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Professional Counselors' Referral Processes to Complementary Health Practitioners

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ABSTRACT

There is a growing interest in the utility of complementary health approaches (CHAs) to promote wellness and health in the United States. Research from medical, allied health, and mental health fields reflect this expanding interest; however, very little research focuses on counselors and the integration of CHAs within practice or referral of counseling clients to Complementary Health Practitioners (CHPs). The current study expanded this research using transcendental phenomenology to explore the experiences, perspectives, and processes in use by current independently licensed professional counselors referring to complementary health practitioners (CHPs). The authors discuss and explore implications of these findings.

KEYWORDS

Complementary health approaches; referral; counseling; complementary health practitioners; creativity in counseling

Complementary health approaches (CHAs) are practices and products of non-mainstream origin (NCCIH, 2016). Some examples of CHAs include massage therapy, yoga, acupuncture, meditation, and chiropractic care, among others (NCCIH, 2016). While the United States historically treats sickness from a biomedical perspective, immigration of individuals from the East exposed the United States to nontraditional healing traditions (Constantine et al., 2004; Yeh et al., 2004). This influence has increased the popularity of using nontraditional methods of preventing and addressing sickness (33% of U.S. adults and 11.6% of children reported using CHAs in 2012; Black et al., 2015; Clarke et al., 2015).

Individuals with mental health diagnoses report using CHAs frequently (Burnett-Zeigler et al., 2016; Kessler et al., 2001; Russinova et al., 2002; Unutzer et al., 2000), with one survey indicating 86% of individuals with schizophrenia, bipolar disorder, and/or major depression indicated CHAs benefitted their mental health (Russinova et al., 2002). Some researchers indicate CHAs decrease anxiety and depression (Kessler et al., 2001; McPherson & McGraw, 2013; Qureshi & Al-Bedah, 2013; Yadav et al., 2012) with preliminary evidence for acupuncture, massage, naturopathy, yoga, meditation, and exercise in the treatment of anxiety disorders (Manocha et al., 2011; Sarris et al., 2012; Yadav et al., 2012) and yoga (Qureshi & Al-Bedah, 2013) and meditation (Manocha et al., 2011) in the treatment of negative mood for those with depression.

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Many persons with mental health diagnoses are already using CHAs, so it is important for counselors to better understand CHAs and their utility with clients to increase wellness. This is particularly important because professional counseling is wellness-focused (Kaplan et al., 2014). While research indicates counselors are beginning to understand what it might look like to integrate wellness-interventions into counseling (Fetter & Koch, 2009; Granello, 2000), professional counselors still have little understanding of what wellness-interventions assist clients, making it difficult to subscribe to a wellness professional identity (Mellin et al., 2011).

CHAs in counseling

Findings suggest community mental health practices integrate CHAs (Collinge et al., 2005) as well as CACREP counselor training programs (Lumadue et al., 2005). Counselors report using nontraditional approaches to increase the mental health of their clients and believe their clients respond favorably to the use of CHAs (Evans et al., 2002; Nichols, 2015). Researchers indicate that CHAs increase client wellness (Granello, 2000, 2013). Because professional counseling is wellness-focused (Kaplan et al., 2014), counselors are in a unique position to determine how CHAs can be effective for increasing client wellness while simultaneously promoting the focus counselors have on wellness as a professional identity (Kaplan et al., 2014). Even so, the ways in which counselors help clients increase their wellness is still in development (Fetter & Koch, 2009; Granello, 2000, 2013; Nichols, 2015) and the practical application of empowering diverse individuals toward wellness is unclear (Mellin et al., 2011).

Referral practices

All counselors should provide culturally appropriate referrals for their clients (American Counseling Association [ACA] *Code of Ethics*, 2014, A.11.a), however, there is a surprising lack of information on appropriate referral practices to any other service and no information about referral practices to complementary health practitioners (CHPs). This leaves counselors with a substantial lack of information on how to refer clients. Regarding referral to CHPs, some counselors may have the competence to integrate the use of CHAs in session with clients (Evans et al., 2002; Nichols, 2015), but many more counselors lack competence or appropriate training to integrate CHAs in session. Therefore, it is unclear what processes counselors use when referring their clients to CHPs. The present study explores the research question: What are independently licensed professional counselors' experiences, perspectives, and processes when referring clients to CHPs?

