=97).

Responses to question 17 indicated that respondents were most likely motivated to include complementary therapy in their counseling work by “Congruence with beliefs about client change” (43.2%) and “Personal experience with complementary therapy” (38.5%). These responses are encouraging that respondents may be actively embracing (i.e., including) the holistic foundation of counseling, as it is aligns with complementary therapy (Myers, 1992; Shannon, 2002; Witmer & Sweeney, 1992).

Survey question 18 also provided additional evidence that counselors are consciously moving toward a more holistic mode of practice. In sharing their beliefs about the inclusion of complementary therapy, most respondents (59.5%) reported that complementary therapy should be included in addition to counseling. Less than 1% of respondents felt that complementary therapy should be included in lieu of counseling. Respondents are essentially saying that counseling and complementary therapy well, “complement” one another – neither should be exclusive nor eliminated. Fear and Woolfe (1996) posited that, “perhaps the counsellor’s striving for theoretical integration reflects the central, if unconscious, therapeutic goal of each and every one of our clients” (p. 410).

Research Question Four

This research question explored respondents’ knowledge and training in complementary therapy. Survey questions 10 through 13 addressed these concerns. Responses may be considered exploratory, based on the fact that the literature lacks data affording useful comparisons.

Respondents indicated via survey question 19 that they were most qualified to discuss “Exercise” (46.9%), “Guided Imagery” (43.7%), “Prayer” (39.9%), “Diet” (35.3%) and “Meditation” (23.6%). Interestingly, these responses closely parallel the answers to survey question 14, concerning which complementary therapies respondents have included in counseling (i.e., “Guided Imagery” (40.5%), “Exercise” (39.3%), “Diet” (30.3%), “Breathwork” (29.4%), “Meditation” (27.9%) and “Prayer” (23.4%), respectively).

Not surprisingly, few respondents possessed licensure or certification in complementary therapy. For those respondents that did indicate having a license or certification, “Reiki” (3.7%), “Meditation” (2.3%) and “Guided Imagery” (2.3%) were most common. However, these were the only modalities receiving a greater than 2% response frequency and amounted to only 54 respondents. In fact, the overwhelming majority of respondents (79.9%) indicated they hold no license or certification in complementary therapy. While some medical professionals have begun to acquire dual credentials (e.g., medical acupuncture), apparently few counselors are willing (or able), to make this commitment.

Regarding sources of knowledge or training in complementary therapy (survey question 12), “Books” (62.3%), “Personal experience with complementary therapy” (47.8%), Colleagues” (43.1%) and the “Internet” (42.0%) were most commonly mentioned. These responses indicate a trend of informal, self-study by respondents to gain additional proficiency in complementary therapy. The responses to the categories of “Workshops” (33.6%) and “Training/education program” (22.3%) are discouraging for counselor education, given the tremendous interest in developing formal complementary therapy curricula within medical education (Bhattacharya, 2000; Wetzel, et al., 1998, 2003).

Finally, according to research question 13, respondents most likely want additional knowledge or training in “Art Therapy” (41.7%), “Guided Imagery” (38.2%), “Meditation” (33.0%), “Music Therapy” (29.2%) and/or “Breathwork” (28.2%). Interestingly, much fewer respondents indicated they would like additional proficiency in the (more) medically oriented modalities of “Acupuncture” (11.4%), “Ayurveda” (9.4%), “Herbs” (13.4%), “Homeopathy” (10.8%) or “Naturopathy” (10.4%).

Research Question Five

This research question explored respondents' personal experiences with complementary therapy via survey question 6 to 9. These responses continue to provide a baseline of data that has been relatively unaccounted for in previous research.

Responses to research question 6 showed that "Exercise" (79.8%), "Diet" (62.6%), "Massage" (62.3%), "Guided Imagery" (61.3%), "Prayer" (58.4%) and/or "Meditation" (56.3%) were the most frequent personally experienced complementary therapies. In addition, 94.5% of respondents have personally experienced at least one complementary therapy.

One related research study was found, which reported on personal use of alternative medicine by health science center faculty (Burg, et al., 1998). In this study, massage (32%), relaxation techniques (24%), dietary supplements (23%) and chiropractic (16%) were most frequently reported as having been personally used. In comparison, respondents to the present study were more likely to have personal experience with complementary therapy. Perhaps counselors are less likely to subscribe to the medical profession's emphasis on "the scientific" as the ultimate determinant of a therapy's legitimacy or usefulness (Baumrucker, 2002; Caspi, et al., 2000; Grollman, 2001; Marcus, 2001)

Respondents most recently personally experienced the complementary therapies of "Prayer" (19.6%), "Exercise" (16.7%) or "Massage" (12.5%), according to survey question 7. Responses to question 8 indicated that respondents' reason for their most recent personal experience with complementary therapy was overwhelmingly "To improve overall wellness" (70.9%). Finally, most respondents (87.4%) to survey question 9 reported receiving "Some" to "Large benefits" from their most recent use of complementary therapy.

In summary, it seems that the majority of respondents are employing relatively easily accessed complementary therapies in their own lives and reporting successful outcomes. In addition, respondents are using complementary therapy to improve their overall wellness, versus a focus on a specific mental or physical health concern. They are also employing modalities that may be considered part of a basic self care strategy and to a large degree do not require professional intervention/practitioners (excepting massage).

Respondents find they receive at least some, and often large, benefits from their personal experience with complementary therapy.

Research Question Six

This research question examined whether there were any associations across demographic variables and research questions 1 to 5. Crosstabulations were conducted for all possible combinations of demographic (dependent/row) variables and research questions 1 through 5 (independent/column) variables.

The significant dependent variables are divided into, client usage, recommendation and referral, inclusion, and knowledge factors, aligned along research questions 1 to 4. Note that there were no significant associations for dependent variables that addressed research question five (personal experience factors).

Client usage factors include "Counselor asked client about use of complementary therapy". *Recommendation and referral pattern factors* comprise "Provided client with a specific referral for complementary therapy", "Client voluntarily brought up use of complementary therapy", "Client requested a recommendation or referral for complementary therapy", "Client concerns for which recommended or referred for complementary therapy" and "Recommended complementary therapy without providing a referral". *Inclusion factors* are "Included complementary therapy in counseling" and "Client requested inclusion of complementary therapy". *Knowledge factors* include "Complementary therapy modalities qualified to discuss".

Significant associations are grouped according to a "pattern of difference" between the actual and expected counts. There was a distinct positive or negative difference between the actual and expected counts depending on the degree of respondents' (greater or lesser) involvement/interaction with complementary therapy.

Positive associations emerged for the independent variables, "Work setting-Private practice/Self-employed", "Position-Outpatient counselor", "Services provided-Individual counseling", "Services provided-Family/couples counseling", "Services provided-Alcohol/Substance abuse counseling" "Mental health license-LPC" and "Theoretical Orientation-Psychodynamic". Negative associations emerged for the independent variables "Work setting-K-12 setting", "Mental health license-None", and "Position-Graduate student (Master's)".

For example, examination of the positive association for the crosstabulation "Work setting-Private practice/Self-employed" x "Client voluntarily brought up their use of complementary therapy" (see Table 10) shows that the actual count of "None" is half of the expected count (19 vs. 37.8). Moving "up" this scale, the actual counts increase in (positive) proportion to the expected counts, until the actual counts are nearly double the expected counts (28 vs. 14.4) for the scale response of "More than two-thirds".

On the other hand, examination of the negative association for the crosstabulation "Work setting-K-12 setting" x "Client voluntarily brought up their use of complementary therapy" (see Table 10) shows that the actual count of "None" is almost 1.9 times the expected count (34 vs. 18.0). Continuing "up" this scale, the actual counts decrease in (negative) relation to the expected counts until the actual counts are only 30% of the expected counts (2 vs. 6.9) for the "More than two-thirds" scale.

Further evidence for this pattern comes from the results found in Table 14. This table indicates that the "Private practice/self-employed" respondent provided a recommendation or referral for complementary therapy for "None" of their clients' concerns in less than 25% of expected cases (14 vs. 54.9). Meanwhile, respondents in K-12 settings provided a recommendation or referral for complementary therapy for "None" of their clients' concerns at more than 2.3 times the expected counts (36 vs. 15.6).

Crosstabulations possessing the largest Cramer's V values are examined next. It was pointed out in chapter four that the row/independent variable of "Work setting-Private practice/Self-employed" independent variable stood out for having five out of the six largest Cramer's V values (see Table 18). This variable was moderately associated with client usage, recommendation and referral patterns, inclusion, and knowledge factors. Furthermore, comparison of the expected and actual counts for the variable of "Work setting-Private practice/Self-employed", confirms a consistently positive pattern across all significant associations. This was also the only independent variable significantly associated with knowledge factors. (See Tables 9, 10, 11, 13, 15, 16 and 17.)

One reason for these consistently greater associations may be that counselors who work in private practice, or are otherwise self-employed, simply have more autonomy to integrate complementary therapy in their practice. In addition, practitioners in private practice almost assuredly have greater professional experience,along with which comes

more flexibility and openness to alternative approaches (Glauser & Bozarth, 2001; Miars, 2002).

