



Western Michigan University  
ScholarWorks at WMU

---

Dissertations

Graduate College

---

4-2013

## Counselor Educator Knowledge, Experience, Attitudes and Beliefs Toward Complementary and Alternative Medicine

Jennifer Mills Langeland  
Western Michigan University, findingmoksha@gmail.com

Follow this and additional works at: <https://scholarworks.wmich.edu/dissertations>



Part of the Alternative and Complementary Medicine Commons, and the Counseling Psychology Commons

---

### Recommended Citation

Langeland, Jennifer Mills, "Counselor Educator Knowledge, Experience, Attitudes and Beliefs Toward Complementary and Alternative Medicine" (2013). *Dissertations*. 149.  
<https://scholarworks.wmich.edu/dissertations/149>

This Dissertation-Open Access is brought to you for free and open access by the Graduate College at ScholarWorks at WMU. It has been accepted for inclusion in Dissertations by an authorized administrator of ScholarWorks at WMU. For more information, please contact [wmu-scholarworks@wmich.edu](mailto:wmu-scholarworks@wmich.edu).



COUNSELOR EDUCATOR KNOWLEDGE, EXPERIENCE, ATTITUDES AND  
BELIEFS TOWARD COMPLEMENTARY AND ALTERNATIVE MEDICINE

by

Jennifer Mills Langeland

A dissertation submitted to the Graduate College  
in partial fulfillment of the requirements  
for the degree of Doctor of Philosophy  
Counselor Education and Counseling Psychology  
Western Michigan University  
April 2013

Doctoral Committee:

Gary Bischof, Ph.D., Chair  
Stephen Craig, Ph.D.  
Karen Horneffer-Ginter, Ph.D.

## COUNSELOR EDUCATOR KNOWLEDGE, EXPERIENCE, ATTITUDES AND BELIEFS TOWARD COMPLEMENTARY AND ALTERNATIVE MEDICINE

Jennifer Mills Langeland, Ph.D.

Western Michigan University, 2013

Following growing public interest and widespread use, many health professions have begun to explore the attitudes toward, knowledge of and experience with complementary and alternative medicine (CAM) of the various stakeholders within their professions. This foundational information has enabled disciplines such as medicine, nursing, psychology, and marriage and family therapy to take a closer look at how students, patients, clients, and faculty think about and utilize CAM and its relevance to their professions. Surveying the practices and attitudes of stakeholders has been an important starting point for professions undertaking the task of integrating these practices into training programs.

This study sought to fill the gap in knowledge about the attitudes, knowledge and experience with CAM among counselor education faculty. Counselor educators ( $N = 130$ ) were surveyed online about their knowledge of and attitudes toward CAM and their personal, clinical and teaching use of CAM practices. Results indicated that the majority of counselor educators have positive attitudes toward CAM and 79% believe it should be integrated into counselor training. Over half the participants believe counseling as a profession is behind other mental health professions in the integration of CAM. The study also found that experience with and knowledge of CAM had significant and

positive relationships with attitudes toward CAM. Results indicated there is already some limited integration of CAM practices within the core curriculum of counseling training programs, primarily in the self-care, treatment approaches, and helping relationships portions of curricula. Counselor educators were more likely to have experience with the subset of practices known as mind-body practices, which include breathing, meditation, progressive muscle relaxation, and guided imagery. Higher ratings of counselor wellness identity were associated with more positive attitudes toward CAM. Females and older counselor educators were more likely to have positive attitudes toward CAM. The association of attitudes toward CAM and year of degree or race/ethnicity were not significant. Limitations of the study include a relatively small sample size, the need for more valid measures, and the length might have led some to not complete the survey. Recommendations for counselor training and future research are offered.

© 2013 Jennifer Mills Langeland

## ACKNOWLEDGMENTS

I would like to acknowledge the people who have helped me reach this goal. First, I would like to thank my father whose support, encouragement and generous spirit have made this endeavor possible. More than anything it has been your belief in me that has carried me through this process and for that I am forever grateful. Since I was a little girl you have told me that I could become whatever I wanted, “just get your PhD in it,” you would say. I understand now you were giving me self-sufficiency, opportunity, creativity and independence. Thank you.

To my mother. During this process I gave birth to my daughter and it was through this experience that I came to appreciate the important gifts you gave your children. You instilled in me the values of a family life anchored in the rhythms of everyday life; home cooked meals, staying organized and keeping a home. I will never be able to express my gratitude for this wisdom as it has brought me enormous peace and joy. It was through these things that you did so well, that I found comfort and balance during the long disconnected days of writing and rewriting and the challenges of raising a young child.

To my daughter Sarah Jane. Your presence in my life has brought me enormous joy. I dedicate this work to you and hope that you pursue what you love, and follow it to the highest peak possible, no matter how difficult the journey.

To my stepdaughter Maya. Thank you for teaching me how to make lemonade, making me laugh, and for being one of the most gifted young writers I know. I am

## Acknowledgments–Continued

grateful to have had an in house grammarian and a willing typist. I know you at only 14 sincerely appreciate the work involved in writing something like this, and I am grateful that you shared in that understanding with me on many occasions.

To my husband Jim. I am grateful for all of the times you lovingly cared for our daughter, adjusted your schedule, put off something that you needed to do, so that I could write and complete this process. You have helped me navigate a world that was challenging for me by encouraging the qualities in me that would help me accomplish this task. You have a natural ability to be disciplined, and rigorous in your pursuit of doing something well and I will always be grateful for lessons I've gleaned from watching you.

To my brother and sister, Gretchen and Bentley. Watching our children grow up together is one of the greatest joys of my life. Thank you for always being there when I would call.

To the chair of my committee, Dr. Gary Bischof. Thank you for your patience. Your gentle support and encouragement along the way kept me connected to the process and brought some ease to the more difficult moments. I am grateful for all of the ways you supported me, honored me, advocated for me, cleared the path and ultimately helped me find my way to the end of this process. I learned from you the collaborative process that is writing. Thank you for all of the editing and feedback that you gave me along the way. I see now how everyone needs a faithful companion during the writing process and how this improves the work.

## Acknowledgments–Continued

To Stephen Craig. It was your enthusiasm and encouragement that brought me to this program. Thank you for your thoughtfulness, your positivity, and the many ways you teach by example.

To Karen Horneffer-Ginter. Thank you for all of the ways you made the process seem less foreign. The ways you thoughtfully offered ideas and then let go, the ways you reinforced in me a sense that I would find the answer. Your way of communicating not only added information to the process but also taught me to trust myself in the process. That you could hold the messier parts of this with me was a gift that helped me stay the course, and find the spiritual gifts in this journey.

To my fellow graduate students with whom I started this journey many years ago; Ericka, Glinda, Candy, Christina. Each of you contributed to my growth in important ways and I thank you. I would also like to thank Joe Morris. Your leadership and kindness I will always carry with me.

To Greg Jarvie. Thank you for being a lighthouse, pointing the way, nurturing a love of this profession, showing me how to avoid the rocky shores, and being the first teacher to really see me. Your humor, love and wisdom I always carry with me, close to my heart.

To Kathi Fuller. You have been a mentor, a guide, and a friend to me. You taught me about strength, perseverance, and getting it done. Thank you for truly seeing me, and lovingly guiding me through becoming a “professional.” The way you live your life has been a source of strength and inspiration, thank you.



## Acknowledgments–Continued

To Karina Ayn Mirsky. You are both a dear friend and a mentor to me. Your ability to hold me in the deepest love has been the fertile soil from which I have grown into the person I am today. Thank you for being the conduit through which I could always find “Self.” I am forever grateful to have someone who truly sees me on this journey. You have taught me how to be both graceful and strong, how to step fully into life, how to give yourself to the world and to take care of yourself in the process. Namaste.

To Tom Holmes. You embody kindness and compassion and it is in that embrace that I have felt my own true nature flower, found true refuge in the heart, and cultivated a way to return to loving presence. My time with you has been filled with *deep with winds of homecoming*. Thank you for being such a safe harbor.

To Jane, thank you for forging a friendship that has kept me sane, and supported me through the difficult times. I am forever grateful to you for all that you have done for me and for the love you have shown my daughter.

To my dear friends, Alycia, Amy, Hilary, and Lucia who have laughed with me, held me in the throes of motherhood, and been faithful companions on this journey. You have each made me realize how important it is to have many sisters in this life. I am grateful for your constant presence and friendship.

To friends farther afield, who are forever anchors in my life. Kathi Snooks, you have meant more to me than words can say, one day I will return to Riverplace and share with you all that you have meant to me. Cindy Hanson, Tracy Hans, thank you for seeing

## Acknowledgments–Continued

me and making me laugh.

To my friends in Leelanau county. I thank you for teaching me about true community. Through each of you I tasted what it meant to be connected to something greater than yourself. You were and continue to be food for my soul. And finally, thanks to everyone at Water Street. Your positivity, encouragement, and conversation kept me going.

As I reflect on achieving this goal, I am moved by how important the qualities each of you embody in some way, have been to me in this process; patience, kindness, love, presence, gentleness, humor, strength, perseverance. May I bring these qualities to the people I serve. May you each know the love that you are.

Jennifer Mills Langeland

## TABLE OF CONTENTS

ACKNOWLEDGMENTS .....	ii
LIST OF TABLES .....	xiii
CHAPTER	
I. INTRODUCTION .....	1
Rationale .....	6
National Context.....	6
Health Professions .....	7
Counselor Education.....	13
Statement of the Problem.....	15
Purpose of the Study .....	16
Research Questions.....	17
Significance of the Study.....	18
Brief Overview of Methods .....	18
Definition of Terms .....	19
II. LITERATURE REVIEW .....	22
Historical Context.....	22
Current Utilization .....	24
Empirical Validation of the Mind-Body Relationship.....	26
Trends in the Use of CAM Among Various Health Professions.....	29
Medicine .....	29

## Table of Contents—Continued

CHAPTER		
	Nursing .....	48
	Psychology.....	57
	Marriage and Family Therapy .....	70
	Social Work .....	75
	Counselor Education.....	80
	CACREP Standards .....	97
	Wellness and Prevention.....	97
	Self-Care .....	98
	Development of Counselor Characteristics .....	98
	Conclusion .....	99
III.	RESEARCH METHODS AND PROCEDURES.....	100
	Research Questions and Hypotheses .....	100
	Research Question 1: Counselor Educator Attitudes Toward CAM .....	100
	Research Question 2: Personal and Professional Experience With CAM .....	101
	Research Question 3: Counselor Educator Beliefs About CAM.....	101
	Research Question 4: Relationship Between Experience and Attitudes .....	101
	Research Question 5: CAM in Teaching and Training .....	102
	Research Question 6: Demographic Variables and CAM .....	102

## Table of Contents—Continued

CHAPTER		
	Research Question 7: Wellness and Prevention as Predictor of Attitudes.....	103
	Research Question 8: Relationship Between Knowledge and Attitudes .....	103
	Participants and Sampling Methods .....	104
	Participant Demographics.....	105
	Instrumentation .....	106
	Complementary and Alternative Medicine Survey: Medical Student Version (Frye et al., 2006).....	107
	MFT Clinical Survey on Mind-Body Therapies (Olson et al., 2011) .....	110
	Family Therapists' Knowledge of and Attitudes Towards Complementary and Alternative Medicine (Caldwell et al., 2006) .....	112
	Wellness and Prevention Orientation (Emerson, 2010) .....	114
	Demographics .....	116
	Data Collection Procedures .....	117
IV.	RESULTS .....	119
	Recoded Data and Data Management.....	119
	Collapsed Variables .....	119
	Treatment of Missing Data .....	120
	Research Question 1: Attitudes and Beliefs Toward CAM.....	120
	Research Question 2: Experience With CAM .....	121

## Table of Contents—Continued

CHAPTER	
Research Question 3: Beliefs About Integration of CAM.....	124
Research Question 4: Experience and Attitudes.....	125
Research Question 5: Incorporating CAM .....	126
Research Question 6: Demographic Variables and CAM Attitudes.....	128
Gender.....	128
Ethnicity.....	128
Age and Year of Degree Completion .....	129
Full vs. Part-time Faculty .....	129
Research Question 7: Wellness and Prevention and Attitudes .....	129
Research Question 8: Relationship Between Knowledge and Attitudes .....	130
Summary .....	131
V. DISCUSSION AND IMPLICATIONS .....	133
Counselor Educator Attitudes.....	133
Experience With CAM .....	134
Experience With Mind-Body Practices .....	136
Knowledge of CAM.....	138
General Knowledge of CAM.....	138
Relationship Between Knowledge and Attitudes .....	138
Beliefs About CAM.....	139

## Table of Contents—Continued

CHAPTER		
	Should CAM be Integrated Into Training?.....	139
	How Does Counselor Education Compare to Other Professions? .....	139
	Professional Identity and CAM .....	140
	CAM in Teaching and Training.....	141
	Integrated Into Core Curriculum .....	141
	Elective Course in CAM/Specific CAM Modality.....	142
	MFTs and Counselor Educators .....	142
	Demographic Variables and Attitudes.....	145
	Limitations .....	149
	Response Rate.....	149
	Degree From Related Field.....	150
	Reliable Attitudes Scale.....	150
	Aggregating CAM Practices.....	151
	Length of Study Survey .....	151
	Self-Selection and Self-Report .....	151
	Recommendations for Future Research.....	152
	Recommendations for the Counseling Profession and Counselor Education.....	153
	Counseling Profession .....	153
	Counselor Education.....	154

## Table of Contents—Continued

CHAPTER	
Summary .....	155
REFERENCES .....	158
APPENDICES .....	174
A. First Email Request CACREP Group .....	174
B. Survey of Counselor Educators' Knowledge, Attitudes and Beliefs Toward CAM.....	176
C. Consent Document.....	182
D. First Email Reminder.....	184
E. Second Email Reminder .....	186
F. Third Email Reminder .....	188
G. First Email Request to CES-Net Group.....	190
H. Thank You Letter at End of Survey.....	192
I. Human Subjects Institutional Review Board Approval Letter .....	194
J. Permission to Use Caldwell et al. (2006) Survey .....	196
K. Permission to Use Counselor Professional Identity (CPI) Measure (Emerson, 2010).....	198



## LIST OF TABLES

1. Mean Differences Between Experience Groups .....	122
2. Average Experience With CAM Practices .....	123
3. Integration of CAM Into Core Curriculum Areas.....	127
4. Average Knowledge of CAM Practices.....	131
5. Comparison of Attitudes Survey Results With MFT Group .....	144

## CHAPTER I

### INTRODUCTION

Public interest in the mind-body connection continues to grow. According to a national survey, 37% of Americans are utilizing Complementary and Alternative Medicine practices, of which, mind-body practices are a subset, and are paying out of pocket for these services (NCCAM website, 2011). Additionally, research suggests that the majority of complementary and alternative visits are made to promote wellness, prevent illness, reduce the symptoms of illness and to address a mental health concern. A growing body of conceptual and empirical literature on the mind-body connection parallels this rise in public interest with many empirical studies reporting the benefits of mind-body practices on physical/mental health and well-being.

There is a natural overlap between the philosophical foundations of many CAM practices and the field of counselor education. Counselor education is grounded in a philosophy of wellness, prevention, and a systemic approach to health and has listed these as necessary components of accredited counselor education programs (CACREP, 2007). Similarly, many mind-body and CAM practices seek to promote general health and well-being, prevent illness and disease and endeavor to achieve this through attention to the whole person. Additionally, counselor education values the development of counselor qualities such as unconditional positive regard, non-judgmental awareness, self-awareness, empathy, compassion, attentive presence, and acceptance (Bentley, 2007; Gremer, 2005; Epstein, 1995; Morgan & Morgan, 2005; Rogers, 1957; Traux &

Carkhuff, 1969; Walsh & Shapiro, 2006). While there is still debate on how best to develop these qualities within counselors, some have suggested that contemplative practices, like mindfulness could be important training tools for developing such counselor qualities (Bentley, 2007; Chrisman, Christopher, & Lichtentein, 2009; Maris, 2009; Schure, Christopher, & Christopher, 2008). Despite the overlap between counselor education and CAM/mind-body practices, counselor education has been slow to take up the task of integrating or researching the role of CAM in counselor education.

Counselor educators are tasked with implementing training practices that promote counselor qualities and steep trainees in a wellness, prevention and systems approach to counselor education (Locke, Myers, & Herr, 2001). However, despite the overlap between the goals of counselor education training and CAM/mind-body practices, counselor educators are lagging behind other health professions in exploring the role these practices could play within training. There is a paucity of research considering use of CAM in training, incorporation of CAM knowledge, skills and attitudes within counselor education curricula, and the use of CAM as treatment approaches within counselor education.

Meanwhile, other health professions including medicine, psychiatry, nursing, psychology and marriage and family therapy have all begun to consider the role of CAM/mind-body practices in training to promote professional qualities, prevent burn-out, or to improve health outcomes through collaborative or integrated treatment approaches (Benjamin et al., 2007; Booth-Laforce et al., 2010; Bagniet, Boon, & Ostbye, 2000; Caldwell, Winek, & Becvar, 2006; Hsiao, et al., 2005; Lie & Boker, 2006; Ong, Shapiro, & Manber, 2008; Olson et al., 2011, Petterson & Olson, 2006; Simon et al., 2003; Wetzel

et al., 2003; Wilson & White, 2007). One important initial step each of these professions took was to assess student/trainee and faculty attitudes and beliefs about these practices.

Assessing the attitudes and beliefs of those educating future professionals generates important data for the profession. First, this information enables the profession to consider whether faculty attitudes differ or align with public interest and to explore possible reasons for this similarity or difference. Second, surveys of this type enable the profession to explore if institutional valuing impacts educator valuing or vice versa. This reveals important information about the ways in which valuing is shaped by personal/professional experience or institutions. Third, surveys of this type enable the profession to determine if these practices are already being integrated and explore what kinds of experiences lead to successful integration, which can inform the development of outcome studies on innovative treatment approaches. Lastly, if there is a philosophical overlap between CAM/mind-body practices and counselor education, the profession has much to contribute to the national dialogue about how these practices, and a more holistic approach to healthcare can be achieved. By not becoming part of the conversation through research and educational practices, counselors may forfeit an opportunity to make a meaningful contribution to this wave of change happening within healthcare.

There are a few studies which have been conducted within counselor education training programs or by counselor educators, looking at the effect of a mind-body course or experiences on specific training outcome measures (Chrisman et al., 2009; Christopher, 2006; Glaser, 2007; Maris, 2009; Newsome et al., 2006; Schure et al., 2008; Shapiro, Brown & Biegel, 2006). Additionally, two studies have attempted to consider attitudes of counselor educators. One of these studies surveyed counselors who were

members of the American Counselor education Association (ACA), southern division. The primary emphasis of this study was to consider gender and ethnic differences between counselors who choose brief and or non-traditional therapeutic approaches. In this case, “non-traditional approaches” were defined using the NCCAM definition of CAM. Additionally, CAM modalities were subsequently listed as examples of non-traditional techniques. There is only one study, which considers the attitudes and beliefs of counselor educators towards CAM (Lumadue, Monk, & Wooten, 2005). Several methodological flaws, however, plague this study including a small sample size, population sample was limited to directors of CACREP programs, language used to describe CAM did not align with established definitions and categories, and the focus of literature review and discussion was on energy medicine and shamanism, two approaches which are less widely studied. These counselor education-related studies will be detailed in Chapter II.

This study sought to fill the gap in research and knowledge within counselor education by surveying the attitudes, experiences and beliefs of counselor educators regarding CAM/mind-body practices. This study improved on previous studies by: (a) defining CAM/mind-body concepts so that they can be expressed or measured quantitatively, (b) aligning terminology with categories and definitions proposed by the NCCAM and used by other health professions, and (c) implementing survey methods that incorporate established, validated methods from previous studies.

To orient the reader to the terminology used in this paper, a brief explanation of terms is provided below. *Complementary and alternative medicine* (CAM) is the umbrella term used by the National Center for Complementary and Alternative Medicine

(NCCAM), a division of the National Institutes of Health, to describe those healthcare practices which fall outside of mainstream medicine. Mind-body medicine, according to NCCAM, is a subset of these practices focused on the interactions among the brain, mind, body, and behavior with the intent to use the mind to affect physical functioning and promote health (What is Complementary and Alternative Medicine, 2001). While the term *mind-body medicine* has been used to describe the study of the biological basis of the connection between the mind and body, as well as health movements within the public sector that focused on the whole person, the term is used here to describe this unique subset of CAM practices as outlined by NCAAM.

According to the NCCAM, mind-body practices include yoga, meditation, mindfulness, acupuncture, hypnotherapy, guided imagery, deep breathing exercises, progressive relaxation, qi gong, and tai chi. There are, however, a variety of other practices that purport to promote mental well-being and balance, which are therefore relevant to mental health providers but not included in the category “mind-body practices.” These practices include: (a) movement therapies, (b) energy field therapies, (c) whole medical systems like Ayurveda and Chinese medicine, traditional healers, homeopathy, naturopathy, and (d) nutritional medicine. Much of the literature to date is plagued by this problem of describing and categorizing these practices in a way that is useful, since many of these practices derive from a holistic philosophy that treats the whole person, and promotes general well-being. For the purposes of this study, NCCAM categories will be utilized. In addition, the term complementary and alternative medicine (CAM) will be used to refer to all categories of practices outlined by NCCAM.

## **Rationale**

Following is a rationale for the study presented here. First, a description of the national context highlights the long-standing and growing interest in mind-body practices in the United States, is presented. Second, an overview of how various health professions including medicine, psychiatry and psychology have responded to this increase in interest is provided. Finally, the relative absence of counselor educators from the conversation is explored as well as the reasons why counselors are uniquely suited to contribute to the research, training practices and delivery of CAM services. This chapter also includes a statement of the problem, significance of the study, research questions, and definitions of key terms. It concludes with a brief overview of the methods that will be used to conduct the study.

### **National Context**

The growing public interest in and research on CAM/mind-body practices has resulted in more dialogue about these practices within various health professions including medicine, nursing, psychiatry, psychology, and marriage and family therapy. This dialogue has taken many forms but generally falls into three categories: (1) CAM as a treatment approach within the profession, (2) CAM to address burnout, self-care, and the development of professional characteristics like empathy, patient-centered awareness, positive regard, cultural sensitivity and professionalism, and (3) exploring what role training institutions play in graduating practitioners that can meet this public demand ethically and responsibly through the incorporation of CAM courses and experiences into the curriculum. The following is a brief summary of how the health professions, particularly medicine and nursing have responded to this wave of interest.

## Health Professions

**Medicine.** There is a considerable amount of dialogue within medicine calling for a reconsideration of the biomedical/disease model of health care that is currently being practiced in the United States (Benson, 1975, 1996; Carlson, 2003; Eisenberg, 2002; Weil, 1995). The concern is that the current model of health care privileges the body over other dimensions of health like the mind, spirituality, and relationship to community and the environment and is therefore inadequate. By focusing on management of symptoms and disease, doctors and other health professionals miss opportunities to ignite the innate healing response in the body, over utilize invasive procedures, or apply ineffective therapies designed only to manage symptoms. Those advocating for a more holistic approach to health care often cite evidence emerging from CAM research that suggests that less invasive mind-body practices have the ability to promote health and healing, alleviate discomfort, and increase overall sense of well-being (Benson, 1996; Field, 2007; Karren et al., 2006; Weil, 1995).

National professional organizations in medicine, both private and governmental, have responded to this growing public interest in CAM. Examples of organizations that support the advancement of CAM/ mind-body knowledge within the medical establishment include the American Holistic Medical Association (AHMA) founded in 1978; Institute of Medicine (IOM), and the NCCAM founded in 1998. The IOM, an independent, non-profit, organization that advises the nation on health matters, as well as the National Institutes of Health (NIH) have both drafted documents on the appropriate and ethical incorporation of CAM into medicine. In 2005 the IOM produced a comprehensive report on CAM use in the United States, which assessed what was known



at the time about Americans' utilization of CAM therapies. In addition, the IOM, at the request of NIH formed a study committee on CAM to explore scientific, policy and practice questions that arise from the increased interest in CAM (IOM, 2012) The committee, in addition to addressing major scientific and policy issues related to CAM discussed the need to identify successful approaches to incorporation of CAM into education in the health professions. This response by the professional organizations and governmental institutions in medicine suggests that CAM and its role in medicine has achieved national status and is deemed an important area of study.

In addition to the response by larger governing bodies, CAM has become an important area of research for medical academics and professionals. This research falls into three areas: (1) CAM as treatment (Jain et al., 2007; Ma & Teasdale, 2004; Teasdale et al., 2000), (2) CAM for burnout prevention, self-care, and developing professional qualities (Elder et al., 2008; Saunders et al., 2007), and (3) CAM in training (Baugniet et al., 2000; Lie et al., 2006; Ranjana et al., 2007). This emerging body of research suggests that the profession is interested in the role of CAM in health. More detail on the emerging research in these areas is provided in Chapter II.

**Nursing.** There is a considerable amount of dialogue in nursing about the integration of CAM into healthcare (Avino, 2001; Boothe-Laforce et al., 2010; Cornman, Carr & Heitkemper, 2006; Gaylord & Mann, 2007, Krietzer et al., 2008; Lasater et al., 2009; Nottingham, 2006; Rojas-Cooley & Grant, 2006; Rakel et al., 2008; Sierpina, et al., 2006; Smith, 2011; Toms, 2011; Wanchai, Armer, & Stewart, 2010). Again, this literature suggests that the biomedical model may be limited, and a more holistic approach to health is warranted. Other reasons for integrating CAM are cited within the

nursing literature including the need for a more holistic approach, emphasis on prevention, and more cost effective and less invasive procedures.

Overall, there has been a positive response concerning the integration of CAM into healthcare from the national professional organization in nursing. The American Holistic Nurses Association (AHNA), nursing's flagship professional organization, has established a national association for holistic nursing. Numerous texts and articles have been written exploring the role of holism, CAM, and mind-body practices in practice and training. In fact, several handbooks summarizing CAM research have been authored or edited by nurses (Adams & Tovey, 2008; Clark, 2003; Decker & Lee, 2010; Dossey & Keegan, 2005). Nurses have a long history of exploring the role of CAM in professional training (Stratton et al., 2007). Nurse educators have started to take stock of attitudes and beliefs of nurse educators, trainees, and patients toward CAM (Baugniet, et al., 2000; Booth-Laforce et al., 2010; Laurenson et al., 2006; Shorofi&Arbon, 2010).

**Mental health professions.** Both serious mental health issues and utilization of CAM/mind-body practices have seen a steady increase over the last few decades (CDC, 2009). Research is showing that people with mental health issues are turning to these practices, sometimes instead of conventional talk therapy, and other times in addition to conventional therapy at record rates (Simon et al., 2004; Kessler, 2001; Unutzer, et al., 2000).

As a result, many mental health care professions have begun to explore the relationship between mental health, physical health and CAM (Benjamin et al., 2007; Booth-Laforce et al., 2010; Baugniet, Boon, & Ostbye, 2000; Caldwell, Winek, & Becvar, 2006; Hsiao, et al., 2005; Lie & Boker, 2006; Ong, Shapiro, & Manber, 2008;

Petterson & Olson, 2006; Simon, et al., 2003; Wetzel, et al., 2003; Wilson & White, 2007).

According to several national surveys, anywhere from 10 to 66% of patients receiving conventional mental health treatment are simultaneously receiving a CAM treatment (Simon et al., 2004; Kessler, 2001; Unutzer et al., 2000). Having depression and/or anxiety is especially associated with an increased likelihood of CAM use (Unutzer et al., 2000). Additionally, clients may not be reporting CAM use to their mental health provider (Simon, 2003). This research suggests that there is widespread use of CAM for mental health concerns and that those receiving mental health treatment may not be letting their provider know about CAM use. This has important implications for treatment outcomes within mental health. If clients are going outside of conventional mental health treatment to deal with a mental health concern, then counselor education may be missing an important intervening variable in treatment. Additionally, the 2002 National Health Interview Study, conducted by the CDC, evaluated characteristics of yoga users and found that most report mental health benefits from yoga practice (Birdee, 2008). If patients are seeking out adjunctive treatments to address mental health concerns and are finding them helpful, it behooves mental health professionals to explore the reasons for choosing, potential benefits of, and the mechanisms of action of these CAM modalities.

It is not surprising that this interest and integration has permeated mental health given that many CAM modalities are categorized as mind-body practices. This overlap, with areas of expertise that have traditionally been the purview of mental health providers creates a confluence that has a variety of implications for mental health professionals and

training programs.

First, consumers are utilizing CAM to deal with mental health concerns (Simon et al., 2003). As a result consumers may ask their mental health provider about CAM modalities and expect that their provider be able to advise, or make appropriate referrals. A variety of resource manuals for mental health providers have emerged, likely in an effort to fill this gap in knowledge, as consumers expect more holistic or integrated care from their mental health providers (Ben-Arye, Frenkel, Klien & Scharf, 2007; Field, 2007; Lake & Spiegel, 2007).

Additionally, consumers in need of mental health services may be trying CAM modalities in lieu of traditional talk therapy. One study large study, which investigated the proportion of mental health visits to CAM practitioners, found that between seven and 11% of visits to a CAM provider were for a mental health concern (Simon et al., 2004). The authors noted that concomitant conventional medical treatment was common, though not always happening, and there was rarely coordination of treatment between the CAM provider and conventional health care provider. This study suggests a gap in service delivery, which may pose problems when treatment is not coordinated.

Secondly, consumers of mental health, like consumers of physical health services may have the expectation that their provider be knowledgeable about CAM and ways to integrate that into traditional therapy. One study, in medicine, revealed that consumers hold the expectation that their physician not only be able to make appropriate referrals to CAM practitioners but highly valued receiving CAM within the medical establishment (Ben-Arye et al., 2007). This may also be true within mental health.

Thirdly, mental health professionals can provide much needed expertise in the

development and implementation of research on CAM and health. Mental health professionals have considerable training in mind and behavior, promotion of wellness, and reduction of stress and this expertise is essential to designing appropriate studies both within medicine and mental health. To leave this work to other mental health professionals, for example, psychologists, fails to recognize the unique contribution that counselors can make, being steeped in guidance, education, prevention, wellness and holism.

Lastly, mental health educators play an important role in how CAM is incorporated into training programs both in terms of delivery of the knowledge and skills of CAM and how the practice of CAM by future health care professionals impacts burnout, professionalism, treatment outcomes, and services provided. Because CAM practices purport to impact qualities such as a sense of well-being, attention, ability to be empathic, and mindfulness, all qualities that we seek to develop in future mental health care professionals, these practices may be useful training tools (Bentley, 2007). Mental health educators may also serve as a bridge between training in mental health and medicine, by providing education on how to appropriately attend to mind-body issues within the medical establishment (Caldwell, Winek & Becvar, 2006; Olson et al., 2011).

Other mental health professions such as psychology, marriage and family therapy and social work, have begun exploring the integration of CAM into the profession. This will be discussed in more detail in chapter two. Counselor education however is lagging behind despite the philosophical overlap between the fields. Following is an evaluation of how the principles of CAM and the philosophy of counselor education overlap and why integration of the two might be important.

## Counselor Education

Underlying this interest in mind-body practices is a philosophical approach to health that is characterized by wellness and prevention, deliberate care of the whole person in order to prolong life and prevent illness or disease. In fact, wellness is defined as “(1) the quality or state of being healthy in body and mind, especially as the result of deliberate effort, (2) an approach to healthcare that emphasizes preventing illness and prolonging life, as opposed to emphasizing treating diseases” (dictionary.reference.com, October 3, 2011). Counselors are uniquely suited to position themselves as experts in mind-body approaches to health, given that the professions emphasizes a wellness, prevention and systemic model of health (Granello, 2011; Locke, Herr, & Myers, 2001)

Many of the mind-body modalities such as yoga, meditation, and mindfulness are rooted in a holistic philosophical approach to health that emphasizes prevention, acknowledges the body’s ability to heal itself if the proper conditions are present, sees mental health and physical health as intricately connected, and places health within a larger spiritual philosophy that helps individuals make meaning of their lives. This positive focus on innate health, prevention, spirituality, and the mind’s role in health resonates with the philosophical foundations of the counselor education profession that has from its inception promulgated a wellness, holistic, and prevention model of health.

If CAM use is increasing and the public is using CAM to treat mental health concerns or are looking for providers that can utilize mind-body practices to deal with a mental health issue, then mental health professions, including counselor education, should be exploring the relevance of these practices within training. There is growing support in the research for mind-body practices as treatment for a variety of mental health

related conditions including attention, depression, anxiety, insomnia, sense of well-being, distress, rumination, and distraction (Carmody, Baer, 2007; Kuyken et al., 2008; Jain et al., 2007; Lazar et al., 2005; Ma & Teasdale, 2004; Miller, Fletcher, & Kabat-Zinn, 1995; Jain et al., 2007; Lazar et al., 2005; Ong, Shapiro, & Manber, 2008).

Explorations in other health and mental health disciplines into the attitudes of various stakeholders have helped researchers understand the nature of mind-body medicine in relation to their profession. From there, a road map for further research into training, treatment, and the use of CAM to develop professional characteristics could be devised. While other professions have already taken stock of consumer and professional attitudes, use in training, personal interest in or clinical use of CAM or mind-body approaches, only one study could be identified in the counselor education profession (Lumadue et al., 2005). The study proposed here seeks to begin to fill this gap. In addition, many other health professions have conducted surveys of trainees and faculty to explore the attitudes and beliefs about these practices (Booth-Laforce, 2010; Ditte et al., 2011; Frye et al., 2006; Hughes, 2007; Laurensen et al., 2006; Lie, Boker, 2006).

Many of the mind body practices purport to support health by reducing stress, pain, susceptibility to illness, or by decreasing anxiety and depression, and increasing one's sense of calm and connection. Given that the goals of these practices overlap with many of the goals of counselor education, it seems logical that counselors would explore the relevance of these approaches within the context of counselor education. It also seems logical given the widespread interest in these approaches that consumers of counselor education may see counselors as a potential resource with regards to CAM. If

counselors are not prepared or have not had training in these approaches, consumers may see them as lagging behind.

The appeal of these practices to someone seeking improvement in their mental or physical well-being is clear; and for this reason traditional medical and mental health service providers are paying attention. Likewise, training programs for doctors, nurses, psychiatrists, psychologists, marriage and family therapists, have all begun to explore the role of mind-body practices in training, treatment, for the prevention of burnout, development of professional qualities and to enhance learning within the training program. When compared with other health professions however, counselors are lagging behind.