Method

To answer the present study's research question, we employed a constructivist paradigm in concert with transcendental phenomenology (Moustakas, 1994). The aim of transcendental phenomenology (TP) is to reveal the essence or meaning of a human experience (Moustakas, 1994). The research team's interest lied in the experiences and perspectives of counselors who referred clients to complementary health practitioners, therefore, TP methodology was the most appropriate to answer our research question.

Constructivist paradigm

When asking questions related to a persons' lived experiences, perspectives, and processes, constructivism is an appropriate paradigm, as constructivism posits that reality is relative to the individual (Guba & Lincoln, 1994). Our research team was most interested in relying on the participants' views of the world and the meaning they associate with their experience (Creswell, 2013). Constructivism allowed for the reality of each participant to come to the surface. Constructivism asserts that the researcher and the researched object are inextricably linked and therefore the findings are "literally created as the investigation proceeds" (Guba & Lincoln, 1994, p. 111). Because there was little research on complementary health approaches and referral processes, it was important for our research team to allow the data to emerge from the interaction between ourselves and the participants as it related to the experiences, perspectives, and processes of the participants, rather than starting with a theory or our perspective (Creswell, 2013; Guba & Lincoln, 1994).

Recruitment and sampling

After obtaining permission from the institution's IRB board, the research team recruited participants for the study by posting a recruitment announcement on the Counselor Education and Supervision Network (CESNET) listserv. Additionally, we reached out to counselors we knew personally who referred clients to CHPs (purposive sampling). Transcendental phenomenology (TP) details that research participants must have experience with the phenomenon (Moustakas, 1994), therefore eliciting information from participants who have experience with referral to CHAs was of the utmost importance. In keeping with recommendations from TP researchers (Creswell, 2013), we interviewed a total of 12 individuals, however, only included 11 participants in the study. We determined that the twelfth participant did not meet inclusion criteria after the interview because the participant did not have referral experience to CHAs. TP participants must have experience with the phenomenon, so we excluded data from the twelfth participant.

Participants

The research team invited counselors with a master's degree in counseling, holding an independent counseling license within the United States, with experience referring clients to CHPs to participate. Most participants identified as Caucasian, White, or with family lineages from European countries (n = 10), with one participant identifying as Hispanic/Mexican (n = 1). All participants identified as cisgender (men, n = 3; women, n = 8) with sexual identities distributed as heterosexual (n = 10) and bisexual (n = 1). Participants' ages ranged from 31 to 63 years old (M = 48 years, SD = 13.96 years). With an open response item to identify religious and/or spiritual orientation, participants identified: none (n= 1), Agnostic (n= 1), Taoist/Buddhist (n= 1), Spiritual (n = 4; one individual identifying as Jewish and another identifying as being raised Catholic but now identifying as "spiritual"), and Christian/Catholic (n = 4). Three individuals reported disabilities, with two of the three reporting ADHD as a disability (the third did not report a specific disability).

Participants in the present study held master's degrees (n = 8) and Doctoral degrees (n = 3) in counseling. Five individuals reported attending a non-CACREP accredited school

and six individuals attended a CACREP accredited school for their master's degree. There were a myriad of counseling specialty areas participants reported (i.e. addictions, clinical mental health, marriage, couples, and family, career, rehabilitation, behavioral medicine and dance movement therapy), and additional certifications, many of which were in CHAs (i.e. Emotional Freedom Techniques, Reiki Master, Crystalline Consciousness Technique, Reconnection/Reconnective Healing, Integrative Energetic Medicine Practitioner). Some participants held more than one certification.

Participants included in the present study practiced counseling in the Southeast (n= 3) and Midwest (n= 8) and in various settings (some participants in multiple settings): university (n = 3), private practice (n = 8), agency (n = 4), and primary care/family medicine (n = 2). The counselors included in the present study have been practicing counseling (post-Master's) between 2.5 and 30 years (M = 17, SD = 9.66).

Data collection

We aligned our interview schedule with Moustakas (1994) who suggested the long interview, involving open-ended comments and questions as the method of choice. The primary researcher interviewed participants in person (seven interviews) or through the online platform, Zoom (four interviews). Interviews ranged between 30 and 75 minutes. Participants signed an informed consent before their interview and recorded and completed a demographic sheet. Throughout the interviews, we used semi-structured interviewing to encourage participants to explore their experiences, perspectives, and processes, but also allowed for an informal and interactive process (Moustakas, 1994).