This positive pattern repeats itself for the variable "Position-Outpatient counselor", although with less differential between the actual and expected counts than for the "Work setting-Private practice/Self-employed" variable. For example, the crosstabulation "Position-Outpatient counselor" x "Client voluntarily brought up their use of complementary therapy" (see Table 10) shows that the actual count of "None" is 64% of the expected count (33 vs. 51.2). Continuing "up" this scale, the actual counts increase in relation to the expected counts until the actual counts are almost 1.5 times the expected counts (28 vs. 19.4) for the scale response of "More than two-thirds". Lastly, this variable was moderately associated with client usage, recommendation and referral patterns, and inclusion factors.

This positive association may be explained by the fact that the majority of respondents may be considered to be effectively working in an outpatient position, since less than 5% reported working in an inpatient position. This leads to the conclusion that the "Position-Outpatient counselor" variable may be redundant and is included within other associations.

For the "Services provided-Individual counseling" variable, the positive pattern of association remained constant, although the differential between actual and expected counts again decreased. This variable was also moderately associated with client usage, recommendation and referral, and inclusion factors.

For example, the crosstabulation "Services provided-Individual counseling" x "Client voluntarily brought up their use of complementary therapy" (see Table 10) shows that the actual count of "None" is 81% of the expected count (79 vs. 96.9). At the other end of the scale, the actual count is 1.1 times the expected count (41 vs. 36.6) for the scale response of "More than two-thirds". The lower differential between the actual and expected counts is reflected in the fact that only two of the six Cramer's V values for "Services provided-Individual counseling" are located in the top 50th percentile of results.

In considering associations related to this variable, note that most respondents (70.2%) reported providing individual counseling services. Therefore, as with the outpatient position above, the provision of individual therapy may be less of a distinct

marker of associations and more properly considered within the context of other associations. In fact, the term, “individual counseling” reflects a redundancy, in that most counseling services (e.g., child/adolescent, family/couples, alcohol/substance abuse) may be individual at times - especially, since the primary “focus” of counseling must usually be assigned to only one person.

The “Services provided-Family/couples counseling” variable maintains the positive pattern of greater involvement in complementary therapy than expected. Once again, this variable was moderately associated with client usage, recommendation and referral, and inclusion factors. Continuing with the same dependent variable (see Table 10), the association between “Services provided-Family/couples counseling” x “Client voluntarily brought up their use of complementary therapy” shows that the actual count of “None” is 64% of the expected count (38 vs. 58.7). Continuing “up” this scale, the actual counts increase in relation to the expected counts until the actual counts are 1.3 times the “More than two-thirds” expected counts (29 vs. 22.2). This association may be partially explained by the family therapy tradition of eclectic and “complementary” approaches (Napier, 1978; Nichols & Schwartz, 1998).

The variable “Services provided-Alcohol/Substance abuse counseling” was moderately associated with client usage, recommendation and referral, and inclusion factors, in the now familiar positive valence. For example, an examination of the crosstabulation “Services provided-Alcohol/Substance abuse counseling” x “Counselor asked client about use of complementary therapy” (see Table 9) shows that the actual count of “None” is only 59% of the expected count (25 vs. 42.3). Continuing “up” this scale, the actual counts increase in relation to the expected counts until the actual counts are over 1.3 times the expected counts (49 vs. 37.4) for the “More than two-thirds” scale. The well-known low rates of success and significant recidivism associated with alcohol and substance abuse counseling may encourage greater openness to complementary therapy approaches (Meng, Luo & Halbreich, 2002).

The “Mental health license-LPC” variable persists with the initially established positive pattern of increasing involvement with complementary therapy. However, the differential continues to remain lower than for the conspicuous “Work setting-Private practice/Self-employed” variable. An examination of the crosstabulation “Mental health

license-LPC" and "Provided client with a specific referral for complementary therapy" (see Table 13) shows that the actual count of "None" is only 70% of the expected count (78 vs. 111.0). Continuing "up" this scale, the actual counts increase in relation to the expected counts until the actual counts are over 1.6 times the expected counts (10 vs. 6.2) for the "More than two-thirds" scale.

This variable was moderately associated with both recommendation and referral and inclusion factors. Along the same lines as the "Work setting-Private practice/Self-employed" variable, these positive associations may be shaped by the greater professional experience of LPC's. Once again, increased autonomy may contribute to greater openness to inclusion and referrals for complementary therapy (Bien, 2004).

Finally, the "Theoretical Orientation-Psychodynamic" variable continues the positive pattern of greater than expected involvement in complementary therapy. This variable was moderately associated with client usage and inclusion factors. The association between "Theoretical Orientation-Psychodynamic" x "Client requested inclusion of complementary therapy" (see Table 16) shows that the actual count of "None" is just over 50% of the expected count (23 vs. 44.3). The actual counts then increase in relation to the expected counts until the actual counts are almost 1.2 times the "More than two-thirds" expected counts (7 vs. 5.9). This positive association may be related to the historical involvement of psychodynamic oriented pracitioners with complementary therapies, especially body-centered approaches (Bridges, 2002; Miller, 2000).

For the "Work setting-K-12 setting" variable, the previously established pattern is repeated, but this time in a negative manner. In a diminishing sense, this variable was moderately associated with client usage, recommendation and referral, and inclusion factors. For example, the association between "Work setting-K-12 setting" and "Provided client with a specific referral for complementary therapy" (see Table 13) shows that the actual count of "None" is almost 1.5 times the expected count (60 vs. 40.6). Continuing "up" this scale, the actual counts decrease in relation to the expected counts until the actual counts are only 43% of the expected counts (1 vs. 2.3) for the "More than two-thirds" scale. This negative association may be explained in part by increasingly restrictive working conditions found in modern K-12 counseling settings (Beale, 2003).

It was also interesting to note the moderate associations between K-12 based respondents and referrals for Alcohol/Substance abuse (8 vs. 16.8) and Medical concerns (8 vs. 15.0) were at around one-half the expected rate (see Table 14). On the other hand, K-12 respondents were more than twice as likely as expected (29 vs. 13.4) to have recommended or referred for the client concern of ADHD. This result is in keeping with the K-12 environment and its ever-present concerns about student inattentiveness (Brown, 2000; Schwiebert, Sealander, & Dennison, 2002).

For the "Mental health license-None" variable, the negative pattern of less than expected involvement in complementary therapy continues. For example, the association between "Mental health license-None" and "Provided client with a specific referral for complementary therapy" (see Table 13) shows that the actual count of "None" is more than 1.3 times the expected count (154 vs. 114.9). Continuing "up" this scale, the actual counts again decrease in relation to the expected counts until the actual counts are less than 50% of the expected counts (3 vs. 6.4) for the "More than two-thirds" scale. Finally, this variable was moderately associated with client usage, recommendation and referral, and inclusion factors. It seems reasonable that respondents who do not hold any state mental health license would have less practical experience, and therefore, be less likely to embrace a complementary therapy paradigm.

Finally, for the "Position-Graduate student (Master's)" variable, this negative pattern is maintained. For example, the association between "Position-Graduate student (Master's)" and "Provided client with a specific referral for complementary therapy" (see Table 13) shows that the actual count of "None" is greater than 1.5 times the expected count (74 vs. 49.2). Continuing "up" this scale, the actual counts diminish in relation to the expected counts until the actual counts are only 70% of the expected counts (7 vs. 10.0) for the "One-third to two-thirds" scale and actually 0% of the expected counts (0 vs. 2.7) for the "More than two-thirds" scale. This variable was moderately associated with just recommendation and referral factors. Again, it seems logical that respondents enrolled as a Master's degree student have less practical experience, which corresponds with lessened involvement with complementary therapy.

Summary of Findings

There were moderately positive associations between counselors who worked in a private practice/self-employed setting, as an outpatient counselor, were licensed as an LPC, provided individual, family/couples, or alcohol/substance abuse counseling and possessed a psychodynamic perspective. These variables were positively associated with client usage, recommendation and referral, inclusion, and knowledge factors. There were moderately negative associations between counselors who worked in a K-12 setting, did not possess a mental health license, and were a Master's student with client usage, recommendation and referral, and inclusion factors.

Work Setting Matters

It seems reasonable to conclude that among respondents to this study, work setting had the greatest single influence on the existence of significant associations. Specifically, reporting a private practice/self-employed work setting was related to positive associations, while working in a K-12 setting was linked to negative associations.

Mental Health Licensure is Critical

Having, or not having, a mental health license was connected with a divergence in significant associations. Specifically, possessing LPC licensure (or equivalent) led to positive associations, while not possessing a mental health license led to negative associations.

Position, Services Provided and Theoretical Orientation Play Key Roles

Respondents reporting being in the position of an outpatient counselor, provided individual, family/couples, or alcohol/substance abuse counseling, and had a psychodynamic orientation contributed to positive associations. On the other hand, respondents who reported being in the position of a Master's gradute student contributed to negative associations.

Alternative Analysis of Associations

These variables and their corresponding associations may also be categorized according to the degree professional experience and openness to a diversity of therapeutic approaches. Greater or lesser professional experience and openness to a diversity of therapeutic approaches equated with positive or negative associations.