### **Statement of the Problem**

There is a natural confluence of CAM and mental health services particularly with regard to the subset of CAM practices termed Mind-Body practices. Many mental health professionals have recognized this and begun to develop research agendas, explore the usefulness of CAM in treatment, and begun exploring the incorporation of CAM into training programs however, counselor education is lagging behind. Very little evidence exists that suggests that counselors are riding this wave of interest despite the fact that counselor education is rooted in principles of wellness, prevention, and systemic approach to health, that naturally fit with the principles of CAM. Meanwhile, other mental health professions have begun to formulate an approach to research, practice, training, and public education as evidenced by the dialogue happening within the professional literature and professional organizations.

Much of the preliminary work undertaken by these professions, particularly



medicine, psychology, and marriage and family therapy, has involved gathering information about knowledge, attitudes, values, and beliefs toward CAM from all constituents including, consumers, trainees, providers and educators (Caldwell et al., 2006; Furnham et al., 2003; Frye et al., 2006; Laurensen et al., 2006; Olson et al., 2011; Pettersen & Olsen, 2006; Wilson & White 2007). This information has then informed research, training and discussions about the ethical integration of these modalities within those professions. This preliminary work also established a cohesive framework, although many studies are plagued by the problems of inconsistent language, and categorizing of these practices, for integration of CAM into the profession. This has enabled various professions to more systematically research CAM's effectiveness, and to position themselves as experts and important collaborators in the movement. The absence of this basic information about the attitudes and use of CAM within counselor education leaves the profession lagging behind. The current study begins to fill this gap by exploring counselor educators' knowledge of, experience with, both personally and professionally, and attitudes and beliefs towards CAM modalities.

### **Purpose of the Study**

The purpose of this study was to determine: (1) counselor educators' knowledge, beliefs and attitudes toward CAM, (2) the level of personal and professional experience with CAM, (3) the relationship between personal/professional experience with CAM and attitudes toward CAM, (4) if CAM is being integrated into counselor training and if so how, (5) the relationship between wellness or prevention orientation and attitudes toward CAM, and (6) how demographic variables including gender, ethnicity, age, or degree of completion of training correlate with attitudes.

## Research Questions

In order to fulfill the purpose of this study as described in the section above, the following research questions were explored:

1. What are counselor educators' attitudes towards CAM?
2. What personal and professional (clinical and teaching) experiences do counselor educators have with CAM?
3. What are counselor educators' beliefs about CAM?
  - a. How do counselor educators integrate CAM into counselor training?
  - b. How does counselor education compare to other mental health professions in terms of acceptance and integration of CAM?
4. What is the relationship between counselor educators' personal and professional experiences with CAM and attitudes toward CAM?
5. Are counselor educators incorporating CAM into teaching and training?
 

If incorporating:

  - a. In which of the eight core CACREP areas?
  - b. Is the course an elective, a general CAM course, or a course on a specific CAM modality?
6. What is the relationship between gender, ethnicity, age, year of degree completion, and full-time versus part-time status and attitudes toward CAM?
7. What is the relationship between counselor educator orientation to wellness and prevention and attitudes about CAM?
8. What is the relationship between counselor educators' knowledge of CAM and attitudes toward CAM?

### **Significance of the Study**

This study was significant in that it provided a clearer picture of counselor educators' knowledge, experience, attitudes and beliefs about CAM and its relevance to counselor education. Other health professionals have begun assessing attitudes of the various stakeholders (e.g., faculty, patients/clients, and students in training) and incorporating the emerging evidence that supports the integration of CAM into health care. However, there is very little evidence that counselor education is actively integrating this knowledge. Additionally, CAM practices and the qualities that may enhance health are being actively explored within these professions. Exploring what counselor educators were doing with regards to CAM enables the profession to more thoughtfully move forward with the integration of these practices into training. As a result of this study, more is known about what counselor educators know and believe about CAM and its relevance to training.

### **Brief Overview of Methods**

This study improved upon the one previous study (Lumadue et al., 2007), which considered the use of CAM in counselor education training programs. A national sample of counselor educators was recruited through two methods. The first method involved identifying potential participants from the CACREP (Council for the Accreditation of Counseling and Related Programs) website, a list of all CACREP programs was generated from the website and programs were randomly selected. Then faculty emails were obtained from the University website for each program selected. The second method entailed posting to the counselor education listserv CES NET. Emails to potential participants were sent using both of these methods with a link to the survey.

The survey constructed for this study drew on surveys of attitudes conducted by other health professions including, medicine, and marriage and family therapy. Statistical methods included descriptive statistics, one sample t-test, independent sample t-test and Pearson correlation statistics.

### **Definition of Terms**

*Complementary and alternative medicine (CAM):* According to the National Center for Complementary and Alternative Medicine (NCCAM), CAM refers to “A group of diverse medical and health care systems, practices and products that are not generally considered part of conventional medicine” (NCCAM, 2011).

*Conventional medicine:* According to NCCAM “conventional medicine (also called Western or allopathic medicine) is medicine as practiced by holders of M.D. (medical doctor) and D.O. (doctor of osteopathic medicine) degrees and by allied health professionals such as physical therapists, psychologists, and registered nurses” (What is Complementary and Alternative Medicine, 2011).

*CAM categories:* The NCCAM has divided complementary and alternative practices into several categories; they are listed and defined below. All definitions were retrieved from the NCCAM website, page title: What is Complementary and Alternative Medicine, 2011:

*Natural products:* “This area of CAM includes use of a variety of herbal medicines (also known as botanicals), vitamins, minerals and other “natural products.” Many are sold over the counter as dietary supplements.” One example of this kind of medicine would be taking omega-3 fatty acids to affect health.

*Mind and body medicine:* “Mind and body practices focus on the interactions among the brain, mind, body, and behavior, with the intent to use the mind to affect physical functioning and promote health.” Examples of mind-body practices include: Meditation, yoga, deep breathing exercises, guided imagery, hypnotherapy, progressive relaxation, qi gong, and tai chi. NCCAM notes that historically that healing systems like Chinese medicine and Ayurveda believe that the mind is important in the treatment of illness and integral to healing. These approaches along with some of the specific therapies they promote are including in whole medical systems however. This may lead to some confusion as NCCAM has included practices like yoga, a part of the Indian system of healing, Ayurveda in this section as well as acupuncture which some might argue belongs in the category on energy therapies since acupuncture purports to work with Chi, which is life force or energy.

*Manipulative and body based practices:* “focus primarily on the structures and systems of the body including the bones and joints, soft tissues, and circulatory and lymphatic systems.” Examples of common therapies in this category include: chiropractic, massage therapy.

*Whole medical systems:* “are complete systems of theory and practice that have evolved over time in different cultures and apart from conventional or Western medicine.” Examples of CAM approaches in this category include Ayurveda, Chinese Medicine and Homeopathy and Naturopathy.

*Other CAM practices:* this category encompasses the wide variety of practices not mentioned above and includes: movement therapies (e.g., Feldenkrais method, Alexander technique, Pilates, Rolfing, Trager technique); practices of traditional healers (e.g.,

curandismo, native American healing practices); energy therapies (e.g., magnet and light therapy, Reiki, healing touch).

*Holistic health:* describes an approach to health that considers the interaction between the mind, body, spirit, community, and environment and how these interactions impact health (Fuller, Brown & Mills, in Teague et al, 2007).

*Mental health profession:* this term is used to describe those professions whose training and practice is in mental, emotional, behavioral health. The professions included in this category include: psychiatry, psychology, marriage and family therapy, social work and counselor education.

*NCCAM:* The National Center for Complementary and Alternative Medicine a division of the National Institutes of Health, originally called the Office of Alternative Medicine was established in October 1998, seeks to “define through rigorous scientific investigation, the usefulness and safety of complementary and alternative medicine interventions and their roles in improving health and health care” (NCCAM Facts-at-a-Glance and Mission, 2011)

## CHAPTER II

### LITERATURE REVIEW

In Chapter I, the rationale for the study of counselor educators' use of CAM practices was discussed. In this chapter, the literature supporting this rationale is presented. First, a more detailed discussion of the historical prevalence of CAM within the culture is presented. Following, a review of the literature on CAM in professional education/training programs of key health care and mental health disciplines is presented including medicine and nursing, psychology, social work, and marriage and family therapy. To conclude, the literature from counselor education is presented.

#### **Historical Context**

Turning to practices that use the mind in service of healing is not a new phenomenon (Harrington, 2008; Kessler et al., 2001). According to Anne Harrington, a medical historian from Harvard, there has rarely been a time in history when curiosity about how the mind impacts the health of the body has not taken root in some form, and this interest has not waned. In fact, the last two decades have seen a steady increase in public interest in the mind-body connection and the practices that purport to leverage this relationship, in service of qualities like health, peace, calm, centeredness, and balance. Concurrently, the last two decades saw a surge in popular media exploring the mind-body connection.

According to some, public interest and the media explosion that followed, was ushered in by the 1991 PBS program with Bill Moyers, titled "Healing and the Mind"

(Harrington, 2008). This program, which reached millions of viewers, initiated a wave of dialogue on television and radio, and in published books, magazine and newspapers articles, sparking new interest in CAM modalities and the role of the mind in healing (Harrington, 2008). Public Broadcasting has since aired another program on mind-body medicine titled “The New Medicine,” which was seen by more than twice as many viewers, suggesting that the public interest that propelled the mind-body movement in the early 1990’s has not waned (PBS, 2006).

Other events that have signaled growth in the mind-body movement include the development of a variety of institutes devoted to studying the relationship between the mind, body and health and educating the public (e.g., Benson-Henry Institute of Mind Body Medicine, Massachusetts General Hospital; Mind-Life Institute; The Center for Mind-Body Medicine). Additionally, several research and training programs were established (e.g., Center for Integrative Medicine, College of Medicine, Arizona; Center for Mindfulness in Medicine, Health Care and Society, University of Massachusetts Medical School). This public interest also drove the establishment of a formal office within the government’s National Institutes of Health. The mission of the Office of Alternative Medicine, established in 1991, which in 1998 became known as the National Center for Complementary and Alternative Medicine (NCCAM), is to organize and define the world of CAM so that evidence based research can be conducted and integrated into mainstream medicine. This growth in various sectors of public life including popular media, education, research, private and public centers or institutions, has been fueled by consumer demand. Importantly, Americans are utilizing CAM/ Mind-body practices to maintain health or deal with a health crisis in record numbers and



this is necessarily putting pressure on purveyors of health to become more knowledgeable about these practices (Eisenberg et al., 2001).

### **Current Utilization**

According to studies conducted by the NCCAM and Harvard Medical School, in 2002, 35% of Americans utilized a CAM practice and in 2007, 38% of Americans utilized CAM suggesting that CAM utilization is on the rise (Tindle et al., 2005; NCCAM, 2007). Likewise, another national survey reported that 67% of respondents had used CAM in their lifetime and that CAM use was positively correlated with age (Kessler, 2001). In other words, as people age they become more inclined to use a CAM modality. When spiritual practices are included in surveys, the number reporting CAM use in a given year jumps to 75% (Barnes et al, 2004).

In addition, as part of the 2007 National Health Interview Study (NHIS), conducted by the Centers for Disease Control (CDC), data was collected on how much money Americans were spending on CAM. The results showed Americans in 2007 spent \$33.9 billion out of pocket on CAM visits, products, classes and materials and made more than 300 million visits to a CAM provider. This constitutes a total of 11.2% of all out-of-pocket health care expenses paid by consumers, a relatively large percentage of overall health care expenditures, according to the authors. The study also highlighted changes in consumer behavior; for instance, compared to results from a similar study in 1997, consumers spent less on homeopathy and more on mind-body practices like yoga, tai chi and qigong (Nahin, et al, 2007).

Some argue that this increase in public interest is a result of growing dissatisfaction with a fragmented health care system that privileges the body over other

dimensions of health (Adler, 2002; Kaptchuk, 2001). This dissatisfaction, however, does not signify a devaluing of conventional care according to other surveys (Eisenberg et al., 2001). In fact, consumers may value both conventional and CAM care, but may be trying to take a more active role in their healthcare and to treat the whole person, body, mind and spirit (Furnham, 1996). One study, conducted by the Department of Family Medicine at the University of Wisconsin, interviewed users and practitioners to uncover the narratives that define CAM and found that the themes of holism, empowerment, access and legitimacy emerged. Overall, these trends suggest that public interest in these modalities is strong. According to the literature, consumers are seeking out more holistic approaches to health, wanting to take control of their health and are most interested in mind-body approaches like meditation, guided imagery and yoga (Barnes et al., 2004; Barrett et al., 2003; Wolsko et al., 2004).

Likewise, public and private institutions have commented on the increasing use of CAM by the public, and the implications for health care delivery systems, research, and the education of health professionals. For example, in 2005 the Institute of Medicine (IOM) was commissioned by NCCAM, 15 other centers and institutes of the National Institutes of Health and the Agency for Healthcare Research and Quality to: describe the public use of CAM; identify major scientific, policy and practice issues related to CAM research and translation into practice; and to develop models for integration (National Academy of Sciences, 2005). The growing public interest in CAM and the response from various sectors of health care suggest that the relevance of CAM to health is strong.

### **Empirical Validation of the Mind-Body Relationship**

There has been an increase in research mapping the biological basis for the mind-body connection (Cohen, 1996; Davidson, et al., 1990; 1992; 1999; 2000; 2003; Glaser, et al., 1998; Herzog, 1990; Jevning, et al., 1996; Kabatt-Zinn, et al., 1992; Kiecolt-Glaser, 1996; Lou et al., 1999; Solberg et al., 1995). This research is emerging from various disciplines including neuroscience, molecular biology, medicine, psychology, psychoneuroimmunology, psychiatry, and others. These studies have uncovered many of the biological mechanisms, which regulate emotion or other aspects of health like stress, including how stress impacts immunity. Additionally, this research has uncovered the neurochemical and neurological basis for our emotions, thoughts and habits of mind elucidating the positive role that contemplative practices, and mental states like happiness, gratitude or compassion have on biological markers of health (Benson, 1983; Benson, Beary, & Carol, 1974; Pert, Dreher, & Ruff, 1998). For example, numerous studies have been conducted on the brain wave activity of experienced meditators, meditating on qualities like compassion (Davidson et al, 1990; Lutz, Brefczynski-Lewis, Johnstone, & Davidson, 2008). Results have indicated that various changes in the body occur when meditators enter a deep meditative state including the reversal of biological markers of the stress response, higher levels of antibodies and immune system related activity, and brain wave states associated with positive feelings (Brefczynski-Lewis, Lutz, Schaefer, Levinson, & Davidson, 2007; Britton, Shahar, Szepsenwol, & Jacobs, 2012; Davidson, Goleman, & Schwartz, 1976; Solberg et al., 1995). One study has shown increased cortical thickness in regular meditators (Davidson et al., 2003).

Increased cortical thickness is one indication of greater ability to maintain focused attention.

Advances in technology over the last four decades have significantly and positively impacted scientists' ability to study changes in the brain and body under certain conditions. Specifically, these technological advances have enabled more in depth study of the relationship between the mind, behavior and emotions, providing concrete evidence of the biological changes that occur when we change our thoughts, activity or shift our emotional state (Lou et al., 1999). This scientific evidence has fueled consumer interest, possibly dispelling notions that CAM practices were hokey, voodoo medicine, or for the less scientific minded. This increase in scientific evidence has played an important role in fueling the popularity of mind-body practices and has likely increased the interest of various health professions in the relationship of these practices to health.

The following paragraphs describe how various health professions have responded to this trend beginning with medicine and nursing and ending with mental health (psychology, marriage and family therapy, social work and counselor education). The focus of the review below is two-fold. First, an overview of what is happening, with regards to CAM, within each professional organization is offered, highlighting journals devoted to CAM, divisions and public campaigns. Then, a detailed review of the literature, within the profession, that focuses on the confluence of professional education/training and CAM is presented.

It is important to note that there are many research collaborations happening within this new field, probably because the holistic nature of CAM crosses many of the

imposed boundaries between medical and mental health research. The result is that a study may have multiple authors from different professions. For example, a study might have as lead author, a medical educator, and have a nurse, or psychologist as second and third author. Likewise, the paper may be published in a psychology journal. The processes for determining where in this review to place these kinds of collaborative papers followed the following criterion and were weighted in this order: (1) the profession of the lead author was considered; (2) the journal was evaluated and effort was made to determine the audience; (3) the profession(s) of the subsequent authors was considered; and (4) occasionally the topic of the article was also considered. Using these criteria collaborative articles were then placed within one of the above-mentioned profession groups and credited as research conducted within that profession. A few articles still proved difficult to categorize. For example, two studies were conducted on attitudes of various health professionals in training (doctors, nurses, social workers, physical therapists, psychologists, etc.). In these cases, the article is discussed in the section corresponding to the lead author's profession, even though, as in one case the article is published in a medical journal.

It is also important to note that the large body of treatment literature related to CAM is not reviewed here in this paper. This body of literature, which considers the efficacy of various CAM modalities in the treatment of specific conditions, is beyond the purview of this literature review. Several high quality reviews of randomized controlled clinical trials exist that point to the usefulness of CAM in the treatment of a variety of conditions. Because the focus of this study is on the confluence of public interest in

CAM and counselor education, this review will focus on how other health/mental health professions and training programs are responding to this interest.

### **Trends in the Use of CAM Among Various Health Professions**

The professional education/training and CAM literature within the disciplines of medicine, nursing, and psychology often falls into three categories: (1) use of CAM within training to develop professional characteristics, (2) curricular innovations, incorporating CAM into training curriculum, and (3) attitudes toward CAM. Not all disciplines discussed here have an established body of literature in each of these areas, however most do. Importantly, all of the professions discussed below have conducted comprehensive surveys of attitudes toward CAM of various stakeholders. The exception is counselor education, and this study seeks to fill this gap. An in depth discussion of the relevance of CAM to counselor education and the few studies which have been conducted will be explored at the end of this review.

#### **Medicine**

In medicine, the response to the public interest in CAM has taken many forms including; response from the professional organizations, substantial empirical and conceptual literature being produced by the profession, and incorporation of CAM topics into medical education.

**Professional organizations' response in medicine.** The professional organizations within the field of medicine (e.g., American Association of Medical Colleges, American Medical Association) have responded by: (a) establishing special interest groups (b) devoting journal issues to the topic (c) collaborating with government

and private institutions to establish best practices, summarize activities, and outline objectives for the field, and (d) making recommendations for the integration of CAM into medical education curriculum.

Likewise, the empirical and conceptual literature within the field suggests that there is significant interest in CAM. This literature not only explores the biological basis of the mind-body connection but also, and various CAM practices and their relevance to particular health issues, but also considers the most ethical way to incorporate the emerging body of research into training and practice (Lake & Spiegel, 2007). The paragraphs below provide a brief review of the empirical literature within medicine that explores the biological basis for the mind-body connection. Then a brief review of summary articles, which evaluate the effectiveness of certain CAM practices in treating particular health issues, is provided. Finally, a more detailed review of what is happening within medical education is provided. Together, the response from the professional organizations, the research mapping the biological basis for many of the CAM practices, the treatment effect of CAM practices, and the response from within medical education suggests that medicine as a whole deems the integration of CAM into health an important topic of study.

**CAM as treatment in medicine.** Within medicine, research on the effects of CAM practices on mental disorders, is often conducted by psychiatrists, suggesting that this group of mental health professionals is actively considering the role of CAM in mental health (Kessler, Soukup, Davis, Foster, Wilkey, Van Rompay, Eisenberg, 2001; Simon, Cherkin, Sherman, Eisenberg, Deyo, Davis, 2003; Unutzer, Klap, Sturm, Young, Marmon, Shatkin, Wells, 2000). For example, Unutzer et al. (2000) used existing survey

data from a national telephone survey (n = 9, 566) to examine the relationship between CAM use and demographic indicators of mental disorders. The researchers found relatively high rates of use of CAM practices among respondents that met criteria for common mental disorders (21%). Interestingly, major depression and panic disorder were more significantly associated with use of CAM than other disorders (e.g., anxiety or substance abuse). The authors conclude that coordination of care is important to improving the treatment of common mental health concerns. Coordination of care would include educating CAM practitioners that a significant number of clients may have mental health issues and need a referral to a mental health practitioner; likewise educating mental health providers on the likely concurrent use of CAM treatments, and ensuring that evidence based practices are being utilized. The researchers also found that factors such as being female, middle age, higher level of education, higher level of medical illness and residing in the Western part of the United States were associated with higher rates of CAM usage.

In another study, Simon et al. (2004) examined the characteristics of mental health visits to CAM practitioners. A representative sample of acupuncturists, chiropractors, massages therapists, and naturopathic physicians from four states were selected. These practitioners reported on 8933 consecutive visits. Researchers determined that between 7 and 11% of visits to an acupuncturist, massage therapist or naturopathic physician were for a mental health concern. This number is similar to what has been reported in conventional primary care. Researchers also found that patients were commonly receiving concomitant mental health care but that coordination of that care was rare. The researchers concluded that mental health providers should expect that



between 10-20% of their patients would be utilizing CAM to treat the mental health concern for which they are seeking treatment.

Lastly, Kessler et al., (2001) studied the use of CAM to treat anxiety and depression. Survey data was collected from a nationally representative population (n = 2,055). Of this sample, 9.4% reported suffering from “anxiety attacks” and 7.2% reported severe depression. Within this group, 56.7% with anxiety and 53.6% with depression reported that they used CAM to treat these conditions. Researchers also found, as in previous studies, that CAM is positively associated with conventional care although the authors note that patients rarely inform conventional practitioners of their use of CAM. The authors conclude that because there are many potential negative interactions between CAM and mental health treatments, evidence of negative side effects from some CAM treatments, as well as positive treatment effects, that it would behoove mental health practitioners to inquire about and be knowledgeable about which treatments are effective and to coordinate care with CAM practitioners. Some medical professionals have responded to this need by compiling manuals that summarize evidence-based studies on use of CAM in mental health.

One such book, authored by psychiatrists, psychologists and CAM practitioners, presents a review of evidence-based CAM treatments for mental health issues and establishes clinical guidelines for ethical use of these therapies in treatment (Lake & Spiegel, 2007). The editors write that the book is a useful resource for “psychiatrists, psychologists, licensed clinical social workers and marriage and family therapists” (p. xix). It is important to note that counselors are not mentioned as a potential audience. The book compares and contrasts conventional medicine and CAM, ultimately

suggesting that an integrative approach is warranted. The authors of the chapters on various CAM modalities explain the historical development of the modality, discuss the quality of available research, present a detailed view of the limitations of current research, and provide a balanced summary of the evidence-based research in the area.

**Medical education literature.** The growing public interest in CAM has prompted those charged with educating future medical professionals to explore the role of CAM in medical education. One event that propelled the integration of CAM into health professions training curricula was an initiative called the *Complementary and Alternative Medicine Education Project*, funded by NCCAM, which awarded 14 colleges of nursing and medicine money to integrate CAM into professional education (NCCAM, 2011). The programs received funding between 2000 and 2003. Various aspects of this project have been reviewed by researchers including: (1) the rationale for implementing, (2) methods used, and (3) results of this project (Gaylord & Mann, 2007; Lee et al., 2007). Gaylord and Mann (2007) summarized the rationale for inclusion of CAM into the curriculum by the grantees and the themes that emerged are presented below:

1. The prevalence and growth of CAM in the United States
2. Response to governmental, legislative, and other mandates
3. Need for enhanced communication between conventional providers and patients using CAM
4. Need to enhance safety of CAM use and interactions with conventional care
5. CAM education's positive impact on broadening core competencies for conventional health care professionals
6. Positive impact on enhancing cultural competency

7. Need for better communication between conventional and CAM providers
8. Potential for improving health care coordination
9. Potential impact on increasing CAM research quality and capacity
10. Potential for enhancing quality of care through informed CAM use

Integration of CAM with conventional health care requires educational venues that prepare conventionally trained caregivers with a sufficient knowledge base for assessing beneficial and detrimental interactions between CAM and conventional care approaches, development of criteria for making informed referrals to CAM practitioners, and enhanced research capacity (p. 927).

The above themes suggest that some in medical education view CAM as relevant to health care and health professional education. Mental health professionals face many of the same conditions cited by physical health providers (e.g., patients who are seeking advice about CAM, patients who utilize CAM for a mental health concern, potential treatment interactions, need for coordination of services, etc.) Thus, regarding CAM, many of the rationales presented above may also apply to mental health. This will be discussed more fully in the section below, on mental health and CAM. What follows is a review of the medical education literature.

A review of the medical education literature reveals three themes: (1) Integration of CAM knowledge, skills and attitudes into the curriculum, (2) attitudes of faculty, physicians and students towards CAM, and (3) the use of CAM within training to develop professional characteristics. This literature is both conceptual and empirical, and signals not only a movement by the profession to dialogue about the role of CAM in

medical education, but also to investigate best practices, obstacles, attitudes, and curricular innovations.

**CAM in medical education curriculum.** Several surveys have been conducted to find out how many medical schools were incorporating CAM into the curriculum. In fact, one study conducted in 1998 found that more than half, 66, of the 124 schools accredited by the American Association of Medical Colleges, offered coursework in CAM (Bhattacharya, 1998). Also in 1998 The American Medical Association surveyed medical schools about their incorporation of CAM topics in a required course or offering a CAM elective and found that 75 medical schools included CAM education in their curriculum (Wetzel, Eisenberg, & Kaptchuk, 1998). A subsequent survey by the same organization found that 82 schools were incorporating CAM into their curriculum, suggesting a rise in the integration of CAM into the curriculum (Barzansky, Jones, & Etzel, 2000). Taken together these surveys suggest that CAM is becoming an important part of medical education.

As mentioned above, the *Complementary and Alternative Medicine Education Project* (NCCAM, 2000) funded 12 medical schools to support curricular innovations in CAM integration. A summary of the curricular approaches utilized by grantees was conducted (Lee et al., 2007). Several approaches were deemed successful including: (1) exclusively putting resources into faculty development (e.g. two-month “CAM Camp”), (2) exclusively integrating CAM content into existing coursework, (3) experiential opportunities for faculty and students, and (4) utilizing evidence-based practice frameworks. In addition, high-level institutional support was also deemed critical to the success of the projects.

Other studies have explored the prevalence of CAM education experiences and courses within medical schools and sought to uncover not only how many schools are integrating this knowledge into their curricula but also what specifically is being taught (Wetzel et al., 1998). Others have explored how to best establish an integrative medicine curriculum (Benjamin et al., 2007).

Studies looking at the incorporation of CAM into medical education curricula have explored whether CAM education changes student interest, valuing, or attitudes toward CAM. In one study researchers designed a course on CAM and evidenced-based medicine (EBM), which included interactive sessions on CAM and evaluated the effectiveness of teaching CAM. Outcome measures included changes in student-perceived knowledge, attitudes and skills. The results were that the majority reported the instruction would be of benefit in their future work (98%). The authors concluded that the integration of teaching EBM principles along with CAM was effective in both teaching about CAM and basic principles within medicine and that together they had an additive effect (Foruoh et al., 2003).

Several studies evaluate the effectiveness of a particular course or curricular innovation within a particular medical education program (Allen et al., 2011; Connelly et al., 2010; Perlman & Stagnaro-Green, 2010). In addition to these single site studies researchers have conducted evaluations of multiple sites and reported on the benefits and challenges of CAM activity both nationally and internationally (Frenkel et al., 2007; Lee et al., 2007). Overall, these studies found that the integration of CAM into medical education curricula had positive results including: increase in faculty development activities, an increase in collaborative relationships both within the university and with

other institutions and creation of new programs. Additionally, researchers noted that while there is considerable agreement about integrating CAM into medical education curricula, how this should be done varies widely although, a few themes emerged. First, a focus on giving physicians evidenced-based knowledge was deemed important. This includes having a process for sorting out misinformation and determining what can reasonably be integrated into the existing health delivery system. Second, experiential opportunities within courses were deemed important though not necessary. Attitudes surveys of various professions have found that experience with a CAM modality increases one's positive attitude toward CAM in general. It may be that this personal experience with CAM gives the health provider an important experience with the possibility of these practices.

In another study, a survey of those teaching CAM courses in medical schools was conducted (Brokaw et al., 2002). The authors cite the rise in CAM education within medical schools and the lack of information detailing what is taught within these courses as the rationale for conducting the survey. The topics that were most often being taught were acupuncture (76.7%), herbs and botanicals (69.9%), meditation and relaxation (65.8%), spirituality/faith/prayer (64.4%), chiropractic (60.3%), homeopathy (57.5%), and nutrition and diets (50.7%). On average, students received about two contact hours of instruction, the course was most often an elective, and a CAM practitioner or "prescribers of CAM therapies" most often taught the course. Only 17.8% of the courses emphasized a scientific approach to the evaluation of CAM effectiveness.

In response to the growing public interest in CAM the Association of American Medical Colleges responded in 1997 by establishing a special interest group on CAM.

The annual meetings have been oriented to exploring some of the fundamental questions associated with integrating CAM into medical education curriculum and included the perspective of both educators and practicing physicians. The questions explored by the panel of leading stakeholders in medical education included: Which CAM topics should be included in the medical school curriculum? What level of CAM information do allopathic doctors need? What teaching methods and formats are most effective? Who should instruct students about CAM risks and benefits? How can education about CAM therapies gain faculty and administrative commitment and support? How can CAM information be incorporated into existing curricula without marginalizing content? And what is a tenable vision for the future of CAM education? Wetzel et al. (2003) summarized what evolved from these discussions over the course of five years. Additionally, they discuss the emerging rationale for incorporating CAM into medical education curriculum.

Wetzel and colleagues (2003) offer several reasons for incorporating CAM into medical education curriculum. First, the increase in utilization of CAM practices by consumers and that consumers may be using CAM to treat specific conditions and may or may not be talking with their physician about it. In fact, research has revealed that less than 40% of patients discuss their use of CAM with their primary care physicians leading to adverse interactions between conventional and CAM treatments (Eisenberg et al., 1998). Second, some consumers are seeking out primary care physicians who can knowledgably advise consumers about evidenced based treatments or have a willingness to integrate CAM into treatment. Third, patients may turn to their primary care physicians for referrals to reputable CAM practitioners. These reasons form the

foundation of the argument about the importance of integrating CAM into medical education. According to the authors, by educating doctors in the science behind CAM/mind-body practices, exposing them to evidence based research, and giving them an opportunity to experience these practices, medical education is ensuring that doctors can act ethically, responsibly refer, or integrate treatments that have been proven successful, and reduce the overuse of invasive, costly procedures that are driving up the costs of healthcare. To inform the successful integration of CAM into medical education the authors summarize the suggestions that have emerged from discussions with medical educators and physicians at the meetings. Ten steps were listed: (1) Define a core curriculum in CAM, (2) Teach one integrated form of medicine, (3) Create opportunities for cross-fertilization (with CAM schools), (4) Involve faculty and students, (5) Develop support and commitment from the institution, (6) Establish a theme in the curriculum, (7) Incorporate CAM in cases, (8) Offer a well-designed elective, (9) Include an experiential component, and (10) Plan across the curriculum from undergraduate to graduate and continuing medical education.

The studies reviewed above suggest that within medicine there is ongoing exploration into the prevalence of and type of CAM integration into medical education. This information has subsequently informed the dialogue and research on how to ethically integrate CAM into the medical education curriculum.

The coherent approach toward the integration of CAM into medical education, highlighted above, was also informed by research that investigated the attitudes and beliefs of educators and physicians towards CAM. This survey research revealed obstacles, discovered that education and valuing CAM were positively correlated, and



uncovered a relationship between institutional valuing and student valuing. It also revealed that there were institutions and educators who were pioneering the incorporation of CAM into medical education, which spawned further research into the curriculum approaches within those programs, to discover what was working and what was not successful. Following is a review of this research that focuses on the attitudes of the stakeholders.

**Attitudes toward CAM in medical education curriculum.** There is a considerable amount of literature in medicine exploring the attitudes of students, faculty and physicians towards CAM. The majority of this literature focuses on medical student or physician attitudes, beliefs, and valuing of CAM (Berman et al., 1995; Berman et al., 1998; Crock et al., 1998; Rosenbaum et al., 2002; Sikand & Laken, 1998; Song et al., 2007). One systematic review of the literature has been conducted on attitudes of health professionals toward CAM (Sewitch, Cepoiu, Rigillo, & Sproule, 2008). This review improved on limitations of other reviews by including health care professionals from various fields (physicians, nurses, dieticians, public health professionals, social workers, medical and nursing school faculty and pharmacists) and concretely defining CAM by using NCCAM definitions. For the purposes of this review attitudes were defined as “beliefs regarding CAM efficacy and/or legitimacy, personal use, clinical practice use and referrals, communication with patients about CAM, level of knowledge, and the need for information regarding CAM therapies” (Sewitch, 2008, p. 141).

Stratton et al. (2007) highlighted the importance of assessing stakeholder attitudes including faculty, students, clinicians and patients in an evaluation of CAM education in health profession programs. These authors reported that programs believed

the evaluation of attitudes was important because of the role they play in behavior and behavior change.

Fewer studies have considered the attitudes of physician faculty (Boucher & Lenz, 1998; Berg & Stoller, 1998; Kreitzer et al., 2002; Lie & Boker, 2006). These studies are similar in that they report that faculty generally believe that the incorporation of CAM education is important, have utilized CAM at similar rates to the mainstream population, report more positive attitudes towards CAM if they have had personal experience with or training in CAM, and often make referrals to CAM practitioners. Several of these studies report that assessment of faculty attitudes is important because the information highlights potential obstacles to integration or meaningful relationships between CAM education/practices and attitudes (Hsiao et al., 2005; Rosenbaum et al., 2002; Song et al., 2007). One study, conducted a survey at one of the nation's largest teaching hospitals on attitudes, awareness and behavior related to CAM among academic physicians (Rosenbaum et al, 2002). This study concluded that more CAM knowledge was directly related to valuing and attitudes toward CAM. The results indicated that most physicians underestimate patient use of CAM approaches. Most faculty believed that only 10-20% patients were using CAM which is in contrast to national statistics that report nearly 40% of the population use CAM, and that people in a health crisis may use CAM more frequently. Among the respondents, the average self-reported knowledge of CAM score was 2.5 on a 5-point scale. This meant that the majority of respondents fell between having heard of CAM and reporting that they knew something about CAM. According to the authors, overall, these results indicate low levels of knowledge about CAM. Another interesting finding was how often and for what CAM therapy physicians

referred patients. The study reported that 77% of physicians referred patients to a CAM modality and that they most often recommended biofeedback (57%), massage therapy (41%), and meditation (40%). The authors point out that the high referral rates for these practices may be due to the fact that these modalities have been available through the counselor education and health promotion program within their particular institution since 1996. Additionally, the faculty that had used CAM were more likely to perceive it as useful, suggesting that experience with CAM impacts valuing. Another interesting finding was that the majority of faculty believed that CAM should be taught as part of medical school curriculum. One important limitation of this study is that yoga was not included in the list of CAM therapies provided to survey participants despite the fact that yoga is one of the more commonly used practices (Barnes, Bloom, & Nahin, 2008). Of importance to counselors is the finding that the presence of a counselor education and health promotion center within the medical institution positively influenced physician knowledge of CAM/mind-body therapies and referrals to the approaches.