Data analysis

Before and throughout data collection, the research team engaged in memoing to document reactions, thoughts, and feelings about the study (bracketing; Hays & Singh, 2012). The research team transcribed each interview after completing each participant interview. To verify each transcription, the primary researcher listened to each participant recording two times to ensure she thoroughly captured participants' statements. As soon as the transcription was complete, the primary researcher sent those transcripts to the research team for analysis. The primary researcher coded all 11 transcripts and other members of the research team coded six and five each, respectively.

We began the first stage of analysis by dividing transcripts into statements or meaning units (horizontalization; Moustakas, 1994). From there, the research team clustered participant statements around themes (Moustakas, 1994). After each researcher identified the themes from the first six transcripts, we met to discuss the textual descriptions, discuss similarities or differences, and remove overlapping and repetitive statements (Moustakas, 1994). We used the textual descriptions from the first six transcripts to code the last five transcripts. If any additional themes emerged from the last five transcripts, we added them to the initial codebook. The final step of data analysis was to combine textual and structural descriptions into themes and subthemes (Moustakas, 1994). The primary researcher then compiled the information into a master codebook with themes, sub-themes, and data points (i.e. participant statements; Hays & Singh, 2012). Our final codebook included eight themes with corresponding subthemes.

Trustworthiness

Researchers using qualitative inquiry must share their personal experience with the studied topic and find ways to increase trustworthiness of the data. The first author used a journal as a way to process and bracket her personal biases throughout the study, including (a) the researcher believes CHAs to be integral in her own personal growth and wellness and (b) believes that clients who see qualified CHPs are more likely to stay healthy during therapy as well as after therapy has commenced.

Additionally, the research team, comprised of two additional members, increased triangulation to verify the accuracy of coded themes (Creswell & Miller, 2000). We also included member-checking to enhance credibility. The second researcher contacted an outside auditor to access all notes, memoing, transcriptions, and iterations of the codebook, increasing confirmability and dependability (Creswell & Miller, 2000). The auditor had experience with qualitative research both through published qualitative articles and teaching in qualitative methodology. We can also confirm transferability through the use of semi-structured interviews which encouraged persistent observation and thick description (Creswell & Miller, 2000; Hays & Singh, 2012; Lincoln & Guba, 1985).

Results

There were eight themes that emerged from participant interviews and coding procedures. These eight themes are: Beliefs and Values that Impacted the Referral Process, Personal Experiences with CHAs, Ethical Concerns Related to CHA Referral, Believed CHAs had Many Benefits for Their Clients, Assessed CHP Before Referral, Assessed Client Suitability for CHA Referral, Considered Their Role and Involvement in the Referral Process, and Determined the Efficacy of the CHA. Table 1 details these findings. We discuss themes and corresponding subthemes below.

Beliefs and values that impacted referral process

All the individuals interviewed held core beliefs and values which impacted their work as counselors. Within this study, we define core beliefs and values as intrinsic convictions and ideals held by the participants that impacted but also transcended their referral process to CHPs.

Participants in this study often talked about humility as a common underlying belief and value in the way they addressed clients and their referral process to CHAs. Cindy shared, " . . . be open minded, more importantly be humble . . . I don't know all the right answers." In addition, participants recognized that humility increased their openness and willingness to learn about CHAs or other modalities that might help a struggling client. Rita shared, "I guess I'm just not a fan of thinking that one thing is the only way to go . . . I mean people are complex beings . . . I feel like you're always going to have to bring in other things to help them." Participants also believed in the connection between the mind, body, and spirit and believed this philosophy to be the underlying foundation of both CHAs and wellness. Clara exemplified this theme by stating, "if we walk our talk as counselors, wellness is integral and a foundation of our profession. Complementary health is a holistic approach and wellness oriented, too."

Table 1. Superordinate and subordinate themes, definitions, and contributions from participants.