In particular, working in a private practice setting and having LPC licensure (or equivalent) was related to greater professional experience. These two variables were positively associated with client usage, recommendation and referral, inclusion, and knowledge factors. In fact, a private practice work setting was the only variable that was aligned in a significant manner with knowledge factors.

Less clear are positive associations between working as an outpatient counselor andr providing individual counseling services. However, it was proposed earlier that these associations may be redundant and, essentially, incorporated within other associations.

In contrast, being a Master's student and not possessing mental health licensure accorded with less professional experience. Consequently, these variables were negatively associated with client usage, recommendation and referral, and inclusion factors.

It is also clear from the results that respondents' degree of openness to a variety of therapeutic approaches results in greater or lesser associations. Specifically, increased openness to diverse therapeutic approaches was connected with positive associations, whereas decreased openness was related to negative associations

In the case of alcohol and substance abuse counseling, this openness may originate from the necessity of trying to come up with effective interventions for this notoriously difficult clinical population. In addition, the psychodynamic and family/couples traditions are also distinguished by their openness to diverse therapeutic approaches.

Conversely, K-12 work settings are notable for their restrictive work environments and have negative associations with various complementary therapy factors. Note that this lack of openness to nontraditional therapeutic approaches is not necessarily related to professional experience. Finally, a private practice work setting and having LPC licensure (or equivalent) may also be indicative of greater openness to a diversity of counseling approaches.

Implications for Clinical Practice

The present study has significant implications for clinical practice. The use of complementary therapy seems to be reflective of a paradigm shift for the counseling

profession. Along with this shift comes an imperative for counselors to commit to a, "proactive stance in relation to wellness issues" (Meyers, 1992, p. 136).

In this study, respondents who possessed greater professional experience and openness to innovative ways to intervene in clients' problems seem to be embracing this transformation in mental health care. These types of counselors have a unique opportunity, and responsibility, to further the commitment of the profession to holistic change across the lifespan (McAuliffe & Eriksen, 1999).

These paradigm-shifting counselors should be advocates for complementary therapy within the profession and help to inform inexperienced counselors. This may be accomplished in part through the provision of educational opportunities for novice (in terms of complementary therapy experience) counselors. However, it is especially critical for these counselors to share their experience with the counselor education community.

It remains unclear how counselors lacking professional experience or impetus to engage with complementary therapy interventions will align with this critical issue. While this responsibility ultimately belongs to future counselors, their charge is in the hands of today's counselor educators.

Implications for Counselor Education

Therefore, it behooves counselor educators to give serious consideration to how this issue should be addressed among the next generation of counselors. Indeed, given the unique contributions of the counseling profession toward a "philosophy" of wellness (Meyers, 1992), counselor educators should be actively guiding new counselors in the direction of learning to "practice" from a holistic perspective.

If, as the present study indicates, those inexperienced with complementary therapy are generally unlicensed counselors and graduate students, then counselor educators are clearly in a unique position to provide leadership toward realizing this end. Clearly, these educators must begin this process by bringing themselves up to speed in understanding and setting educational standards and professional examples in alignment with fundamental professional principles.

Given the difficulties and complexities of simply meeting current educational standards in counselor education (i.e., CACREP), this is certainly no small task. One

possible solution is to increase the collaboration between counseling professionals with experience in complementary therapy and the counselor education community.

However, it is important for counselor educators to recognize that the process of paradigm change takes time, sometimes measured in terms of generations (Kuhn, 1970). Along the way, old paradigms are not necessarily invalidated, but rather superseded under newer, more inclusive, approaches (Shannon, 2002). Furthermore, a paradigm shift can generate extremes of emotion, especially when these changes appear to threaten secure and comfortable ways of (professional) being. This can be a positive sign if, as Shannon, puts it, "paradigm crisis, … precedes a paradigm shift" (p. 10).

The medical education community has been embroiled in just such a controversy over the past decade, debating the role of complementary therapy within their particular profession (Baumrucker, 2002; Caspi, et al., 2000; Marcus, 2001; Grollman, 2001; Wetzel, et al., 2003). Counselor education would do well to learn from this example and courageously begin the process of examining the "imperative that these topics be included in medical [counselor] education from the preclinical years through residency and beyond" (Wetzel, et al., p. 191).

Limitations

The results of this study should be considered in light of the following limitations:

1. It was assumed, though not necessarily the case, that respondents reported accurate information, represented themselves honestly and only completed the survey once.
2. Respondents were all required to be members of the American Counseling Association (ACA). As a result, the results cannot necessarily be extended to counselors who are not ACA members.
3. The majority of respondent demographics were found to be incongruent with those reported by the ACA. Therefore, the results are limited in their representativeness of ACA membership. As reported earlier, respondents were significantly more likely to report a student status, which resulted in a cascade affect across other variables (i.e., lower income and earned degree, and a greater variety of work settings).
4. While the final survey response rate of almost 22% is more than acceptable from an online survey perspective, it is still low in comparison with traditional mail based approaches to data collection (Dillman, 2000).

5. The survey was only open for data collection for a short time during the month of November. Because of this brief window of opportunity, a number of respondents may not have had a chance to participate in the survey.
6. Counselors with a previous interest in complementary therapy may have been more likely to complete the survey. They may also have had greater training, knowledge and professional and personal experience with complementary therapy than non-respondents.
7. Respondents more comfortable with electronic communication may have possibly outnumbered non-respondents. This issue may also have negatively contributed to the generalizability of the results.
8. The list of complementary therapies employed in the survey cannot be considered complete. In addition, knowledge and training categories, motivations for inclusion, client concerns, and reasons for not having recommended or referred complementary therapy may not be comprehensive.

Recommendations for Research, Practice and Education

Recommendations emerging from the present study are grouped according to the categories of research methodology and recommendations specific to practice and education.

Research Methodology

1. The survey should be expanded to include counselors that are not members of the ACA.
2. Statistical import would be improved by employing Likert/ordinal or interval scales in place of the numerous nominal scales.
3. The use of a multimodal approach to data collection (i.e., Internet and postal mail) may increase the response rate.
4. Future analysis should be conducted to account for the large number of respondents who reported a student status. This may enhance the representativeness of the sample.

Practice and Education

5. Counselors should ask clients about their use of complementary therapy as a matter of course. It is safest to assume that all clients potentially avail themselves of complementary therapy.

6. Counselors need to be aware of the efficacy of particular complementary therapies and the complementary therapies most likely to be used by clients for specific mental health concerns.
7. It is essential that all counselors begin the process of familiarizing themselves with complementary therapy resources and establishing a network of qualified practitioners for referrals.
8. Continuing education should be offered, which provides counselors with a working knowledge of complementary therapies and guidelines for recommendation and referral.
9. Counselor educators should encourage active dialog concerning complementary therapy throughout the counseling curriculum.
10. Counselors in private practice should reach out to inexperienced counselors and the counselor education community.
11. Counselors in K-12 settings and those without licensure need support and encouragement to become more engaged with complementary therapy.

Conclusion

The data from this study is, for the most part, encouraging in its implication that counselors are beginning to shift toward a paradigm, which "focuses on the unique phenomenological world of the client while engaging the client as an equal partner in the therapeutic process" (Gerber & Basham, 1999, p. 418). This collaborative attitude takes full advantage of clients' abilities and preferences in designing intervention strategies.

There is little reason to think that clients will necessarily limit themselves to "conventional" approaches – unless counselors are unconsciously encouraging these limitations in their clients. Recall that Knaudt, et al. (1999) found that clients were able to cite very specific advantages for their use of complementary therapy. Their research established that clients' believe that salutogenic (i.e., health enhancing) effects are a cornerstone of the complementary therapy milieu.

However, discussion of client-counselor communication specific to complementary therapy suggests that the profession still has a good deal of work to do before it can be considered truly holistic. In addition, lack of knowledge and training in

complementary therapy further contributes to the gap between counselors and complementary therapy.

These factors combine to create a "paradigm lag", where the basic tenants of counseling, including wellness, prevention, and client-centeredness become lost. The irony is that as modern market pressures increase the demand to be accountable for therapeutic outcomes, the counselor is left in a double bind with regards to effective interventions. Paradoxically, this reality presents an opportunity for the counseling profession to decide whether to expend the energy to commit to a truly comprehensive approach to therapy – one that would by definition include complementary therapy.

The most efficacious psychotherapy would ideally incorporate all of one's being and social system (Schaef, 1994). The therapist of the future will more and more find ways to incorporate complementary therapy into counseling. Therefore, exposure to complementary therapy is recommended in the training of all counselors.

Counseling is at a crossroads where it can no longer afford to ignore the holistic interplay of our world, cultures, individual minds, emotions and the phenomenon of being. According to Myers (1992), counseling has realized a paradigm shift with regard to its philosophy. However, the counseling profession has yet to commit this philosophy fully into practice.

There exists a great urgency for healing within our world. Science continues to provide many answers for why we hurt and what might help to heal our individual and collective pains. Yet, to conclude with the words of Sam Keen (1995, p. 335), counseling is, in the end, about the "questions".