Other studies have focused on the attitudes of patients or physicians from various medical disciplines (Ben-Arye et al., 2008; Hsiao et al., 2005; Song et al., 2007). These studies suggest several reasons for exploring the attitudes of patients or physicians: (a) understanding patient attitudes uncovers potential interest in integrative services, (b) to explore the sources of interest or negative attitudes, and (c) to determine the role education plays in shaping attitudes.

Another theme that surfaced repeatedly in the literature on attitudes toward CAM was that more knowledge and/or personal experience one had with CAM was positively correlated with more positive attitudes, belief in effectiveness and valuing of CAM. This

relationship was evident with both faculty and students (Chaterji et al., 2007; Riccard & Skelton, 2008; Rosenbaum et al., 2002). Given the inherent philosophical differences between CAM and allopathic medicine it is not surprising that knowing less about CAM, which is often perceived as lacking the rigor of western medicine, would result in negative attitudes toward CAM. These studies seem to suggest that simply relying on current attitudes to determine if integration of CAM into medical education is important would not be wise given that in most instances some, even moderate exposure to CAM, results in an increase in positive attitudes toward CAM (Chaterji et al., 2007; Rosenbaum et al., 2002).

Another recurrent finding was that attitudes of medical students toward CAM were relatively positive (Lie & Boker, 2006; Riccard & Skelton, 2008). Students often reported that integration of CAM into the curriculum and philosophical approach in training was important and would benefit them professionally (Lie & Boker, 2006). This was true of students who were exposed to CAM within their medical education curriculum and who were in programs that did not address CAM (Furnham & McGill, 2003; Riccard & Skelton, 2008).

In one study conducted at Georgetown University School of Medicine, positive attitudes about CAM were true of first year students and as well as senior students (Chaterji et al., 2007), although in some instances researchers found that opinions toward CAM degraded over time, especially when not exposed to CAM material (Furnham & McGill, 2003; Riccard & Skelton, 2008). One explanation for the negative shift in attitudes toward CAM over time is that students become more indoctrinated into a philosophical approach that runs contrary to CAM. In one study, although attitudes

declined over time, mean scores represented positive attitude across all years of medical education studied (Riccard & Skelton, 2008). Another study found that student attitudes toward CAM stay relatively stable across time although in this study there was acknowledgement of the institution valuing CAM. Institutional valuing was described as CAM being integrated into the philosophical approach, curriculum, centers within the health system that offered CAM, or the presence of faculty who valued CAM (Lie & Boker, 2006).

Research on student attitudes found that CAM was believed to be more holistic than conventional medicine and that CAM can offer patients more time to discuss and deal with health issues (Furnham & McGill, 2003). These findings suggest positive attitudes and interest in more holistic approaches. Students in this study not only held positive values toward CAM, yet maintained a sense of skepticism towards the safety and efficacy of CAM. These studies collectively suggest that skepticism and concern about the safety of CAM is not indicative of negative attitudes toward CAM.

In an evaluation of NIH funded CAM education programs, researchers determined that the attitudes of stakeholders (students, faculty and clinicians) were necessary components of behavior and behavior change but were not sufficient predictors (Stratton et al., 2007). This study used information gathered from the 12 health education programs that received CAM education project grants between 2000 and 2003. The recipients were both nursing education and medical education programs. Ultimately, the researchers surmised that across all programs evaluating stakeholder attitudes was an important part of CAM education programs and enhanced the development and refinement of the curriculum.

**CAM in the development of professional characteristics in medicine.** Several studies in medicine have considered the role of CAM in the development of competent medical professionals (Elder et al., 2007; Elder, Hustedde, Rakel, & Joyce, 2008; Saunders et al., 2007; Shapiro et al., 2005). Specifically these studies explore the role CAM activities play in the development of professional characteristics like self-awareness, recognition of personal bias, reflection, improved physician-patient communication, self-care, dutifulness, mindfulness, self-efficacy, and job satisfaction (Carmody & Baer, 2007; Elder et al., 2008; Saunders et al., 2007). This body of literature also suggests that some CAM practices like mindfulness may lead to increased levels of mindfulness, non-judgmental awareness, and lower levels of perceived stress and higher levels of psychological well-being (Carmody & Baer, 2007). The relationship between high levels of stress, negative emotion, and high levels of medical or psychological symptoms have been related to poor job performance, burnout, and better patient care (Saunders et al., 2007).

In one study researchers explored the ways in which CAM education projects, funded by NCCAM, contributed to learner professionalism (Elder et al., 2008). Specific attention was given to how CAM may play a unique role this development. The purpose of this study was to investigate training in values and attitudes that might be uniquely obtained through CAM education. The authors made a point to distinguish training in values and attitudes towards CAM from education in CAM skills and knowledge as well as medical skills and knowledge in order to determine if there was a unique effect. Participants were asked to rate their project's impact, on a scale of 1 to 5, with 1 = very low and 5 = very high, on the following: (1) Philosophy or perspective on health and

illness (mean = 4.00), (2) Attitudes valuing interdisciplinary care (mean = 3.73), (3) Commitment to personal growth as fundamental to the practice of medicine (mean = 3.67), (4) Valuing of self-care for physician well-being (mean = 4.07), (5) Recognition that multiple, often unknown factors influence healing (mean = 3.73), and (6) Recognition that personal, cultural, ethnic, and spiritual beliefs may affect patient treatment decisions (mean = 4.4). The CAM education projects exposed students to a wide range of mind-body techniques including spirituality experiences, which according to the authors “enriched students’ understanding of healing” (p.131). The results also indicated that the CAM education projects successfully fostered self-care mitigating the stress of service delivery. The results point toward a positive interaction between professionalism and CAM education.

In another study a survey was administered to the same group of grantees to determine the value project leaders placed on curricular activities that developed self-awareness and what activities they chose to develop this quality (Elder et al., 2007). The 14 project directors rated activities promoting self-awareness as highly or very highly valued components of CAM education. Specific activities that increased self-awareness included evidenced based CAM activities that uncover personal biases or impair critical thinking, personal health experiences to expand definition of health beliefs, and mind-body medicine skills group to personally integrate the use of mind-body techniques for wellness and stress management. The authors concluded that both didactic and experiential CAM activities foster student self-awareness and personal growth.

In a study of medical students enrolled in a Mindfulness Based Stress Reduction (MBSR) program at the University of Massachusetts Medical School, researchers

explored the relationship of MBSR training on a variety of outcome measures including level of mindfulness scale, perceived stress, medical and psychological symptoms and wellbeing (Carmody & Baer, 2007). The results showed that levels of mindfulness increased significantly over the course of the eight-week program. In addition, extent of home practice of the MBSR skills was significantly correlated with degree of change in mindfulness, and significant reduction in medical and psychological symptoms and stress and an increase in wellbeing. This study suggests that a specific CAM practice, MBSR, is significantly correlated with improvements in factors associated with job-satisfaction, quality patient care, and professionalism. These factors have been described as important both by the Association of Medical Colleges and medical school faculty who oversee curriculum development (Maudsley & Fryer-Edwards, 2003; Saunders et al., 2007).

In another study of Medical students at Georgetown University Medical Center, researchers studied the affect of a Mind Body Skills (MBS) course on levels of self-awareness and reflection. The 11-week MBS course was developed through an NCAAM grant at the Center for Mind Body Medicine and offers opportunities for development of knowledge, skills and attitudes and incorporates experiential exercises. Students received two contact hours of instruction each week. The first hour included a meditation and “check-in” where students shared something personal. During the second hour students were presented with a specific mind-body practice and then had the opportunity to practice. At the end of the 11-week course students completed a variety of self-report measures including six open-ended questions about the MBS course, which this study focused on. Five main themes evolved from the qualitative analysis of the open-ended questions: (1) connections, (2) self-discovery, (3) learning, (4) stress relief, and (5)



medical education. The authors note the central themes that emerged, self-discovery, stress relief, and a related category, connections (opportunity to share feelings, dispel feelings of isolation and loneliness and connect with others) are supported by other studies of medical student stressors. Medical education is becoming increasingly interested in ways to reduce stress and psychological symptoms since both of these factors have been associated with poorer performance, and lower levels of empathy and professionalism. The authors conclude that the MBS course may be a way to not only increase medical students' knowledge and skills of CAM but also to develop professional characteristics like professionalism, empathy, self-awareness and reflection.

These studies suggest that CAM has the potential to develop professional characteristics in medical student trainees that are linked to better patient outcomes and lower levels of burnout within the profession, although much work needs to be done to determine the strength of these connections. The studies above note a variety of limitations including poorly defined interventions, limited sample sizes, and use of different self-report measures across studies, making generalization difficult. Medical education has clearly taken up the task of studying the relationship between CAM and the development of characteristics that enhance professionalism. Next, a review of what is happening with regards to CAM in the field of Nursing is presented.

## **Nursing**

**Professional organizations' response in nursing.** Nursing has taken many steps to integrate CAM into the profession. For example, the American Nurses Association (ANA) officially recognized Holistic Nursing as a nursing specialty in December 2006 (AHNA, 2011). The American Holistic Nurses Association (AHNA) defines Holistic

Nursing as “all nursing that focuses on healing the whole person and integrates complementary and alternative approaches (CAM) into clinical practice” (AHNA, 2011). In fact, nurse educators have written about the historical development of nursing which, from its inception has taken a holistic approach to healing and caring and integrated complementary therapies (Breda & Schulze, 1998; Snyder & Lindquist, 2006). Florence Nightingale, who is said to have laid the foundation for professional nursing, took a holistic approach to caring and healing. She not only advocated good nutrition, music, and a clean environment to promote health, but was also famous for discussing the interconnection between the mind body, environment and health (Nightingale, 1859,1936,1992). Nursing as a profession has made a strong link between the philosophical foundations of nursing and CAM (AHNA, (n.d.); Breda et al., 1998; Dossey, Keegen, & Guzzetta, 2005; Halcón, Chlan, Kreitzer, & Leonard, 2003; Snyder et al., 2006). This strong connection between the philosophies of CAM and Nursing has resulted in a considerable amount of dialogue about the role of CAM in nursing.

A search on the homepage of the ANA using the terms “complementary and alternative” revealed 31 articles, suggesting a moderate amount of dialogue about the topic (Nursing world, 2011). In addition, almost half of the State Boards of Nursing (47%) have taken the position that CAM and nursing are philosophically aligned and nurses are therefore permitted to practice a range of these therapies (Sparber, 2001). The fact that State level boards of nursing and the national professional organization have acknowledged the relationship between CAM and nursing suggests that nursing as a profession is engaged in integrating CAM, and deems the integration necessary and important. Other evidence that nurses value the integration of CAM exists and includes

writing, research, and curriculum development. The following paragraphs highlight some of the work being done in these areas.

Nurses have authored numerous books on CAM (Dossey, Keegen, & Guzzetta, 2005; Freeman, 2004; Fontaine, 2010; Rankin & Bex, 2001; Snyder & Lindquist, 2006). Among these are books documenting the emerging scientific evidence for use of CAM modalities with certain health conditions (Freeman, 2004; Fontaine, 2010; Rankin-Box, 2001). The books are designed for use by nurses practicing integrative medicine and provide evidenced based information on the ethical integration of CAM modalities into nursing practice.

Other books point to the philosophical foundations of holistic nursing, which not only integrate CAM modalities, when appropriate, but share the principles promulgated by CAM traditions (Dossey et al., 2005; Snyder & Lindquist, 2006). These books describe an approach to nursing that considers the whole person, body-mind-spirit, and which values a person's subjective experience of health. One example of this holistic approach, which mirrors CAM philosophy, is evidenced in Dossey et al.'s (2005) definition of healing. This excerpt is from their book titled *Holistic Nursing: A Handbook for Practice*. The process of bringing together aspects of one's self, body-mind-spirit, at deeper levels of inner knowing leading toward integration and balance with each aspect having equal importance and value; can lead to more complex levels of personal understanding and meaning; may be synchronous but not synonymous with curing (p. 6). This definition mirrors the philosophical foundations of many CAM modalities, which focus on assessing and treating the whole person (NCCAM, 2011). NCCAM provides the following definition of mind-body practices:

Mind and body practices focus on the interactions among the brain, mind, body, and behavior, with the intent to use the mind to affect physical functioning and promote health. Many CAM practices embody this concept—in different ways. (NCCAM , 2012)

The similarities between the two philosophies are apparent. Both focus on the importance of the mind in promoting health and well-being.

Other books both espouse an integrative or holistic philosophy and provide an overview of some of the more common CAM modalities (Snyder & Lindquist, 2006). Books of this type do not, as others do, summarize the current empirical literature for various CAM modalities. Rather, they seek to give the nurse practitioner basic information about the history, cultural context, definitions, descriptions of interventions, and the scientific basis for CAM modalities. The purpose of these books seems to be to educate practitioners, more generally, about the field of CAM. Whereas, books which focus on detailing the scientific evidence for each modality provide nurses or health care professionals, who are practicing integrative medicine, guidance on how to ethically integrate CAM into practice.

Additionally, within the profession there are two journals devoted to holistic nursing and CAM: *Holistic Nursing Practice*, and *Journal of Holistic Nursing*. Having two journals devoted to publishing scholarly research on holistic nursing and CAM as well as publishing scholarly books on the topic suggests that the nursing profession is actively engaged in integrating the field of CAM into the profession.

These journals are supported by the existence of a specialty area in Holistic Nursing. The specialty area creates a structure, which supports research, training and education about CAM. For example, the specialty area creates demand for faculty who have expertise in this area, supports research conducted on CAM and nursing, and

generates a body of practitioners that have training in CAM and holistic approaches to healing and caring. As a result, nurses have authored numerous books and research papers, been awarded several grants, and participated in national projects related to CAM.

**CAM as treatment in nursing.** Nursing has also conducted research evaluating the efficacy of CAM practices for particular health issues. Numerous reviews of this research have been conducted which summarize the role of CAM in the treatment of various conditions or amelioration of symptoms including pain, cancer treatment, heart disease, women's health, depression, and post-operative healing (Anderson & Taylor, 2011; Bell, 2010; Carpenter, Crigger, Kugler, & Loya, 2008; Monroe, 2009; Wirth, Hudgins, & Paice, 2005). For example, Carpenter et al. (2008) reviewed the literature on hypericum use (also known as the herb St. John's Wort) and its effect on depression. The authors conclude that hypericum has sufficient support from the research to be recommended for use with depression although several limitations are mentioned. Importantly the review highlights the importance of this information to nursing practice and makes several recommendations about how nurses communicate this information to patients.

Wirth et al. (2005) reviewed 34 publications on the use of herbal therapies to reduce pain. The authors report that there is insufficient evidence supporting the use of herbal therapies for pain. The authors suggest that the information provided should be used educate nurses and patients on the use of herbal therapies with pain.

Anderson and Taylor (2011) reviewed randomized controlled trials on healing touch to establish the clinical efficacy of healing touch for medical conditions. The

authors conclude that some evidence exists that energy therapies may be effective with certain conditions. However, they noted that relatively few studies exist, and these studies are plagued by various methodological flaws, which limit generalizability or the ability to establish causation. The authors note that healing touch was established within the field of nursing and has been incorporated into nursing practice, and therefore warrants more systematic study.

Another review considered the use of Therapeutic Touch (TT) for pain management (Monroe, 2009). The author highlights the evolution of Therapeutic Touch within the nursing profession and summarizes the research conducted between 1997-2007. The majority of the studies found statistically significant, positive results for the use of TT in pain management. The author concludes that Therapeutic Touch is a non-invasive technique that can effectively reduce pain. Finally, the author recommends that nursing consider TT for pain management especially with osteoarthritis, musculoskeletal or burn pain.

In another review, Bell (2010) describes the research on CAM use by patients who are considered survivors of cancer, to provide nurses with an understanding of CAM use in survivorship. The author cites the unmet needs of cancer survivors, post cancer treatment, as an important area of concern for oncology nurse practitioners. The author concludes that patients desire strategies for self-care that will decrease stress, residual symptoms, and increase quality of life after cancer treatment. Various CAM modalities are highlighted as effectively addressing these concerns. Taken together these reviews suggest that nurses are actively engaged in reviewing research on CAM and integrating it ethically into the profession.

**CAM in professional education and training for nursing.** In addition, nursing has begun considering the role of CAM in nursing education (Cornman, Carr, & Heitkemper, 2006; Fenton & Morris, 2003; Halcón et al., 2003; Kim et al., 2006; Lee et al., 2007; Melland & Clayburgh, 2000; Pepa & Russell, 2000; Reed, Pettigrew, & King, 2000; Richardson, 2003; Zeller et al., 2001). Some schools have integrated CAM into particular courses within the curriculum (Fenton & Morris, 2003; Richardson, 2003) while others have developed stand-alone courses (Melland & Clayburgh, 2000; Pepa & Russell, 2000; Reed, Pettigrew, & King, 2000). Richardson (2003) surveyed undergraduate nursing programs and found that 77% of the schools that responded reported integrating CAM into the curriculum in some form. This suggests that a significant number of nursing schools have taken up the task of integrating CAM into professional education.

Similarly, researchers have considered the role of mind-body education in nurse education programs. Lawson and Horneffer (2002) considered the effect of a patient mind-body education course that was grounded in three principles promoted within the nursing field: wellness promotion, treating the whole person, and CAM education. The course was offered to patients within an integrative medicine clinic and through other community based venues and included both educational and experiential components. The researchers, using a pre-post design, found that the patients experienced positive physical, emotional and spiritual changes at the end of the course. In their conclusion the authors suggest that nurses may become important purveyors of CAM/mind-body related information in primary care settings and therefore training within nursing education programs is essential (Lawson & Horneffer, 2002).

**CAM in the development of professional characteristics in nursing.** Some researchers have explored the role of concepts like self-care and the development of professional characteristics like self-awareness, health promotion mindset, and positive self-concept within the nursing curriculum (Horneffer, 2005). While in this study specific CAM practices were not mentioned, practices which cultivated self-reflection and which developed more self-awareness were considered. Importantly, the author found that self-care and self-concept in nursing students were important correlates to a health promotion mind-set. Many mind-body programs have the cultivation of self-awareness as a key experiential component. For example, the Center for Mind Body Medicine states in their mission statement that, “The Center teaches scientifically-validated mind-body medicine techniques that enhance each person’s capacity for self-awareness and self-care to health professionals around the world” (CMBM, 2012). The link between mind-body practices the concepts of self-awareness and self-care is established and those interested in the education of future nurses are exploring the role these practices might have in developing competent caring professionals.

Similar to medicine, nursing has taken stock of stakeholder (patient, nurse, student and faculty) attitudes towards CAM (Booth-Laforce et al., 2010; Laurenson, MacDonald, McCready, & Stimpson, 2006; Shorofi & Arbon, 2010). One example is a study conducted by Tracy and Lindquist (2003). The researchers considered the role critical care nurses’ attitudes, knowledge and experience with CAM play in the integration of CAM in critical care situations. The authors proposed a model relating nurses’ CAM knowledge, experience and attitudes to facilitation of CAM in the critical care environment. This model suggests that when nurses are exposed to CAM in their



training they are more likely to facilitate CAM therapies in critical care situations. Likewise, lack of knowledge or experience is often correlated with negative attitudes, making nurses less likely to facilitate a CAM therapy even when requested by the patient (p. 291). The authors suggested that a beginning step in understanding barriers to the integration of CAM therapies would be to assess the attitudes of critical care nurses and their use of CAM. Therefore, they conducted a national survey of critical care nurses. The results of the survey suggested that overall use of therapies with patients was high (92% used diet and exercise; 80% used relaxation; 70% used prayer; 68% massage; 60% counselor education). Attitudes toward CAT (authors use this abbreviation for Complementary and Alternative Therapies: CAT) were also reported as very high with 98% of respondents saying that they were eager to incorporate CAT into critical care. Most participants (75%) also indicated a moderate or high level of experience with more popular CAT therapies (massage, prayer, counselor education, relaxation techniques). Overall, this study suggests there is value in exploring critical care nurse's attitudes, knowledge and practice patterns with CAM.

Other studies have considered attitudes toward and knowledge of CAM of students and faculty in nursing programs and the impact of CAM education on these factors (Booth-Laforce et al., 2010; Laurenson, et al., 2006; Halcón et al., 2003). For example, Halcón et al. (2003) conducted a cross-sectional survey of undergraduate nursing students ( $n = 73$ ), MS and PhD students ( $n = 47$ ), and faculty ( $n = 50$ ) in a university-based nursing program. Interestingly, 95% of students and faculty believed that CAM should be integrated into clinical care. Overall, the study reported positive attitudes toward CAM by both faculty and students. Participants reported that they

desired more knowledge and that the greatest barrier to integration was lack of evidence supporting the use of CAM for various conditions.

The researchers conclude that curricular change is needed to fully integrate CAM into the curriculum and that faculty development and nursing research are two important areas to begin with to facilitate such integration. Overall this study suggests that nursing faculty and students may hold very positive attitudes toward CAM. One reason for this high percentage may be that many of the core tenets of CAM are taught in nursing curriculum (Dossey et al., 2005; Snyder & Lindquist, 2006).

It is apparent from the review above, that two of the major health professions, medicine and nursing, are exploring ways to integrate the field of CAM into conventional health care. Each of the professions are engaged in empirical research considering the efficacy of CAM treatments, the role of CAM in developing the health care professional, and the role of CAM in professional education. Likewise, several mental health professions have taken up the task of considering the role of CAM within their professions. Following is a review of the research on CAM and mental health followed by review of what the fields of Psychology, Social Work and Marriage and Family Therapy are doing to explore the role of CAM within their professions.

## **Psychology**

**Psychology's theoretical relationship to CAM.** Psychologists have been theorizing about the integration of the mind and body for several decades (Buchanan, 1812; Edwards, 1754; James, 1896; 1902; Parish, 1805; Wozniak, 1992). Robert Wozniak (1992), in his history of the mind-body relationship in psychology chronicles the academic works of numerous psychologists that explored this topic. Beginning with

Jonathan Edwards from the eighteenth century, Wozniak describes the early evolution of psychological thought that posited a link between the mind and the body. To make the case that philosophers in the field of psychology have been exploring the mind body connection for many years, he critiques the works of among others, Joseph Parrish, Joseph Buchanan, Catherine Beecher and William James. He describes how each of these philosophers explored the connection between the mind and body, finally ending the discussion with William James. Wozniak suggests that one common thread in all of these works is the ardent quest to dismantle the mind body dualism that had been promulgated earlier by philosopher Rene Descartes (Serendip, 1995; Wozniak, 1992). This historical account suggests that psychology has a long history of exploring the relationship between the mind and body.

More contemporarily, the field of psychology has taken up the task of dialoguing and researching about the integration of the mind and body. George Engel (1977) an internist, who wrote about the need to integrate the biological, psychological and social domains had a significant influence on the field of psychology (Suls & Rothman, 2004). Engel (1977) coined the term *biopsychosocial* which came to signify a more holistic approach to mental and physical health and according to some serves as the conceptual base for the field of health psychology (Suls & Rothman, 2004) and for behavioral health psychology training programs (Newton, Woodruff-Borden, Stetson, 2006). Suls and Rothman (2004) in their review of the evolution of research, theory and practice in health psychology suggest that the biopsychosocial model and health psychology have made great strides over the last three decades. In fact the authors state, “As a guiding framework, the biopsychosocial model has proven remarkably successful as it has

enabled health psychologists to be at the forefront of efforts to forge a multilevel, multi-systems approach to human functioning” (p.119). Continuing success relies, according to the authors, on a strong commitment to the biopsychosocial model.

Likewise, Ronald Levant (2005), the President of the American Psychological Association in 2005, stated that one of his initiatives, as president of the organization would be to “put forth a vision of integrated care, a care system that offers ‘Health Care for the Whole Person’” (p. 1090). He also suggested that the biopsychosocial model needs to be fully integrated into training practices since the future of psychology will be increasingly in health care. This commitment to principles that align with many of the theoretical foundations of mind-body practices purported within CAM, suggests that psychology is actively embracing the mind-body movement and responding to the increased public interest in this topic.

Likewise, many contemporary psychologists are not only researching the relationship between psychology, holistic or biopsychosocial approaches to health, and CAM but are taking on leadership positions in integrative health centers, mind-body oriented research centers, and national institutions like NCCAM (Astin, 2004; CMBM, 2012; NCCAM, 2011). For example, the Center for Mind-Body Medicine (CMBM), in Washington DC, offers a mind-body medicine training program which centers around self-care. The program’s mission is to highlight the importance of self-care practices in healing especially with under-served populations, trauma, and medical students. The faculty at the CMBM are diverse and include several doctors, psychiatrists, psychologists, social workers and marriage and family therapists. Notably, there are no counselors on staff.

**Professional organization’s response in psychology.** There is evidence that the primary professional organization within psychology deems the study of CAM important. The flagship professional organization, The American Psychological Association (APA), has responded to growing consumer interest and empirical research by creating a special division devoted to mind-body practices and making mind-body medicine the focus of their public education campaign (APA, 2011). This campaign, titled Mind/Body Public Education Campaign, has as its mission the promotion of psychologists as the “best trained” professionals to address the connection between physical and mental health and support healthy lifestyle and behavior change. The campaign focuses on issues like stress, heart disease and obesity, which all have a mind and body component.

Additionally, APA has made the integration of psychology with health and wellness a priority by including this as an objective in their strategic plan. Goal 2 of the strategic plan, which is to expand psychology’s role in advancing health states, “Key stakeholders realize the unique benefits psychology provides to health and wellness and the discipline becomes more fully incorporated into health research and delivery systems.” In addition this objective states that psychology, as a profession, should “promote the application of psychological knowledge for improving overall health and wellness at the individual, organizational, and community levels” (APA, 2011). These objectives suggest that psychology is aware of the relationship between the mind and body and is taking an active role in providing health and wellness services in these domains.

Likewise, a search on APA’s website using the terms “complementary and alternative” revealed 48 hits. Articles ranged from an overview of NCCAM research

guidelines to an interview with Margaret Chesney, a Ph.D. Psychologist who served as deputy director of NCCAM, suggesting that there is considerable dialogue within the profession, specifically about CAM. This large number of articles published on the website suggests that psychologists are actively dialoguing about the role of psychology within health, the mind-body relationship, holism and CAM.

Additionally, APA solicited an independent market research organization, Harris Interactive, to conduct a national survey on stress for the organization. The survey asked Americans about their understanding of the relationship between stress and physical and mental health. The report produced by APA, titled *Stress in America: Our health at risk*, concluded that while 9 out of 10 Americans believed that there is a link between stress and chronic disease and depression, only one-third of those surveyed believed stress could negatively impact their health. The result, according to APA is a serious disconnect that warrants attention (APA, 2011). In this report APA goes on to suggest a role for psychologists in dealing with this issue. This report suggests that psychology as a profession is taking an active role in exploring the relationship between stress, the mind and the body, and its role in health and forging a new role for psychology in health. This macro level attention to a more holistic philosophical approach, which is also promulgated by many CAM modalities, suggests that the field of psychology is actively considering the more holistic, mind-body approaches to health.

In addition, APA has established a division devoted to *health psychology*. While this division does not explicitly promote CAM, its mission suggests alignment with the general philosophies of CAM modalities. Health psychology has as its mission the development of a theory of health that incorporates the role of the mind, positive emotion

and wellness in both physical and mental health (APA, 2012). As a result research is being conducted by health psychologists that considers the role of psychological constructs like emotion, temperament, mood, and behavior in health and illness (Baum & Posluszny, 1999; Bishop, Yardley, & Lewith, 2007; Diefenbach et al., 2003; Furnham & Smith 1988; Gonzales, Penedo, LLabre, & Duran, 2007; Porter & Diefenbach, 2009; Sirois & Gick, 2002). This research is diverse and includes studies on the role of beliefs in the use of CAM (Bishop et al., 2007); how behavior influences the progression of illness or health (Baum et al., 2007); the role of motivation in CAM use (Sirois & Gick, 2002); negative mood and medication adherence in HIV patients (Gonzales et al., 2007); and psychosocial correlates of CAM use by men with prostate cancer (Diefenbach et al., 2003).

Another arm of psychology, called *positive psychology*, advocates that positive emotions such as optimism, hope, gratitude, and happiness, play an important role in health. In addition to conducting research on this topic, positive psychologists have helped to spur public dialogue about the role of positive emotions like happiness, gratitude, and compassion in health (Emmons & Crumpler, 2000; Lyubomirsky, King & Diener, 2005; Seligman, 1991; Taylor et al., 2007). It is important to note that happiness, gratitude and compassion are all qualities purportedly achieved through the practice of certain CAM modalities (NCCAM, 2012). For example, various forms of meditation require the individual to focus on things they are grateful for (NCCAM, 2012). Some forms of biofeedback also have participants cultivate gratitude or compassion to improve heart rate variability and thus reduce stress (Heartmath, 2012).

Numerous yoga texts promote the idea that happiness can be achieved through consistent yoga practice (Rama, 1989; Stryker, 2011). As a result, some of the practices developed by positive psychology, designed to increase positive emotion, life satisfaction, and mediated stress, draw heavily from various CAM traditions (Seligman, 1991)

Positive psychology has established an empirical connection between the role of positive emotions and the health of the body, forging strong, evidence-based links between the condition of the mind and the health of the body (Cowen, 1994; Emmons & Crumpler, 2000; Fredrickson, 2001; Haidt, 2000; Lyubomirsky et al., 2005; Myers, 2000; Ryan & Deci, 2000; Seligman, 1991; Seligman, Steen, Park, & Peterson, 2005; Taylor et al., 2007). These studies begin with the premise that positive mental states generate physical changes in the body, which, promote healing, health and wellbeing, thus providing evidence for the mind-body connection. While not all research within positive psychology is directly related to CAM or mind-body practices, much of the research has an obvious if not explicit connection to the practices dubbed complementary or alternative. Most commonly, meditation or a secularized form of this practice is the technique invoked to generate positive thinking, emotion or experience. One example of this is the use of mental focus on something that a person is grateful for to invoke positive feelings, and reduce depressive symptoms (Seligman et al., 2005).

Psychologists have also authored numerous books on the topic. Psychologists have also authored many books and book chapters on the use of CAM in mental health or the use of specific CAM modalities in treatments (Germer, Siegel, & Fulton, 2005; O'Donohue & Cummings, 2008; Horneffer-Ginter, 2012)



**CAM as treatment in psychology.** Similarly, psychologists have been studying the role of meditation, mindfulness, yoga and other CAM modalities in reducing stress, preventing relapse and decreasing negative psychological symptoms (Astin, 1997; Baer, 2003; Carmody & Baer, 2007; Jain, Shapiro, Swanick, Roesch, Mills, Bell, Shwartz, 2007; Ma, & Teasdale, 2004; Teasdale et al., 2000).

For example, Baer (2003) conducted a meta-analytic review of empirical studies examining the effects of mindfulness-based interventions, and concluded that mindfulness based interventions may help to alleviate a variety of mental health problems. The author stated, however, that many studies contained serious methodological flaws including lack of control groups and small sample sizes which make it difficult to draw strong conclusions. Despite these issues, the author states that overall the interventions could be designated as “probably efficacious” and that some would qualify as having “well-established” treatment effects.

In another study researchers considered which particular qualities of a CAM intervention, in this case an 8-week mindfulness course, lead to change in negative symptomology (Carmody & Baer, 2007). The authors reported that time spent in-home practice of formal meditation exercises (body scan, yoga, sitting meditation) was significantly related to improvements in psychological functioning. Specifically, the authors found that time spent meditating was a significant predictor of decrease in psychological symptoms and of increase in mindfulness. Thus, practice time and increase in mindfulness proved to be significant predictors of reduced psychological symptoms (Carmody & Baer, 2007).

Others have researched the role of mindfulness-based programs on specific mental health concerns (Jain et al., 2007; Ma & Teasdale, 2004; Ong, Shapiro, Manber, 2008; Shapiro, 2009; Teasdale et al., 2000). For example, Ma and Teasdale (2004) considered the effect of mindfulness-based cognitive therapy (MBCT) on the prevention of relapse in patients with recurrent depression. The researchers found that depression relapse was most often remediated in patients who received (MBCT), were recently recovered from a major depressive episode and who had experienced three or more major depressive episodes. That is, 36% of those receiving MBCT relapsed compared with 78% of the treatment as usual group. Interestingly, the study also revealed that MBCT was less effective in preventing relapse for patients whose depression was precipitated by a significant life event. These studies suggest that psychologists are actively researching the role of mind-body practices in the treatment or prevention of various mental health conditions.

**Development of professional characteristics and CAM.** Within training programs in psychology researchers are also considering the role of certain CAM practices on trainee development, and as self-care strategies (Moore, 2008; Shapiro, Brown, & Biegel, 2007). The following is a review of these studies.

In one study, researchers looked at the effects of a mindfulness based stress reduction (MSBR) program on therapists in training (Shapiro, Brown, & Biegel, 2007). The authors highlight the importance of self-care in the management of compassion fatigue and vicarious trauma. More specifically they note that therapists in training are particularly vulnerable to stress related problems like depression, emotional exhaustion and anxiety, reduced self-esteem, decreased job satisfaction, and loneliness. Particularly,

therapists in training may experience poor concentration and reduced attentional skills due to stress, which negatively impacts performance. For these reasons, the authors posit that teaching trainees a self-care practice that reduces stress could have a significant impact on performance and personal well being. To test this hypothesis the researchers utilized a prospective, cohort controlled design. A total of 64 students in a master's level counselor education psychology program elected to participate. Students were enrolled in one of three courses (Stress and Stress Management, Research methods, psychological theory) The stress and stress management course received the MSBR intervention. The other two groups received instruction as usual and were structurally equivalent to the intervention course. The MSBR intervention lasted 8 weeks and was modeled after the well-established MSBR program designed by Kabat-Zinn. The intervention group received weekly two hour sessions which included training in sitting meditation, body scan, Hatha yoga, guided loving-kindness meditation, and formal mindfulness practices for day-to day life experiences. Distress and well-being were measured using the validated scales of the 20-item Positive and Negative Affectivity Schedule (PANAS; Watson, Clark & Tellegen, 1988). Additionally, stress levels were measured using the 10-item Perceived Stress Scale (PSS; Cohen, Kamarck, & Mermelstein, 1983). The results indicated that students in the intervention group (MSBR training) reported significant pre/post course declines in perceived stress, negative affect, and self-compassion, suggesting that MSBR also aids in emotional regulation.