Superordinate Themes	Superordinate Definition	Participants Contributing to this Theme	Subthemes	Subtheme Definition	Participants contributing to this subtheme
Beliefs and Values that Impacted Referral Process	Intrinsic convictions and ideals held by the participants that impacted but also transcended counselors' referral process to CHAs.	All	Embodied the spirit of humility	The conviction that counselors always have room to grow.	Robert, Rita, Kristy, Ruby, Bruce, Ruth, Jared, Cindy
			Unconstrained by empiricism	The ability to understand the importance and applicability of scientific experiments to the understanding of truth, but not being bound by this philosophy as the only way to know truth.	Rita, Cindy, Ruby
			Believed in a connection between mind, body, and spirit	The belief that mind, body, and spirit are connected and because of this connection, holistic and wellness-oriented interventions are the most healing because they address this connection.	Kristy, Rita, Jared, Cindy, Clara, Eliza
			Complexity of humanity	The awareness of each person's uniqueness and the ever-changing dynamics within each person.	Clara, Rita, Jared, Tara, Cindy
			Limitations to talk therapy	The belief that talk therapy provides powerful benefits and yet talk therapy is not always the best mode of therapy for each client.	Eliza, Robert, Rita
			CHAs supplement counseling	The belief that CHAs supplement what happens in therapy, particularly in relation to providing additional treatment interventions and enhancing therapy.	Clara, Eliza, Kristy, Rita, Robert, Ruby, Ruth, Cindy, Jared, Tara, Bruce
Personal Experience with CHAs	Having some experience or knowledge of CHAs.	All	Knowledge/Awareness of CHAs	The increased comfort with CHAs based on an introduction to these modalities through information and/or experience.	Eliza, Rita, Cindy, Jared, Ruth, Tara
			Experienced positive effects from CHAs	Having some form of positive personal experience with various CHAs.	Ruby, Eliza, Clara, Rita, Cindy, Bruce, Tara, Jared, Ruth
			Examined CHA research	The importance of reading research and exploring how CHAs may impact mental health (both positively and negatively).	Eliza, Kristy, Bruce, Cindy, Jared, Ruth
			Trained in CHAs	Formal and extended training, CEU's, and/or certifications in a CHA.	Eliza, Rita, Tara, Cindy, Bruce

(*Continued*)

Table 1. (Continued).

Superordinate Themes	Superordinate Definition	Participants Contributing to this Theme	Subthemes	Subtheme Definition	Participants contributing to this subtheme
Ethical Concerns Related to CHA Referral	Applicable ACA Code of Ethics tenants or codes considered and applied to the referral process to CHP.	All	Fostered client autonomy	Fostering the right to control the direction of one's life (ACA Code of Ethics, 2014)	Rita, Clara, Robert, Kristy, Ruby, Jared, Ruth, Tara, Bruce, Cindy, Eliza
			Avoided actions that could create harm	Avoiding actions that cause harm (ACA Code of Ethics, 2014)	Robert, Ruth, Ruby, Tara, Cindy, Rita, Clara, Bruce
			Accepted responsibility for client welfare	Personal duty to make sure each client gets the best treatment possible, regardless if it is provided by you.	Rita, Robert, Kristy, Jared
			Told clients the truth	Dealing truthfully with individuals with whom counselors come into professional contact (ACA Code of Ethics, 2014)	Ruby, Ruth, Tara
Believed CHAs had Many Benefits for their Clients	Believing CHAs have benefits that can assist clients.	All	Increased wellness	Increased ability to care for oneself by balancing more than one dimension of wellness.	Eliza, Kristy, Rita, Ruby, Bruce, Ruth, Tara
			Broadened possibilities for healing	CHAs provide more options for treatment interventions.	Tara, Rita, Eliza, Cindy, Kristy, Robert, Ruby, Ruth, Jared, Bruce,
			Increased client progress in counseling	CHAs speed up treatment and can help clients get "unstuck."	Kristy, Eliza, Robert, Rita
			Provided somatic interventions	CHAs can offer interventions at the body-level that may mediate mental health issues	Robert, Rita, Eliza, Kristy, Bruce, Jared, Ruth, Tara
			Increased client support systems	CHAs, specifically those with group approaches, increase client connection and engagement with like-minded individuals.	Kristy, Cindy, Bruce, Tara
Assessed CHP Before Referral	Assessment included whether the participant believed the CHP is an appropriate referral for their client(s).	All	Used intuition to decide if a CHP was appropriate for clients	Assessing, without conscious reasoning, CHP and the likelihood they would be an appropriate referral source.	Ruby, Robert, Jared, Cindy, Tara
			Assessed CHP reputation	Deciding, based on CHP reputation, whether the CHP would be an appropriate referral.	Kristy, Rita, Clara, Jared
			Verified CHP training credentials	Assessing level of training and certifications.	Rita, Eliza, Clara, Ruby, Cindy, Jared, Ruth, Bruce
			Assessed goodness of fit between CHP and client	Assessing the personality fit between client and CHP.	Clara, Kristy, Robert, Eliza, Ruby, Bruce

(*Continued*)

Table 1. (Continued).