> One day, as we move through the process of preparing ourselves, we will discover that, without realizing it, we have already come a long distance in our journey together. The preparations will have fused with the journey. Then we will find, to our surprise, that theory and practice have embraced each other, that our contemplation of the self has become inseparable from our compassionate action for others, that our patient waiting in the fertile darkness has become our manner of trusting in the Unknown God, that our questions have become our joy.

Summary

Chapter 5 summarized the results of the study. Special emphasis was given to the providing a context of the results within the extant literature. In addition, where no such or limited literature was found, theoretical constructs were engaged. A summary of the

key findings of the study were then deliberated. The implications of the study for clinical practice and counselor education were then presented. Finally, limitations and recommendations were offered.

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APPENDIX A

Survey Instrument

Welcome to the Online Survey of

Counselors' Experiences with Complementary and Alternative Therapy!

Your responses are important, as there has been little research to date, which specifically addresses counselors' experiences with complementary and alternative therapy. This study has importance for research, policy, education and practice in counseling. It will support the counseling profession in furthering its commitment to mental health from a holistic perspective of wellness across the lifespan.

Your responses are confidential. No response can be linked to an individual participant.

The risks to participating in this study are minimal. In rare instances, some participants may experience some discomfort associated with their self-disclosure about their experiences with complementary and alternative therapy. If during or after the participation in this research you experience any psychological discomfort, you may contact Trent Davis, who is a trained therapist (contact information listed below).

You have the freedom to withdraw from the research at any time without being penalized in any capacity. There will be no monetary compensation for participants involved in this study.

This research project has been approved, as required, by the Institutional Review Board (IRB) for Research Involving Human Subjects at Virginia Polytechnic Institute and State University. Submission of the survey is evidence of your voluntary willingness to participate.

Should you have any questions or concerns about this research or its conduct, research participants rights, and whom to contact in the event of a research-related injury, you may contact:

Trent A. Davis, EdS, 540-951-7230 (trdavis5@vt.edu)
Hildy Getz, Faculty Advisor, 540-231-8194 (hgetz@vt.edu)
David M. Moore, Chair, IRB, 540-231-4991 (moored@vt.edu)

Instructions for completing the survey:

- The survey includes [39] questions and should take about [10-15] minutes to complete.
- PLEASE ANSWER EVERY QUESTION! Incomplete surveys may not be included in the results (due to limitations of the software used to create the survey).
- You may use the scroll bar to move through the questions.
- For each question, use your mouse to click on the appropriate answer.
- For those questions that require you to enter a number or type your answer, use your mouse to click in the text box first, then begin typing.
- When you are finished, use your mouse to click on the "Submit" button at the end of the survey. You will then see a page telling you that your answers have been submitted.

Note: Please complete the survey only once.

Below is a list of Complementary and Alternative Therapy (CAT) modalities, which may be helpful in completing the survey:
Acupuncture
Aromatherapy
Art therapy

Ayurveda
Breathwork
Dance/Movement therapy
Diet
Exercise
Guided imagery
Healing/Therapeutic Touch
Herbs
Homeopathy
Magnetic therapy
Massage
Meditation
Music therapy
Naturopathy
Prayer
Qigong
Reiki
Vitamins
Yoga

If you have any questions or have difficulty in completing the survey, please contact me directly at trdavis5@vt.edu for assistance.

Thank you for taking the time to complete this survey!

Sincerely,

Trent Davis
PhD Candidate
Counselor Education
Virginia Tech
Blacksburg, Virginia

Questions 1-5 relate to your clients' use of Complementary and Alternative Therapy (CAT).

1. During the past year, approximately how many of your clients did you specifically ask about their use of CAT?

- ☐ I did not see any clients during the past year - CLICK HERE to skip to question 6.
- ☐ None
- ☐ Less than one-third
- ☐ One-third to two-thirds
- ☐ More than two-thirds

2. During the past year, approximately how many clients voluntarily brought up their use of CAT with you?

- ☐ None
- ☐ Less than one-third
- ☐ One-third to two-thirds

- [ ] More than two-thirds

3. During the past year, which of the following CAT's have your clients reported using? (Check all that apply)

- [ ] No clients' reported using any CAT's
- [ ] Acupuncture
- [ ] Aromatherapy
- [ ] Art therapy
- [ ] Ayurveda
- [ ] Breathwork
- [ ] Dance/Movement therapy
- [ ] Diet
- [ ] Exercise
- [ ] Guided imagery
- [ ] Healing/Therapeutic Touch
- [ ] Herbs
- [ ] Homeopathy
- [ ] Magnet therapy
- [ ] Massage
- [ ] Meditation
- [ ] Music therapy
- [ ] Naturopathy
- [ ] Prayer
- [ ] Qigong
- [ ] Reiki
- [ ] Vitamins
- [ ] Yoga

Other, please specify: _____

4. Please check the statement that most accurately describes any positive effects, on average, in your clients' overall wellness or mental health because of their use of CAT.

- [ ] No clients' reported use of CAT
- [ ] No positive effects
- [ ] Only slight positive effects
- [ ] Some positive effects
- [ ] Great positive effects
- [ ] Not sure of positive effects

5. Please check the statement that most accurately describes any negative effects, on average, in your

clients' overall wellness or mental health because of their use of CAT.

- ○ No clients' reported use of CAT
- ○ No negative effects
- ○ Only slight negative effects
- ○ Some negative effects
- ○ Great negative effects
- ○ Not sure of negative effects

Questions 6-9 are about your personal experience with CAT.

6. Have you ever personally experienced any of the following CAT's? (Check all that apply)

- ☐ I have not personally experienced any CAT's - CLICK HERE to skip to question 10.
- ☐ Acupuncture
- ☐ Aromatherapy
- ☐ Art therapy
- ☐ Ayurveda
- ☐ Breathwork
- ☐ Dance/Movement therapy
- ☐ Diet
- ☐ Exercise
- ☐ Guided imagery
- ☐ Healing/Therapeutic Touch
- ☐ Herbs
- ☐ Homeopathy
- ☐ Magnet therapy
- ☐ Massage
- ☐ Meditation
- ☐ Music therapy
- ☐ Naturopathy
- ☐ Prayer
- ☐ Qigong
- ☐ Reiki
- ☐ Vitamins
- ☐ Yoga

Other, please specify: _____

7. Which one of the following CAT's did you most recently personally experience?

- ○ Acupuncture

- ○ Aromatherapy
- ○ Art therapy
- ○ Ayurveda
- ○ Breathwork
- ○ Dance/Movement therapy
- ○ Diet
- ○ Exercise
- ○ Guided imagery
- ○ Healing/Therapeutic Touch
- ○ Herbs
- ○ Homeopathy
- ○ Magnet therapy
- ○ Massage
- ○ Meditation
- ○ Music therapy
- ○ Naturopathy
- ○ Prayer
- ○ Qigong
- ○ Reiki
- ○ Vitamins
- ○ Yoga
- ◉ Other, please specify: _____

8. Considering your most recent personal experience with CAT, why did you seek out this specific CAT? (Check all that apply)

- ☐ To improve overall wellness
- ☐ A specific mental health concern
- ☐ An acute medical condition
- ☐ A chronic medical condition
- ☐ Just to try it, no specific wellness, mental health or medical concern

Other, please specify: _____

9. With respect to your most recent use of CAT, how beneficial was this CAT for you?

- ○ No benefits
- ○ Only slight benefits
- ○ Some benefits
- ○ Large benefits

○ Not sure about benefits

Questions 10-13 are concerned with <u>your knowledge and training in CAT</u>.

10. Which of the following CAT modalities would you consider yourself qualified to discuss? (Check all that apply)

- ☐ I do not consider myself qualified to discuss any CAT modality
- ☐ Acupuncture
- ☐ Aromatherapy
- ☐ Art therapy
- ☐ Ayurveda
- ☐ Breathwork
- ☐ Dance/Movement therapy
- ☐ Diet
- ☐ Exercise
- ☐ Guided imagery
- ☐ Healing/Therapeutic Touch
- ☐ Herbs
- ☐ Homeopathy
- ☐ Magnet therapy
- ☐ Massage
- ☐ Meditation
- ☐ Music therapy
- ☐ Naturopathy
- ☐ Prayer
- ☐ Qigong
- ☐ Reiki
- ☐ Vitamins
- ☐ Yoga

Other, please specify: _____

11. Do you currently hold a license or certification in any of the following CAT modalities? (Check all that apply)

- ☐ I am not currently licensed or certified in any CAT modality
- ☐ Acupuncture
- ☐ Aromatherapy
- ☐ Art therapy
- ☐ Ayurveda

- [ ] Breathwork
- [ ] Dance/Movement therapy
- [ ] Diet
- [ ] Exercise
- [ ] Guided imagery
- [ ] Healing/Therapeutic Touch
- [ ] Herbs
- [ ] Homeopathy
- [ ] Magnet therapy
- [ ] Massage
- [ ] Meditation
- [ ] Music therapy
- [ ] Naturopathy
- [ ] Prayer
- [ ] Qigong
- [ ] Reiki
- [ ] Vitamins
- [ ] Yoga