In another study, clinical psychology trainees practiced brief mindfulness exercises (10 minutes) as a voluntary lunchtime activity (Moore, 2008). The study investigated whether these brief sessions could facilitate the development of personal

understanding. The study utilized a convenience sample of 23 students in a psychology-training program in the United Kingdom. Students had to attend 8 sessions in order to be included in the study. A repeated measures pre-post design was utilized. Perceived Stress was utilized (PSS14; Cohen et al., 1983). The Kentucky Inventory of Mindfulness Skills (KIMS; Baer, Smith, & Allen, 2004) was used to measure the tendency to be mindful in daily life. The results did not show significant changes across pre-post means on the KIMS. However, one subscale “Observe” designed to test skill at observing internal and external mental and physical states was the only subscale which had significant differences between the pre and post scores. The authors suggest that the scale may simply have not been sensitive enough to detect changes. However, another explanation may be that the 8-10 brief sessions were not adequate to produce measurable changes. The fact that significant changes were found in the “Observe” subscale may also be an artifact of innate proclivity for observation, held by those who choose mental health as a profession or which are cultivated within training programs. The authors note that written responses by participants indicated more positive results from participate.

Taken together, these studies indicate that psychology is actively researching the impact of CAM practices like mindfulness on trainee’s well-being and performance.

**CAM in psychology training.** Psychology, like other health professions, has begun to explore the attitudes of various stakeholders toward CAM (Bassman & Uellendahl, 2003; Hyland, Lewith, & Westoby, 2002; Wilson & White, 2007). In the following paragraphs the studies on attitudes of psychologists toward CAM are reviewed.

Wilson and White in 2007 developed a scale titled Psychologist’s Attitudes toward Complementary and Alternative Therapies (PACCAT). The scale was created by

adapting several attitudes scales developed for use in medicine (Halcon, Chlan, Kreitzer, & Leonard, 2003; Hyland, Lewith & Westoby, 2003; Lewith, Hyland, & Gray, 2001).

The researchers cite the lack of a scale that can assess beliefs and attitudes of psychologists and other mental health professionals as the reason for development. Other reasons cited for developing a scale were growing public interest and need for knowledgeable professionals who can refer, ethically treat and create policies regarding CAM. The final scale contained 11 items. The survey was administered to undergraduate, post-graduate and Master's psychology students attending a large University in Australia ( $N = 163$ ). Six practicing psychologists also took the survey to determine how relevant the scale would be to professionals in practice. A factor analysis was performed and three factors emerged (1) *knowledge* of CAM (2) attitudes toward *integration* of CAM into and (3) concerns about the *risks* associated with CAM. These subscales, according to the authors, provide users with more detailed knowledge about CAM.

Potential limitations of this study include a high percentage of female respondents; respondents were geographically limited to one large University in Australia and therefore may have problems generalizing to other groups, and the sample size was small. However, the researchers noted that this was a preliminary attempt to construct an instrument that would be relevant to the field of psychology.

In a follow up study, the 11-item scale developed above, PACCAT (Wilson & White, 2007) was administered to practicing psychologists ( $N = 122$ ). A factor analysis was performed and similar themes were found; knowledge, integration and risks. The researchers found that psychologists' attitudes were generally positive. The majority of

psychologists agreed that clinical care should include the best of conventional and complementary or alternative therapies. Psychologists in this study were less likely to agree that knowledge about these therapies should have been integrated into their training or that knowledge of these practices was important to them as a practicing psychologist. Psychologists also believed more strongly that these practices should be subjected to more rigorous scientific testing than psychology students.

Finally, Bassman and Ullendahl (2003) conducted a preliminary survey of 1,000 members of the American Psychological Association, asking about attitudes toward, use of and beliefs about CAM. The authors note that the response rate was too low (20%,  $N = 202$ ) for generalization but suggest that the results provide an opportunity to begin a dialogue. The authors conclude that the respondents were generally positive about CAM but were also ambivalent and in some cases opposed to the use of CAM as treatment for mental health issues. Approximately half of the respondents were uncertain as to whether state laws permitted the incorporation of alternative healing modalities into psychology practice. Several thought that the law forbids this integration. The majority of respondents were recommending CAM treatments to clients, said they were interested in learning more, and viewed alternative approaches as legitimate. According to the authors, this points to a gap between current laws/policy and professional interest in CAM and beliefs that these practices could be helpful. The authors also report that the results suggest there is an increase in referrals to CAM practitioners by psychologists. They suggest that educational programs should be responding by providing more coursework in this area.

Similar to the medical and nursing professions, psychology has responded to the increased public interest and scientific research documenting the mind-body connection by: (1) drawing theoretical connections between CAM and psychology, (2) constructing a professional response, (3) conducting research on the mind-body connection and particular CAM practices in the treatment of common psychological problems, and by (4) surveying stakeholder attitudes and beliefs about CAM.

### **Marriage and Family Therapy**

**Marriage and family therapy's philosophical relationship to CAM.** Marriage and Family Therapy (MFT) shares a strong theoretical relationship between the philosophies of CAM/ Mind-Body practices and the philosophical tenets of the profession. Both promote a systems approach to health and the integration of mind and body based systems of healing. In the field of MFT this philosophical overlap has resulted in a distinct response to the emerging interest and need for more integrative care. The response of MFTs to CAM in particular has been less pronounced than in the professions highlighted above, and focused more on macro level forms of integration, namely the integration of family therapists in health care settings, known as Collaborative Family Health Care. However, the strong philosophical overlap between this specialty area and the philosophical tenets of CAM practices has likely spurred the dialogue about the relevance of CAM to the profession. Below, a brief discussion of the philosophical relationship between CAM and the collaborative family health care movement is provided. Then a discussion of the research on attitudes toward CAM is presented.

MFTs have forged strong ties with medicine, establishing, researching and creating training programs in collaborative family health care. The specialty in

collaborative family health care recognizes the role of mental health and relationships in physical health issues and strives to bridge the gap in service delivery between these domains.

The collaborative model in family health care has emerged over the last several decades to counter the fragmentation in Western approaches to care (Seaburn, Lorenz, Gunn, Gawinski & Mauksch, 1996). Likewise it was becoming more obvious that the separate treatment systems for mental and physical health were not serving patients (Patterson, Peek, Heinrich, Bischoff, & Scherger, 2002). In fact, it has been estimated that 70% of primary care visits are primarily for psychosocial concerns, and therefore warrant collaboration between mental health providers and physicians (Patterson et al., 2002). MFTs forged relationships with primary care providers and established a specialty area now called collaborative family health care (Patterson et al., 2002).

Marriage and family therapists often cite their theoretical grounding in a systems approach that is looking at problems from multiple vantage points, recognizing the interconnections between families, work, individuals, environment, social relationships and health behaviors as the reason they are best suited for work as collaborative health care providers. Likewise the philosophy of the collaborative family health care movement draws heavily from the biopsychosocial model proposed by George Engel (1977), which was described above.

This grounding in an integrative, systems approach, and training that promotes consideration of interconnections and relationships, has forged a natural interest in CAM (Caldwell, 2010). Interest in this case is measured by the amount of dialogue, research and training initiatives being implemented within the profession.



A recent summary article of couples and family interventions for health-related issues reviews randomized controlled trials of family based interventions for common chronic illnesses and diseases (Shields, Finley, Chawla, & Meadors, 2012). According to the authors there are large numbers of MFTs working in healthcare settings, bridging the mental and physical health divide, however, research on the interventions they provide is only in the developmental stage. Nevertheless, this review highlights the prevalence of MFTs in healthcare settings and suggests that as a profession they have responded to meet the demand for more integrated care.

The literature within MFT does not fall into the categories proposed above (treatment, development of professional characteristics, training practices), however there is evidence of considerable interest in the topic. For example, in 2010 an issue of the *Family Therapy Magazine*, a periodical of the American Association for Marriage and Family Therapy, devoted an entire issue to the topic. Topics included ethics and alternative therapies, a call for MFTs to expand and update their knowledge of CAM, and an introduction to CAM.

#### **CAM in marriage and family therapy professional education and training.**

Two national surveys have considered the attitudes, beliefs and practices of MFTs and found that MFTs overwhelmingly have positive attitudes and beliefs about CAM and the integration of CAM into professional practice (Caldwell, Winek & Becvar, 2006; Olson, Robinson, Geske, & Springer, 2011). As research cited above suggests, when there is a philosophical overlap between the profession and CAM practices, providers and educators in that profession are more likely to value CAM. It is not clear if the natural

overlap in philosophies of CAM and the counselor education field have resulted in the same kind of valuing. Further discussion of the studies in MFT is offered below.

MFT has begun to explore the attitudes of faculty and students towards CAM and the implications of these findings for the profession. In 2006 a national study was conducted looking at the relationship between Marriage and Family Therapists and CAM (Caldwell, Winek, & Becvar, 2006). Participants ( $N = 424$ ) were clinical members of the American Association for Marriage and Family Therapy. Researchers used a survey method to ask participants about their level of knowledge of several CAM modalities, attitudes toward CAM and beliefs about use in MFT. The results indicated that MFT's were aware of and had some knowledge of common CAM practices (71%) and likewise were aware of their clients' use of CAM. Additionally, as a group, MFT's reported that they personally utilized CAM. Specifically, MFT's most commonly utilized meditation, nutritional supplements, massage, chiropractic, relaxation techniques, guided imagery, diet/ lifestyle changes, hypnosis, herbal medicine and prayer therapies. This list is similar to what the general population reports using most frequently (Eisenberg et al., 1993). Less than half of the MFT's surveyed (46.5%) indicated that they had knowledge of a CAM provider to whom they could refer, even though a relatively large percentage (88%) reported that they recommended CAM to clients.

Interestingly, MFT's most often recommended CAM to White clients as opposed to persons of color and female MFT's were more likely to recommend CAM than their male counterparts. The researchers also asked participants about how they had acquired their knowledge. Most MFT's reported that their knowledge of CAM had come from personal experience or exploration. Another interesting conclusion drawn by the

researchers was that several of the CAM practices had transitioned from alternative to “mainstream” including relaxation techniques, guided imagery, meditation, diet lifestyle changes, hypnosis, and or prayer therapies. The authors noted that only about 20% of the respondents indicated that they were qualified to teach or practice these therapies. These results indicate a significant gap between interest in and use of CAM as well as a belief that the practices could be helpful to clients and MFT’s level knowledge of these practices.

Another study, conducted by Olson, Robinson, Geske, and Springer (2011) surveyed the attitudes, beliefs and practices of graduate faculty and students ( $N = 146$ ) from accredited Marriage and Family Therapy programs in the United States and Canada. The authors cite the growing public interest in CAM as well as the overlap between the philosophical foundations of CAM and mental health as reasons for further exploration of this topic within MFT. The authors also note that because clients may be using CAM therapies to deal with mental health issues it is important for training programs to ensure that future MFTs have the appropriate knowledge and skills to integrate CAM into treatment and/or refer the client to an appropriate practitioner. The authors note that the limited available data suggests “there is growing awareness of MBTs (mind-body therapies) among some mental health professionals but a lack of training and comfort implementing/integrating MBTs into practice remains an issue” (p. 321).

The results indicated that the majority of respondents believed that training programs should teach about mind-body therapies (MBTs) (95.6%). Interestingly, the respondents also overwhelmingly believed that faculty should train and supervise MBT as possible adjunctive treatments (89.9%). MFTs were aware that some MBTs could be

useful in treating stress, panic disorder, and generalized anxiety. However, fewer reported that MBTs would be useful in treating depression and PTSD, despite the fact that several controlled clinical trials have shown positive results in the treatment of these conditions with MBTs (Kessler et al., 2001). When respondents were asked about barriers to practice or education, the majority (85.9%) responded that limited or no training in these techniques was the primary reason they did not integrate these practices into clinical practice.

In another study, Becvar, Caldwell and Winek (2006) conducted a qualitative study of MFTs and their relationship with CAM. The authors found four themes that pervaded the interviews: definitional issues, depth of awareness of CAM, fit with MFT, and ethical considerations. The authors found that there was considerable variation in how much practitioners knew about CAM, and in how they defined CAM. They also found that interest utilization and awareness of CAM was consistent with findings within the general population.

Taken together the data above suggest that the majority of MFTs believe mind-body therapies would be useful for their clients, MFTs are very interested in the practices as are their clients, however lack of training, experience and education keeps them from integrating practices that they believe would be helpful.

## **Social Work**

**Social work's philosophical connection to CAM.** Social work, like nursing, has a long history of working within the medical setting. Hospital social work, which later became known as Medical Social Work, was developed in the late 19<sup>th</sup> century. During this time hospitals sought out social service providers to “help connect the client’s

environmental system with the hospital where care was rendered” (Dziegielewski, 2003, p. 50). According to Dziegielewski (2003), a common theme in the history of hospital social work is drawing a connection between the person, the environment and the institution.

Ida Cannon (1877-1960), social worker by training, is often credited with establishing the first medical social work program in the country (Bartlett, 1973). Cannon was hired by Dr. Richard Cabot to direct the country’s first social service program within a hospital setting at Massachusetts General Hospital. She held this post for more than three decades and during this time she worked to establish social work as an integral part of medical care both nationally and at home. In 1913 her book titled *Social Work in Hospitals: A Contribution to Progressive Medicine* was published which outlined the mission of medical social work and how to go about developing programs within hospitals. Cannon in 1952 authored a book titled *On the Frontier of Medicine: Pioneering in Medical Social Service*, which chronicled her four decades of experience in establishing social work within the medical community.

**Professional organizations’ response in social work.** The National Association of Social Workers, the flagship international professional organization for social work, highlights *hospital social work* as an important specialization in the field (NASW, 2012).

The organization defines hospital social work, on their website, as follows:

Hospital social workers help patients and their families understand a particular illness, work through the emotions of a diagnosis, and provide counselor education about the decisions that need to be made. Social workers are also essential members of interdisciplinary hospital teams. Working in concert with doctors, nurses, and allied health professionals, social workers sensitize other health care providers to the social and emotional aspects of a patient’s illness. Hospital social workers use case management skills to help patients and their families address and resolve

the social, financial and psychological problems related to their health condition. (NASW, 2012)

The presence of a specialty in hospital or medical social work along with the establishment of social workers in the hospital setting beginning in the late 19<sup>th</sup> century and continuing to present day, suggests that social work has a long history of integrating the practice of social work with the practice of medicine.

There is also evidence within the field of social work that integration of CAM into social work education has become an important topic of conversation, although fewer studies have been conducted than in the professions highlighted above (Dziegielewski, 2003; Finger & Arnold, 2002; Harriette, 2001; Loveland Cook, Becvar, & Pontious, 2008; Meinert, 2009; Neighbors et al., 2007). The focus of much of the literature in social work is on the utilization of CAM by ethnic minorities (Barner et al., 2010; Choi & Jinseok, 2010; Neighbors et al., 2007).

The Social Work education program at the University of Michigan was highlighted in a 2006 article in *Explore: The Journal of Science and Healing* (Sierpina & Kreitzer, 2006). The column, *Innovations in Integrative Healthcare Education: Massage, Medical and Social Work Student Initiatives*, highlights professional training programs that are weaving CAM education into healthcare education. According to the article the social work education program at the University of Michigan provides not only a foundational course titled, “*Complementary, Alternative and Indigenous Healing Systems*,” but also an advanced course titled “*Theory and Practice of Mind-Body Connections for Health and Self-Care*.” These courses according to Larry Gant, Ph.D., a professor within the program, were implemented to fill the growing need for more

holistic social workers and to fill the gap between the client demand and social worker knowledge of CAM.

In an article in the journal *Health and Social Work*, authors Ai, Rollman and Berger (2010) review the literature on the co-morbidity of cardiac disease and mental health issues. They detail the well-established connection between cardiac disease and mental health and suggest that social workers have a critical role to play in the future of integrative care. They highlight the role of social workers in providing assessments to various stakeholders and that these assessments may be more accurate and helpful if social workers have been trained in an integrative approach, with attention to overlap between the mental and physical domains. The authors call for an end to social work education curricula that unnecessarily separate information on physical health and mental health. Similarly, they suggest that new more integrative curriculum models will produce social workers that are able to meet the demand for more integrated care.

In another study conducted by social work educators, differences in CAM use among African Americans, Whites (non-Hispanic) and Caribbean Blacks was studied (Woodward et al., 2009). This study used existing data that had been collected from two national surveys. Both surveys were part of the Collaborative Psychiatric Epidemiology Studies (CPES) funded by NIH. The researchers compared socio-demographic characteristics, mood and anxiety diagnoses and CAM use. The results indicated that whites are two times more likely to report using CAM (39%) than African Americans (24%) and black Caribbean's (12%). The researchers also found that there were significant differences between Caribbean blacks and African Americans in the types of CAM use and whether they used CAM in conjunction with a mood disorder. African

Americans were also more likely to use prayer or spiritual healing (which was included as a CAM modality) than the other two groups. Other interesting demographic differences were noted. Women overall were more likely to use CAM than men and higher levels of education were predicted of an increase in CAM use.

Another study authored by a social worker in collaboration with the College of Pharmacy at the University of Texas at Austin considered the patterns of CAM use in African Americans (Brown, Barner, Richards, & Bohman, 2007). The authors analyzed data from the 2002 National Health Interview Survey to determine the prevalence of CAM use in the African American community as well as use for treatment of disease, illness and prevention. The researchers found that users of CAM were more likely older, college educated and insured, which corresponded with previous studies. Additionally, prayer was found to be the most common CAM modality utilized with over 60% reporting use of this modality followed by herbal medicines (14.2%) and relaxation (13.6%). The authors point to a need for more detailed information about whether African Americans use CAM in conjunction with or as an alternative to conventional medicine.

Another article authored by social worker Dziegielewski (2003) seeks to highlight the importance of social workers becoming more educated about CAM practices. Specifically, the author discusses herbal preparations, essential oils, and flower essences in the clinical environment. Attention is given to contraindications, side effects and clinical effectiveness for particular conditions. The author cites increased use in the general population as well as the emerging evidence that clients are using these therapies



and not discussing them within the therapeutic setting as reasons social workers should be more knowledgeable and comfortable with CAM.

In an article titled “*Complementary and Alternative Medicine in Health and Mental Health: Implications for Social Work Practice*,” the authors describe the growing public interest and utilization of CAM and its implications for social work practice, education, research and policy in the health care field (Cook, Becvar & Pontious, 2000). In describing the relationship between CAM and social work, the author’s state, “a longstanding strength of social work practice is its sensitivity to the social, environmental and cultural contexts that shape people’s lives. One rapidly changing context in health care involves beliefs and practices outside of the traditional allopathic system of medical care” (p. 40). The authors call for client intakes and evaluations to include CAM use. Additionally, they suggest that social work education should include courses that educate future social work professionals about the differences between allopathic approaches to health and the philosophies that undergird CAM. Likewise they suggest that social workers should participate in research looking at the efficacy of various CAM modalities in treating mental health issues. Lastly, the authors state that social workers can play an important role in legitimizing CAM treatments, conducting research in this area and bridging the gap between conventional medicine and CAM.

Taken together, these conceptual and empirical articles suggest that social work is actively addressing the increased interest in CAM and beginning to explore ways to integrate this knowledge base into social work practice and education.

### **Counselor Education**

Counselor education, unlike the other mental health professions mentioned above,

has not developed any formal professional relationships with medicine. This absence is notable given that most mental health professions have responded to the growing research and public interest in more holistic, effective, non-invasive and economical care and specifically to integrative mind-body practices and CAM. As we saw above, Psychology has established two specializations, health and positive psychology that promulgate a symbiotic relationship between mental and physical health. Marriage and Family Therapy has a long history of forming relationships with primary care providers in order to attend to the complex needs of patients and families in those settings. Social Work has also established themselves as important players in providing comprehensive care that includes attention to a person's social environment in the medical setting. As we saw in the review above, when mental health professions have articulated a relationship between the foundational tenets of the profession and physical health they have also explored the role of CAM practices in the profession.

**Counselor education's philosophical connection to CAM.** Counselor education, despite having a philosophical foundation that emphasizes care of the whole person, promotion of wellness and prevention of illness, has not explicitly forged relationships within medicine or made as much progress researching, dialoguing and integrating mind-body research or CAM into teaching and practice. The following review will begin with a discussion of counselor education's professional organization response to CAM/mind-body research. Next a review of the relatively small amount of conceptual or empirical research on CAM/mind-body practices is presented. Following an overview of counselor education's philosophical tenets is presented along with an argument for why CAM modalities might be important tools for the profession. Finally,

the rationale for conducting a comprehensive survey of attitudes, knowledge and beliefs about CAM, as has been done in other professions, is provided. A case is made that this is an important step in integrating mind-body research and CAM practices.

**Professional organization response in counselor education.** Counselor education's flagship professional organization, the American Counselor education Association (ACA) sets the tone of the organization nationally by providing leadership, public education, and professional support for counselors and counselor educators. For this reason I consulted the ACA website and personally contacted the ACA research representative to inquire about CAM activities within the profession.

A search on ACA's main website using "complementary and alternative medicine," as search terms revealed "no results." Using the search terms "mind-body" revealed 9 results, all articles written in the professional magazine, *Counselor Education Today*. Only one of those articles was devoted to a discussion of Mind-body techniques within counselor education. One article, titled "*Reconnecting the Head and the Body*" focused on the importance of integrating counselors into physical healthcare settings (Rollins, 2010).

Another article titled "*Making the Mind Body Connection*" (Christenson, 2009) argued that counselors are using a variety of innovative techniques that include CAM practices, with the goal of helping clients achieve wellness. The author interviewed seven people, described as counselors, asking them to describe how they use mind-body wellness techniques and concepts in counselor education. Of the group, one interviewee was a licensed MFT, two were listed as Licensed Professional Counselor's (LPC), one was described as a full-time Mindfulness professional, one as a certified life-coach, and

one as a professor in human development and psychological counselor education at Appalachian State University. Only two of these individuals were listed as being an LPC. All however, were members of ACA. The professional backgrounds of those interviewed was quite varied and therefore make it difficult to ascribe the dialogue to counselor education, although it was published in a counselor education magazine. It is also important to note that the definitions of mind-body wellness and types of practices given by those interviewed in the article were quite varied, and several diverged considerably from definitions given in other professions and by NCCAM. Interviewees were asked to explain how they practice mind-body wellness and the following were mentioned: emotional regulation, qigong, stress management, cognitive behavioral therapy in conjunction with Reiki, and positive thinking. These responses suggest that some within ACA very broadly define the concept of mind-body and suggest a potential lack of awareness of the larger national dialogue within medicine and mental health where definitions of this concept are similar and align with NCCAM.

A call was placed to Vikki Cooper, Librarian for ACA to find out what other CAM activities might be going on within the profession. Vikki searched the ACA library using the search terms “complementary and alternative medicine,” “CAM,” and “mind-body.” This search resulted in one article published in *Vistas*, a digital collection of peer-reviewed articles published by counselors for counselors (Birdsdall, Pritchard, Elison-Bowers, Smith, & Klein, 2010). The title of the article, “Are Private Counselors Comfortable Treating Combat Related Trauma?” focused on counselors’ level of comfort and beliefs about their training experiences. The authors conclude that there is a need to more adequately train counselors in dealing with combat trauma and suggest that a

holistic approach is warranted. CAM is briefly mentioned as possibly useful in treatment of combat veterans. The fact that this is the only study cataloged by ACA that mentions complementary and alternative medicine suggests that counselor education as a profession may be lagging behind other mental health professions in integrating CAM. This is especially apparent when contrasted with the professional organization of psychology, the American Psychological Association.

**Teaching self-care in counselor education through CAM.** Three research articles in counselor education consider the effects of CAM practices on promotion of self-care in counselor education students (Christopher, Christopher, Dunnagan, & Schure 2006; Maris, 2009; Newsome et al., 2006). It is important to note that all three of these articles emerged from one intervention; the implementation of a 15-week course loosely based on the Mindfulness Based Stress Reduction (MSBR) program at Montana State University. One article examines the course from the perspective of curriculum development in counselor education. Another article examines the focus group, qualitative and quantitative data collected pre and post implementation and the last article is a self-study presented by one student from the course.

In the article by Christopher et al. (2006), the authors sought to describe the course and the outcomes to aid other programs in developing this type of course. They note that although accredited programs talk about the importance of self-care little is done to directly teach these strategies. To address this need a course was developed titled Mind/Body Medicine and the Art of Self-Care. The course highlighted mindfulness and other contemplative practices and used the well-researched Mindfulness Based Stress Reduction (MSBR) program, developed by Kabat-Zinn (1990), as a guide. The authors

hypothesized that mindfulness practice would benefit counselors in training in a variety of ways. First, counselors would be less reactive to stress-related or anxiety provoking events. Second, counselors in training would gain new ways of relating to their emotional life that include awareness and tolerance. As a result the authors speculated that counselors would become more present, and connect more fully with their clients.

The course had six objectives: (1) To provide students with techniques and skills for self-care, (2) to foster students' understanding of indigenous traditions of contemplative practice from both Eastern and Western cultures, (3) to foster students' awareness of mind-body medicine and contemporary attempts to adapt contemplative practice to health care, (4) to foster students' awareness of mind-body research regarding the effectiveness of contemplative practice in behavioral medicine (5) to foster students' awareness of ethical considerations in the application of mind-body medicine, (6) to foster awareness of the impact of culture and cultural understandings of well-being on the counselor education process. The impact of the course was measured by gathering focus group data at the end of the course.

The authors reported that students found the course very helpful and that it had a significant impact on their personal and professional lives. The authors noted several themes that emerged from the qualitative data gathered from students: (1) improved ability to focus, (2) greater awareness of self or clients, and (3) feeling better equipped both emotionally and mentally to deal with daily stress in their personal lives.

In the article titled "Teaching Counselors Self-Care Through Mindfulness Practices," by Newsome et al. (2006), essentially summarizes the impact of the course described above, by evaluating four years of data. Data used in this evaluation included

focus group and qualitative reports, along with quantitative course evaluation data. Results were similar to those reported in the above study including increased personal awareness, awareness of others, improved ability to focus, and feeling better equipped to deal with stress. The authors also reported a few other themes that were considered significant. First, students reported an increase in their ability to let go of negative thoughts and emotions. Second, students reported increased clarity of thought as a significant outcome of the course. To conclude the authors suggest that contemplative practices could play an important role in developing key counselor qualities and directly teaching self-care techniques to students.

Finally, Maris (2009), a student in the course described above, describes her experience with the course in an article titled “The Impact of a Mind-Body Medicine Class on Counselor Training.” In this summary of her experience she echoes the themes mentioned above: (1) increased tolerance for difficult emotions, (2) decrease in reactivity, and (3) increased focus. Maris credits this course with helping her become a more confident and effective counselor. The connection between mindfulness practice and increased sense of self-efficacy is echoed in another study by Bentley (2008), and described below.

**CAM and the development of counselor qualities.** Four studies, including two unpublished dissertations, have been conducted on the effects of various CAM practices on counselor qualities (Bentley, 2008; Chrisman, Christopher, & Lichtenstein, 2009; Glaser, 2007; Schure, Christopher, & Christopher, 2008). The two published qualitative studies were based on the same set of data that was collected from students in the 15 week course offered at Montana State University that was mentioned above. These

articles however, focused on how the course impacted counselor qualities like mindfulness, effects on counselor education skills, fostering connectedness and therapeutic relationships.

In the article titled, “Mind-Body Medicine and the Art of Self-Care: Teaching Mindfulness to Counselor education Students Through Yoga, Meditation and Qigong” (Schure et al., 2008) the authors examined the influence of yoga, meditation, and qigong on counselor education graduate students. Again, the details of this intervention have been described in the above-mentioned articles and will not be repeated here. However, this article focused on a particular set of qualitative data collected in the form of written responses to 4 questions at the end of the course. The data was collected over a period of 4 years. Student responses were analyzed using qualitative software (NVivo).

Several themes emerged from the data. Many positive physical changes were noted including increased flexibility and reduction of pain. Emotional changes were also frequently noted. Students reported more ability to deal with stress, strong negative emotions, and felt more accepting of themselves and others. Others themes included greater self-confidence, greater spiritual awareness, ability to take more personal responsibility, and increased capacity for empathy.

Student also reported several benefits to their role as a therapist. Themes included: being more present and aware of what was happening with the client, being more attentive to the therapy process, more comfort with silence, and deepening the therapist connection with clients. The authors conclude that this type of course has significant positive influences on counselor education student’s personal and professional lives.



The two unpublished dissertations (Bentley, 2008; Glaser, 2007) looked the impact of a contemplative practice (mindfulness) on stereotyping, empathy, control of attention, and development of self-efficacy.

In Bentley's (2008) study, it was hypothesized that there would be a relationship between mindfulness and counselor self-efficacy mediated by attention and empathy. The study surveyed 179 master's level counselor education interns and doctoral counselor education students recruited from 15 counselor education programs around the country, to determine their levels of mindfulness, attention, empathy and counselor self-efficacy using several measures. A path analysis supported the hypothesis that mindfulness is a significant predictor of counselor education self-efficacy and that attention was a mediator of that relationship. Additionally, doctoral students scored significantly higher on measures of mindfulness, attention and counselor education self-efficacy. Females also scored higher on measures of empathy. It was found that empathy was not a significant predictor of counselor education self-efficacy. The author concludes that mindfulness may be an important variable in the development of key counselor training outcomes. This is the only study of this kind in counselor education; considering the ways in which mindfulness directly impacts key counselor characteristics.

Glaser's (2007) study examined the effects of a mindfulness intervention on stereotyping and empathy in a sample of university undergraduates. The intervention was a 20-minute mindfulness meditation or a 20-minute control condition. Post intervention, the participants watched a scripted video of a counselor education session. Individuals were then asked to fill out several measures that assessed state mindfulness,

memory, empathic identification, attributions regarding the client's problems, an open-ended description of the client, and three individual client orientation measures. The author hypothesized that students who received the mindfulness intervention would report more state mindfulness, remember client information more accurately, be less likely to stereotype the client, be more empathic, incorporate external factors into their conceptualization of the client's issues and show more positive orientation to the client. Results indicated that those students who received the mindfulness intervention scored higher than the control group on state mindfulness measures. No other main effects were found.

One limitation of this study is that the intervention was delivered only one time, and was short in duration. Most studies reporting positive effects with mindfulness interventions are longer in duration and occur over the course of several weeks.

Lastly, in another article reporting on the 15-week intervention with graduate students in a counselor education program at Montana State University, Chrisman et al. (2009) evaluated the impact of the qigong portion of the intervention on counselor education students. As mentioned before this course titled Mind-Body Medicine and the Art of Self-Care, was offered to graduate students in a master's level counselor education program. As part of the course students participated in a 75-minute mindfulness practice, using qigong, twice a week for 15 weeks. Qualitative data was collected at the end of the qigong practice on the first and last day of class in the form of writing about their experience with the practice. The themes that emerged from this set of data reflect what was mentioned before: (1) positive physical changes (2) positive emotional changes and (3) positive mental changes. In addition, the authors noted that students repeatedly

expressed more awareness of the group and an expanded sense of connection to the group after the last experience with qigong. The authors speculate that this practice in particular had the effect of increasing one's sense of connection to others. The authors also conclude that by offering a variety of practices to students and not limiting offerings to the more common ones like yoga and meditation may help students find methods that work best for them.

This study alludes to the ways in which contemplative practices may foster spiritual experiences like increased sense of connection to others. This has important implications for counselors. Counselors have a philosophical orientation to wellness that includes treating the whole person and attending to mind, body and spirit. Clients may seek out counselors who are able to address spiritual issues and CAM practices could be an important and underutilized resource for doing this.

**Surveys of attitudes toward CAM in counselor education.** Two studies have considered the attitudes toward CAM of practitioners or faculty in counselor education programs (Evans et al., 2011; Lumadue, Monk, & Wooten, 2005). A discussion of both studies follows along with an overview of the limitations of each study.

One study, conducted by Evans et al. (2011), considered the attitudes of American Counselor education Association- Southern Region members toward brief and non-traditional approaches to counselor education. Potential participants ( $N = 350$ ) were mailed a survey with 22 likert type questions and a number of open response questions; 151 members responded. The researchers report that the demographic make-up of the participants was diverse and representative. Employment information was collected and reported as follows: 132 counselors, 2 social workers, 9 psychologists, 3 educators, and 4

in other areas. Therefore the majority of participants this study were employed as practicing counselors. Additionally, the article did not provide specifics on how brief and non-traditional approaches were defined for participants, or if these terms were defined. In fact the use of the term “nontraditional approaches” suggests that these researchers may not be aware of the discussion in other field highlighting the importance of standardizing the language of complementary and alternative medicine. The authors state that the “current definition of nontraditional therapy used by the OAM is...” This reference to the Office of Alternative Medicine (OAM) is outdated for an article published in 2011 as this office was transformed into the National Center for Complementary and Alternative Medicine (NCCAM).

In another study, Lumadue, Munk and Wooten (2005) sought to determine the status of Complementary and Alternative approaches in the training of counselors (the authors alternate between use of the language, complementary and alternative and alternative and complementary. I follow their usage in the following summary). To do this the authors surveyed the directors of CACREP accredited programs. The surveys were mailed and sixty-two program directors completed and returned the survey. The authors defined Complementary and Alternative therapies as “those therapeutic practices that fall outside of the established traditional realm of medical, psychiatric, and psychological practice” (p. 13). The following practices were listed as examples: hypnotherapy, breath work, EMDR, prayer, meditation, Qigong, Reiki, thought field therapy, neurolinguistic programming, and “other types of energetic interventions” (p.13).