Superordinate Themes	Superordinate Definition	Participants Contributing to this Theme	Subthemes	Subtheme Definition	Participants contributing to this subtheme
Assessed Client Suitability for CHA Referral	Assessing if the client was ready for additional sources of healing.	All	Assessed what the client needed most from therapy	Considering what the client is coming to counseling for and what the client's goals were for counseling.	Ruby, Eliza, Robert, Rita, Cindy, Jared, Ruth
			Assessed the level of trust between themselves and their client	Assessing how long clients had been coming to counseling and whether there had been enough trust built over time for a client to positively receive the referral recommendation.	Clara, Rita, Bruce, Jared, Eliza
			Assessed whether their clients were interested in CHAs as a part of treatment	Assessing whether or not the client is interested and open to pursuing CHAs as a part of their treatment.	Clara, Cindy, Jared, Ruth, Bruce, Eliza, Ruby, Tara, Kristy
			Assessed the cultural fit of the client with the CHA	Awareness of various cultural implications when making a referral to CHAs and how this might interact with the referral process in either a positive or negative way.	Rita, Kristy, Clara, Ruby, Eliza, Ruth, Bruce, Cindy, Tara, Jared, Robert, Ruby
			Assessed if the client was motivated to follow through on a referral	Assessing how motivated a client was to get better.	Clara, Kristy, Tara, Ruth, Cindy, Rita
			Assessed whether the CHA aligned with the client's symptom(s)	Aligning client symptoms with specific CHAs known to mediate those issues	Kristy, Clara, Rita, Ruby, Robert, Tara, Ruth, Cindy
			Assessed client's interests and preferences for goodness of fit with CHAs	Aligning CHAs with client preferences because they are more likely to engage with CHAs if it is something they are truly interested in or prefer.	Rita, Ruby, Robert, Bruce, Tara, Cindy, Ruth, Jared, Kristy
Considered Their Role and Involvement in the Referral Process	Counselors' understanding of their role in referring clients to CHP.	All	Educated clients on CHAs	Introducing clients to CHAs through psychoeducation within the counseling session.	Robert, Kristy, Rita, Eliza, Clara, Ruby, Bruce, Tara, Cindy, Jared, Ruth
			Collaborated and connected with CHP	Intentionally connecting and seeking out CHP referral sources for clients.	Rita, Eliza, Robert, Jared, Clara, Ruby, Bruce, Cindy, Tara, Ruth
			Consulted with trusted sources	Having trusted people to consult with for their referral recommendation.	Robert, Rita, Ruby, Clara, Robert, Tara, Jared, Bruce, Cindy, Robert, Eliza
			Assessed level of involvement	Assessing, with each client, how involved the counselor should be in the referral process.	Ruby, Eliza, Robert Jared, Tara, Ruth, Cindy, Clara, Eliza, Rita, Kristy,
Determined the Efficacy of the CHA	Assessing the benefit of the CHA modality as a part of the therapeutic process.	All	Distinguished if CHAs decreased their clients' presenting concerns	Assessing whether the CHA modality decreased whatever concerns the CHA was supposed to be addressing.	Tara, Jared. Eliza, Cindy, Ruth, Rita, Kristy
			Consulted with CHP	Conferring with the CHP to check in on clients and their progress.	Tara, Rita, Cindy, Bruce, Eliza, Robert
			Elicited client feedback about their experience	Clients providing information to the counselor about the CHP and CHA.	Eliza, Robert, Kristy, Clara, Ruby, Rita, Bruce, Jared, Tara, Ruth, Cindy

Personal experiences with CHAs

Each participant talked about having some experience or knowledge of CHAs that increased their comfort in referring their clients to CHPs. While each participant had various experiences and knowledge of CHAs, participants mentioned that their level of exposure to CHAs increased or decreased (depending on if the exposure was positive or negative) the likelihood they would refer their clients to similar CHAs. Most participants (n = 10) had some form of positive personal experience with CHAs, making them more comfortable referring clients to CHPs. Many participants also talked about how their positive experience with CHAs piqued their interest in further understanding why CHAs worked. Eliza spoke specifically about her training in energy medicine, "I went out and I experienced some of these things [CHAs]. I was reflecting on them, how they were helpful in my own life and with people I know … I got trained [sic] and so I understood a lot more."