Other, please specify: _____

12. Within the past year, which of the following sources have you used to gain additional knowledge and/or training in CAT? (Check all that apply)

- [ ] I have not sought additional knowledge and/or training in CAT
- [ ] Books
- [ ] Colleagues
- [ ] Internet
- [ ] Magazines/Non-refereed journals
- [ ] Personal experience with CAT
- [ ] Refereed journals
- [ ] Training/educational program
- [ ] Video/DVD
- [ ] Workshops

Other, please specify: _____

13. In which of the following CAT modalities would you like additional knowledge or training? (Check all that apply)

- [ ] I would not like additional knowledge or training in any CAT modality
- [ ] Acupuncture

- [ ] Aromatherapy
- [ ] Art therapy
- [ ] Ayurveda
- [ ] Breathwork
- [ ] Dance/Movement therapy
- [ ] Diet
- [ ] Exercise
- [ ] Guided imagery
- [ ] Healing/Therapeutic Touch
- [ ] Herbs
- [ ] Homeopathy
- [ ] Magnet therapy
- [ ] Massage
- [ ] Meditation
- [ ] Music therapy
- [ ] Naturopathy
- [ ] Prayer
- [ ] Qigong
- [ ] Reiki
- [ ] Vitamins
- [ ] Yoga

Other, please specify: _____

Questions 14-18 are concerned with the inclusion of CAT in your practice of counseling.

14. Within the past year, how often did you include CAT, in some form, in your practice of counseling?

- ○ I did not see any clients during the past year - CLICK HERE to skip to question 25.
- ○ Never
- ○ Less than one-third
- ○ One-third to two-thirds
- ○ More than two-thirds

15. Within the past year, how often did clients request the inclusion of CAT, in some form, in their counseling?

- ○ Never
- ○ Less than one-third
- ○ One-third to two-thirds

- [ ] More than two-thirds

16. Within the past year, which of the following CAT's have you included, in some form, in your practice of counseling? (Check all that apply)

- [ ] I did not include CAT in my practice of counseling
- [ ] Acupuncture
- [ ] Aromatherapy
- [ ] Art therapy
- [ ] Ayurveda
- [ ] Breathwork
- [ ] Dance/Movement therapy
- [ ] Diet
- [ ] Exercise
- [ ] Guided imagery
- [ ] Healing/Therapeutic Touch
- [ ] Herbs
- [ ] Homeopathy
- [ ] Magnet therapy
- [ ] Massage
- [ ] Meditation
- [ ] Music therapy
- [ ] Naturopathy
- [ ] Prayer
- [ ] Qigong
- [ ] Reiki
- [ ] Vitamins
- [ ] Yoga

Other, please specify: _____

17. Within the past year, what motivated you to include CAT, in some form, in your practice of counseling? (Check all that apply)

- [ ] I did not include CAT in my practice of counseling
- [ ] Client requested CAT
- [ ] Congruence with beliefs about client change
- [ ] Nothing else working
- [ ] Personal experience with CAT
- [ ] Professional climate encourages inclusion
- [ ] Research supporting CAT

Other, please specify:

18. Which of the following statements best describes your beliefs about the inclusion of CAT in the practice of counseling?

- CAT should never be included in the practice of counseling.
- CAT should be included in lieu of counseling.
- CAT should be included in addition to counseling.
- CAT should be included both in lieu of and in addition to counseling.
- Not sure about the inclusion of CAT in counseling.

Questions 19-24 are concerned with your CAT recommendation and referral patterns.

19. Over the past year, approximately how many of your clients specifically requested a recommendation or referral from you for CAT?

- None
- Less than one-third
- One-third to two-thirds
- More than two-thirds

20. Over the past year, approximately how often have you recommended CAT to a client, without providing a specific referral for CAT?

- Never
- Less than one-third
- One-third to two-thirds
- More than two-thirds

You are now halfway done!

21. Over the past year, approximately how often have you provided a client with a specific referral for CAT?

- Never
- Less than one-third
- One-third to two-thirds
- More than two-thirds

22. Over the past year, for what client concerns have you recommended CAT or referred for CAT? (Check all that apply)

- No clients referred for CAT
- ADHD
- Alcohol and/or substance abuse

- [ ] Anxiety
- [ ] Depression
- [ ] Eating disorder
- [ ] Medical concern
- [ ] Personality disorder
- [ ] Somatic problems
- [ ] Trauma/PTSD

Other, please specify:

23. What are some of the reasons you may NOT have referred for or recommended CAT to a client? (Check all that apply)

- [ ] Client discomfort with CAT
- [ ] Ethical and scope of practice issues
- [ ] Has not come up as a client concern
- [ ] Incongruence with my beliefs about client change
- [ ] Lack of knowledge and/or training in CAT
- [ ] Lack of research supporting CAT
- [ ] Not sure what to recommend
- [ ] Not sure who to refer to
- [ ] Poor acceptance by counseling profession

Other, please specify:

24. How important is it that any client referrals you make are to licensed or certified CAT practitioners?

- ○ Not important at all
- ○ Only slightly important
- ○ Somewhat important
- ○ Very important
- ○ Not sure of importance

Questions 25-33 ask about your professional credentials and practice.

25. What is your highest earned degree?

- ○ Bachelor's
- ○ Master's
- ○ Educational Specialist
- ○ Doctorate
- ◉ Other, please specify:

26. What state mental health license, if any, do you currently hold? (Check all that apply)

- ☐ I am not currently licensed
- ☐ LPC (or LMHC, LCPC, CPC, LPCC)
- ☐ LMFT
- ☐ MFCC

Other, please specify: _____

27. Are you a Nationally Certified Counselor (NCC)?

- ○ Yes
- ○ No

28. How long have you been practicing as a counselor?

- ○ 0-6 years
- ○ 7-12 years
- ○ 13-19 years
- ○ 20+ years

29. During the past year, approximately how many counseling clients did you see during any given week?

- ○ I did not see any counseling clients during the past year
- ○ 1-6 clients/week
- ○ 7-12 clients/week
- ○ 13-19 clients/week
- ○ 20+ clients/week

30. During the past year, which of the following mental health services did you provide? (Check all that apply)

- ☐ I did not provide any mental health services during the past year
- ☐ Child/adolescent therapy
- ☐ Individual therapy
- ☐ Family/couples therapy
- ☐ Group therapy
- ☐ Alcohol/substance abuse counseling
- ☐ Testing
- ☐ Consulting
- ☐ Supervision

Other, please specify: _____

31. Which of the following best describes your current position? (Check all that apply)

- ☐ Administrator

- [ ] Inpatient counselor
- [ ] Outpatient counselor
- [ ] School counselor
- [ ] Counselor educator
- [ ] Counselor supervisor
- [ ] Undergraduate Student
- [ ] Graduate student (Master's level)
- [ ] Graduate student (Doctoral level)
- [ ] Retired

Other, please specify: _____

32. Which of the following best describes your present work setting? (Check all that apply)

- [ ] Business/industry
- [ ] College/university
- [ ] Community agency
- [ ] Government setting
- [ ] Hospital
- [ ] K-12 setting
- [ ] Private practice/self-employed
- [ ] Psychiatric facility

Other, please specify: _____

33. To which of the following theoretical orientations do you adhere? (Check all that apply)

- [ ] Behavioral
- [ ] Cognitive-behavioral
- [ ] Family systems
- [ ] Person-centered
- [ ] Psychodynamic
- [ ] Reality
- [ ] Solution focused

Other, please specify: _____

Questions 34-38 ask for general demographic information. The final question asks for any additional input you may have on counseling and CAT.

34. What is your zip code?

_____

35. What is your Gender?

- ○ M
- ○ F
- ○ Prefer not to disclose

36. How old are you?

- ○ 18-24
- ○ 25-34
- ○ 35-44
- ○ 45-54
- ○ 55-64
- ○ 65 and above
- ○ Prefer not to disclose

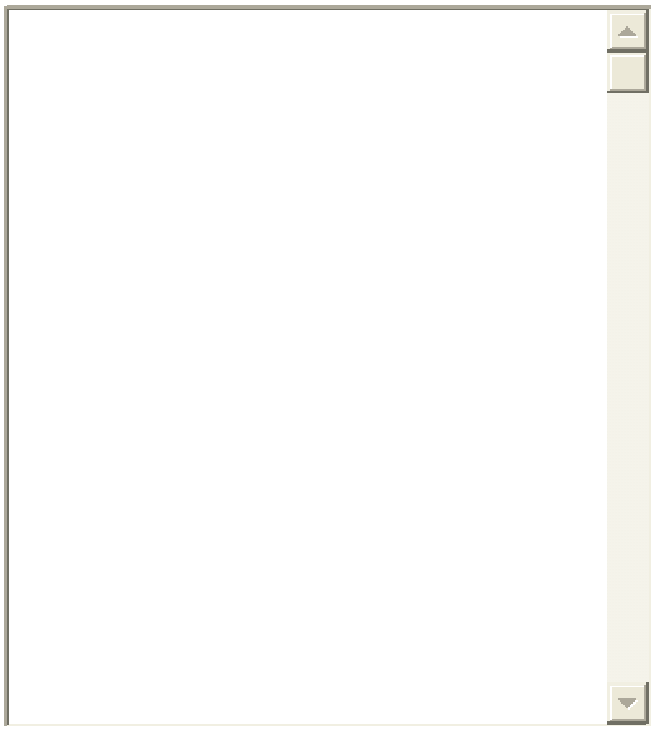
37. What is the race or ethnicity with which you primarily identify?