The survey consisted of 6 Yes/No type questions including: (1) Does your program offer any courses or seminars on alternative or complementary therapies? (2) Would your program support faculty teaching or discussing alternative or complementary therapies? (3) Does your program or would your program support research on alternative or complementary therapies? (4) Does your program or would your program support students conducting research in the area of alternative or complementary therapies? (5) Does or would you program support any faculty supervision of students using alternative and complementary therapies? and (6) Are any of your faculty trained in any alternative or complementary therapies? If yes, please list approaches. The last question was open ended: Please add any comments you would like to make.

The authors reported that 54% of the programs, responding to the survey, currently offer courses or seminars that focus on or include alternative and complementary therapies. The majority of the programs surveyed said they would support faculty teaching courses or seminars that focus on or include discussion of alternative and complementary therapies (89%). However, only 67% support supervision of students in this area. Over half of the programs reported that at least one faculty member was trained in alternative and complementary therapies. The top 10 types of approaches offered within training programs that were mentioned were (listed from most frequent to least frequent: (1) Hypnosis (2) Meditation (3) Neurolinguistic Programming (4) Body-Mind /Holistic (5) Reiki (6) Yoga (7) Dream Work (8) Biofeedback (9) Body-mind holistic (10) Tai Chi. Data for the other questions was not reported.

There are several limitations to this study. First, the language used by the authors varies throughout the article when describing the therapies or approaches that they are

inquiring about. They begin by talking about alternative practices, then alternative and complementary therapies in the title and they say, “for the purpose of this study, these approaches were designated as complementary and alternative methods (CAM).” The use of language here is out of sync with NCCAM’s acronym that stands for complementary and alternative medicine (CAM). Near the end of the article the authors use “creative therapies” to describe these approaches as well as “complementary and alternative mental health treatments”(p.16). This variation in language suggests that the authors may be out of touch with the more customary terminology used by NCCAM or be unaware of the attempts by other professions to standardize the language used and to what it is referring, to improve the quality of research in this area.

Another limitation of this study is that only 62 programs responded to the survey. It is not clear from the article how the CACREP programs were sampled or how the authors defined “program.” Some institutions for example have several programs and likewise, program directors or liaisons may oversee several programs within the institution. By sampling only program directors this presumes that program directors are aware of all faculty activities or experience with CAM within a particular institution.

Additionally, it is difficult to compare this study to similar studies in other fields because the method and instrument were quite different from the others. For example, other mental health professions have used portions of other surveys, developed in medicine and nursing, that had been validated or used by multiple sites. Likewise, examples of CAM practices given by the authors, varies considerably from other CAM studies.

Lastly, the discussion presented by the authors focused primarily on alternative practices such as energy medicine, eye movement desensitization, thought field therapy, shamanism, biofield based energy psychology, and expressive arts therapies. Many of these therapies are outside of mainstream awareness and are not frequently the subject of rigorous research. While many of these approaches may be valid and warrant further study, public awareness of the approaches, or widespread research of the approaches has not begun. It would be of interest to the profession to begin by aligning our research of CAM with some of the more recognized and researched therapies. To enter the dialogue we must survey what others have done, and outline a comprehensive approach to this inquiry.

Very little has been done in counselor education to address the growing interest and research in the area of mind-body medicine. Counselors however have a lot to offer this discussion given their philosophical orientation towards prevention, wellness, self-care and a systems approach to counselor education. The following paragraphs highlight the theoretical foundations that make counselors well suited to contribute to the dialogue on research and practice of CAM in mental health. Each of these orientations is echoed in many CAM modalities and therefore situates counselors as important players in the conversation about integrative medicine, mind-body medicine, and use of CAM in treatment and training. However, counselors have not fully articulated this relationship nor has the profession explored how it fits into the larger conversation. Counselor education's emphasis on wellness, as you will see, is very holistic and bridges the mind-body divide. Likewise the standards emphasize the importance of self-care in counselor training and yet little direction is given on how to nurture this habit in trainees. Other

professions, as shown above have begun looking at the role of some CAM practices in the development of desired professional characteristics. Counselor education has begun to explore this relationship although is still relatively behind other professions.

**Professional focus on wellness and prevention in counselor education.** A few counselor educators have been at the forefront of developing wellness as a foundational tenet of counselor education (Myers, Sweeney, & Witmer, 2001). Jane Myers and Tom Sweeney have written many articles aimed at formulating a holistic theory of wellness within counselor education (Myers & Sweeney, 2008; Myers & Sweeney, 2005; Sweeney & Myers, 2005). In addition to developing a theoretical model of wellness, Myers and Sweeney developed an assessment tool designed to test for wellness as described in their theoretical model (Myers, Luecht, & Sweeney, 2004). Despite this focus on wellness and prevention, little has been done to connect this emphasis to CAM practices or philosophical foundations consistent with CAM.

Recently, a book edited by Granello (2011), titled *Wellness Counselor Education*, was published and is the first major textbook in counselor education to address the relationship between wellness, counselor education and CAM. Specifically, the book considers counselors' roles as important stakeholders in the transition to a more holistic form of healthcare in the United States where wellness and prevention are deemed as important as treatment. The book highlights current problems in healthcare including lack of coverage for preventative care, increase in costly lifestyle related conditions like heart disease and diabetes, and increase in mental health expenditures, and presents counselors as uniquely suited to address some of these concerns. In Chapter 1, Granello and Witmer (2011) propose a wellness paradigm as an antidote to the current medical model that they



argue is failing and suggest that counselors, who are trained in wellness and prevention, have the skills to address both disease management and prevention.

They also go on to propose that people are seeking not just health as the absence of disease but general wellness. Wellness, according to Granello and Witmer (2011) encompasses spiritual, mental, emotional, physical and social factors. More specifically, the authors state that “ a meaningful life, realistic and rational thinking, a positive attitude, regular exercise, nutritional eating and satisfying work, leisure and interpersonal relationships are dimensions for improving the quality of living and extending the length of life” (p.11). They propose that wellness is “an emerging treatment paradigm for both healthcare generally and the mental health field specialty” (p. 8).

The authors go one to draw a connection between wellness and CAM practices. They present the historical development of the wellness movement and highlight the integration of this movement into counselor education theory and practice. The authors suggest that the 1985 publication of Dr. Mel Witmer’s book, *Pathways to Personal growth: Developing a Sense of Worth and Competence*, was a significant milestone for integrating the wellness paradigm into the profession of counselor education. The authors also cite the opening of the Office of Alternative Medicine (now known as NCCAM) as evidence of a national movement toward wellness and go on to devote an entire chapter to complementary and alternative treatments and the role of these treatments in counselor education.

In the chapter on complementary and alternative treatments, the author states that CAM modalities are important tools for wellness counselors. The chapter describes in detail various practices as outlined by NCCAM, and importantly, grounds the

conversation in the larger national dialogue about growing public interest in CAM. According to Granello (2011), counselors may deliver CAM services, when appropriately trained or recommend these practices to clients. This chapter goes on to provide ethical considerations when recommending CAM to clients. Taken together this is the first major publication in counselor education which focuses on a wellness approach and which also suggests the use of CAM to address the wellness needs of clients.

Likewise, the training standards put forth by the Council for Accreditation of Counselor education and Related Programs (CACREP) points to wellness and prevention as important philosophical orientations for the profession. The following paragraphs discuss how the standards highlight wellness and prevention.

### **CACREP Standards**

The Council for Accreditation of Counselor education and Related Educational Programs (CACREP) is the accrediting body for counselor training programs. This organization establishes a set of standards, which are to be implemented in training programs. The standards are designed to ensure that students develop a professional counselor identity and master the knowledge and skills to practice effectively (CAREP, 2009). The case is made below that counselor education's accreditation standards require that training programs teach wellness and prevention models, self-care, encourage the development of professional characteristics and that the role of CAM in training is neglected.

### **Wellness and Prevention**

The standards state that there are eight core curricular experiences that counselor education training programs should provide. Included in these is the development of a

wellness and prevention orientation. The standards also highlight the importance of teaching theories for “facilitating optimal development and wellness over the lifespan” (CACREP, 2009, p. 11).

### **Self-Care**

Regarding professional functioning, the standards state that programs provide instruction in the role self-care plays in professional functioning. As noted above, many professional training programs, including one counselor education program, are considering the role CAM might play in the development of self-care in the development of this skill and the impact on the development of professional characteristics.

### **Development of Counselor Characteristics**

The standards also state that training programs should provide information on counselor characteristics that promote the helping process. As noted above, other professions are exploring the role of CAM practices in developing important professional characteristics, including those relevant to counselor education such as empathy, attention, non-judgmental awareness, sense of connection to others. The natural overlap of these practices and the standards for training however, neglect to address the role CAM might play in developing these characteristics.

The professional standards within the profession of counselor education state that wellness, prevention, self-care, and counselor development are important aspects of counselor training programs. The relationship between these concepts and CAM has been explored in other professions, and is beginning to be explored in counselor education. However, there is little understanding of whether counselor-training programs

are exploring this connection or value CAM as a potential training tool. This study seeks to fill this gap.

### **Conclusion**

To conclude, counselor education has made very little progress in researching the role of CAM in counselor education as evidenced by the limited number of studies and lack of dialogue about CAM within the profession. Four of the nine articles discussed above emerged from one intervention at a single university, suggesting that very few programs, clinicians or counselor educators are actively engaged in researching this topic. Other professions are well ahead of counselor education in exploring, researching and dialoguing about the role of CAM in professional practice and training. Likewise, other professions have surveyed the attitudes, beliefs and knowledge about CAM of various stakeholders to foster understanding about how to meet the burgeoning public demand for these services, their relationship to mental health and the integration of CAM into training and practice. This study sought to fill the gap in counselor education by investigating counselor educator knowledge, attitudes and beliefs about CAM so that further strides can be made.

## CHAPTER III

### RESEARCH METHODS AND PROCEDURES

The purpose of this study was to explore the attitudes, knowledge, beliefs and behaviors of counselor educators towards CAM. This chapter describes the research methods and procedures that were used to conduct the study. First the research questions and hypotheses are presented. Next, the population sample is described and methods for recruiting participants are outlined. Finally, the instrumentation and procedures for collecting and analyzing the data are described.

#### **Research Questions and Hypotheses**

##### **Research Question 1: Counselor Educator Attitudes Toward CAM**

What are counselor educators' attitudes towards CAM?

**Hypothesis 1:** It was hypothesized that counselor educators' attitudes toward CAM would be positive. According to the literature in medicine, nursing psychology and marriage and family therapy, attitudes toward CAM of faculty and students are generally positive (Booth-Laforce et al., 2010; Baugniet, Boon, & Ostbye, 2000; Caldwell, Winek, & Becvar, 2006; Hsiao, et al., 2005; Lie & Boker, 2006; Ong, Shapiro & Manber, 2008; Olson et al., 2011, Petterson & Olson, 2006; Simon et al., 2003; Wetzal et al., 2003; Wilson & White, 2007). Therefore it was predicted that counselor educators would follow this trend.

**Data Analysis:** One sample t-test.

### **Research Question 2: Personal and Professional Experience With CAM**

What personal and professional (clinical and teaching) experiences do counselor educators have with CAM?

**Hypothesis 2:** According to the literature, psychologists, social workers and marriage and family therapists declare some experience, both personal and professional, with CAM. It was predicted that counselors would show similar trends.

**Data Analysis:** Descriptive statistics.

### **Research Question 3: Counselor Educator Beliefs About CAM**

What are counselor educators' beliefs about CAM?

- a. How do counselor educators integrate CAM into counselor training?
- b. How does counselor education compare to other mental health professions in terms of acceptance and integration of CAM?

**Hypothesis 3:** Other health mental health professions have explored faculty beliefs about integration of CAM into teaching and practice and found positive results. That is, most faculty believe that the integration of CAM is a good idea. It was predicted that counselors would follow this trend. It was hypothesized that counselor educators would be as accepting as other professions but be viewed as integrating less than other professions.

**Data Analysis:** Descriptive statistics.

### **Research Question 4: Relationship Between Experience and Attitudes**

What is the relationship between counselor educator personal and professional experiences with CAM and attitudes toward CAM?

**Hypothesis 4:** It was hypothesized that there would be a significant and positive relationship between experience and attitudes. Previous research in other health professions has found that experience with CAM positively correlated with attitudes and beliefs (Baugniet et al., 2000; Frye, et al., 2006).

**Data analysis:** Pearson correlation.

#### **Research Question 5: CAM in Teaching and Training**

Are counselor educators incorporating CAM into teaching and training?

If incorporating:

- a. In which of the eight core CACREP areas?
- b. Is the course an elective, a general CAM course, or a course on a specific CAM modality?

**Hypothesis 5:** Other health and mental health professions are incorporating CAM education into training and practice to varying degrees. It is unclear from the literature whether or not counselors are integrating CAM into training and practice and therefore this question was exploratory.

**Data Analysis:** Descriptive Statistics

#### **Research Question 6: Demographic Variables and CAM**

What is the relationship between gender, ethnicity, age, year of degree completion, and full-time versus part-time status and attitudes toward CAM?

**Hypothesis 6:** It was hypothesized that there would be a positive relationship between being female and positive attitudes toward CAM. It was also hypothesized that age would negatively correlate with attitudes. Some research in other health professions has found that being female is predictive of personal CAM use, positive attitudes or

willingness to incorporate CAM, as is being younger (Ditte et al., 2011; Frye et al., 2006; Rosenbaum et al., 2002). It was predicted that counselors would follow the trend with gender and age. Whether or not ethnicity is predictive of attitudes is uncertain. This question also sought to explore the relationship between ethnicity, year of degree completion, full versus part-time employment status and attitudes toward CAM.

**Data Analysis:** *t*-test, independent samples *t*-test, and Pearson correlation

### **Research Question 7: Wellness and Prevention as Predictor of Attitudes**

What is the relationship between counselor educator orientation to wellness and prevention and attitudes about CAM?

**Hypothesis 7:** It was hypothesized that there would be a significant and positive relationship between a wellness and prevention orientation and attitudes toward CAM. Because the philosophies of CAM and Counselor Education, especially the focus on wellness and prevention, are very similar, it was hypothesized that the stronger the orientation to wellness and prevention the more positive one's attitude toward CAM would be.

**Data Analysis:** Pearson correlation

### **Research Question 8: Relationship Between Knowledge and Attitudes**

What is the relationship between counselor educators' knowledge of CAM and attitudes toward CAM?

**Hypothesis 8:** Previous research has shown that some knowledge of CAM is loosely associated with beliefs about effectiveness of CAM therapies (Bagniet et al., 2000). Based on these preliminary findings it was predicted that knowledge and attitudes would be positively correlated.



## Data Analysis: Pearson Correlation

### Participants and Sampling Methods

The inclusion criteria for this study were as follows. All participants had to meet the criterion of being a counselor educator. That is, hold a degree in counselor education or related field, and be employed as a counselor educator in a counselor-training program. Both full-time and part-time counselor educators were included in the study. Exclusion criteria included any person who was not a counselor educator, counselor educators who were not currently teaching (for example only in private practice), and counselor educators-in-training.

It was estimated that the population size (counselor education faculty) was approximately 1300 (personal communication, Kimble, 2011). A sample size of 130 was achieved, which is 10% of the larger population of counselor education faculty.

Counselor educators were contacted and asked to participate through two different sources. First, a random sample of counselor education master's and doctoral programs was selected from CACREP's website. The website maintains a list of all CACREP accredited programs at colleges and universities from all regions of the United States and provides links to their websites. Lists of all master's and doctoral programs were printed for each region; North Central, Southern, North Atlantic, Rocky Mountain, and Western. Every third school was selected from the combined lists. I then accessed the school's website, located the counselor education program and searched for faculty within the program. Faculty email addresses were then copied and pasted into an excel file. When I was unable to locate the faculty for a particular program I went to the next school on the CACREP list. This method ensured that all geographic regions were represented in

proportion to the number of schools in that region. Additionally, to ensure that doctoral programs were adequately represented, a separate list of doctoral programs was generated and every third school was selected from that list. When a school was selected that was already selected from the master's list, the next doctoral program on the list was selected. This ensured that an adequate number of doctoral programs would be represented in the population sample. This sample group was then emailed a request to participate in the study (Appendix A). The email contained a hyperlink to the online survey and consent document (Appendices B and C). This sample then received three email reminders sent every two weeks after the initial message was sent (Appendices D, E, and F).

The second method of recruitment involved contacting potential participants through CES-NET, a prominent counselor education list serve. The list serve is an online discussion forum for counselor educators. An email was posted to the list-serve inviting non-student counselor educators to participate in the study. The email (Appendix G) provided potential participants with a link to the consent form and online survey. This group was then emailed three reminders, one every two weeks after the initial emailing (Appendices D, E, and F).

### **Participant Demographics**

A total of 317 potential participants viewed the survey, 212 started the survey and 130 completed the survey. Of the potential participants that dropped out ( $n = 75$ ), 58 dropped out after reading the consent form, 3 dropped out after completing question number six and 17 dropped out after completing question number seven. Most of the participants were full-time ( $n = 109$ ) and teach in a counselor education program ( $n = 110$ ). The majority of the participants were female ( $n = 73$ , 55%; male,  $n = 59$ , 45%).

The reported ethnicity of participants was as follows. American Indian ( $n = 0$ ), Asian, Asian American/Pacific Islander ( $n = 1$ ), African American ( $n = 8$ ), Hispanic ( $n = 2$ ), Caucasian ( $n = 109$ ), Other ( $n = 9$ ). Preliminary analysis revealed that the numbers in each minority category were too small to show any significant relationship with attitudes. Therefore all ethnic minority groups were collapsed ( $n = 20$ ) and compared against the Caucasian group ( $n = 109$ ) to test whether there were significant differences between the two.

### **Instrumentation**

The instrument used in this study was a survey that was developed by the researcher and incorporated two pre-existing subscales. In total there were 77 questions and the survey was administered online. The following is a description of the how this survey was developed and the pre-existing subscales that were used.

Because there is no comprehensive survey in counselor education of attitudes, knowledge, experience, beliefs and attitudes toward CAM, a survey had to be constructed. As noted in the literature review in Chapter II, the only survey in counselor education asked six yes/no questions of Counselor Education program directors. The survey constructed for this study asked participants about their knowledge, experience, beliefs and attitudes toward CAM. Several demographic questions were included: gender, age, ethnicity, if teaching in a CACREP program, full or part-time, and year of degree completion. To construct a sound survey, with data that could be compared to previously studied groups several steps were taken. First, several surveys of attitudes from other health and mental health professions were reviewed for (1) their relevance to this study and (2) general themes around which questions were constructed.

Three surveys were identified as particularly relevant to this study (Caldwell et al., 2006; Frye et al. 2006; Olson et al., 2011). Two of these surveys were used as guides when constructing the current survey (Frye et al., 2006; Olson et al., 2011). No specific questions from these surveys were used in the current survey. A subscale from the third survey (Caldwell et al., 2006) was used verbatim because of its relevance to the current study and to facilitate comparison between the current study population of counselor educators and the MFT group studied by Caldwell et al. (2006). A more detailed description of how these surveys informed the development of the current survey is described below. Lastly, a portion of a professional identity subscale was included verbatim to allow the researcher to test for the relationship between level of professional identity and CAM attitudes (Emerson, 2010). This subscale is described in detail below.

Both the prevention and wellness subscale, by Emerson (2010) and the attitudes subscale by Caldwell et al. (2006) had items that needed to be reversed scored. The following is a description of those items.

**Complementary and Alternative Medicine Survey: Medical Student Version (Frye et al., 2006)**

This survey was useful because the survey was constructed according to the themes that emerged from a comprehensive review (across professions) of existing surveys of attitudes toward CAM. These themes were instructive since they surfaced in both mental health and health professions' construction of CAM attitudes surveys. It was determined that using these themes in the construction of questions for the existing survey would strengthen the survey. According to the authors, a general review of the literature revealed several themes relevant to their survey: (1) attitudes toward learning

about CAM topics, (2) anticipated usefulness of learning methods, (3) knowledge and experience with types of CAM therapies, (4) estimation of CAM use in the population of U.S., (5) Students' use of CAM in their own self-care, and (6) Attitudes toward biopsychosocial/holistic or integrative model of medical practice. Following is an overview of how each of these themes was utilized in the development of the current study.

These themes guided the development of the current survey in the following ways. Theme (1): Attitudes toward learning about CAM topics. We of course wanted to study counselor attitudes toward CAM and therefore this theme was determined very relevant to the study. The attitude questions were reviewed and the language of these questions considered. To address this theme however, questions from another survey were used verbatim. More detail is provided below.

Theme (2): Anticipated usefulness of learning methods. Because other professions are much further along in terms of offering educational opportunities in training it is not surprising that this theme emerged (Caldwell et al., 2006; Furnham et al., 2003; Frye et al., 2006; Laurensen et al., 2006; Olson et al., 2011; Pettersen & Olsen, 2006; Wilson & White 2007). In fact, the NIH grants mentioned in the literature review required that the medical and nursing programs receiving CAM integration funding evaluate the effectiveness of various teaching/learning methods. Because it is unclear whether counselor educators are even teaching about CAM this theme was deemed not important to the current study.

Theme (3): Knowledge and experiences with CAM. Because much of the research on this area shows a strong correlation between knowledge/experience with

CAM and attitudes, it was deemed important that this current study collect information about counselor educator knowledge and experience with CAM. Some surveys, including the Frye et al. (2006) survey, asked more generally about knowledge or experience with categories of CAM practices. For example, a question would ask whether or not the participant has experience with mind-body practices or natural products in general. For the current survey, we chose to ask about individual modalities, as listed by NCCAM in each of the four main categories. This was done so that the researchers could explore which practices counselor educators had more experience with or knowledge of and to see if any themes emerged.

Theme (4): Estimation of use in the U.S. population. This theme helps researchers determine whether or not students and faculty within the profession are in touch with what is happening in the general population. For example, if participants underestimate use they may not believe that CAM integration is important. For the purposes of this study it was determined that estimation of general population use was not as important as whether or not counselors were aware of what is happening with regards to integration of CAM in other mental health professions. In the interest of keeping the survey a reasonable length, one question was added asking how counseling compare to other professions with regards to integration of CAM. This revision maintains elements of the original theme by considering how aware counselors are of what it happening in a larger group.

Theme (5): Students' use of CAM in their own self-care. This theme obviously focuses on students, which is not the focus of this study. However, the literature suggests that CAM is being utilized to teach self-care to students within a variety of health

professions. For the purposes of this preliminary study of counselor educators it was deemed important to determine if courses are being taught and if so in which of the eight CACREP-core areas. Because self-care, treatment approaches, and counselor development were all important in CAM in the literature, these were added to the list of eight CACREP core areas in the question asking participants “in which of the core areas is CAM being integrated into the curriculum.” The eight core content areas outlined in the CACREP standards include: professional identity, social and cultural diversity, human growth and development, career counselor education, helping relationships, group work, assessment, and research and program evaluation.

The final theme (6): Attitudes toward the biopsychosocial model, was deemed most relevant to medicine and nursing. Because the tenets of the conventional medical model are often in conflict with the tenets undergirding many CAM practices, researchers within these fields sought to uncover whether or not this philosophical difference might influence attitudes. To address more specifically how philosophy influences attitudes, it was determined that aspects of counselors’ professional identity might be predictive of attitudes toward CAM. For this reason subscale questions were included from a scale designed to determine counselors’ level of professional identity, specifically, counselors’ level of wellness and prevention orientation. More details on this subscale are provided below.

#### **MFT Clinical Survey on Mind-Body Therapies (Olson et al., 2011)**

Olson et al. (2011) conducted a survey of attitudes, beliefs and practices of graduate faculty and students from accredited marriage and family therapy programs in the United States and Canada. This survey was particularly relevant to the current study

because it was geared toward faculty in a mental health profession. However, no specific questions were used from this survey. Again, this survey served as a guide and particular attention was given to themes within the survey. The survey had 23 Likert type questions. The survey focused on mind-body therapies and therefore did not inquire about the full range of CAM practices listed by NCCAM. It was determined that for the purposes of this study it was important to understand counselors' relationship to the full range of CAM practices.

This survey provided guidance in the development of the training questions in the current survey. First, the questions regarding teaching and integration into training and practice were deemed important to the current study. For example, Olson et al. (2011) inquired "should MFT training programs introduce mind-body therapy topics to graduate students?" and "should MFT faculty train/teach and supervise students in the practice of mind-body therapies as an adjunctive or integrative treatment to traditional relational/systemic approaches to therapy?" These questions were adapted and reworded as follows for the current study: "CAM should be integrated into counselor training," "Does your program offer an elective course on general CAM practices?" "Does your program offer a general course on CAM?" These questions seek to uncover what is happening with regards to courses on CAM in counselor education. In particular, it was deemed important to inquire about where in the curriculum these courses were placed. In order to understand where counselor educators were placing CAM in the curriculum the following question was included: "My program integrates CAM into the following core areas of the curriculum..." This information could be useful if counselor educators begin to formalize CAM education in counselor training.



Another way the Olson et al. (2011) survey informed the current survey was in how they asked about experience. The Olson et al. survey asked specifically about experience in personal life and in clinical practice with each mind-body modality. For the current study, level of experience was divided into three categories: personal, clinical, and teaching in order to determine the relationship between these types of experience. All nineteen modalities outlined by NCCAM (the same modalities used in the knowledge subscale) were listed and participants are asked to rate on a three point likert scale (1- Don't use at all, 2- Occasionally, 3- Often) their level of experience in the use of CAM in personal, clinical, and teaching realms.

### **Family Therapists' Knowledge of and Attitudes Towards Complementary and Alternative Medicine (Caldwell et al., 2006)**

Caldwell et al. (2006) constructed a survey to measure marriage and family therapists' attitudes towards CAM. The survey was administered to a sample of 1000 Clinical Members of the American Association for Marriage and Family Therapy. The survey was mailed to potential participants and a 44.3% response rate was achieved.

The Caldwell et al. (2006) survey contains four sections: (1) knowledge of and attitudes toward complementary and alternative medicine, (2) recommendation of CAM and relationship with CAM providers, (3) general practice patterns, and (4) attitudes about CAM. Sections 1 and 4 have obvious language overlap and based on this author's observations, it seems that section one is actually only investigating knowledge of CAM, not attitudes. Likewise, section one seems to be inquiring about experience with or use of these therapies as well. The authors listed 26 CAM therapies and asked participants to check a box indicating whether they had knowledge of the practice, had used the practice

or had at least one client who had used the practice. This format was utilized in the current study although it was modified to specifically focus on level of knowledge and level of experience as two separate questions.

The 22-question attitudes subscale of the Caldwell et al. (2006) survey is used in its entirety, with the permission of the authors. Minor adjustments to language were made to make the survey more relevant to counselor education and counselor educators. For example, the word psychotherapy was replaced with counselor education and the word therapist was replaced with counselor. The scale used a Likert type format with responses ranging from (1) strongly agree to (5) strongly disagree. Examples of questions include: (1) Most clients are interested in CAM, and (2) CAM use can be dangerous in that it may prevent people from getting the treatments of conventional medicine. Using this subscale will enable comparisons to be made between the MFT group studied by Caldwell et al. (2006) and counselor educators from the current study. No psychometric data was provided by the authors of this survey.

Additionally, the attitudes subscale (from Caldwell et al., 2006) required that several items be reverse scored so that strongly disagreeing with a statement would be an indication of positive attitudes. Items 1, 5, 6, 7, 8, 13, 14, 15, 18, 19, and 21 were reversed scored so that selecting 1 would indicate positive attitudes. For all other questions selecting 5 (strongly agree) was an indication of positive attitudes. To transform the values of the items that needed to be reversed scored the LOOKUP function in EXCEL was performed. The following is a description of the surveys, which informed the construction of the current survey.

### **Wellness and Prevention Orientation (Emerson, 2010)**

As noted earlier, the philosophy of many CAM practices overlaps with the wellness, prevention and systemic focus within counselor education. Wellness and prevention have been highlighted as important components of counselor professional identity (Emerson, 2010). It is hypothesized that when counselors are strongly aligned with these components of professional identity they will also have more positive attitudes toward CAM. For these reasons questions that assess these components of counselor professional identity were included in the survey.

The dissertation of Carla Henderson Emerson (2010) focused on the construction and validation of a Counselor Professional Identity (CPI) Measure. Emerson synthesized the many definitions of professional identity, established a comprehensive working definition, and constructed a measure to test level of professional identity. Counselor professional identity was said to encompass 6 components, including knowledge and understanding of: (1) history of counselor education, (2) counselor education philosophy, (3) the roles and functions of counselors, (4) professional ethics, (5) professional pride, and (6) professional engagement. Of importance to this current study is component two, counselor education philosophy. Emerson found that the philosophy subscale included four factors, which correlated with the four components of the counselor education philosophy subscale: (1) developmental approach, (2) wellness approach, (3) focus on prevention, and (4) empowerment. Out of all of the questions on the measure, 8 questions were found to load on the factors of wellness and prevention and were therefore included in the survey for this current study. Items that loaded below the .33 level were dropped from the subscale and therefore not included in this study. The wellness

component of the counselor education philosophy subscale contained five items (e.g., “I consider all aspects of a client’s life when providing services”) and had a Cronbach’s alpha of .667. The prevention component contained three items (e.g., “Prevention is just as important as remediation in my work as a counselor.”) and had a Cronbach’s alpha of .426. The Cronbach alpha is a measure of internal consistency and the moderate or low levels reported here are likely due to the small number of questions in each factor and the variation in the population (participants included master’s and doctoral students as well as faculty). Since professional identity develops over the course of training and time, this may have negatively impacted internal consistency. The author however concludes that the questions reasonably test whether a counselor has a strong orientation towards wellness and prevention, which have been established as key factors in professional identity.

To answer these questions a six-point Likert scale is provided. Emerson argues that this format was chosen to avoid the neutral choice that three or five point scales often provide. By eliminating the neutral category the researcher is able to make stronger conclusions about participant choices. This six-point scale was adopted in the current survey for the wellness and prevention subscale.

The prevention and wellness subscale contained one item that needed to be reversed scored (Item 6: “Counseling is not for those who are functioning well”). All other questions on this scale were worded so that agreement was an indication of higher levels of prevention and wellness identity. However, agreement with question six would be an indication of low prevention identity. The values for this item were reordered so

that strongly disagreeing with statement (1) was recoded as (6) thereby properly representing the level of prevention identity.

Various Likert levels are used throughout the current survey and there are two reasons for this. First, when portions of other surveys were used in their entirety the exact Likert scale was also used to facilitate generalization and to maintain scale integrity. For example, the Caldwell et al. (2006) attitudes subscale used a five-point Likert scale which used the following levels: 1- strongly disagree; 2- disagree; 3- neither agree nor disagree; 4- agree; 5- strongly agree. This format was maintained for this study. Additionally, the Emerson (2010) professional identity measure utilized a six-point format. This format was maintained for the professional identity subscale used in the current survey again to maintain survey integrity.

Second, for the knowledge and experience subscales, a five level format was adopted. It was determined that keeping the levels as consistent as possible was important for analysis purposes.

### **Demographics**

Several demographic variables including age, gender, race/ethnicity, and year of graduation from terminal degree program were collected to explore what relationship these variables have to CAM attitudes. Other studies have collected this information and found that women tend to more positively value CAM than men and in some cases are more open to CAM modalities which have not been scientifically proven as effective (Chaterji et al., 2007; Greenfield et al., 2006; Petterson & Olsen, 2007; Riccard & Skelton, 2008; Rosenbaum et al., 2002). Likewise, in one study, age was predictive of willingness to refer to CAM, that is younger participants were more likely to refer

(Rosenbaum et al., 2002). Another study in medicine found that white medical students had more positive attitudes towards CAM, although researchers acknowledged that lack of geographic and racial/ethnic diversity in the sample could have impacted the results (Frye et al., 2006). The current study sought to explore whether counselor educators followed these same patterns.

Another demographic question asked if the participant was teaching in a CACREP program to ensure that the sample group consisted of CACREP faculty; the majority of whom held a teaching appointment in a CACREP accredited program.

Another demographic question asked about year of degree completion. This was done in order to test if there was a relationship between year of degree completion and attitudes. It was hypothesized that since CAM has become more popular in the last three decades those who have been teaching for longer would have less exposure to these practices in their training.

### **Data Collection Procedures**

This study used a survey method to answer the research questions. Participants were emailed an introductory email requesting their participation in the study (Appendix A). The email contained a hyperlink to the survey. At the same time, an introductory letter and request for participation was posted on CES-Net (Appendix G). After two weeks a second email reminding potential participants was sent to both groups (Appendix D). Two weeks later a second reminder email was sent (Appendix E) and then two weeks later a third email reminder was sent (Appendix F). In total, potential participants received four emails inviting participation. The researcher provided a monetary incentive for participating (being placed in a drawing for one of three \$50 Visa/American Express

gift cards). Gift cards were awarded to three participants that were randomly selected from a pool of participants that emailed the researcher requesting to be entered in the drawing. Participants were asked to read a letter of consent, which detailed what the study entailed, risks and benefits of participation, and which explained that consent to analyze and report on the information they provide was given by completing the survey (Appendix C). Participants were also made aware of how their participation was voluntary and reminded that no identifying information would be collected. Following completion of the survey participants were shown a page thanking them for their participation and that described what they needed to do to be entered into the drawing (Appendix H). Those wishing to enter the drawing were instructed to email the student investigator; email addresses were not associated with the participant's survey responses. Data collection procedures were not initiated until receiving approval from the Western Michigan University Human Subjects Institutional Review Board (Appendix I), and permission to use the Caldwell et al. (2006) survey (Appendix J) and Emerson (2010) survey (Appendix K) were obtained.

## CHAPTER IV

### RESULTS

This chapter summarizes the statistical findings of the data collected from the online survey discussed in Chapter III. First, a description of how the data was managed, recoded and the treatment of missing data is presented. Next, the results for each of the hypotheses presented in Chapter III are presented.

#### **Recoded Data and Data Management**

##### **Collapsed Variables**

Very few participants indicated that they were American Indian ( $n = 0$ ; 0%), Asian American or Pacific Islander ( $n = 1$ , .8%), African American ( $n = 8$ , 6%), Hispanic/Hispanic American, ( $n = 2$ , 1.5%), or Other ( $n = 9$ , 6.8%). The majority of participants reported that they were Caucasian American ( $n = 109$ , 82%). This data is slightly more skewed toward Caucasians than the data from CACREP on doctoral students (personal communication, Kimble, 2012). Since no data is available on the ethnic makeup of CACREP faculty, data on the ethnic makeup of doctoral students is used to consider whether or not participants in this survey approximate the ethnic makeup of faculty. It is important to note however, data on doctoral students may not translate into an accurate representation of CACREP faculty. Data from CACREP on the ethnic makeup of doctoral students reports the following numbers: Caucasian (59.51%); African



American (20.65%); Indian (.68%); Asian/Pacific Islander (3.55%); Hispanic (5.73%); Other (5.04%) (Kimble, 2012).