Research, whether through additional training or reading research on the effects of CHAs for certain mental health issues, increased the likelihood that these participants would refer clients to CHAs. One participant (Robert) did not have any personal experience with CHAs; however, lacking personal experience did not deter him from referring clients because he had examined research to inform his practice and concluded that CHAs would help his clients. It is important to mention that poor research backing or lack of knowledge on a certain CHA decreased the likelihood that participants would refer. Ruth shared, "I don't think I have enough understanding [of acupuncture]. I mean, I've had it for pain things … but I guess I'm reluctant about its effectiveness for that, let alone for depression or something."

Ethical concerns related to CHA referral

All participants (n = 11) spoke about ethical concerns and the importance of fostering client autonomy and empowering the client to make choices that align with who they are. As Tara pointed out, "I like to empower my clients and have them feel and be in control, so a lot of times … I go with the approach of 'knowledge is power.'" Approaching clients with this mind-set encouraged participants to accept responsibility for their client's welfare, avoid any action that could potentially cause harm to their client, and provide clients with honest communication about specific CHAs and the practitioners who administered them. Rita shared feeling the personal responsibility of not only referring to appropriate CHPs but also appropriate CHAs:

> I wouldn't want to refer a client to a place that does hypnosis not knowing the person [CHPs], not knowing where they're coming from, not knowing what their intentions are … cause [sic] that's on me …. I just sent you [client] to this person and you know, I don't even know if I feel comfortable with that particular method.

Believed CHAs had many benefits for their clients

All participants within this study reported the benefits of CHAs when used as an adjunct to therapy. Most participants reported the benefits of using CHAs over the challenges or risks. Many participants discussed the importance of having tools for a variety of clients.

Participants spoke specifically about how CHAs are particularly useful when clients are stuck and talk therapy is not working. Eliza discussed the importance of using CHAs to help move clients through difficult places, "whether someone's gonna [sic] do yoga, or use the meridian system with acupuncture, or do energy medicine like what I practice, it's just a way of helping the body to naturally move past stuck places." In addition, participants noted that because clients have access to CHAs as a part of their healing in therapy, these practices become a part of their healing and can continue outside of the counseling relationship, increasing wellness even when clients are discharged from therapy. Kristy shared how each area of wellness impacts the other and the importance of using CHAs as a way to impact all these areas, "obvious [impact of CHAs] would be improved emotional . . . and psychological health which is what I would be after. Physical health, which of course dramatically impacts [client functioning], and spiritual health."

Assessed CHP before referral

All participants discussed the importance of assessing the complementary health practitioner (CHP) before referring clients to them. Participants described that this assessment begins as soon as the participants meet a potential CHP and throughout the referral process. Participants reported using a variety of ways to determine that a CHP would be helpful for a client. Participants often reported using their gut instinct to first determine which CHP they would consider referring to; however, when I asked participants to quantify what they meant by "gut instinct," they described observing CHPs in different settings, seeing if they have good boundaries with colleagues and clients, determining if the CHP has a good reputation with family, friends, or coworkers, and verifying any training credentials. All participants had different comfort levels when referring. While Rita disclosed that she would be comfortable referring to anyone with a certification in their training method, Cindy discussed feeling more comfortable referring a client to someone who had a professional degree (e.g. nurse, counselor, social worker) who was also trained in certain CHAs as this would help her feel they had some form of professional credibility and could properly handle situations if a client was triggered. Participants also mentioned that just because they felt comfortable with a CHP who practiced a certain modality, did not mean that they would refer all their clients to that one particular practitioner. Bruce shared, "I think the biggest challenge that we have is trying to connect clients or patients to the right provider," which was a common theme amongst other participants as well.

Assessed client suitability for CHA referral

All participants (n = 11) indicated that a substantial part of the referral process was the importance of assessing if the client was ready for additional sources of healing. Participants discussed assessing what the client wanted and needed most from therapy and then deciding whether CHAs would be effective to help mediate the client's symptoms. In addition, participants discussed the importance of assessing client interest and motivation in using CHAs as a part of therapy. If a client did not show interest in or lacked motivation to use CHAs as a part of treatment, participants discussed the importance of listening to their client and not pushing.