- ○ African American
- ○ Asian
- ○ Caucasian
- ○ Hispanic/Latino
- ○ Native American
- ○ Prefer not to disclose
- ◉ Other, please specify: _____

38. What is your pre-tax annual income from counseling-related employment?

- ○ $0-$12,499
- ○ $12,500-24,999
- ○ $25,000-39,999
- ○ $40,000-59,999
- ○ $60,000 and above
- ○ Prefer not to disclose

39. Please use the box below to enter any additional information or comments concerning counseling and CAT.



Congratulations... you have now completed the survey!

Please read below and then click the "Submit" button to send your survey:
All information filled out in this survey will be kept strictly confidential. No identifying information will be used in reporting the results of this project. By submitting your answers to this survey, you are volunteering to be a participant in the survey and you are giving an implied consent.

Submit

APPENDIX B

First contact:
Email announcing research study

Subject: Help with dissertation

Dear Counseling Colleague,

I am writing to ask for your help with my dissertation research. The purpose of this research is to explore the Experiences of Mental Health Counselors with Complementary and Alternative Therapy.

I have specifically contacted you because of your membership in the American Counseling Association (ACA), which also provided your email address.

Within the next couple of days, you will be receiving a follow-up email with a request to complete an online survey. (Look for an email with the subject line "Complementary Therapy Survey".)

Thank you in advance for your time and consideration. It is only with the generous help of counselors like yourself that this research will be successful.

If you have any questions, feel free to contact me directly at trdavis5@vt.edu.

Sincerely,

Trent Davis
PhD Candidate
Counselor Education
Virginia Tech
Blacksburg, VA

P.S. As a token of appreciation for your help, I created a useful webpage listing of *Complementary and Alternative Therapy Web Resources for Counselors*.
To access the list, simply click on the following link:
http://filebox.vt.edu/users/trdavis5/CAT/index.htm

APPENDIX C

Second contact:
Email announcing study is open for data collection

Subject: Complementary Therapy Survey

Dear Counseling Colleague,

Here is the link to the online survey of Counselors' Experiences with Complementary and Alternative Therapy. *It should only take 10-15 minutes to complete the survey!* Note: This study is applicable to all counseling disciplines, including counseling students.

The survey is now open for data collection and will remain available for approximately three weeks. During this period, you may access the survey at your convenience, 24 hours per day.

To access the survey, simply click on the following link:
http://survey.vt.edu/survey/entry.jsp?id=1079639313264

This should open the survey in a new browser window (i.e., Netscape, Internet Explorer). If this does not work, then you may have to open your browser and copy the above link directly into the address line.

When the survey opens, you will be prompted for the password listed below. This step was taken to insure the validity of the data.

Password: summer

I will also be sending two additional email reminders approximately one week apart to encourage those who have not taken the opportunity, to contribute to this research. *Please ignore these reminders if you already completed the survey.* (Due to the anonymous nature of the survey, I have no way of knowing who has responded or not).

If you have any questions, feel free to contact me directly at trdavis5@vt.edu.

Thank you very much for helping with this important study.

Sincerely,

Trent Davis
PhD Candidate
Counselor Education
Virginia Tech
Blacksburg, VA

P.S. As a token of appreciation for your help, I have created a useful webpage listing of *Complementary and Alternative Therapy Web Resources for Counselors*. To access the list, simply click on the following link:
http://filebox.vt.edu/users/trdavis5/CAT/index.htm

APPENDIX D

Third contact:
1st thank you and reminder to complete survey

Subject: Reminder: Complementary Therapy Survey

Dear Counseling Colleague,

Last week you were sent an email with a link to an online survey concerning the Experiences Of Counselors with Complementary And Alternative Therapy. (Note: This study is applicable to all counseling disciplines, including counseling students.)

If you have already completed the survey, please accept my sincere THANKS! *You may simply ignore this reminder.* If not, please take the opportunity to contribute your valuable input to this research. (Due to the anonymous nature of the survey, I have no way of knowing who has responded or not).

I am especially grateful for your help, because it is only by asking counselors like you to share their experiences that researchers can understand the experiences of counselors with Complementary and Alternative Therapy.

The survey is still open for data collection at your convenience (24 hours per day). *It should only take about 10-15 minutes to complete the survey.*

To access the survey, simply click on the following link:
http://survey.vt.edu/survey/entry.jsp?id=1079639313264

This should open the survey in a new browser window (i.e., Netscape, Internet Explorer). If this does not work, then you may have to open your browser and copy the above link directly into the address line.

When the survey opens, you will be prompted for the password listed below. (This step was taken to insure the validity of the data.)

Password: summer

If you have any questions, feel free to contact me directly at trdavis5@vt.edu.

I sincerely hope to hear from you soon,

Trent Davis
PhD Candidate
Counselor Education
Virginia Tech

P.S. As a token of appreciation for your help, I created a useful webpage listing of *Complementary and Alternative Therapy Web Resources for Counselors*. To access the list, simply click on the following link:
http://filebox.vt.edu/users/trdavis5/CAT/index.htm

APPENDIX E

Fourth contact:
2nd thank you, reminder to complete survey,
and announcement of closing of data collection period

Subject: Last Reminder: Complementary Therapy Survey

Dear Counseling Colleague,

This a final request for help with my dissertation research on Counselors' Experiences with Complementary and Alternative Therapy. I sincerely hope you will choose to contribute to this important study. (Note: This study is applicable to ALL counseling disciplines, including counseling students.)

THE SURVEY WILL REMAIN OPEN FOR ONLY THREE MORE DAYS AND WILL CLOSE ON WEDNESDAY, NOVEMBER 24 AT 12 PM! *It should only take about 10-15 minutes to complete the survey.*

If you have already completed the survey, THANK YOU! *You may simply ignore this reminder*. If not, please take the opportunity to contribute your valuable input to this research. (Due to the anonymous nature of the survey, I have no way of knowing who has responded or not).

I am happy to report the responses so far have been very informative regarding counselors' experiences complementary and alternative therapy. Many respondents have emphatically stated this is an important area of research for our profession. I believe the results will serve as an important source of baseline data for professional practice, education, and policy decisions - and, most importantly, to inform future research efforts.

I am writing you one last time because of the importance of having your experiences become a part of these results. It is only from hearing from every counselor that we can be sure the results are truly representative.

YOU HAVE MY ASSURANCE THIS IS THE LAST E-MAIL YOU WILL RECEIVE ASKING FOR YOUR PARTICIPATION IN THIS STUDY!

To access the survey, simply click on the following link:
http://survey.vt.edu/survey/entry.jsp?id=1079639313264

This should open the survey in a new browser window (i.e., Netscape, Internet Explorer). If this does not work, then you may have to open your browser and copy the above link directly into the address line.

When the survey opens, you will be prompted for the password listed below. This step

was taken to insure the validity of the data.

Password: summer

If you have any questions, feel free to contact me directly at trdavis5@vt.edu.

Again, I sincerely hope to hear from you soon,

Trent Davis
PhD Candidate
Counselor Education
Virginia Tech
Blacksburg, VA

P.S. As a token of appreciation for your help, I created a useful webpage listing of *Complementary and Alternative Therapy Web Resources for Counselors*. To access the list, simply click on the following link:
http://filebox.vt.edu/users/trdavis5/CAT/index.htm

APPENDIX F

Complementary and Alternative Therapy (CAT)

Web Resources for Counselors

Meta-sites:

Please note that there is often a good deal of duplication across these sites. However, they each have their individual strengths and limitations. I have tried to highlight each site's notable qualities.

Alternative Medicine Foundation
http://www.amfoundation.org/
"Providing consumers and professionals with responsible, evidence-based information on the integration of alternative and conventional medicine." Check out their Resource Guides (under "Main Projects").

Alternative Medicine Health Care Information Resources
http://www-hsl.mcmaster.ca/tomflem/altmed.html#gen
An encyclopedic resource for both general and specific information on CAT. Highly recommended, though not pretty to browse.
(Compiled and maintained by Tom Flemming, McMaster University Health Sciences Library, Hamilton, Ontario, Canada.)

The Alternative Medicine Homepage
http://www.pitt.edu/~cbw/altm.html
Of note for its thorough listing of CAT databases and government resources.
(Created and maintained by medical librarian, Charles B. Wessel, M.L.S., Health Sciences Library System, University of Pittsburgh.)

Association of College and Research Libraries (ACRL)
http://www.ala.org/ala/acrl/acrlpubs/crlnews/backissues2002/september/complementary.htm
Reliable meta-site. Notable for the global level of its CAT links

American Medical Student Association (AMSA)
http://www.amsa.org/programs/gpit/compmed.cfm
An interesting site which covers CAT from a (medical) student's perspective. Useful for mental health students as well. See their suggested activities for educating others about CAT.