The ethnic minority categories contained very few numbers and therefore no significant relationships could be found between ethnicity and attitudes or beliefs. To test whether being a member of an ethnic minority group correlated with attitudes, the ethnic minority groups were combined to increase the numbers in this category so that analysis could consider whether or not minorities as a group showed any statistically significant differences from the White/Caucasian group (Minority:  $n = 20$ ); Caucasian:  $n = 109$ ).

### **Treatment of Missing Data**

Cases were removed using the following criteria. If one half or more of the survey was not completed the case was removed. If the majority of one or more subscales were incomplete the case was removed. The remaining cases were retained, leaving 130 completed cases for analysis. Missing data in the remaining 130 cases showed no particular pattern. The missing data in the remaining cases was dealt with using the mean substitution method when appropriate. However, some participants answered the majority of the survey but did not answer one or more of the demographic questions. These questions were retained and therefore total numbers for demographic questions may be less than 130.

### **Research Question 1: Attitudes and Beliefs Toward CAM**

Research question one sought to understand counselor educator attitudes toward CAM. It was predicted that counselor educators' attitudes toward CAM would be positive and follow the trend in other mental health professions.

A one-sample *t*-test (one-tailed) was conducted using the value 3, which was the neutral value in the 5-point Likert scale as the comparison mean. The results of the *t*-test indicated that counselor educator attitudes were significantly positive ( $t(129) = 15.88, p = .000$ ), as compared to the neutral value 3. The mean attitude score was 3.54 ( $SD = .39$ ). It is important to note that it is possible that counselor educators with negative attitudes toward CAM chose not to participate. This is a limitation of the study and limits generalizability. However, this research was exploratory and intended to be a starting point for understanding counselor educator attitudes.

### **Research Question 2: Experience With CAM**

Research question 2 asked, What personal and professional (clinical and teaching) experiences do counselor educators have with CAM? It was hypothesized that like other mental health professions, counselor educators would show some experience with some of these practices and that counselors would be similar to the general population where 30-40% have tried a CAM practice.

Descriptive statistics showed that 100% of counselor educators had some personal experience with at least one CAM practice. When the most highly ranked vitamin and mineral supplements were excluded, 99% of counselor educators sampled reported having some personal experience with at least one CAM practice. The percentage was calculated using the data from the personal experience portion of the survey. All respondents who indicated that, in their personal lives, they 2-rarely; 3-occasionally; 4-frequently; 5-everday use a CAM practice were counted as having some experience with CAM.

Counselor educators reported having the most personal experience with the vitamin and mineral supplements category ( $M = 3.42$ ). The four practices that counselor educators reported having the most *personal* experience with after vitamin and mineral supplements were: breathing exercises ( $M = 3.38$ ); meditation ( $M = 2.97$ ); guided imagery ( $M = 2.89$ ); and progressive muscle relaxation ( $M = 2.75$ ). All of these practices are considered mind-body practices according to NCCAM.

A post-hoc paired samples t-test did not reveal any significant differences between the clinical and teaching groups ( $t(129) = .893, p = .374$ ). Both teaching experience and clinical experience with CAM appeared to be lower than personal experience. To test whether this difference was significant, a paired samples t-test was run. These comparisons revealed that a personal experience with CAM was significantly different from both teaching experience and clinical experience (Table 1). Table 2 shows the mean scores for experience with CAM practices across personal, clinical and teaching categories.

Table 1

*Mean Differences Between Experience Groups*

<b>Group</b>	<b><i>M</i></b>	<b><i>SD</i></b>	<b><i>df</i></b>	<b><i>t</i></b>	<b><i>p</i></b>
Total <i>Personal</i> Experience & Total <i>Teaching</i> Experience	2.08 1.61	.53	129	9.89	.000
Total <i>Personal</i> Experience & Total <i>Clinical</i> Experience	2.08 1.59	.51	129	10.85	.000
Total <i>Teaching</i> Experience & Total <i>Clinical</i> Experience	1.61 1.59	.26	129	.89	.374

Table 2

*Average Experience With CAM Practices*

<b>CAM Practice</b>	<b>Personal</b>	<b>Clinical</b>	<b>Teaching</b>
Vitamin and Mineral	3.42	1.52	1.48
Breathing Exercises	3.38	2.95	3.03
Meditation	2.97	2.48	2.52
Guided Imagery	2.98	2.86	2.78
Progressive Muscle Relaxation	2.75	2.54	2.55
Massage	2.71	1.41	1.39
Yoga	2.33	1.66	1.62
Herbal Medicine	2.23	1.34	1.29
Homeopathy	1.85	1.26	1.34
Chiropractic	1.74	1.14	1.08
Movement Therapies	1.71	1.54	1.44
Acupuncture	1.55	1.22	1.30
Traditional Healers	1.54	1.45	1.34
Energy Therapies	1.54	1.31	1.22
Chinese Medicine	1.52	1.15	1.11
Hypnotherapy	1.48	1.48	1.48
Tai Chi	1.45	1.16	1.15
Ayurveda	1.24	1.08	1.05
Qi Gong	1.15	1.08	1.06

*Note.* Mean scores in order of most to least experience for Personal category.

Another way to consider this data is to look at the raw number of participants who marked that they had experience with CAM practices frequently or very frequently in the clinical and teaching categories. Of particular interest is a subset of mind-body practices ranked as most commonly used by the general population (i.e., meditation, breathing exercises, progressive muscle relaxation, and guided imagery, see explanation in next chapter for why these categories were singled out). The data below consider the number of counselor educators stating that they frequently or very frequently utilize one of these practices in the clinical setting or in teaching. Of the 130 participants in this study, 49 (38%) said they were teaching about breathing techniques in their courses while 57

(44%) said they were using these practices clinically. With regards to meditation practices, about a quarter of participants said they were teaching about (n=31, 24%) or clinically using (n=32, 25%) meditation. For guided imagery 39 (30%) said they were teaching about guided imagery and 43 (33%) said they were using it clinically. Finally, for progressive muscle relaxation 30 (23%) said they were frequently or very frequently teaching about it and 33 (25%) said they were using it clinically.

Because the mean scores for experience with certain practices looked higher than others, a post hoc analysis was run to test whether the mean differences in counselor educator experience with mind-body practices and non-mind-body practices was significant. The results indicated that there was a significant difference between the two groups. The mean score on the personal experience with mind-body practices was 2.86. The mean score on the personal experience with non-mind-body practices was 1.81. The differences between the mean scores of these two groups, according to the paired samples *t*-test was significant  $t(129) = 16.926, p = .000$ . That is to say, higher mean experience with the mind-body group was significantly different from the mean scores of the general CAM group.

### **Research Question 3: Beliefs About Integration of CAM**

Research question 3 asked counselor educators about their views on the integration of CAM into the profession and how the profession compares to other mental health professions with regards to acceptance and integration of CAM into treatment and training. Beliefs about the integration of CAM into the profession were explored through two questions. First, participants were asked to rate their level of agreement with the following statement: “Complementary and Alternative Medicine should be integrated

into counselor training.” Second, participants were asked how Counselor Education compares to other mental health professions with regards to acceptance and integration into treatment and training.

Most counselor educators reported that CAM should be integrated into training ( $n = 101$ , 78%). Regarding responses to the statement about whether CAM should be integrated into counselor training,  $n = 25$ , 19% strongly agreed;  $n = 36$ , 28% agreed;  $n = 40$ , 30% somewhat agreed;  $n = 15$ , 12% somewhat disagreed;  $n = 9$ , 7% disagreed; and  $n = 5$ , 4% strongly disagreed.

In response to the statement: “Compared to other mental health professions with regards to acceptance and integration of CAM into treatment and training, counseling is...”  $n = 6$ , 5% thought counseling was very ahead of other professions;  $n = 9$ , 7% thought counseling was slightly ahead of other professions;  $n = 45$ , 35% responded that counseling was on par with other professions;  $n = 57$ , 44% thought counseling was slightly behind other professions; and  $n = 13$ , 10% thought counseling was very behind other professions. To summarize, over half of respondents thought that counseling was slightly behind or very behind other professions in this area ( $n = 70$ , 54%) and one third of counselor educators thought counseling was on par and 12% thought the counseling profession was ahead.

#### **Research Question 4: Experience and Attitudes**

Research question four asked: What is the relationship between counselor educators’ personal and professional experiences with CAM and their attitudes toward CAM? It was hypothesized that there would be a significant and positive relationship between experience and attitudes. Previous research in other health professions has

found that experience with CAM positively correlated with attitudes (Baugniet et al., 2000; Frye, et al., 2006).

A Pearson correlation, one-tailed, was run looking at the relationship between overall experience and attitudes. Results indicated that the two variables were strongly correlated and that there is a positive relationship between attitudes toward CAM and experience with CAM  $r(128) = .56, p < .01$ . These results suggest as expected that more experience is associated with more positive attitudes toward CAM practices.

### **Research Question 5: Incorporating CAM**

Research question 5 addressed whether counselor educators are incorporating CAM into teaching and training. More specifically, if counselor educators were incorporating CAM, into which of the eight core areas is the material incorporated and is the course an elective (general or specific), a stand-alone course, or integrated into another course?

Regarding the question “Does the counseling program in which you teach integrate CAM into the core curriculum,” the majority of respondents replied “no,” their program does not integrate CAM into the core curriculum ( $n = 107, 82\%$ ). However, 23 (18%) respondents replied “yes,” indicating that there are some programs currently integrating these concepts into the core curriculum.

Those who responded that they were integrating CAM were then asked to identify the core areas of the curriculum in which CAM was being integrated. Participants could check more than one area. The most common response was that CAM was integrated into portions of the curriculum devoted to self-care ( $n = 21$ ). The second most common

response was treatment approaches ( $n = 17$ ), and the third most common was helping relationships ( $n = 12$ ). Table 3 gives the number of responses for each core area.

Table 3

*Integration of CAM Into Core Curriculum Areas*

Core Area	Frequency
Self-care	21
Treatment Approaches	17
Helping Relationships	12
Social and Cultural Diversity	9
Counselor Development	8
Professional Identity	4
Human Growth and Development	3
Group Work	3
Career Counseling	1
Research and Program Evaluation	1
Assessment	0

With regards to the question: “does the counseling program in which you teach offer an elective course on general CAM?” the majority said “no” ( $n = 111$ , 85%), while several replied “yes” ( $n = 16$ , 12%), and a few participants said they did not know ( $n = 3$ , 2%).

Another question asked if the participant’s counseling program offered a course on a specific CAM modality (as opposed to a more general course). Interestingly, 18 participants responded affirmatively that their program offers a course on a specific CAM modality while most did not (110 = no, 2 = don’t know). The following specific CAM modality courses were identified (every participant response is listed): relaxation, movement, breathing; art, drama, dance music therapies, meditation, hypnosis; movement, healers; EFT, breathing, energy, visualization; expressive arts; meditation;



meditation; hypnotherapy, progressive relaxation, guided imagery; relaxation, yoga, breathing, imagery' art therapy, drama therapy, ecopsychology; movement breathing, hypnotherapy; Hakomi; and progressive muscle relaxation, guided imagery.

### **Research Question 6: Demographic Variables and CAM Attitudes**

Research question six asked about the relationship between gender, ethnicity, age, year of degree completion, and full-time versus part-time status and attitudes toward CAM.

#### **Gender**

Of the participants, 72 were female and 58 were male. A *t*-test was run to compare the means of the gender group variables (female and male) to attitudes, in order to see if there was a significant difference between the two groups. Results from the independent samples *t*-test indicated that there was a significant difference between the two groups  $t(112.687) = 5.193, p < .000$ . Levene's test for equality of variances was very sensitive, .25 was the criterion ( $p = .181$ ), and therefore equal variances were not assumed. The mean attitude was slightly higher for females than for males (female,  $M = 3.7$ ; male,  $M = 3.4$ ). Results suggest that this difference is significant. That is to say that for this sample, female counselor educators are slightly more likely to hold positive attitudes toward CAM than male counselor educators.

#### **Ethnicity**

In order to test whether there were differences between ethnic groups on the attitudes scale ethnic groups needed to be collapsed as was discussed earlier in this chapter. An independent samples *t*-test was then run to determine if there was a

significant difference in attitudes between the ethnic minority group ( $n = 20$ ) and the Caucasian/White Non-Hispanic group ( $n = 109$ ). Results indicated no significant difference between the ethnic minority group ( $M = 3.55$ ) and the Caucasian/Non-Hispanic group ( $M = 3.54$ ),  $t(127) = .173$ ,  $p = .174$ .

### **Age and Year of Degree Completion**

A Pearson correlation was run to test if there was a relationship between a person's age or year they completed their degree and attitudes toward CAM. Results indicated that there was a significant relationship between age ( $r(128) = .153$ ,  $p = .041$ ) and attitudes. That is to say, as age increased so did positive attitudes toward CAM.

There was no significant relationship between year of degree completion and attitudes toward CAM ( $r(128) = -.024$ ,  $p = .393$ ).

### **Full vs. Part-time Faculty**

An independent samples t-test was run to test if there was a significant difference between the full-time ( $n = 108$ ) versus part-time status ( $n = 20$ ) and attitudes. Results indicated that there was no significant difference between these two groups, ( $t(126) = -.442$ ,  $p = .571$ ).

### **Research Question 7: Wellness and Prevention and Attitudes**

Research question 7 asked about the relationship between counselor educator orientation to wellness and prevention and attitudes toward CAM? It was hypothesized that there would be a positive relationship between the wellness and prevention subscale and attitudes. That is to say, the more counselor educators were oriented to prevention and wellness the stronger their attitudes and beliefs about CAM would be. There was no

significant relationship between the orientation towards wellness and prevention scale and attitudes,  $r(128) = .121, p = .085$ .

Next, to test whether there was a significant relationship between either the prevention subscale or the wellness subscale and attitudes, the mean scores for each portion of the scale were computed separately and compared to the attitudes scale. The prevention subscale showed no significant relationship to attitudes,  $r(128) = .050, p = .285$ . However, the wellness portion of the subscale was significantly and positively correlated with attitudes toward CAM  $r(128) = .173, p = .024$ . That is, a stronger wellness identity was associated with more positive attitudes toward CAM.

#### **Research Question 8: Relationship Between Knowledge and Attitudes**

Research question 8 considered the relationship between counselor educators' knowledge of CAM and attitudes about CAM. Knowledge was measured on a 5 point Likert scale with 1 indicating that you know nothing about the practice; 2-know very little; 3-know something; 4-knowledgeable; 5-very knowledgeable. A mean score for knowledge was calculated by averaging participant responses on the Likert scale to all questions about knowledge of each CAM practice. Table 4 shows the mean scores for knowledge of each CAM practice.

A Pearson correlation was run to test the relationship between level of knowledge and attitudes. Results indicated that there is a strong positive relationship between level of knowledge and attitudes,  $r(128) = .393, p < .01$ . That is, the more knowledge a participant had of CAM the more positive their attitudes toward CAM were.

Table 4

*Average Knowledge of CAM Practices*

<b>CAM Practice</b>	<b><i>M</i></b> ( <i>N</i> = 130)
Guided Imagery	3.86
Breathing Exercises	3.86
Progressive Muscle Relaxation	3.62
Meditation	3.11
Yoga	2.81
Massage	2.65
Hypnotherapy	2.58
Vitamin and Mineral	2.54
Movement Therapies	2.26
Acupuncture	2.33
Chiropractic	2.25
Traditional Healers	2.25
Herbal Medicine	2.21
Energy Therapies	2.19
Tai Chi	2.16
Homeopathy	2.05
Chinese Medicine	1.74
Qi Gong	1.55
Ayurveda	1.45

*Note.* Mean scores in order from most to least knowledge

### Summary

The counselor education faculty in this study reported very positive attitudes toward CAM. This study found a significant positive relationship between experience and attitudes and a significant positive relationship between knowledge and attitudes. That is, the more experience and knowledge one had with CAM the more likely they were to have positive attitudes toward the practices. Counselor educators who reported a strong wellness identity were also more likely to have positive attitudes toward CAM. The same was not true for prevention identity. The majority of counselor educators

reported some level of agreement that CAM should be integrated into training and just over half of the counselor educators in this study also believed that the counseling profession was not doing as much as other mental health professions in this area.

This study did not find a significant relationship between ethnicity, full versus part-time faculty, or year of degree completion and attitudes. However, the study did find a moderately significant relationship between gender and attitudes, with female faculty having more positive attitudes. Likewise, this study did find a significant relationship between age and attitudes; as age increased so did positive attitudes toward CAM.

Interestingly, there is some integration of CAM into counselor education curriculum and training happening. Participants reported that if they were integrating CAM into training it was most commonly being integrated into self-care, treatment approaches, and helping relationships portions of the curriculum.

## CHAPTER V

### DISCUSSION AND IMPLICATIONS

The following chapter discusses the major findings and concludes with a discussion of the limitations of the study and recommendations for the counseling profession and counselor education. The purpose of the research was to explore the attitudes, beliefs, and levels of knowledge and experience that counselor educators have with CAM.

#### **Counselor Educator Attitudes**

Assessing the attitudes of various stakeholders including faculty teaching future health professionals is important because of the role that attitudes play in behavior and behavior change (Stratton et al., 2007). In order for counselor education to begin to understand the role of CAM in the profession, attitudes toward CAM needed to be assessed. Assessing attitudes helps the profession understand the status of attitudes and behaviors and provides a foundation for integrating these practices into counselor training.

This study found that not only are counselor educator attitudes toward CAM very positive but that their attitudes are highly correlated with experience with and knowledge of CAM. That is to say, the more experience one had, whether that be personal experience or professional, the more likely the person was to have positive attitudes toward CAM. The same was true for having some knowledge of even a few CAM practices; overall this correlated positively with attitudes toward CAM. The implication

of these findings are that even moderate exposure to CAM, whether in the form of learning about the practices or experiencing them, is positively related to attitudes. The implication of this for the counseling profession as it considers the role of CAM within counselor training, is that providing experience with and knowledge about these practices may be important components to advance this integration. Likewise, experience and information about CAM in training may lead to counselors being more open to client curiosity or use of these practices. Future research should consider whether or not experience and exposure to CAM information has the ability to change attitudes. It might be also be important to explore how much exposure or experience is necessary to have a positive impact on attitudes. Similarly research should focus on whether or not experience or exposure in counselor training impacts how counselors relate to clients who are interested in or using CAM.

### **Experience With CAM**

In this study 99% of counselor educators reported having some experience with CAM. This number was computed by looking at participants who responded with a 2, 3, 4, or 5 on the Likert scale indicating that they infrequently, occasionally, frequently, or very frequently utilize a CAM practice. Vitamin and mineral supplements was not included in this calculation however, when included the number rises to 100%. With the exception of vitamin and mineral supplements, which counselor educators reported the most experience with, mind-body practices ranked the highest in terms of experience with CAM practices. These practices included breathing exercises, meditation, guided imagery, and progressive muscle relaxation. One explanation for why counselor educators had more personal experience with this group of practices may be that these

have been part of counselor education history and training, particularly breathing exercises, progressive muscle relaxation and guided imagery. These practices were an outgrowth of behaviorism and the exploration of the cognitive mediating role of body based practices such as these. It is possible that counselor educators were exposed to some of these practices in training. However, the data suggests that there is a gap in counselor educators having personal experience with these practices and using them in their clinical and teaching settings. This may suggest a need for more training on how to incorporate these practices into teaching and training. Future research could explore why counselor educators have more personal experience with these practices and if these practices were addressed in their training.

Mean scores for personal experience with CAM were higher than means for clinical or teaching experience. It makes sense that people are more likely to have personal experience with the CAM practices prior to teaching about them or using the practices clinically. Analyses revealed that the differences between personal experience and both clinical and teaching experience were significant. That is to say, participants were more likely to have personal experience with CAM than experience with them clinically or in teaching. It is possible that this research is highlighting the gap in research and training practices that could help counselors find appropriate ways to integrate these practices into their teaching and clinical work. Future research should explore the reasons why counselor educators with personal experience with CAM, and who believe that CAM should be integrated into training, may not be integrating these practices into training.



Some attitudes surveys in mental health have focused on experience with a particular subset of CAM practices known as mind-body practices. These practices have particular relevance to mental health because they claim to positively impact the mental/emotional components of well-being.

### **Experience With Mind-Body Practices**

Counselor educators favored a group of practices called mind-body practices. The following is a rationale for considering mind-body practices independently of the other CAM practices. The mind-body practices that ranked in the top ten for both the general population (NCCAM, 2007) and survey participants in this study were considered as a potentially significant subset of CAM practices. These mind-body practices included meditation, progressive muscle relaxation, guided imagery, and breathing exercises. First, mind-body practices are a unique form of CAM, which focus on using the mind in service of some positive change in the body, or using the body in a particular way to invoke changes in the mind. Many mind-body practices by definition generate qualities that counselors hope to achieve in counseling, such as peace, calm, happiness, joy, centeredness, a sense of refuge, and an ability to act wisely, with focus and non-reactively. For this reason it seemed important to look at counselor educator responses to this particular group of practices. Likewise, some evidence suggests that these practices are more widely used by mental health professionals (APA, 2011; Baer, 2003; Germer, Siegel, & Fulton, 2005; O'Donohue & Cummings, 2008; Shapiro, Brown, & Biegel, 2007).

Acupuncture and qi gong are listed as mind-body practices by NCCAM but are not included in this particular analysis for two reasons. Acupuncture requires the

insertion of sterile needles into the body, which requires extensive training and is outside of the realm of ethical professional practice for mental health providers. All other mind-body practices can be learned and taught without extensive training or need for additional professional certification. Qi gong, which involves a series of movements paired with controlled breathing, is not as mainstream as the other practices, and has not been the subject of as much research. In NCCAM research on CAM use by the general population this practice did not rank in the top ten. For this reason the mind-body practices that ranked in the top ten for both counselors and the general population were considered.

This research did find that this group of practices (breathing exercises, progressive muscle relaxation, guided imagery, and meditation) was particularly significant for counselor educators. To test whether there was a significant difference between personal experience with the mind-body group (breathing exercises, progressive muscle relaxation, guided imagery and meditation) and personal experience with the remaining CAM practices a paired sample t-test was run comparing the means of both groups. The results indicated that there was a significant difference between experience with mind-body practices and experience with the other CAM practices. Counselor educators were more likely to have experience with the mind-body group of practices than other CAM practices and this difference was significant. Given the nature of the mind-body practices and their relation to counseling, it is not surprising that counselor educators would have more experience and knowledge of mind-body practices. This research seems to acknowledge the natural fit between these practices and the practice of counseling. As was shown in Chapter II, other medical and mental health professions have made note of the relevance of these practices to the field of mental health and begun

research and professional dialogue around integration of these practices into traditional forms of therapy.

## **Knowledge of CAM**

### **General Knowledge of CAM**

Counselor educators reported having the most knowledge about guided imagery, breathing exercises, progressive muscle relaxation, meditation and yoga. Interestingly these were the same five practices that MFTs reported having some familiarity with in the Olson et al. (2011). Again interest in these practices may indicate that counselors are aware of the overlap between these practices and mental health. More research is needed however, to understand why these practices are of most interest counselor educators.

### **Relationship Between Knowledge and Attitudes**

This research found a significant relationship between knowledge of CAM and attitudes. Studies in other professions have found a relationship between even a small amount of knowledge about a CAM practice and positive attitudes toward CAM (Rosenbaum et al., 2002). One implication of this finding for counselor education is that basic knowledge of one or more CAM practices may change attitudes for the positive. That is, if counselor educators are exposed to even basic concepts in CAM their attitudes toward CAM might improve or increase. As noted before positive attitudes are associated with many other qualities like openness, curiosity about, willingness to engage and receptivity. If over 30% of the population is engaging in a CAM practice (NCCAM, 2011) and by some estimates 10 to 66% of patients receiving conventional mental health care are simultaneously receiving a CAM treatment (Kessler, 2001; Simon et al., 2004;

Unutzer et al., 2000) then positive attitudes toward CAM or openness to these practices may be important within the therapeutic context. Ensuring that trainees can approach client use of CAM with openness and receptivity may be an important condition of the therapeutic relationship. Likewise, clients may not be reporting their CAM use to therapists (Simon, 2003), a problem echoed in medicine, which may have important implications for treatment.

### **Beliefs About CAM**

#### **Should CAM be Integrated Into Training?**

Counselor educators overwhelmingly believed that CAM should be integrated into counselor training to some degree (78%). Participants varied as to whether they strongly agreed (19%) with the statement, agreed (28%) or agreed somewhat (30%). However, this research seems to suggest that there may be a gap between what faculty believe should be happening within counselor training with regards to CAM and what is currently happening, based upon the extent of integration of CAM in the programs of the study participants.

#### **How Does Counselor Education Compare to Other Professions?**

Over half of counselor educators reported that they believe that the profession was slightly behind or very behind other professions with regards to acceptance and/or integration of CAM into the profession. This concurs with the evidence presented in Chapter II. While many other health and mental health professions have begun the process of integrating CAM into training and practice, counseling has only a handful of research publications and most recently one book on the topic. There are no journals

devoted to CAM, health or the confluence of mind-body medicine in counseling. Similarly, there are no divisions, or working groups devoted to understanding the role of CAM in counseling. Counselors are also absent from many of the national panels and interdisciplinary teams making policy and funding decisions about CAM. Where other mental health professions have professional statements or standards regarding CAM, counseling does not have either.

### **Professional Identity and CAM**

Orientation to prevention and wellness are two important aspects of counselor professional identity (Emerson, 2010). Prevention and wellness are also two important characteristics of many CAM practices. Interestingly, the eight-question subscale, as a whole, testing for prevention and wellness identity, was not significantly related to positive attitudes toward CAM as expected. However, when the wellness and prevention scales were separated, the wellness subscale was correlated with positive attitudes.

Wellness has been a cornerstone of counseling philosophy for several decades (Witmer, 2012). Wellness counselors according to Granello and Witmer (2012) “seek to prevent illness, minimize disease, improve overall quality of life, and increase the longevity of the client” (p. 29). The positive correlation between wellness identity and attitudes may have something to do with the fact that CAM practices and wellness have significant areas of overlap. For example, it is easy to see the relationship between improving one’s quality of life and getting a massage, or doing yoga. Likewise, many CAM practices are often spoken of in the context of holistic health and wellness. It is possible that the preventative aspects of CAM are less understood or well studied.

Because there is less research on the preventative aspects of CAM practices participants

may have had reservations about this relationship. Future research should explore what counselor educators believe about the preventative aspects of CAM. One important line of inquiry would be to consider if counselors believe there is a need for more research in this area. Similarly, on a measure of internal consistency the prevention portion of the subscale had a relatively low Cronbach alpha, .426. The wellness portion of the subscale had a Cronbach alpha of .667. This lower reliability score on the prevention subscale may indicate that the measure is not accurately or reliably measuring prevention and that may have impacted these results.

Another reason that prevention and attitudes were not strongly correlated could be due to the practical pressure to learn to diagnose clients. Counseling is a younger profession and is up against an institutional culture that requires diagnosis in order to treat and receive reimbursement. This imperative to diagnose runs counter to the idea that some may seek counseling prior to being diagnosable in an effort to prevent problems from becoming more serious issues. Because prevention is not as currently valued in our health care system it is possible that counselor educators are valuing this aspect of identity less. More research is needed to understand the source of this finding.

### **CAM in Teaching and Training**

#### **Integrated Into Core Curriculum**

Only a small number of counselor educators (18%) stated that their program was integrating CAM into the core curriculum. In contrast, the majority of counselor educators (79%) believe that CAM has a place within the counselor education curriculum.

When those who were integrating CAM into their curriculum were asked to identify which core areas CAM content was being integrated, the three most commonly reported areas were self-care, treatment approaches, and helping relationships. This suggests counselor educators may see CAM as relevant to each of these core curriculum areas. Future research should focus on understanding how counselor educators are integrating CAM into these core areas. Specifically inquiring about how CAM is relevant to self-care, treatment and the helping relationship should be explored. Additionally, these core areas would be good starting points for discussion about where CAM might best fit in the curriculum.

### **Elective Course in CAM/Specific CAM Modality**

The types of elective courses currently being taught provide some insight into the types of modalities that counselor educators may value. Of the participants in this study, 18 responded that their program offers a course on a specific CAM modality. Several modalities were listed by participants as a specific course offered in their program. The themes that emerged from this list include: a) art related modalities such as dance, art, drama, music; and b) contemplative practices like breathing, progressive relaxation, guided imagery and meditation. Also mentioned with less frequency were yoga, ecopsychology and healers. This list may provide a starting point for a conversation within the profession about the relevance and importance of these modalities to counselor education training.

### **MFTs and Counselor Educators**

The study conducted on attitudes of MFTs by Caldwell et al. (2006) found that MFTs most commonly utilized meditation, nutritional supplements, massage,

chiropractic, and relaxation techniques. Counselor educators were more likely to utilize vitamins and mineral supplements, breathing exercises, meditation, guided imagery, and progressive muscle relaxation. This difference in use of practices is interesting. MFTs utilized body-based practices such as massage and chiropractic more frequently than did counselor educators. It is not clear why this was the case. More research is needed to understand what aspects of training or professional identity may give rise to this difference.

The attitudes subscale used in this current study, created by Caldwell et al. (2006), consisted of 22 questions and was originally tested on a large sample of MFTs. Karen Caldwell provided this researcher with the mean scores for each question from the MFT sample. No mean scores for individual participants was available which would have enabled more in depth analysis. However, to establish a point of comparison, mean scores for each question were also computed for the counselor education group. Table 5 provides a visual comparison of mean scores for each of the 22 questions. Overall, the responses for each question were similar, suggesting that MFTs and counselor educators were similar in their attitudes toward CAM, at least as measured by this scale.

In another study conducted by Olson et al. (2011) of faculty and graduate students from an accredited Marriage and Family Therapy programs in the U.S. and Canada, the majority of respondents believed that training programs should teach about mind-body therapies (95.6%,  $N=146$ ). This study surveyed participants only about mind-body therapies as defined by NCCAM (meditation, yoga, guided imagery, hypnotherapy, progressive muscle relaxation, qi gong and tai chi). Participants also believed that faculty should train and supervise mind-body therapies to be used as adjunct treatments (89.9%).



Table 5

*Comparison of Attitudes Survey Results With MFT Group*

<b>Item</b>	<b>Counselor Educator (N = 130)</b>	<b>MFT (N = 424)</b>
1. Client use of CAM is irrelevant to counseling	3.99	4.05
2. Most clients are interested in CAM	2.86	3.05
3. I would not refer to CAM provider until I had good knowledge of practice/practitioner	4.25	4.46
4. It is important to know about client's CAM use	4.11	4.23
5. Assumptions of CAM do not fit my approach to counseling	3.85	4.03
6. There is an inadequate scientific basis for CAM	2.94	2.99
7. CAM use should be supervised by physicians	3.46	3.73
8. CAM use can be dangerous and prevent use of conventional medicine	3.15	3.08
9. Well informed clients can make adequate decisions about CAM	4.11	4.17
10. If clients believe CAM would help, I would explore it with them	4.25	4.27
11. Collaborating with CAM providers is important to me	3.12	3.02
12. I rely primarily on empirical studies when recommending treatment	3.42	3.08
13. Most CAM practices are outside of the scope of practice of counselors	2.82	3.11
14. CAM should be regulated by peer reviewed boards	2.39	2.48
15. Therapists should notify licensing boards about incorporating CAM	3.08	2.89
16. It is important to expand healthcare infrastructure to include CAM practitioners	3.68	3.81
17. Healthcare providers should take into account the interconnection of body, mind, and spirit	4.51	4.63
18. CAM practices are just a financial con trick	4.22	4.23
19. CAM should only be used as a last resort	4.08	4.07
20. There are fewer side effects to most CAM practices when compared to conventional medications	3.35	3.37
21. I have serious concerns about counselors incorporating CAM into their practice	3.58	3.61
22. I rely primarily on my intuition and general knowledge when recommending treatment to clients.	2.65	3.02

*Note.* MFT = marriage and family therapist. Please see Appendix B for the complete versions of the questions listed above. The response set for the above questions on the current survey were as follows: a 5-point Likert scale with 1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree. The following items on the current survey were reversed scored: 1, 5, 6, 7, 8, 13, 14, 15, 18, 19, and 21.

Since the Olson (2011) study considered the attitudes of both faculty and graduate students and focused solely on mind-body therapies as defined by NCCAM, direct comparisons to the current study are not possible. However, it seems important to consider the strong support of MFTs in this study for the integration of mind-body therapies into training and practice. The current study asked more generally about counselor educators' support for the integration of CAM as a whole. Future studies should consider asking more specifically about the integration of mind-body therapies into training and practice as was done in the Olson survey. The percentage of counselor educators who stated that they agreed, to some degree, that CAM should be integrated into training was 78%. This number may have been higher had mind-body therapies been singled out.

The Olson (2011) study also asked participants about barriers to practice and education. The primary barrier mentioned in this study, to using mind-body therapies in practice was limited knowledge or training in mind-body skills. The current study did not ask about barriers to integration. Future research should explore whether limited knowledge and training is also the primary barrier for counselor educators, or what other barriers might exist.

### **Demographic Variables and Attitudes**

Tests were run to consider the relationship between various demographic variables and attitudes toward CAM. Previous studies detailed in chapter two have found relationships between certain variables and CAM attitudes and the results from this study concurred with some of those findings but also differed in some meaningful ways.

**Ethnicity.** There is a need to understand racial and ethnic differences in relationship to CAM. Current studies do not adequately address what may be at the root of differences alluded to in a few studies. Culture may play an important role in the types of CAM practices a person chooses. When survey questions have included culture-specific healing practices or prayer, interest in these practices from other ethnic groups increases (Brown, Barner, Richards, & Bohman, 2007). Future studies should find ways to address the need for more information in this area including using statistical procedures that can detect significant differences even when the numbers in particular groups are low.

NCCAM (2007) reports the following CAM use by race/ethnicity among adults. American Indian/Alaskan Native (50.3%); White (43.1%); Asian (39.9%); Black (25.5%); Hispanic (23.7%). In the NHIS (2002) study, which is a representative, population based survey of adults in the U.S., it was found that whites were more likely to use multiple CAM practices than other ethnic minority groups with one exception; it was found that Hispanics were more likely than whites to combine CAM therapies. Interestingly, when prayer is included as a CAM practice, the percentage of African Americans using CAM increases to (67.6%) (Brown et al., 2007) which is higher than the national average of 62% when prayer is included (NCCAM, 2004).