Participants additionally assessed various intersectionalities when determining client suitability for CHAs. Participants discussed socioeconomic status (SES), gender, race/ethnicity, religious background, mental health status, age, and disability or physical limitation and the impact of this intersectionality on their referral. Some participants discussed how certain intersectionalities could create barriers that participants could work around (e.g. for individuals with disabilities or physical limitations, there are some CHAs that would not impact a physical limitation or could be modified for a person with a physical limitation). There were other participants who would consider whether or not the CHA would actually be beneficial because it would create some undue burden on the client (e.g. clients who could not afford CHAs since many CHAs are not covered by insurance), did not align with their client's religious views, or the client had a severe and persistent mental illness. Participants also discussed race and ethnicity; however, reports were inconsistent. While one participant mentioned individuals in non-majority groups to be more open to CHAs, another participant reported the exact opposite.

Considered their role and involvement in the referral process

When discussing referrals to CHPs, participants naturally discussed their role in the process. Some participants took a more hands-on approach to referral and others were more relaxed in their approach, however, all participants discussed their role as educator in providing psychoeducation to their clients about CHAs, specifically clarifying any CHAs their clients did not understand. In addition, many participants talked about their role as a collaborator and connector with CHPs to make the referral process as easy and smooth for their clients as possible. Kristy, Jared, Tara, and Rita spoke about professionals in their community that they have built relationships with over time and how they refer clients to those individuals in which they have built relationships.

Participants also discussed their level of involvement in the referral process based on each individual client and their specific needs. Both Rita, Clara, and Eliza discussed how they collaborate with clients so they feel supported and empowered to pursue referrals. Eliza discussed how she differentiated between how involved she might need to be for particular clients, "so, for someone who's curious and is kind of on the path for exploration, I would keep things more general and just maybe make suggestions of things that they might be interested in, from reading to actually practicing something."

Determined the efficacy of the CHA

Another part of the referral process to CHAs is the assessment of the benefit of the CHA modality as a part of the therapeutic process. It was clear that all participants (n = 11) generally believed that CHAs would be beneficial for all client, however, participants mentioned concern regarding whether the CHAs mediated the concerns the clients entered counseling with. Additionally, participants consulted with both CHPs and clients about whether they believed the interventions were working.

The most (n = 11) utilized way the participants assessed the efficacy of CHAs was through client feedback. This feedback was either elicited by the counselor or the client might offer information freely without needing counselor inquiry. Rita shared her process, "I'll ask them how's that going? … Are you getting your needs met there? Or … what's

happening? How is it helping you? I learn whether or not it's working out or whether we need to go in a different direction." Jared reported an informal way he assessed whether or not the CHA might be working, "if they seem to be getting better, they're self-reporting, they're not coming [to therapy] as much, they're resolving their issue that they came in with, I think those would be the ways that I would informally [know it worked]." While some participants used consultation with the CHP to help understand how the CHA was positively affecting their client, many participants reported not having time to follow up with CHPs and leaving it to the client to report their experience.

Findings and implications

This study aimed to address a gap in the literature by presenting the qualitative experiences, perspectives, and referral practices of counselors referring to CHPs.

Experience and beliefs

Findings from this study indicate that increased knowledge or awareness of CHAs and experiences where a participant had a positive interaction with a CHA usually increased the likeliness the counselor would refer their clients to CHAs. This finding confirms previous qualitative research findings indicating that both experience with and openness to complementary therapies were important factors when integrating complementary therapies into counseling (Nichols, 2015).

Increased wellness interventions

Participants were aware of the importance of referral to CHAs in helping increase client wellness, a focus of the counseling profession and a main tenant of counselor professional identity (Kaplan et al., 2014). More than half of the participants spoke specifically about the importance of CHAs as a wellness enhancing tool for their clients. Participants made specific connections between the underlying philosophy of many CHAs and wellness, indicating the foundation of both was the theory of holism or the interconnection of multiple parts. In the counseling literature, Myers et al. (2000) described wellness in a similar fashion, positing wellness as the integration of the mind, body, and spirit. Participants shared the importance of having interventions that addressed all facets of wellness rather than just the mind, indicating that many CHAs address more than one facet (e.g. yoga can address physical, mental, spiritual, and social wellness facets). Participants identified that clients who used CHAs were not only increasing physical, mental, emotional, and spiritual facets of wellness, but also have the option of increasing social wellness through certain CHAs too.