The Cochrane Collaboration
http://www.cochrane.org/index0.htm

"Produces and disseminates systematic reviews of healthcare interventions and promotes the search for evidence in the form of clinical trials and other studies of interventions." Check out the the Cochrane Library for reviews of CAT evidence.

Complementary & Alternative Medicine (CAM) Resources
http://www.library.tufts.edu/hsl/cam/cam_web.html
A very nice lsiting of links for alternative medicine systems out of Tufts University. Not fancy, though.

Healing People
http://www.healingpeople.com/ht/index.tmpl
Coverage of Chinese/Oriental Medicine, Homeopathy, Aromatherapy, Bodywork, Ayurveda, and Western Herbalism. Notable for its professional advisory board and resources for professionals.

HealthWorld Online
http://www.healthy.net/indexNet.asp
A very well done site, which seems to cover it all. Wins the best looking site (and quote!) award.

HolisticOnline.com
http://www.holisticonline.com/herb_home.htm
Another good meta-resource. Notable for CAT guidance for a wide variety of concerns (see their Diseases and Conditions section).

National Center for Complementary and Alternative Medicine (NCCAM)
http://nccam.nih.gov/
The federal government's primary organization for matters related to CAT; part of the National Institutes of Health. Provides an excellent overview of CAT. See the sections on "Treatment Information by Disease or Condition" and "Treatment Information by Treatment or Therapy" (under "Health Information").

New York Online Access to Health (NOAH)
http://www.noah-health.org/en/alternative/index.html
Excellent inventory of CAT approaches. Notable for its coverage of CAT for specific health conditions and concerns. And, its direct from New York City!

Sites for specific CAT's:

Acupuncture
Acubriefs
http://acubriefs.com/
A free searchable database with over 16,000 citations referencing acupuncture, supported in part by a grant from the Medical Acupuncture Research foundation. Especially for the scientist.

Acupuncture.com
http://acupuncture.com/
Cover all matters acupuncture.

The Layman's Guide to Acupuncture
http://acupuncture.edu/laymans/index.htm
A very basic guide to acupuncture.

Aromatherapy
AromaWeb
http://www.aromaweb.com/default.asp
Excellent recipes for using essential oils.

National Association for Holistic Aromatherapy (NAHA)
http://www.naha.org/
Aromatherapy organization devoted to increasing the professionalism of the field.

Ayurveda
AllAyurveda.com
http://www.allayurveda.com/
Set up like an online resource book. (Note: after picking a topic from the index, scroll down to see the information).

National Institute of Ayurvedic Medicine (NIAM)
http://niam.com/corp-web/index.htm
"Recognized as the largest and most authentic resource of information on Ayurveda in the United States." Notable for its founder being both an MD and Ayurvedic practitioner.

Breathwork
Breath-Directed Inner Healing & Transformation
http://www.holisticmed.com/inner/breath.html
Covers the main breathwork approaches.

Diet
American Dietetic Association (ADA)
http://www.eatright.org/Public/
Wide range of scientifically-based nutrition advice.

Kushi Institute: What is Macrobiotics ?
http://www.kushiinstitute.org/whatismacro.html
Promotes the "use of macrobiotic principles to address and adjust environmental, dietary and lifestyle influences" (on health). Shows the familar food pyramid with a healthy twist.

Exercise
American Council on Exercise (ACE)

http://www.acefitness.org/
Provides evidence-based exercise guidelines. Check out the Fit Facts one-page information sheets (under "Get Fit" heading).

Guided imagery
Academy for Guided Imagery
http://www.academyforguidedimagery.com/
Offers a bibliography of pertinent research, professional trainings and practitioner referrals.

Healing/Therapeutic Touch
Barbara Brennan School of Healing
http://www.barbarabrennan.com/
Hands-on energy healing.

Healing Touch International
http://www.healingtouch.net/
Provides a professional certification program.

Herbs
(also see the Traditional Chinese Medicine Herbal resources under Acupuncture.)

Herb Research Foundation
http://www.herbs.org/
Promotes scientific-based information on herbs. Go to HRF Research Reviews under "News & Views".

Homeopathy
ABC Homeopathy
http://www.abchomeopathy.com/
Am interesting site because of their "Online Remedy Finder".

National Center for Homeopathy
http://www.homeopathic.org/index.html
"By providing general education to the public about homeopathy, and specific education to homeopaths, we help to make homeopathy available throughout the United States." A good consumer resource.

Magnetic therapy
Magnetic Therapy: Plausible Attraction?
http://www.csicop.org/si/9807/magnet.html
An interesting article on the possibility of magnetic therapy being more than a placebo. Published by *Skeptical Inquire*r magazine.

Using Magnets To Treat Pain
http://www.nccam.nih.gov/health/magnet/magnet.htm

NCCAM research report "provides an overview of the use of magnets for pain, summarizes current scientific knowledge about their effectiveness for this purpose, and suggests additional sources of information".

Massage
American Massage Therapy Association
http://www.amtamassage.org/
The main professional association for massage therapists. A good source of information for consumers, including qualified referrals.

Associated Bodywork & Massage Professionals
http://www.abmp.com/home/index.html
Another professional association for massage therapists with additional information.

Meditation
International Meditation Society
http://www.vcn.bc.ca/ims-hq/
"Promoting World Peace through Meditation."

The World Wide Online Meditation Center
http://www.meditationcenter.com/
A fun site! Straight-forward meditation instruction in a variety of techniques. Pick your room!

Transcendental Meditation program
http://www.tm.org/index.html
"A scientifically validated program." This is the one that started it all.

Movement therapy
American Society for the Alexander Technique
http://www.alexandertech.com/index.html
"A proven approach to self-care, the Alexander Technique is a method that people of all ages and abilities can learn to relieve the pain and stress caused by everyday misuse of the body."

American Dance Therapy Association
http://www.adta.org/
Professional organization, which promotes the "psychotherapeutic use of dance/movement as a process which furthers the emotional, cognitive, social and physical integration of the individual".

International Feldenkrais Federation
http://www.feldenkrais-method.org/
Dr. Moshé Feldenkrais' contribution to the unity of body and mind.

Naturopathy
American Association of Naturopathic Physicians
http://www.naturopathic.org
Professional society representing naturopathic physicians who are licensed or eligible for licensing as primary care providers.

Naturopathy Online
http://www.naturopathyonline.com/
A consumer oriented site. Very nice.

Prayer
Intercessory prayer (remote prayer with the intention of healing) remains extremely controversial.
See *Healing Words: The Power of Prayer and the Practice of Medicine* by Larry Dossey (1993, HarperCollins: New York).
Also see "Interview with Larry Dossey, M.D. On the role of prayer and meditation in medicine" in *The Share Guide*
http://www.shareguide.com/Dossey.html

Qigong
Qigong Association of America
http://www.qi.org/index.html
Basic information on Qigong. FYI, Qi (chi) means energy and gong (kung) means a skill or a practice. Qigong therefore means a skill or practice of cultivating energy.

National Qigong (Chi Kung) Association
http://www.nqa.org/
An organization which promotes Qigong.

Reiki
International Center for Reiki Training
http://www.reiki.org/
All things Reiki. Disorganized site. Scroll down to get to site's table of contents.

Vitamins
FDA Guide to Dietary Supplements
http://www.cfsan.fda.gov/~dms/supplmnt.html
No reference to vitamins would be complete without the FDA.

Health Supplements Information Service
http://www.hsis.org/default.htm
"Present facts about health supplementation in a simple, straightforward way." Check out their "Myths & Facts" section.

Yoga
American Yoga Association

http://www.americanyogaassociation.org/contents.html
General information about yoga, how to choose a qualified teacher and the history of yoga.

International Association of Yoga Therapists
http://www.iayt.org/
A nice site for those interested in Yoga research and education.

Other sites of interest
American Art Therapy Association
http://www.arttherapy.org/
"Art therapy is based on the belief that the creative process involved in the making of art is healing and life-enhancing."

American Music Therapy Association
http://www.musictherapy.org/
"Through musical involvement in the therapeutic context, clients' abilities are strengthened and transferred to other areas of their lives."

Journals:

Advances in Mind-Body Medicine
http://www.advancesjournal.com/aj/login/index.jsp
Some peer-reviewed monographs

Alternative Medicine Review
http://www.thorne.com/alternative/alter_main.html
Peer-reviewed monographs

Alternative Therapies in Health and Medicine
http://www.alternative-therapies.com/at/login/index.jsp
Peer-reviewed monographs

BMC Complementary and Alternative Medicine
http://www.pubmedcentral.gov/tocrender.fcgi?action=archive&journal=10
Peer-reviewed monographs

Skeptical Inquirer: The Magazine for Science and Reason
http://www.csicop.org/
The title says it all. A publication of the Committee for the Scientific Investigation of Claims of the Paranormal.