The results of the current study that did not find a difference in attitudes toward CAM based upon ethnicity need to be viewed with caution since there were relatively small numbers in the minority groups and subsequently these groups were collapsed into one group in order to be compared to the Caucasian group. It is unclear as to whether the underrepresentation is due to sampling error, survey bias that makes Caucasians more

likely to respond to a survey on CAM, or because ethnic minority groups are underrepresented within counselor education.

**Gender.** This study found that with regards to attitudes toward CAM, there was a significant difference between males and females. Specifically, females were more likely to positively value CAM than males. This result concurs with previous studies that have looked at differences between male and female attitudes toward CAM in medicine and by NCCAM. More research is needed to understand why females may hold more positive attitudes toward these practices. It is interesting that this difference persisted within the counseling profession. It may be that some of the same qualities that enable women to seek help whether for medical treatment or mental health treatment may influence attitudes toward CAM practices. These qualities, like openness, flexibility, and moral reasoning may influence attitudes towards these practices.

**Age.** Interestingly, the relationship between age and attitude did not follow the trend of previous research. For this study, as age increased, so did positive attitudes toward CAM. Other studies have found that age and attitudes are negatively correlated, with older individuals reporting less positive attitudes toward CAM. This was particularly true in medicine. These studies speculated that younger generations were more open to CAM practices because they were more likely to have positive exposure to CAM and that older generations were more rooted in a medical philosophy that saw CAM as too unconventional. However, NCCAM has reported that older individuals are more likely to use CAM practices (NCCAM, 2007). One possible explanation is that Western medicine is strongly steeped in a philosophy that runs counter to many of the more holistic philosophies promoted within CAM practices. Although this culture in

medicine is changing with the emergence of new research, older professionals may be more identified with a philosophy formulated during their training, when CAM was seen as lacking rigor and was not respected. Mental health professions may not be as influenced by the Western medical model presented in training and therefore the differences between younger and older professionals less amplified.

Future research however should consider the length of time in the profession along with the year the degree was earned as possible intervening variables. Additionally, research questions, which explore one's level of activity in the profession, could be important to ask as well. If a person is steeped in a particular philosophy presented during training, and then does not remain active in the field, or in the case of faculty if they are not engaged in regular clinical practice, then they may lose touch with client needs of philosophical changes in the profession. While age was an interesting variable to explore, parsing out level of professional activity, length of time in the profession, year degree was completed, and whether one is involved in active clinical practice may provide richer information.

Additionally, being older and well-educated in a mental health profession may impact attitudes towards CAM in important ways. How education and philosophical orientation and age interact could be an important area for future research to explore. Likewise, it may be that there is an important relationship between historical trends in CAM and mind-body interest/research and interest in the general public. For example, historian Anne Harrington noted that there have been key events in history that have increased public interest in CAM practices. One important wave of interest came after a public broadcasting event in 1991 with Bill Moyers titled "Healing and the Mind." She

noted that this one event created a huge surge in interest in these practices that reverberated for several decades (Harrington, 2007). Likewise, NCCAM has noted that interest in particular practices has waxed and waned over the years. Most recently, they noted that homeopathy, which in the late 90's was very popular had dropped out of the top ten practices used by the general population. Similarly, yoga in recent years has made its way into the top five (NCCAM, 2007). The reasons for these changes in public interest are probably many and varied and very likely are connected to the attention that the media gives to the topic and the research that is emerging at the time. Future research might consider taking Anne Harrington's historical account of mind-body practices and identifying waves of interest across several decades and looking at the relationship between these waves of interest and age.

**Year of degree completion.** This study did not find a significant relationship between year of degree completion and attitudes toward CAM. However, as noted above, future research should look at not only year of degree completion, but also level of professional activity and clinical experience as a group of factors that might influence attitudes.

### **Limitations**

#### **Response Rate**

There are several limitations of this study. First of all, the response rate was relatively low. Thus, caution should be exercised in generalizing these results to all counselor educators. Although it is important to note that according to CACREP there are approximately 1300 counselor educators nationwide (Kimble, 2012). The number of participants in this study was 130, which is 10% of the national population. While it is

unclear whether or not this sample is representative of the national population of counselor educators, 10% of the population provides a good start at assessing faculty attitudes.

### **Degree From Related Field**

Another limitation of the study is that counselor educators who responded to this study may have received their training in a related field other than counseling. Until recently, standards allowed programs to hire faculty with degrees from related fields. It is possible that some of the respondents received training for example in psychology. This study did not ask about the type of academic program in which the counselor educator was trained; future studies might consider inquiring about this. Without information about what professional degree the respondents hold it is difficult to know how training and program of study have influenced the responses in this study.

### **Reliable Attitudes Scale**

The attitudes scale constructed by Caldwell et al. (2006) has not been rigorously tested beyond the original study with MFTs. The problem of lack of consistent use of a well-tested measure of attitudes toward CAM is one that plagued many other fields as they have researched attitudes toward CAM. This current study chose to use the Caldwell et al. survey to allow for comparisons between MFT and counseling. Future studies should focus on refining this measure and retesting it, to ensure that the scale is valid and reliably testing attitudes towards CAM. Caldwell et al. (2006) began the process of performing a factor analysis on the questions to determine which questions loaded for particular factors. Additional research is needed to see if these factors reliably

emerge. Likewise, more exploration is needed to determine what these factors may be representing in terms of behavior and attitudes toward CAM.

### **Aggregating CAM Practices**

Future studies should consider more focused questions on particular CAM practices. By asking counselor educators about all CAM practices it is possible that the data has been skewed. For example, one's belief about or attitude toward acupuncture may vary dramatically from one's attitude toward meditation. Initially, it seemed important to consider CAM practices collectively, however future research should consider looking more specifically at the mind-body practices that counselors reported more experience and knowledge with and which may have particular relevance to the profession. Using the categories of CAM practices provided by NCCAM could also be useful in comparing practices in different areas.

### **Length of Study Survey**

The length of the survey used in this study probably deterred some from completing the survey. Analysis by QuestionPro indicated that over 300 people viewed the survey, but only 130 fully completed the survey. Likewise, a large number of those who started the survey dropped out halfway through the survey. While on average the survey only took participants 10-15 minutes to complete, a shorter survey may have yielded a higher number of completed and usable surveys.

### **Self-Selection and Self-Report**

It is possible that those who chose to participate in the survey were more interested in CAM to begin with. As with any survey of this type it is important to



consider that there may be some bias in how or why people decided to participate. It is also important to note that there are limitations to what we can definitively know with self-report data. For example, we cannot know from this data a person's true level of knowledge about a particular CAM practice. This survey simply asked what the person believed their level of knowledge was and belief about knowledge and actual knowledge are not the same thing.

### **Recommendations for Future Research**

Throughout the discussion above of the major results of this study, suggestions have been offered about future research. Here, some general recommendations regarding future research in this area are made. Future research should explore more in depth the kind of experiences counselor educators have with CAM and what specifically CAM courses look like. Likewise, a good next step would be to inquire about the relevance of mind-body practices to counselor education training by specifically exploring how CAM may be integrated with self-care and treatment approaches portions of the curriculum.

The quantitative nature of this study allowed for exploration of the overall lay of the land, or what, in general, is happening with regards to CAM in counselor education. However, the survey was long. In order to capture information about a broad set of practices from a large group of people, and to improve the validity of this research, subscales from other studies were utilized and all CAM practices were included. No assumptions were made about which CAM practices counselors would be most drawn to. Future research could use these findings as a guide, inquiring more deeply about the practices that counselor educators indicated they had the most experience with or knowledge about. It also seems important that future research consider qualitative or

mixed methods to gain more information about counselor educators' beliefs about these practices and how to integrate them into training.

Several respondents emailed the researcher directly to share more of their personal thoughts about the integration of these practices in counselor training. These thoughtful comments were always supportive but also highlighted the complexity of the issues with integration of CAM including some of the ethical dilemmas counselors may face. Several noted that by considering the diverse group CAM practices as a single group the results of the survey may be skewed. Their recommendations were to study practices more relevant to counselors. Several participants emailed to say that they were glad to see that this topic was finally getting some attention.

### **Recommendations for the Counseling Profession and Counselor Education**

#### **Counseling Profession**

Other health and mental health professions have begun to consider the role of CAM in the development of professional characteristics, in treatment and in training, however the profession of counseling is lagging behind. This was supported by the results of this study in which over half of the participants believed counseling is behind other professions in its integration of CAM. Counselor educators in this study reported positive attitudes and a significant amount of experience with CAM, particularly the mind-body practices. In these ways counselor educators look similar to other mental health professions. However, despite having positive attitudes, and a strong belief that CAM should be integrated into training, fewer research articles have been published, less is being done within the national professional organization, and the current training standards do not address CAM in training.

As a profession, counseling could establish working groups, divisions, or a national campaign, which focuses on wellness and CAM. By highlighting counseling's philosophical foundation in wellness and the relationship between CAM and wellness, the profession could bring important attention to the unique contributions of counselors.

Likewise, establishing a research agenda, focused on the ways in which certain CAM practices promote wellness could spur new research in this area. Counselors are well positioned to establish an important line of research on wellness and CAM. In this way counselors could become part of the national conversation of the role of CAM in wellness, prevention and health. Establishing journals, which support this kind of research would be another important step in this process.

### **Counselor Education**

Counselor education needs to establish training programs, which enable the field to compete in this environment. Important first steps include establishing a national dialogue about the role of CAM in counseling, creating training standards, and developing programs that enable counselors to specialize in wellness and prevention in the health care setting. Currently there is an opportunity for counselor education to highlight its foundation in wellness and prevention and lead this emerging field of mind-body medicine by establishing a framework for working as prevention or wellness specialists.

Within training programs, counselor educators could take several steps. First, counselor educators could begin to research the ways in which mind-body practices develop professional characteristics like empathy, unconditional positive regard, trust, and being a healing presence. Other programs have begun to use contemplative practices

like meditation and mindfulness to cultivate these qualities with positive results.

Likewise, counselor educators could explore the role of mind-body practices in self-care for the graduate student and the future counselor. Some evidence exists that mind-body practices like mindfulness and meditation reduces burnout, stress, and fatigue.

Conducting research on the relationship between these practices and self-care is an important first step.

It is also important that CACREP consider the role of CAM in counselor training. The profession needs to begin to dialogue about where this body of information fits within counseling curricula and if new curriculum standards need to be established. Other professions have found it important to establish CAM competencies, guidelines for ethical conduct, curriculum standards, research agendas, journals, and divisions within their organization devoted to CAM. Counseling has much to offer with regards to CAM and clients could benefit from what CAM has to offer.

### **Summary**

CAM use in the general population is widespread (NCCAM, 2011). Many people are using a variety of CAM practices to reduce stress, combat depression and anxiety, and deal with chronic health issues. Research on mind-body practices in particular indicates that some CAM practices such as meditation, mindfulness, yoga, breathing exercises, biofeedback, and progressive muscle relaxation are useful in dealing with a variety mental health issues. It is estimated that 10-20 % to two thirds of the population are using one or more CAM modalities to deal with a mental health concern (Simon et al., 2004; Kessler, 2001; Unutzer et al., 2000). For these reasons mental health professions including psychiatry, psychology, social work and marriage and family therapy have

begun integrating CAM into treatment, training, research agendas and practice. Counselor education however is lagging behind and has done little to explore the role of CAM in counseling or counselor training. One first step, for evaluating the role of CAM in the profession, that medicine, psychology and marriage and family therapy took, was to survey stakeholder attitudes. In an effort to fill this gap in knowledge in counselor education this study explored counselor educator attitudes, knowledge, experience and beliefs about CAM. Results indicated that counselor educators had very positive attitudes toward CAM and the majority of respondents believed that CAM should be integrated into counselor education training. Counselor educators were also more likely to have experience with mind-body practices. If CAM was being taught in a training program it was most likely mind-body practices. When CAM was being integrated into the core curriculum it was most commonly included in the self-care, treatment approaches, and helping relationships portions of the curriculum.

This research suggests that counselor educators have some knowledge of and experience with CAM (particularly with mind-body practices), believe it should be integrated into training and that counselor education is behind other professions with acceptance and integration of CAM into the profession. Future research should consider exploring the content of courses being taught on CAM in counselor education, what practices counselors and counselor educators are using most frequently and what client experiences are with CAM and counseling. Training programs should identify interested faculty to consider the role of these practices within their curriculum. Similarly, counseling, as a profession should consider the role of CAM in the CACREP standards,

establishing national competencies and ethical guidelines for training programs to implement.

## REFERENCES

- American Association of Medical Colleges (n.d.). *About the AAMC: Mission*. Retrieved from <https://www.aamc.org/about/>
- American Holistic Nursing Association (2011). About us. Retrieved from <http://www.ahna.org/AboutUs/>
- Anderson, J. & Taylor, A. (2011). Effects of healing touch in clinical practice: A systematic review of randomized clinical trials. *Journal of Holistic Nursing*, 29(3), 221-228.
- Astin, J. (1997). Stress reduction through mindfulness meditation: Effects on psychological symptomatology, sense of control, and spiritual experiences. *Psychotherapy and Psychosomatics*, 66(2), 97-106.
- Astin, J. A. (1998). Why patients use alternative medicine: Results of a national study. *Journal of the American Medical Association*, 279(19), 1548-1553.
- Astin, J., Shapiro, S., Eisenberg, D., & Forsys, K. L. (2003). Mind-body medicine: State of the science, implications for practice. *Journal of the American Board of Family Practice*, 3(16), 131-147.
- Astin, J. A. (2004). Mind-body therapies for the management of pain. *The Clinical Journal of Pain*, 20 (1), 27-32.
- Astin, J. A., & Forsys, K. (2004). Psychosocial determinants of health and illness: Integrating mind, body, and spirit. *Advances in Mind-Body Medicine*, 20(4), 14-21.
- Astin, J. A., Sierpina, V. S., Forsys, K., & Clarridge, B. (2008). Integration of the biopsychosocial model: Perspectives of medical students and residents. *Academic Medicine*, 83(1), 20-27.
- Baer, R. A. (2003). Mindfulness training as a clinical intervention: A conceptual and empirical review. *Clinical Psychology: Science and Practice*, 10(2), 125-143.
- Baldwin C. M., Kroesen K., Trochim W. M., & Bell I. R. (2004). Complementary and conventional medicine: A concept map. *BMC Complementary and Alternative Medicine*, 4(2). Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/15018623>

- Barnes, P. M., Powell-Griner, E., McFann K., & Nahin, R. L. (2004). Complementary and alternative medicine use among adults: United States, 2002. *Advance Data*, 343, 1-19.
- Bartlett, H. (1975). Ida Cannon: Pioneer in medical social work. *Social Service Review*, 49(2), 208-229.
- Baugniet, J., Boon, H., & Ostbye, T. (2000). Complementary/alternative medicine: Comparing the views of medical students with students in other health care professions. *Family Medicine*, 32(3), 178-184.
- Becvar, D., Caldwell, K., & Winek, J. (2006). The relationship between marriage and family therapists and complementary and alternative medicine approaches: A qualitative study. *Journal of Marital and Family Therapy*, 31(1), 115-126.
- Beecher, C. E. (1831). *The elements of mental and moral philosophy, founded upon experience, reason, and the Bible*. Hartford, CT: Peter B. Gleason & Co.
- Bell, R. M. (2010). A review of complementary and alternative medicine practices among cancer survivors. *Clinical Journal of Oncology Nursing* 14(3), 365-370.
- Ben-Arye, E., Frenkel, M., Klein, A., Scharf, M. (2008). Attitudes toward integration of complementary and alternative medicine in primary care: Perspectives of patients, physicians and complementary practitioners. *Patient Education and Counselor education*, 70(3), 395-402.
- Bentley, D. P. (2007). *Mindfulness and counselor education self-efficacy: The mediating role of attention and empathy*. (Doctoral dissertation). Retrieved from Dissertations and Theses database. (UMI No. 3273312)
- Birdsall, B. A., Pritchard, M. E., Elison-Bowers, P., Smith, B. C., & Klein, A. (2010). *Are private counselors comfortable treating combat-related trauma?* Retrieved from [http://counselor educationoutfitters.com/vistas/vistas10/Article\\_86.pdf](http://counselor educationoutfitters.com/vistas/vistas10/Article_86.pdf)
- Bishop, S. R., Lau, M., Shapiro, S., Carlson, L., Anderson, N. D., Carmody, J., Segal, Z. V., Abbey, S., Specia, M., Velting, D., & Devins, G. (2004). Mindfulness: A proposed operational definition. *Clinical Psychology: Science and Practice*, 11(3), 230-241.
- Booth-LaForce, C., Scott, C., Heitkemper, M., Cornman, J., Lan, M. C., Bond, E., & Swanson, K. (2010). Complementary and alternative medicine (CAM) attitudes and competencies of nursing students and faculty: Results of integrating CAM into the nursing curriculum. *Journal of Professional Nursing*, 26(5), 293-300.
- Breda, K. L., & Schulze, M. W. (1998). Teaching complementary healing therapies to nurses. *Journal of Nursing Education*, 37(9), 394-397.



- Brigham, A. (1832). *Health*. Hartford, CT: F. J. Huntington.
- Bright, M. A. (2002). *Holistic health and healing*. Philadelphia, PA: F. A. Davis.
- Brown, C. M., Barner, J. C., Bohman, T., & Richards, K. (2007). Patterns of complementary and alternative medicine (CAM) use in African Americans. *Journal of Alternative and Complementary Medicine*, 13(7), 751-758.
- Buchanan, J. (1812). *The philosophy of human nature*. Richmond, VA: John A. Grimes, Main Street.
- Caldwell, K. L., Winek, J. L., & Becvar, D. S. (2006). The relationship between marriage and family therapists and complementary and alternative medicine approaches: A national survey. *Journal of Marital and Family Therapy*, 32(1), 101-114.
- Cannon, I. M. (1952). *On the social frontier of medicine: Pioneering in medical social service*. Cambridge, MA: Harvard University Press.
- Carpenter, C., Crigger, N., Kugler, R., & Loya, A. (2008). Hypericum and nurses: a comprehensive literature review on the efficacy of St. John's Wort in the treatment of depression. *Journal of Holistic Nursing*, 26(3), 200-211.
- Carr, J. E. (1996). Psychology and mind-body segregation: are we part of the problem? *Journal of Clinical Psychology in Medical Settings*, 3(2), 141-144.
- Chaterji, R., Tractenberg, R.E., Amri, H., & Lumpkin, M. (2007). A large-sample survey of first and second year medical student attitudes toward complementary and alternative medicine in the curriculum and in practice. *Alternative Therapies in Health and Medicine*, 13(1), 30-35.
- Cherkin D. C., Deyo R. A., Sherman, K. J., Hart, L. G., Street, J. H., Hrbek, A., Cramer, E., Milliman, B. J., Mootz R., Barassi J., Kahn J. R., Kaptchuk, T. J., & Eisenberg, D. M. (2002). Characteristics of licensed acupuncturists, chiropractors, massage therapists, and naturopathic physicians. *The Journal of the American Board of Family Practice*, 15(5), 378-90.
- Chrisman, J. A., Christopher, J. C., & Lichtentein, S. J. (2009). Qigong as a mindfulness practice for counselor education students. *Journal of Humanistic Psychology*, 49(2), 236-257.
- Christopher, J. C., Christopher, S., Dunnagan, T., & Schure, M. (2006). Teaching self-care through mindfulness practices: The application of yoga, meditation, and qigong to counselor training. *Journal of Humanistic Psychology*, 46(4), 494-509.

- Christopher, J. C., Chrisman, J. A., Trotter-Mathison, M., Schure, M. B., Dahlen, P., & Christopher, S. B. (2012). Perceptions of the long-term influence of mindfulness training on counselors and psychotherapists: A qualitative inquiry. Erratum. *Journal of Humanistic Psychology, 52*(2), 248-248.
- Connelly, E. N., Elmer, P. J., Morris, C. D., & Zwickey, H. (2010). The vanguard faculty program: Research training for complementary and alternative medicine faculty. *Journal of Alternative and Complimentary Medicine, 16*(10), 1117-1123.
- Cornman, J., Carr, C., & Heitkemper, M. (2006). Integrating CAM into nursing curricula: CAM camp as an educational intervention. *Journal of Professional Nursing, 26*(5), 293-300.
- Council for Accreditation of Counseling and Related Educational Programs [CACREP]. (2009). *2009 standards for accreditation*. Alexandria, VA: Author. Retrieved from <http://www.cacrep.org/doc/2009%20Standards%20with%20cover.pdf>
- Cowen, E. L. (1994). The enhancement of psychological wellness: Challenges and opportunities. *American Journal of Community Psychology, 22*(2), 149-179.
- Danner, D., Snowdon, D., & Friesen, W. (2001). Positive emotion in early life and longevity: Findings from the nun study. *Journal of Personality and Social Psychology, 80*(5), 804-813.
- Davidson, R. J., Kabat-Zinn, J., Schumacher, J., Rosenkranz, M., Muller, D., Santorelli, S. F., Urbanowski, F., Harrington, A., Bonus, K., & Sheridan, J. F. (2003). Alterations in brain and immune function produced by mindfulness meditation. *Psychosomatic Medicine, 65*(4), 564-570.
- Diener, E., & Diener, C. (1996). Most people are happy. *Psychological Science, 7*(3), 181-185.
- Diefenbach, M. A., Hamrick, N., Uzzo, R., Pollack, A., Horwitz, E., Greenberg, R., & Engstrom, P. (2003). Clinical, demographic and psychosocial correlates of complementary and alternative medicine use by men diagnosed with localized prostate cancer. *Journal of Urology, 170*(1), 166-169.
- Ditte, D., Schulz, W., Ernst, G., & Schmid-Ott, G. (2011). Attitudes towards complementary and alternative medicine among medical and psychology students. *Psychology, Health and Medicine, 16*(2), 225-237.
- Dossey, B., Keegan, L., & Guzzetta, C. E. (2000). *Holistic nursing: A handbook for practice* (3<sup>rd</sup> ed.). Sudbury, MA: Jones and Bartlett.

- Dziegielewska, S. F. (2003). *The changing face of health care social work: Professional practice in managed behavioral health care*. New York: Springer Publishing Company.
- Edwards, J. (1754). *A careful and strict enquiry into the modern prevailing notions of that freedom of will, which is supposed to be essential to moral agency, virtue and vice, reward and punishment, praise and blame*. Boston, N. E.: S. Kneeland, in Queen-Street, MDCCLIV.
- Eisenberg, D. M., Kessler R. C., Foster C., Norlock F. E., Calkins D. R., & Delbanco T. L. (1993). Unconventional medicine in the United States: Prevalence, costs, and patterns of use. *The New England Journal of Medicine*, 328(4), 246-252.
- Eisenberg, D. M., Kessler R. C., Van Rompay, M. I., Kaptchuk, T. J., Wilkey, S. A., Appel, S., & Davis, R. B. (2001). Perceptions about complementary therapies relative to conventional therapies among adults who use both: Results from a national survey. *Annals of Internal Medicine*, 135(5), 344-51.
- Eisenberg, L. (2002). Complementary and alternative medicine: What is its role? *Harvard Review of Psychiatry*, 10(4), 221-230.
- Eisenberg, D. M. (2005). The Institute of Medicine report on complementary and alternative medicine in the United States—personal reflections on its content and implications. *Alternative Therapies in Health and Medicine*. 11(3), 10-15.
- Eliopoulos, C. (1999). *Integrating conventional and alternative therapies and holistic care for chronic conditions*. St. Louis, MO: Mosby.
- Elder, W., Rakel, D., Heitkemper, M., Hustedde, C., Harazduk, N., Gerik, S., & Haramati, A. (2007). Using complementary and alternative medicine curricular elements to foster medical student awareness. *Academic Medicine*, 82(10), 951-955.
- Elder, W. G., Hustedde, C., Rakel, D., Joyce, J. (2008). CAM curriculum activities to enhance professional training in medical schools. *Complementary Health Practice Review*, 13(2), 127-133.
- Emmons, R. A. & Crumpler, C. A. (2000). Gratitude as a human strength: Appraising the evidence. *Journal of Social & Clinical Psychology*, 19(1), 56-69.
- Engel, G. (1977). The need for a new medical model: A challenge for biomedicine. *Science*, 196(4286), 129-136.
- Epstein, M. (1995). *Thoughts without a thinker: Psychotherapy from a Buddhist perspective*. New York: Basic Books.

- Ernst, L. S., & Ferrer, L. (2009). Reflection of a 7-year patient care program: Implementing and sustaining an integrative hospital program. *Journal of Holistic Nursing, 27*(4), 276-271.
- Eton, D. T., Koffler, K., Cella, D., Eisenstein, A., Astin, J. A., Pelletier, K. R., & Riley, D. (2005). Developing a self-report outcome measure for complementary and alternative medicine. *Explore, 1*(3), 177-85.
- Evans, M. P., Valdez, A. A., Burns, S., & Rodriguez, V. (2002). Brief and nontraditional approaches to mental health counseling: Practitioners' attitudes. *Journal of Mental Health Counseling, 24*(4), 317-321.
- Field, T. (2011). Yoga clinical research review. *Complementary Therapies in Clinical Practice, 17*(1), 1-8.
- Fontaine, K. (2000). *Healing practices: Alternative therapies for nurses*. Englewood Cliffs, NJ: Prentice Hall.
- Fontaine, K. (2010). *Complementary and alternative therapies for nursing practice* (3<sup>rd</sup> ed.). Englewood Cliffs, NJ: Prentice Hall.
- Foss, T. P. (1977). Nontraditional approaches to mental health and their relation to counselor education psychology. *The Counseling Psychologist, 7*(2), 21-23.
- Forjuoh, S. N., Rascoe, T. G., Symm, B., & Edwards, J. C. (2003). Teaching medical students complementary and alternative medicine using evidence-based principles. *Journal of Alternative and Complementary Medicine, 9*(3), 429-439.
- Freeman, L., 2004. *Mosby's complementary and alternative medicine* (2<sup>nd</sup> ed.). Mosby: University of Michigan.
- Fredrickson, B. (2001). The role of positive emotions in positive psychology: The broaden-and-build theory of positive emotions. *American Psychologist, 56*(3), 218-226.
- Frenkel, M., Ben-Arye, E. (2001). The growing need to teach about complementary and alternative medicine: Questions and challenges. *Academic Medicine, 76*(3), 251-254.
- Frenkel, M., Frye, A., Heliker, D., Finkle, T., Yzaquirre, D., Bulik, R., & Sierpina, V. (2007). Lessons learned from complementary and integrative medicine curriculum change in a medical school. *Medical Education, 41*(2), 205-13.
- Fugh-Berman, A. (1997). *Alternative medicine: What works*. Baltimore, MD: Williams and Wilkins.

- Furnham, A., & Smith, C. (1988). Choosing alternative medicine: A comparison of the beliefs of patients visiting a general practitioner and a homoeopath. *Social Science and Medicine*, 26(7), 685-689.
- Furnham, A., & McGill, C. (2003). Medical students' attitudes about complementary and alternative medicine. *The Journal of Alternative and Complementary Medicine*, 9(2), 275-284.
- Gaboury, I., Bujold, M., Boon, H., & Moher, D. (2009). Interprofessional collaboration within Canadian integrative healthcare clinics: Key components. *Social Science & Medicine*, 69(5), 707-15.
- Gaylord, S., & Mann, J. (2007). Rationales for CAM education in health professions training programs. *Academic Medicine*, 82(10), 927-933.
- Gonzalez, J. S., Penedo, F. J., Llabre, M. M., Durán, R. E., Antoni, M. H., Schneiderman, N., & Horne, R. (2007). Physical symptoms, beliefs about medications, negative mood, and long-term HIV medication adherence. *Annals of Behavior Medicine*, 34(1), 46-55.
- Gremer, C. K., Siegel, R. D., & Fulton, P. R. (2005). *Mindfulness and psychotherapy*. New York: The Guilford Press.
- Haidt, J. (2000, March). The positive emotion of elevation. *Prevention and Treatment*, 3. Retrieved from <http://journals.apa.org/prevention/volume3/pre0030003c.html>
- Halcón, L., Chlan, L., Kreitzer, M. J., & Leonard, B. J. (2003). Complementary therapies and healing practices: Faculty/student beliefs and attitudes and the implications for nursing education. *Journal of Professional Nursing*, 19(6), 387-397.
- Harrington, A. (2008). *The cure within: A history of mind-body medicine*. New York: W. W. Norton & Company.
- Hattie, J. A., Myers, J. E., & Sweeney, T. J. (2004). A factor structure of wellness: Theory, assessment; analysis, and practice. *Journal of Counseling & Development*, 82(3), 354-364.
- Hess, D., Everett, G., Tuchmann, L., & Dossey, B. (2006). Holistic nursing and the New Mexico board of nursing: Integrative practices subcommittee formation, development, and activities. *Journal of Holistic Nursing*, 24(2), 132-138.
- Horneffer, K. (2006). Embracing emotional pain as a means of spiritual growth: Tools from the East. In K. B. Helmeke & C. F. Sori (Eds.), *The therapist's notebook for integrating spirituality in counselor education: Homework, handouts and activities for use in psychotherapy* (pp. 267-285). Binghamton, NY: Haworth Press.

- Horneffer-Ginter, K. (2012). *Full cup thirsty spirit*. Carlsbad, NM: Hay House Insights.
- Hsiao, A. F., Hays, R., Ryan, G., Coulter, I. D., Andersen, R. M., Hardy, M., Diehl, D., Hui, K. K., & Wenger, N. (2005). A self-report measure of clinicians' orientation toward integrative medicine. *Health Services Research, 40*(5), 1553-1569.
- Hughes, B. M. (2007). How should clinical psychologists approach complementary and alternative medicine? Empirical, epistemological, and ethical considerations. *Clinical Psychological Review, 28*(4), 657-675.
- Jain N., & Astin, J. A. (2001). Barriers to acceptance: An exploratory study of complementary/alternative medicine disuse. *Journal of Alternative and Complementary Medicine, 7*(6), 689-696.
- Jain, S., Shapiro, S., Swanick, S., Roesch, S. C., Mills, P., Bell, I., & Schwartz, G. (2007). A randomized controlled trial of mindfulness meditation verses relaxation training: Effects on distress, positive states of mind, rumination, and distraction. *Annals of Behavior Medicine, 33*(1), 11-21.
- James, W. (1902). *The varieties of religious experience: A study in human nature. Being the Gifford Lectures on Natural Religion delivered at Edinburgh in 1901-1902*. New York: Longmans, Green, and Co.
- Kabat-Zinn, J. (1990). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness*. New York: Delacorte.
- Kabat-Zinn, J. (1994). *Wherever you go, there you are: Mindfulness meditation in everyday life*. New York: Hyperion.
- Kabat-Zinn, J. (2000). Indra's net at work: The mainstreaming of Dharma practice in society. In G. Watson & S. Batchelor (Eds.), *The psychology of awakening: Buddhism, science, and our day-to-day lives* (pp. 225-249). Nork Beach, ME: Weiser.
- Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. *Clinical Psychology: Science and Practice, 10*(2), 144-156.
- Keegan, L. (2001). *Healing with complementary and alternative therapies*. New York: Delmar.
- Kessler, R. C., Davis, R. B., Foster, D. F., Van Rompay, M. I., Walters, E. E., Wilkey, S. A., Kaptchuk, T. J., & Eisenberg, D. M. (2001). Long-term trends in the use of complementary and alternative medical therapies in the United States. *Annals of Internal Medicine, 135*(4), 262-268.



- Kessler, R. C., Soukup, J., Davis, R. B., Foster, D. F., Wilkey, S. A., Van Rompay, M. I., & Emsberg, D. M. (2001). The use of complementary and alternative therapies to treat anxiety and depression in the United States. *The American Journal of Psychiatry*, *158*(2), 289-294.
- Kim, S., Erlen, J., Kim, K., & Sok, S. (2006). Nursing students' and faculty members' knowledge of, experience with, and attitudes toward complementary and alternative therapies. *Journal of Nursing Education*, *45*(9), 375-378.
- Kreitzer, M. J., & Sierpina, V. (2006). Innovations in integrative healthcare education: Massage, medical and social work student initiatives. *Explore*, *2*(1), 75.
- Kreitzer, M. J., Sierpina, V., Maiers, M., Delagran, L., Bladwin, L., Evans, R., & Chase, M. (2008). Ways of knowing: Integrating research into CAM education and holism into conventional health professional education. *Explore*, *4*(4), 278-281.
- Kuhn, M. A. (1999). *Complementary therapies for health care providers*. Philadelphia, PA: J. B. Lippincott.
- Laurenson, M., MacDonald, J., McCready, T., & Stimpson, A. (2006). Student nurses' knowledge toward CAM therapies. *British Journal of Nursing*, *15*(11), 612-615.
- Lawson, K., & Horneffer, K. J. (2002). Roots and wings: A pilot of a mind-body-spirit program. *Journal of Holistic Nursing*, *20*(3), 250-263.
- Lazar, S. W., Kerr, C. E., Wasserman, R. H., Gray, J. R., Greve, D. N., Treadway, M. T., McGarvey, M., Quinn, B. T., Dusek, J. A., Benson, H., Rauch, S. L., Moore, C. I., & Fischl, B. (2005). Meditation experience is associated with increased cortical thickness. *NeuroReport*, *16*(17), 1893-1897.
- Lee, M. Y., Benn, R., Wimsatt, L., Cornman, J., Hedgecock, J., Gerik, S., Zeller, J., Kreitzer, M. J., Allweiss, P., Finklestein, C., & Haramati, A. (2007). Integrating complementary and alternative medicine instruction into health professions education: Organizational and instructional strategies. *Academic Medicine*, *82*(10), 939-945.
- Levant, R. (2005). Graduate education in clinical psychology for the 21<sup>st</sup> century: Educating psychological health care providers. *Journal of Clinical Psychology*, *61*(9), 1087-1090.
- Lie, D., & Boker, J. (2004). Development and validation of the CAM health belief questionnaire (CHBQ) and CAM use amongst medical students. *BMC Medical Education*, *4*(2). Retrieved from <http://www.biomedcentral.com/1472-6920/4/2>

- Lie, D., & Boker, J. (2006). Comparative survey of complementary and alternative medicine (CAM) attitudes, use and information-seeking behavior among medical students, residents, & faculty. *BMC Medical Education*, 6(58). Retrieved from <http://www.biomedcentral.com/1472-6920/6/58>
- Lie, D., Shapiro, J., Pardee, S., & Najm, W. (2008). A focus group study of medical students views of an integrated complementary and alternative medicine (CAM) curriculum: Students teaching teachers. *Medical Education Online*, 13(3). Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2759094/>
- Locke, D. C., Myers, J. E., & Herr, E. L. (2001). *The handbook of counselor education*. Thousand Oaks, CA: Sage Publications.
- Loveland Cook, C. A., Becvar, D. S., Pontious, S. L. (2000). Complementary alternative medicine in health and mental health implications for social work practice. *Social Work in Health Care*, 31(3), 39-57.
- Lumadue, C. A., Monk, M., & Wooten, H. R. (2005). Inclusion of alternative and complementary therapies in CACREP training programs: A survey. *Journal of Creativity in Mental Health*, 1(1), 7-19.
- Lutz, A., Brefczynski-Lewis, J., Johnstone, T., & Davidson, R. J. (2008). Regulation of the neural circuitry of emotion by compassion meditation: Effects of meditative expertise. *PLoS ONE*, 3(3). Retrieved from <http://www.plosone.org/article/info:doi/10.1371/journal.pone.0001897>
- Lyubomirsky, S., King, L.A. & Diener, E. (2005). The benefits of frequent positive affect: Does happiness lead to success. *Psychological Bulletin*, 131, 803-855.
- Ma, H., & Teasdale, J. (2004). Mindfulness based cognitive therapy for depression: Replication and exploration of differential relapse prevention effects. *Journal of Consulting and Clinical Psychology*, 72(1), 33-40.
- Maris, J. A. (2009). The impact of a mind/body medicine class on counselor training. *Journal of Humanistic Psychology*, 49(2), 229-235.
- Micozzi, M. S. (2001). *Fundamentals of complementary and alternative medicine* (2<sup>nd</sup> ed). Philadelphia, PA: W. B. Saunders.
- Miller, J. J., Fletcher, K., & Kabat-Zinn, J. (1995). Three-year follow-up and clinical implications of mindfulness meditation-based stress reduction intervention in the treatment of anxiety disorders. *General Hospital Psychiatry*, 17(3), 192-200.
- Monroe, C. (2009). The effects of therapeutic touch on pain. *Journal of Holistic Nursing*, 27(2), 85-92.