Ethics

Findings from this study suggest that counselors' think about ethical concerns of CHA referral. While there were not many articles on counselors' referral process to glean from, Zuriff (2000) mentioned the importance of the referring clinician to be "forthright about how the procedure works" (p. 47). This aligns with many participants in this study,

indicating the importance of telling their clients the truth (veracity) about the referral, exploring the benefits and detriments to the CHAs, and answering any questions clients might have.

Other findings within this study indicate that participants assessed both the CHP and whether their client was suitable for a CHA referral before discussing the referral with a client, which aligns with the ACA *Code of Ethics* (2014) standard A.11.a, which states counselors should be "knowledgeable about culturally appropriate referral sources and suggest these alternatives" (p. 6). Findings in other studies indicate the importance of assessing client factors before referring (Iarussi & Shaw, 2016). These previous studies do not discuss referral specific to the topic discussed in this article, therefore, it is important to note that this article adds to our understanding of what counselors believe is most important to assess when determining appropriateness of clients for CHAs. This article indicates that counselor's look at what is most needed in therapy (i.e. What is the main goal of therapy? Why is the client here? Will adding CHAs assist the client in meeting this goal?), level of trust between client and counselor, cultural fit, level of interest in CHAs, motivation, and clients' interests/preferences.

Multicultural interventions

Participants in this study also assessed how various cultural factors played a role in the referral process. Participants discussed the importance of assessing client and referral cultural factors that might make the referral a better fit for the client, which is in comportment with the counseling *Code of Ethics* (ACA, 2014). For instance, participants reported being aware of the SES of their clients and not referring to CHAs that would be monetarily inaccessible for their client. Additionally, participants discussed the importance of religion and spirituality, as some CHAs better aligned with certain religious or spiritual backgrounds over others.

While some participants discussed the importance of cultural factors in the referral process, only Rita mentioned CHAs as a culturally appropriate intervention for non-dominant and marginalized people groups. Some participants also mentioned that they would be more hesitant to recommend a referral to CHAs if their client was a person of color or identifying with a non-dominant group, which is the opposite of previous recommendations, as CHAs are a culturally appropriate and wellness enhancing intervention for minority populations (Constantine et al., 2004; Yeh et al., 2004). Because most participants did not explore this concept, or rejected this notion altogether, participants may be unaware that CHAs could be even more effective with certain cultural groups and actually help increase treatment prognosis.

Limitations

There were limitations to this study related to the constitution of the research team and method. This research team encompassed three European-American individuals, therefore, the research team lacked input from individuals embodying racial or ethnic backgrounds. We also chose to conduct semi-structured individual interviews, which relies on self-report data. This can limit the variability of responses gathered throughout the interview process. While

semi-structured interviews provide structure and fluidity in terms of what participants share (Hays & Singh, 2012), asking participants specific questions may have limited responses.

Regarding our sample of participants, most individuals in our sample identified as White, cisgender, and heterosexual. Therefore, information and experience from a more racially, ethnically, and sexually diverse sample may have provided additional information for this research study. Additionally, all but one participant had personal experience with CHAs. It is likely we would have garnered different responses from counselors who did not have personal experience with CHAs.

Future research directions

The lack of information on best-practices regarding proper referrals, especially referrals to practitioners while the client is still being seen by a counselor, may cause problems for counselors who want to refer to CHAs but are unsure about the process. As a profession, it is important for counselors to be able to make appropriate referrals and have evidence to support the referral's alignment with client concerns. While it is clear from this study that professional counselors are engaging in a process to refer their clients to CHPs, it is also clear that there is no systematic way professional counselors are doing so. Future researchers can examine referral models and their applicability to the referral process to CHPs, create referral models for counselors referring to CHPs, and establish best practices for the referral process to CHPs. In addition, as research on CHA integration and referral continues, qualitative studies exploring clients' experiences with CHAs and quantitative studies investigating CHAs effects on mental health might help increase referral sources for wellness enhancing interventions and, in doing so, increase counselor subscription to wellness as a professional identity.

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