Consumer Health Digest
http://www.ncahf.org/digest04/index.html
Free weekly e-mail newsletter edited by Stephen Barrett, M.D., and cosponsored by

NCAHF and Quackwatch. It summarizes scientific reports and other information relevant to consumer protection and consumer decision-making.

Evidence-based Complementary and Alternative Medicine
http://ecam.oupjournals.org/
Peer-reviewed monographs

Journal of Alternative and Complementary Medicine: Research on Paradigm, Practice, and Policy
http://www.liebertpub.com/publication.aspx?pub_id=26
Peer-reviewed monographs

Scientific Review of Alternative Medicine
http://www.sram.org/
Peer-reviewed monographs

Scientific Review of Mental Health Practice
http://www.srmhp.org/index.html
Peer-reviewed monographs

Townsend Letter for Doctors & Patients
http://www.townsendletter.com/

Note: All of the listed sites were tested and found to be functional. Please let me know if you have any questions, comments or find any nonworking sites at trdavis5@vt.edu

VITA

TRENT A. DAVIS

PHONE (540) 951-7230 ▪ E-MAIL TRDAVIS5@VT.EDU
1950 OILWELL ROAD ▪ BLACKSBURG, VIRGINIA 24060

EDUCATION

2001 - 2005 Virginia Tech Blacksburg, VA
PhD in Counselor Education

- May, 2005
- Dissertation: Counseling and Complementary Therapy: A National Survey of Counselors' Experiences.

1997 - 2001 James Madison University Harrisonburg, VA
MA/EdS in Community Counseling Psychology

- 3.975 GPA for 66 credit hours
- Also completed 28 graduate credits in Computer Science

1985 - 1993 Virginia State University Petersburg, VA
BS in Electronic Engineering Technology

- 3.65 GPA with Distinction

1982 - 1985 John Tyler Community College Chester, VA
AAS in Electronic Engineering Technology

- 3.65 GPA – Magna Cum Laude

TEACHING EXPERIENCE

1996 - 2001 James Madison University Harrisonburg, VA
Adjunct Instructor

- Taught Lifetime Wellness and Fitness. This general education course addressed the multi-faceted components of personal wellness from a wholistic perspective. Lecture and lab components designed to help students take responsibility for making informed and thoughtful choices in creating a healthy lifestyle.

- Taught Road and Mountain Cycling. Responsible for the safety and education of a diverse group of undergraduate students. Emphasis on personal development, as well as, skill building.

1994 - 1998 Virginia Community Colleges Various Locations
Adjunct Instructor

- Provided instruction for both credit and non-credit computer, engineering, and electronic classes at various community colleges, including: Blue Ridge Community College, Piedmont Virginia Community College, and Dabney S. Lancaster Community College.

2004 - Present New River Valley Community Services Blacksburg, VA
Outpatient Clinician

- Provided individual, group and family counseling, case management, psychoeducation, and crisis intervention services to clients with serious mental illness, substance use disorders, mental retardation and multiple problems. Performed diagnostic evaluations and prepared appropriate treatment plans, employing knowledge of theories of personality, psychology, psychopathology and therapeutic interventions. Interfaced with families/caregivers, and other agencies as necessary. Participated in and coordinated multi-disciplinary/community treatment planning for clients as needed to ensure continuity of care. Maintained community referral network. Maintained accurate chart documentation, including progress notes, treatment plans, and treatment plan reviews, to meet agency, state licensure and third party reimbursement standards. Addressed ethical and legal concerns as they related to outpatient clinical services.

2002 - 2004 Mental Health Association of the New River Valley
Counselor Blacksburg, VA

- Provided supervised short and long-term pro-bono counseling to uninsured, low to moderate income clients. Conducted individual therapy for clients presenting with a wide variety of issues, including the chronically mentally ill. Involved with community outreach activities such as National Depression Screening Day, suicide prevention, etc.

2002 - Present Virginia Tech Counselor Education Blacksburg, VA
Graduate Assistant

- Responsible for supervising Masters' level counselor education students engaged in practicum and internship in both school and community settings. Interfaced as needed with supervisees' onsite counseling liaisons. Provided one-to-one and triadic supervision to Masters' students. Responsible for progress and process notes related to professional growth of supervisees. Participated in weekly group supervision-of-supervision meetings. Facilitated a personal growth group of Master's students. Co-taught Counseling Theories and Internship for Master's-level counseling students. Provided content and technical support for online courses and activities.

2001 - 2003 Virginia Tech - ADA Office Blacksburg, VA
Assistant Grant Coordinator

- Conducted research concerning issues facing upper class students with disabilities in higher education as part of a grant sponsored by the for the Virginia Board for People with Disabilities. Grant funded to obtain information about factors that facilitated or were barriers to student success in college from upperclassmen with disabilities. Responsible for

all aspects of research project including - coordinating and conducting focus groups at various universities, assimilating and analyzing qualitative data, preparing findings for publication, and presenting results to various stakeholders. Prepared quarterly budget and outcome reports for sponsor. Regularly involved with other outreach activities of ADA office, including College Bound and Real World Day.

2000 - 2002 Augusta Medical Center Fishersville, VA
EAP Counselor

- Provided supervised individual, couple, and family counseling services to employees of local industries, as well as the medical center as part of 700-hour internship experience in Community Wellness Department. Formulated client assessments and intervention strategies. Facilitated ongoing support groups for recovering medical patients. Taught stress management workshops to EAP clients, patients, and community groups. Originated, developed, and implemented a pilot stress reduction program for medical patients, counseling clients, and the general public; employing various holisitic techniques such as, mindfulness meditation, yoga, and guided imagery, among others.

Fall 1999 James Madison University Harrisonburg, VA
Counselor

- Provided supervised counseling services to a general undergraduate student population as part of a practicum experience at university counseling center. Assessed client needs, developed intervention plans, and maintained progress notes in client files. Participated in various in-service trainings and process groups.

1994 - 1996 James Madison University Harrisonburg, VA
Graduate Assistant

- Graduate assistant in University's Center for Multimedia. Coordinated "House Calls" program which provided one-on-one instruction and support to faculty and staff in various computer technologies.
- Graduate assistant in the Department of Computer Science. Assisted with general class duties and taught undergraduate classes as needed.

1994 - Present Private Practioner Blacksburg, VA
Massage Therapist/Jin Shin Do Acupressurist

- Provided a wide variety of ongoing remedial and preventative therapies to a diverse group of clients. Employed different modalities to suit each individual's needs and presenting concern. Worked within strict legal and ethical guidelines.

1995 - 2001 Allegheny Outdoor Adventures White Sulfur Spg., WV
Adventure Guide

- Lead corporate and family groups in various outdoor activities, including mountain biking, canoeing, and hiking. Responsible for ensuring the safety and enjoyment of clients in challenging outdoor environments.

1994 - 2001 Private Practioner Harrisonburg, VA

Yoga/Stress Management Instructor

- Provided Yoga and stress management instruction to many local facilities and organizations, including, but not limited to: Valley Wellness Center, Rockingham Memorial Hospital, State of Virginia and James Madison University. Emphasis on relaxation and centering with an awareness of each individual's unique experience.

SCHOLARLY CONTRIBUTIONS

Presentations

- February, 2003, *The Role of Complementary and Alternative therapies in Counseling and Counselor Education*, Virginia Counseling Graduate Student Conference, Williamsburg, Va.
- March, 2001, *The Body in Psychotherapy*. Virginia Counseling Graduate Student Conference, Williamsburg, Va.

Presentations related to Virginia Board for People with Disabilities grant - *Upper Classmen with Disabilities in Higher Education: Academic Goals, Challenges, Triumphs*:

- October, 2003, *DCDT International Conference*, Roanoke, VA,
- July, 2003, *National AHEAD Conference*, Dallas, TX.
- March, 2003, *Virginia Transition Forum*, Roanoke, VA.
- March 2003, *International Dyslexia Association Conference*, Richmond, VA.
- October, 2002, *AHEAD in VA Conference*, Richmond, VA.
- September, 2002, *Virginia HELP*, Richmond, VA.

Publications

- Reilly, V.J. & Davis, T.A (2005). *ADA, 504, and the Office of Civil Rights: Understanding the Regulatory Environment*. In E. E. Getzel & P. H. Wehman (Eds.), *Going to College*. Brookes Publishing: Baltimore, MD.
- Davis, T.A., & Reilly, V.J. (2003). Students see faculty, staff as biggest stumbling blocks to learning. *Disability Compliance for Higher Education, 9*(2), 1-2.
- Davis, T.A., & Reilly, V.J. (2003). *Upper Classmen with Disabilities in Higher Education: Academic Goals, Challenges, Triumphs*. Manuscript under review.
- Davis, T.A. (2002). *The Role of Personal Therapy in the Training of Counselors*. Manuscript under review.
- Created and disseminated brochures summarizing *Virginia Board for People with Disabilities Research Findings* to Parent Resource Centers and other agencies throughout Virginia.

- American Counseling Association
- Chi Sigma Iota Honor Society
- Mental Health Association of the New River Valley, Rising Star Award, 2002 & 2003.
- United States Association for Body Psychotherapy
- Nationally Certified in Therapeautic Massage and Bodywork since 1994.