- Moore, K. A., & Cooper, C. L. (1996). Stress in mental health professionals: A theoretical overview. *International Journal of Social Psychiatry, 42*(2), 82-89.
- Myers, J. E., Sweeney, T. J., & Witmer, J. M. (2000). The wheel of wellness counselor education for wellness: A holistic model for treatment planning. *Journal of Counseling & Development, 78*(3), 251-266.
- Myers, J. E., Luecht, R. M., & Sweeney, T. J. (2004). The factor structure of wellness: Re-examining theoretical and empirical models underlying the wellness evaluation of lifestyle (WEL) and the five-factor wel. *Measurement and Evaluation in Counselor Education and Development, 36*(4), 194-208.
- Myers, J. E., & Sweeney, T. J. (2005). *Counseling for wellness: Theory, research, and practice*. Alexandria, VA: American Counseling Association.
- Myers, J. E., & Sweeney, T. J. (2008). Wellness counselor education: The evidence base for practice. *Journal of Counseling Development, 86*(4), 482-493.
- Nahin, R. L., Barnes, P. M., Stussman, B. J., & Bloom, B. (2009). *Costs of complementary and alternative medicine (CAM) and frequency of visits to CAM practitioners: United States, 2007. National health statistics reports; no 18*. Hyattsville, MD: National Center for Health Statistics.
- National Association of Social Workers. (2011). *Social workers in hospitals and medical centers: An occupational profile*. Retrieved from <http://workforce.socialworkers.org/studies/profiles/Hospitals.pdf>
- National Center for Complementary and Alternative Medicine. (2011). *What is complementary and alternative medicine?* (NCCAM Publication No. D347). Retrieved from <http://nccam.nih.gov/health/whatiscam>
- Newsome, S., Christopher, J. C., Dahlen, P., & Christopher, S. (2006). Teaching counselors self-care through mindfulness practice. *Teachers College Record, 108*(9), 1881-1900.
- Nguyen, L. T., Davis, R. B., Kaptchuk, T. J., & Phillips, R. S. (2011). Use of complementary and alternative medicine and self-rated health status: results from a national survey. *Journal of General Internal Medicine, 26*(4), 399-404.
- Nightingale, F. (1859). *Notes on nursing*. Philadelphia, PA: Lippincott.
- Ong, J. C., Shapiro, S., & Manber, R. (2008). Combining mindfulness meditation with cognitive-behavior therapy for insomnia: A treatment development study. *Behavior Therapy, 39*(2), 171-182.

- Ostafin, B. D., Chawla, N., Bowen, S., Dillworth, T., Witkiewitz, K., & Marlatt, A. G. (2006). Intensive mindfulness training and the reduction of psychological distress: A preliminary study. *Cognitive and Behavioral Practice, 13*(3), 191-197.
- Parrish, J. (1805). *An inaugural dissertation on the influence of the passions upon the body, in the production and cure of disease*. Philadelphia, PA: Kimber, Conrad, & Co.
- Pelletier, K. R. (2000). *The best alternative medicine: What works, what does not*. New York: Simon & Schuster.
- Perlman, A., & Stagnaro-Green, A. (2010). Developing a complementary, alternative and integrative medicine course: One medical school's experience. *Journal of Alternative and Complementary Medicine, 16*(5), 601-605.
- Pettersen, S., & Olsen, R. V. (2006). Exploring predictors of health sciences students' attitudes towards complementary and alternative medicine. *Advances in Health Sciences Education, Theory and Practice, 12*(1), 35-53.
- Rankin-Box, D. (2001). *The nurses handbook of complementary therapies* (2<sup>nd</sup> ed.). Edinburgh: Bailliere Tindall.
- Reisser, P. C., Mabe, D., & Velarde, R. (2001). *Examining alternative medicine*. Downers Grove, IL: InterVarsity.
- Riccard, C., & Skelton, M. (2008). Comparative analysis of 1<sup>st</sup>, 2<sup>nd</sup>, and 4<sup>th</sup> year MD students' attitudes toward complementary alternative medicine (CAM). *BMC Research Notes, 1*(84). Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/18799010>
- Richardson, S. (2003). Complementary health and healing in nursing education. *Journal of Holistic Nursing, 21*(1), 20-35.
- Roberts, S. A., Kiselica, M., & Fredrickson, S. (2002). Quality of life of persons with medical illnesses: Counselor education's holistic contribution. *Journal of Counseling Development, 80*(4), 422-432.
- Rollins, J. (2010, January). Reconnecting the head with the body. *Counseling Today*, Retrieved from <http://ct.counseling.org/2010/01/reconnecting-the-head-with-the-body/>
- Rosenbaum, M. E., Nisly, N. L., Ferguson, K. J., & Kligman, E. W. (2002). Academic physicians and complementary and alternative medicine: An institutional survey. *American Journal of Medical Quality, 17*(1), 3-9.

- Rush, B. (1786) *An Oration, Delivered before the American Philosophical Society; Containing An Enquiry into the Influence of Physical Causes upon the Moral Faculty*. Philadelphia, PA: Charles Cist.
- Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, 55(1), 68-78.
- Rys, G. J. (1999). The call for collaborative care: Mind-body behavioral medicine practice. (Doctoral dissertation). Retrieved from Dissertations and Theses database. (UMI No. 9951161)
- Salmon, P., Sephton, S., Weissbecker, I., Hoover, K., Ulmer, C., & Studts, J. L. (2004). Mindfulness meditation in clinical practice. *Cognitive and Behavioral Practice*, 11(4), 434-446.
- Saunders, P. A., Tractenberg, R. E., Chaterji, R., Amri, H., Harazduk, N., Gordon, J., Lumpkin, M., & Haramati, A. (2007). Promoting self-awareness and reflection through an experiential mind-body skills course for first year medical students. *Medical Teacher*, 29(8), 778-784.
- Schreiner, I., & Malcolm, J. P. (2008). The benefits of mindfulness meditation: Changes in emotional states of depression, anxiety, and stress. *Behaviour Change*, 25(3), 156-168.
- Schneider, C. D., Meek, P., & Bell, I. R. (2003). Development and validation of IMAQ: Integrative medicine attitude questionnaire. *BMC Medical Education*, 3(5). Retrieved from <http://www.biomedcentral.com/1472-6920/3/5>
- Schure, M. B., Christopher, J., & Christopher, S. (2008). Mind-body medicine and the art of self-care: Teaching mindfulness to counselor education students through yoga, meditation, and qigong. *Journal of Counseling and Development*, 86(1), 47-56.
- Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse*. New York: Guilford Press.
- Seligman, M. E. P. (1991). *Learned optimism*. New York: Knopf.
- Seligman, M. E. P., Steen, T. A., Park, N. & Peterson, C. (2005). Positive psychology progress: Empirical validation of interventions. *American Psychologist*, 60(5), 410-421.
- Sewitch, M. J., Cepoui, M., Rigillo, N., & Sproule, D. (2008). A literature review of health care professional attitudes toward complementary and alternative medicine. *Complementary Health Practice Review*, 13(3), 139-154.

- Shapiro, S., Astin, J., Bishop, S., & Cordova, M. (2005). Mindfulness based stress reduction for health care professionals: Results from a randomized controlled trial. *International Journal of Stress Management*, 12(2), 164-176.
- Shapiro, S. (2009). The integration of mindfulness and psychology. *Journal of Clinical Psychology*, 65(6), 555-560.
- Shapiro, S. L., Brown, K. W., & Biegel, G. (2007). Teaching self-care to caregivers: Effects of mindfulness-based stress reduction on the mental health of therapists in training. *Training and Education in Professional Psychology*, 1(2), 105-115.
- Shapiro, S. L., Carlson, L. E., Astin, J. A., & Freedman, B. (2006). Mechanisms of mindfulness. *Journal of Clinical Psychology*, 62(3), 373-386.
- Shorofi, S., & Arbon, P. (2010). Nurses' knowledge, attitudes, and professional use of complementary and alternative medicine (CAM): A survey at five metropolitan hospitals in Adelaide. *Complementary and Alternative Therapies in Clinical Practice*, 16(4), 229-234.
- Simon, G. E., Cherkin, D. C., Sherman, K. J., Emswiler, D. M., Deyo, R. A., & Davis, R. B. (2004). Mental health visits to complementary and alternative medicine providers. *General Hospital Psychiatry*, 26(3), 171-177.
- Sirois, F. M., & Gick, M. L. (2002). An investigation of the health beliefs and motivations of complementary medicine clients. *Social Science and Medicine*, 55(6), 1025-1037.
- Snyder, M., & Lindquist, R. (1998). *Complementary/alternative therapies in nursing* (3<sup>rd</sup> ed.). New York: Springer.
- Sparber, A. (2001). State boards of nursing and scope of practice of registered nurses performing complementary therapies. *Online Journal of Nursing*, 6(3), 10.
- Spencer, J. W., & Jacobs, J. J. (1999). *Complementary/alternative medicine: An evidence-based approach*. St. Louis, MO: Mosby.
- Stauffer, M. D. (2008). Mindfulness in counselor education and psychotherapy: A literature review and quantitative investigation of mindfulness competencies. (Doctoral dissertation). Retrieved from Dissertations and Theses database. (UMI No. 3295653)
- Stratton, T. D., Benn, R., Lie, D., Zeller, J., & Nedrow, A. (2007). Evaluating CAM education in health professions programs. *Academic Medicine*, 82(10), 956-961.

- Sweeney, T. J., & Witmer, J. M. (1991). Beyond social interest: Striving toward optimum health and wellness. *Individual Psychology: Journal of Adlerian Theory, Research & Practice*, 47(4), 527-540.
- Taylor, E. (1983). *William James on Exceptional Mental States: The 1896 Lowell lectures*. New York: Charles Scribner's Sons.
- Teasdale, J. D., Segal, Z., & Williams, J. M. (1995). How does cognitive therapy prevent depressive re-lapse and why should attentional control (mindfulness) training help? *Behaviour Research and Therapy*, 33(1), 25-39.
- Teasdale, J., Segal, Z., Williams, J. M., Ridgeway, V. A., Soulsby, J., Lau, M. A. (2000). Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. *Journal of Consulting and Clinical Psychology*, 68(4), 615-623.
- Teasdale, J. D. (2008). Mindfulness-based cognitive therapy to prevent relapse in recurrent depression. *Journal of Consulting and Clinical Psychology*, 76(6), 966-978.
- Tindle, H. A., Davis, R., Phillips, R., & Eisenberg, D. (2005). Trends in use of complementary and alternative medicine by U.S. adults: 1997-2002. *Alternative Therapies*, 11(1), 42-51.
- Tracy, M. F., & Lindquist, R. (2003). Nursing's role in complementary and alternative therapy use in critical care. *Critical Care Nursing Clinics of North America*, 15(3), 289-294.
- Traux, C. B., & Carkhuff, R. R. (1967). *Toward effective counselor education and psychotherapy*. Chicago, IL: Aldine.
- Ütnutzer, J., Klap, R., Sturm, R., Young, A. S., Marmon, T., Shatkin, J., & Wells, K. B. (2000). Mental disorders and the use of alternative medicine: Results from a national survey. *The American Journal of Psychiatry*, 157(11), 1851-1857.
- VanLone, J. S. (2007). Review of the book *Counseling for Wellness*. *Counseling and Values*, 51(3), 238-240.
- Walsh, R., & Shapiro, S. (2006). The meeting of meditative disciplines and Western psychology. *American Psychologist*, 61(3), 1-13.
- Wetzel, M., Eisenberg, D., & Kaptchuk, T. (1998). Courses involving complementary and alternative medicine at US medical schools. *The Journal of the American Medical Association*, 280(9), 784-787.

- Wetzel, M., Kaptchuk, T. J., Haramati, A., & Eisenberg, D. (2003). Complementary and alternative medical therapies: Implications for medical education. *Annals of Internal Medicine*, 138(3), 191-196.
- White, K. (2000). Psychology and complementary and alternative medicine. *Professional Psychology: Research and Practice*, 31(6), 671-681.
- Wilson, L., & White, K. (2007). Development of an attitudes towards therapies scale for psychologists. *Clinical Psychologist*, 11(2), 37-44.
- Wirth, J. H., Hudgins, J. C., & Paice, J. A. (2005). Use of herbal therapies to relieve pain: A review of efficacy and adverse effects. *Pain Management Nursing*, 6(4), 145-167.
- Witmer, J. M., & Sweeney, T. J. (1992). A holistic model for wellness and prevention over the life span. *Journal of Counseling Development*, 71(2), 140-148.
- Wolsko, P. M., Eisenberg, D. M., Davis, R. B., & Phillips, R. S. (2004). Use of mind-body medical therapies. *Journal of General Internal Medicine*, 19(1), 43-50.

## Appendix A

### First Email Request CACREP Group

## First Email Request CACREP Group

Dear Counselor Educator,

Want to learn more about research helping to advance the field of Counselor Education?

At the bottom of this email is a hyperlink to a consent document and an online survey, which asks questions about your attitudes, knowledge and experiences with ***Complementary and Alternative Medicine (CAM)***. CAM, which encompasses activities like yoga, meditation, and acupuncture, is being researched in other mental health fields and this study seeks to fill a gap in knowledge in counselor education.

Your institution was chosen randomly from a list of CACREP accredited programs and your email was obtained from your program's website.

I understand this takes time out of your busy day (approximately 20 minutes), but remember, you are helping to advance our field and contributing to a knowledge base that ultimately serves our students and our clients. Understanding the attitudes and knowledge of counselor education faculty with regards to CAM is an important first step. **And** you could...

### **WIN \$50!**

After taking the survey, you will have the option to be entered in a drawing for one of three \$50 VISA gift cards.

*To be included in the study you must be a current faculty member, full or part-time, in a counselor education program.*

LINK to the Consent and SURVEY:

<http://counseloreducatorsCAM.questionpro.com>

Thanks for reading! This study has been approved by the WMU HSIRB.

Jennifer Langeland, M.S., LPC  
 Doctoral Candidate  
 Counselor Education and Counseling Psychology  
 Western Michigan University  
[Jennifer.langeland@wmich.edu](mailto:Jennifer.langeland@wmich.edu)  
 269-330-4695

Faculty Supervisor:  
 Gary H. Bischof, Ph.D.  
[gary.bischof@wmich.edu](mailto:gary.bischof@wmich.edu)



## Appendix B

Survey of Counselor Educators' Knowledge, Attitudes and Beliefs Toward CAM

## Counselor Educators' Knowledge, Attitudes and Beliefs Towards Complementary and Alternative Medicine

For the purposes of this survey **Complementary and Alternative Medicine (CAM)** is defined as a diverse group of health care systems, practices and products that are not generally considered part of conventional medicine.

Q1.

Please indicate your <b>level of knowledge</b> of each of the following Complementary and Alternative Medicine modalities.					
1- Know Nothing 2- Know very little 3-Know something 4-Knowledgeable 5-Very Knowledgeable					
Ayurveda	1	2	3	4	5
Chinese Medicine	1	2	3	4	5
Homeopathy	1	2	3	4	5
Meditation	1	2	3	4	5
Yoga	1	2	3	4	5
Acupuncture	1	2	3	4	5
Breathing Exercises	1	2	3	4	5
Guided Imagery	1	2	3	4	5
Hypnotherapy	1	2	3	4	5
Progressive Muscle Relaxation	1	2	3	4	5
Qi Gong	1	2	3	4	5
Tai Chi	1	2	3	4	5
Herbal Medicine/Botanicals	1	2	3	4	5
Vitamin and Mineral supplements	1	2	3	4	5
Spinal Manipulation/Chiropractic	1	2	3	4	5
Massage	1	2	3	4	5
Movement Therapies	1	2	3	4	5
Traditional Healers	1	2	3	4	5
Energy Therapies (Magnet Therapy, Light Therapy, Reiki, Healing touch)	1	2	3	4	5

Q2.

Please indicate how often you engage with these techniques in the following areas:															
1- Never    2-Infrequently    3-Occasionally    4-Frequently    5-Very Frequently															
Personal Life					Teaching About in Course(s)					Clinical					
Ayurveda	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Chinese Medicine	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Homeopathy	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Meditation	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Yoga	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Acupuncture	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Breathing Exercises	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Guided Imagery	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Hypnotherapy	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Progressive Muscle Relaxation	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Qi Gong	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Tai Chi	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Herbal Medicine/Botanicals	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Vitamin and Mineral supplements	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Spinal Manipulation/Chiropractic	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Massage	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Movement Therapies	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Traditional Healers	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Energy Therapies (Magnet Therapy, Light Therapy, Reiki, Healing touch)	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5

Rate your level of agreement with the following statement:

Q3. CAM should be integrated in counselor training

- 1- Strongly agree
- 2- Agree
- 3- Somewhat agree
- 4- Somewhat disagree
- 5- Disagree
- 6- Strongly disagree

Q4. Compared to other mental health professions with regards to acceptance and/or integration of CAM into treatment and training, counseling and **counselor education**:

- 1- Accept or integrate CAM **much less** than other mental health professions
- 2- Accept or integrate CAM **slightly less** than other mental health professions
- 3- Accept or integrate CAM **about the same as** other mental health professions
- 4- Accept or integrate CAM **slightly more** than other mental health professions
- 5- Accept or integrate CAM **much more** than other mental health professions

Q5. Does the counselor education program in which you teach offer an elective course on *general* CAM?

- a. Yes
- b. No
- c. Don't Know

Q6. Does the counselor education program in which you teach offer an elective course on a *specific* CAM modality/modalities?

- a. Yes If yes, please indicate which modality/modalities
- b. No
- c. Don't Know

Q7. Does the program in which you teach integrate CAM into the core curriculum

- a. Yes (if yes then please answer next question)
- b. No (if no please skip next question)
- c. Don't know

Q8. Into which of the following core areas has your program integrated CAM knowledge, skills and/or behaviors. Please check all that apply.

1. Professional Identity	
2. Social and Cultural Diversity	
3. Human Growth and Development	
4. Career Counselor education	
5. Helping Relationships	
6. Group Work	
7. Assessment	
8. Research and program evaluation	
9. Self-Care	
10. Treatment approaches	
11. Counselor Development	

Q9. Please indicate your level of agreement with each of the following statements

- (1) Strongly disagree
- (2) Disagree
- (3) Somewhat disagree
- (4) Somewhat agree
- (5) Agree
- (6) Strongly Agree

Q10.

Focusing solely on a client or students' problems is the way to create successful behavior change.	1	2	3	4	5	6	aPhW1
I consider all aspects of a client's life when providing counseling services	1	2	3	4	5	6	bPhW2
In counseling, it is important to combine my focus to include both the clients' strengths and problems.	1	2	3	4	5	6	cPhW4
Understanding a client holistically (e.g., mind, body, and spirit) is important.	1	2	3	4	5	6	dPhW5
The goal of counseling's wellness perspective is to help each person achieve positive mental health to their maximum degree.	1	2	3	4	5	6	ePhW6
I encourage others to seek counseling services before symptoms and problems escalate.	1	2	3	4	5	6	fPhP1
Counseling is not for those who are functioning well. [reverse code]	1	2	3	4	5	6	gPhP3
Prevention is just as important as remediation in my work as a counselor.	1	2	3	4	5	6	hPhP4

Q11.

Please indicate your agreement or disagreement with these statements using the following scale:

**1 = Strongly Disagree (SD)**

**2= Disagree**

**3= Neither Agree or Disagree**

**4= Agree**

**5= Strongly Agree (SA)**

		SD			SA
1	Clients' use of CAM is irrelevant to the conduct of counseling.	1	2	3	4 5
2	Most clients are interested in CAM.	1	2	3	4 5
3	I would not refer clients to a CAM health practitioner until I thoroughly knew about the practice and the practitioner.	1	2	3	4 5
4	It is important to know about client's CAM use to better understand what they believe will support good health.	1	2	3	4 5
5	The assumptions of CAM treatments do not fit well with my approach to counseling.	1	2	3	4 5
6	There is an inadequate scientific basis for many CAM practices.	1	2	3	4 5
7	CAM use should be supervised by physicians.	1	2	3	4 5
8	CAM use can be dangerous in that it may prevent people from getting the treatments of conventional medicine.	1	2	3	4 5
9	Well informed clients can make adequate decisions about CAM treatments.	1	2	3	4 5
10	If clients believe a CAM treatment will help them, I would explore this treatment option with them.	1	2	3	4 5

11	It is a priority for me to build a collaborative practice with CAM practitioners.	1	2	3	4	5
12	I rely primarily on empirical studies when recommending any treatment approach to clients.	1	2	3	4	5
13	Most CAM practices are outside the scope of practice of counselors.	1	2	3	4	5
14	CAM should be regulated by peer reviewed boards.	1	2	3	4	5
15	In states that require a written professional disclosure statement as part of their licensing process, therapists should notify their licensure boards about incorporating CAM into treatment.	1	2	3	4	5
16	It is important to expand the health care infrastructure to include CAM practitioners.	1	2	3	4	5
17	Health care providers should take into account that the health of body, mind and spirit are related.	1	2	3	4	5
18	CAM practices are generally just a financial con trick.	1	2	3	4	5
19	CAM should only be used as a last resort when conventional treatments have nothing to offer.	1	2	3	4	5
20	There are fewer side effects to most CAM practices when compared to conventional medications.	1	2	3	4	5
21	I have serious concerns about counselors who attempt to incorporate CAM treatments into their practice of counseling.	1	2	3	4	5
22	I rely primarily on my intuition and general knowledge when recommending any treatment approach to clients.	1	2	3	4	5

## Demographics:

Q12 Gender	1= Male 2=Female 3=Transgender
Q13 Race/Ethnicity	1= American Indian 2= Asian/Asian American or Pacific Islander 3= African American 4=Hispanic 5= Caucasian/White Non-Hispanic 6= Other
Q14 Age	What is your age _____
Q15 Your employment status as a counselor educator is:	1= Full time 2= Part time
Q16 Year completed terminal degree	_____
Q17 Do you teach in a CACREP accredited program?	Yes No

Appendix C  
Consent Document

You are invited to participate in a research project entitled “Counselor Educator knowledge, attitudes and beliefs about Complementary and Alternative Medicine (CAM)” designed to investigate the knowledge, attitudes and beliefs of counselor educators toward CAM. The study is being conducted by **Gary H. Bischof, PhD and Jennifer Langeland, M.S.** from Western Michigan University, Department of Counselor Education and Counseling Psychology. This research is being conducted as part of **dissertation** requirements for **Jennifer Langeland**.

This online survey is comprised of 77 likert type questions and 3 fill in the blank, and will take approximately 20 minutes to complete. Your replies will be completely anonymous. You may choose to not answer any question and simply leave it blank. Completing the survey indicates your consent for use of the answers you supply. This consent document has been approved for use for one year by WMU’s Human Subjects Institutional Review Board (HSIRB). Do not participate after (date)

**Questions?** Should you have any questions prior to or during the study, you can contact the primary investigator, Gary Bischof, at 269-387-3713, or [gary.bischof@wmu.edu](mailto:gary.bischof@wmu.edu). You may also contact the Chair, Human Subjects Institutional Review Board at 269-387-8293 or the Vice President for Research at 269-387-8298 if questions arise during the course of the study.



## Appendix D

### First Email Reminder

## First Email Reminder

Counselor Educator!

Recently, you received a request to participate in an online survey about *Counselor Educators' views on Complementary and Alternative Medicine*. I know you're busy, but your participation is important and could help advance our field. It will only take approximately 20 minutes of your time AND you could **WIN \$50!!**

Click on the link below to learn more about and take the survey.

<http://counseloreducatorsCAM.questionpro.com>

Thanks in Advance for Participating!

Jennifer Langeland, M.S., LPC  
Doctoral Candidate  
Western Michigan University

Appendix E  
Second Email Reminder

## Second Email Reminder

Counselor Educator,

I need your help!

As you know, for research to have meaningful results, it is important that many people participate. You recently received an email from me requesting that you take a short, 20 minute, online survey about your attitudes, knowledge and experiences with ***Complementary and Alternative Medicine***. This effort can only provide meaningful information to our field if many of you participate. I hope you will consider taking the survey to help to advance our understanding about this important area and bring counselor education up to speed with other health professions.

Click on the link below to learn more about and take the survey.

<http://counseloreducatorsCAM.questionpro.com>

Thanks!

Jennifer Langeland, M.S., LPC  
Doctoral Candidate  
Western Michigan University

## Appendix F

### Third Email Reminder

## Third Reminder Email

Counselor Educator,

Final chance to help with this research!

As you know, for research to have meaningful results, it is important that many people participate. You recently received an email from me requesting that you take a short, 20 minute, online survey about your attitudes, knowledge and experiences with ***Complementary and Alternative Medicine***. This effort can only provide meaningful information to our field if many of you participate. I hope you will consider taking the survey to help to advance our understanding about this important area and bring counselor education up to speed with other health professions.

Click on the link below to learn more about and take the survey.

<http://counseloreducatorsCAM.questionpro.com>

Thanks!

Jennifer Langeland, M.S., LPC  
Doctoral Candidate  
Western Michigan University

## Appendix G

### First Email Request to CES-Net Group

## First Email Request to CES-Net Group

Dear Counselor Educator,

Want to learn more about research helping to advance the field of Counselor Education?

At the bottom of this email is a hyperlink to a consent document and an online survey, which asks questions about your attitudes, knowledge and experiences with ***Complementary and Alternative Medicine (CAM)***. CAM, which encompasses activities like yoga, meditation, and acupuncture, is being researched in other mental health fields and this study seeks to fill a gap in knowledge in counselor education.

You are receiving this email because you participate in the Counselor Education list-serve, CESNET.

I understand this takes time out of your busy day (approximately 20 minutes), but remember, you are helping to advance our field and contributing to a knowledge base that ultimately serves our students and our clients. Understanding the attitudes and knowledge of counselor education faculty with regards to CAM is an important first step. **And** you could...

### **WIN \$50!**

After taking the survey, you will have the option to be entered in a drawing for one of three \$50 VISA gift cards.

**To be included in the study you must be a current faculty member, full or part-time, in a counselor education program.**

LINK to the Consent form and SURVEY:

<http://counseloreducatorsCAM.questionpro.com>

Thanks for reading! This study has been approved by the WMU HSIRB.

Jennifer Langeland, M.S., LPC  
 Doctoral Candidate  
 Counselor Education and Counseling Psychology  
 Western Michigan University  
[Jennifer.langeland@wmich.edu](mailto:Jennifer.langeland@wmich.edu)  
 269-330-4695

Faculty Supervisor:  
 Gary H. Bischof, Ph.D.  
[gary.bischof@wmich.edu](mailto:gary.bischof@wmich.edu)



## Appendix H

Thank You Letter at End of Survey

## Thank You Letter at the End of the Survey

Thank you for your participation in this research!

If you would like to be entered into the drawing for one of 3 \$50 Visa gift cards, please email me at:

[jennifer.langeland@wmich.edu](mailto:jennifer.langeland@wmich.edu)

Please put "drawing" in the subject line. This emailed information will not be associated with your anonymous survey responses and your email address will be deleted once the gift cards are awarded.

Thanks again for participating.

Jennifer

Appendix I

Human Subjects Institutional Review Board Approval Letter

# WESTERN MICHIGAN UNIVERSITY



Human Subjects Institutional Review Board

Date: July 24, 2012

To: Gary Bischof, Principal Investigator  
Jennifer Mills Langeland, Student Investigator for dissertation

From: Amy Naugle, Ph.D., Chair

Re: HSIRB Project Number 12-07-23

This letter will serve as confirmation that your research project titled "Counselor Educators' Knowledge of Attitudes and Beliefs about Complementary and Alternative Medicine" has been **approved** under the **exempt** category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note: This research may **only** be conducted exactly in the form it was approved. You must seek specific board approval for any changes in this project (e.g., ***you must request a post approval change to enroll subjects beyond the number stated in your application under "Number of subjects you want to complete the study."*** Failure to obtain approval for changes will result in a protocol deviation. In addition, if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

**Reapproval of the project is required if it extends beyond the termination date stated below.**

The Board wishes you success in the pursuit of your research goals.

**Approval Termination: July 24, 2013**

Walwood Hall, Kalamazoo, MI 49008-5456  
PHONE: (269) 387-8293 FAX: (269) 387-8276

Appendix J

Permission to Use Caldwell et al. (2006) Survey

Date: Thu, 20 Oct 2011 09:25:50 -0400  
 From: Karen Caldwell <[caldwllkl@appstate.edu](mailto:caldwllkl@appstate.edu)>  
 Subject: Re: Fwd: 2006 JMFT article & CAM survey  
 In-reply-to: <[4E9FF50A.2000804@appstate.edu](mailto:4E9FF50A.2000804@appstate.edu)>  
 To: [gary.bischof@wmich.edu](mailto:gary.bischof@wmich.edu)  
 Cc: winekjl <[winekjl@appstate.edu](mailto:winekjl@appstate.edu)>

Hi Gary,  
 I'm glad to hear that you're interested in our work. I've attached the survey we used in the 2006 study. Hope this is useful to you and your student.

Karen Caldwell, PhD  
 Professor  
 Department of Human Development and Psychological Counseling  
 Appalachian State University  
 Boone, NC 28608  
 828-262-6045

On 10/20/2011 6:16 AM, winekjl wrote:

Karen:  
 I do not have a copy of this. If you do I am supportive of providing it for Gary.

Thanks  
 Jon

Subject: 2006 JMFT article & CAM survey  
 Date: Wed, 19 Oct 2011 21:09:01 -0400  
 From: Gary Bischof <[gary.bischof@wmich.edu](mailto:gary.bischof@wmich.edu)>  
 To: [winekjl@appstate.edu](mailto:winekjl@appstate.edu)

Hi Jon,  
 I have a Counseling doc student who saw your study below; she is doing her dissertation on surveying Counselor Educators about their attitudes and use of CAM approaches in counseling training programs. The survey you all did is similar to what she would like to do. Would you be able to share the survey used in this study. I would greatly appreciate it and would certainly cite you all if we use some of it.

Thanks,  
 Gary Bischof  
 Western Michigan University  
 Coordinator, Marriage, Couple & Family Counseling

The relationship between marriage and family therapists and complementary and alternative medicine approaches: A national survey. Caldwell, Karen L.; Winek, Jon L.; Becvar, Dorothy S.. Journal of Marital and Family Therapy 32. 1 (Jan 2006): 101-113

## Appendix K

Permission to Use Counselor Professional Identity (CPI) Measure (Emerson, 2010)

Hello Jennifer,

Your dissertation research sounds very interesting. You can formally have my permission to use part of my Counselor Professional Identity Measure in your dissertation work. Typically when I give permission to use the measure I ask for data related to the measure so I may contact you for that at some point. Perhaps we will cross paths and can talk further about it one of these days. Good luck finishing everything up and congratulations on getting this far.

-Carla Emerson

On Thu, Mar 7, 2013 at 2:29 PM, Jennifer Langeland <[findingmoksha@gmail.com](mailto:findingmoksha@gmail.com)> wrote:

Hello Dr. Emmerson,

I recently used a portion of the professional identity scale, that you developed for your dissertation, in my dissertation.

I am realizing that I failed to ask for your permission to use this sub scale. I apologize.

My study looked at counselor educator attitudes, experience, knowledge and beliefs about Complementary and Alternative Medicine(CAM). I used the wellness and prevention portions of the scale to explore whether these aspects of professional identity correlated with attitudes toward CAM. Interestingly, I found that wellness was strongly and positively correlated but the prevention sub scale did not correlate with attitudes. I would be happy to share with you the full results if you are interested. I appreciate the work you did on this. I believe it strengthened my study and helped me make the case that counselors, who have a professional emphasis on wellness in their training, are well suited to lead the discussion on use of CAM in mental health.

I apologize that I am asking for permission at this point. My graduate college would like for me to have on record that you have granted me permission to use the scale. I appreciate your understanding.

Please feel free to contact me or my chair, Dr. Gary Bischof, if you have any questions.

Jennifer Mills Langeland, PhD (ABD)  
Western Michigan University  
Counselor Education  
[269-330-4695](tel:269-330-4695)

Gary Bischof, PhD, Chair  
[gary.bischof@wmich.edu](mailto:gary.bischof@wmich.edu)