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Effects of Integral Health Care within LGBTQ Populations

Submitted By Megan M. Gramlow, B.A.

MSW Clinical Research Paper

Presented to the faculty of the School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota

In partial fulfillment of the Requirements for the Degree of
Master of Social Work

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Committee Members
Dr. Richa Dhanju, Ph.D.
Janet Dahlem, MA
Kathleen Fluegal, LICSW

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

LGBTQ populations are at a high risk to experience increased stress, due to a long history of oppressive circumstances (Alexander, 2002). Because increased stress levels raise the risk of experiencing a mental and physical illness, those identifying as LGBTQ are particularly more vulnerable to experiencing symptoms of illness (Johnson, 2007; Meyer, Dietrich, & Schwartz, 2008). A review of the literature indicates that LGBTQ populations face barriers within mainstream health care services, such as knowledgeable providers and culturally sensitive care. Additionally, little or no research has been done to explore the role of holistic, integral health services for LGBTQ populations. The aim of this research is to explore the effects of providing LGBTQ populations with alternative health care services. Mixed methods were used in conducting this research: qualitative interviews with holistic practitioners who work with LGBTQ identifying clients and surveys filled out by people identifying as LGBTQ. Inductive grounded theory and statistical analysis were used to compile and analyze the findings. Results indicate that those identifying as LGBTQ are more likely to engage in alternative health care modalities than the general population. Furthermore, it was found that benefits of utilizing alternative health care services include: overall wellbeing, stress relief, increased energy, clarity, balance, self-awareness, and mental, physical and spiritual health, as well as education, a lesser need to use pharmaceuticals and an increased awareness of the mind-body connection. Additionally, the findings show that alternative health care meets the needs of those who feel alienated within the mainstream health care system by providing an accepting, open environment and individualized care. Further research must be conducted to assess the physiological effects of oppression and the long-term benefits of specific alternative health care modalities.

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Sexual and gender minority populations - those identifying as lesbian, gay, bisexual, transgender, or queer (LGBTQ), present a high risk for increased stress due to oppression, harassment, discrimination, stigmatization, and social isolation (Alexander, 2002). Consequently, the increased stress associated with sexual and gender minorities raises the risk for mental illness to occur within LGBTQ populations (Meyer, Dietrich, & Schwartz, 2008). Because LGBTQ populations present higher risk factors for mental illness and stigmatization than sexual and gender majorities (Alexander, 2002), they demonstrate a greater need for cultural sensitivity and preventative health care which is currently not adequately provided through traditional medical model health care approaches (Mayer, Bradford, Makadon, Goldhammer, & Lander, 2008). This gap in preventative health care and deficit in cultural sensitivity within the traditional medical model may be filled through the use of integral health care techniques, which help individuals manage stress and foster a deeper sense of self-awareness and connection to the community (Proulx, 2008; Russinova, Wewiorski, & Cash, 2002). While some research has been done to study the effects of integral health care approaches within the general population suffering from stress and mental illness (Proulx, 2008; Russinova, Wewiorski, & Cash, 2002), little or no research has been done to study the effects of integral health care approaches used within LGBTQ populations.

It is difficult to study the needs and issues of LGBTQ populations because of the lack of reliable and representative data available. Furthermore, the sparse research available has been conducted using different combinations of sexual and gender minority groups: LBGTQ, LGBT, LGB, LG, L, G, B, and T. However, as of 2004, it was estimated that at least 4.1 percent of the U.S. population, ages 18 to 44, identified

as LGB (Mayer et al., 2008). In addition, this is the first decade in U.S. history that an identifiable group of LGBT elders exists (Mayer et al., 2008). While LGBTQ populations have made considerable gains in social acceptance over the last few decades, they are still at a high risk for external stressors, including: discrimination, stigmatization, isolation, marginalization, and reduced social support (Alexander, 2002). Additionally, LGBTQ populations are more susceptible to internal stressors, including: internalized homonegativity and stigma consciousness (Cox, Berge, Dewaele, & Vincke, 2010). Consequently, elevated stress levels exist within LGBTQ populations, which in turn puts this population at a greater risk to experience a mental illness (Alexander, 2002), as well as a variety of negative physiological impacts (Johnson, 2007).

Because of the external and internal stressors caused by the systematic oppression of LGBTQ populations, these individuals are found to have an elevated prevalence of anxiety, depression, substance abuse, suicidal ideation, suicide attempts, eating and body image disorders, physical and emotional abuse, obesity issues and other physiological changes (Johnson, 2007; Mayer et al., 2008; Meyer et al., 2008). A study with 388 LGB respondents demonstrates the prevalence of mental health issues within these populations: 69.8 percent of LGB populations had experienced a mental health disorder, 44 percent had an anxiety disorder, 30.7 percent had a mood disorder, 30.7 percent had Major Depressive Disorder, 38.4 percent had a substance abuse disorder and 8.3 percent had attempted suicide (Meyer et al., 2008). These findings demonstrate that preventative health measures should be taken to alleviate mental health risks and stressors, associated with LGBTQ populations.

This topic of study is concerning to the social work profession because it is founded upon the promotion of social justice and alleviating inequalities and oppression faced by all populations. The LGBTQ population is a sexual and gender minority group which faces an unthinkable amount of daily life challenges in terms of social discrimination, legal inequality, and stigmatization. Social workers have a duty to promote mental health and advocate for those who experience injustice (NASW, 2008). While there has been an increase in LGBTQ awareness and the creation of specific sexual and gender minority health clinics (Mayer et al., 2008), the LGBTQ population continues to present unique needs that are not being addressed by the current medical model and associated mental health therapy systems, as evidenced by the consistent high rates of suicide, depression, and substance abuse (Meyer et al., 2008). Moreover, while social workers are responsible for treating mental health issues within oppressed clients, they may often be unaware of or unable to treat the related physiological and bodily issues that also afflict those who have experienced oppression and trauma. This deficit in awareness underlines a gap in service and appropriate referral for populations who have experienced oppression and trauma and express associated somatic symptoms.

The purpose of this study is to examine the ways in which alternative therapies can provide unique support for LGBTQ populations. This study will be informed by a review of the literature, analyzing several items: first, the psychosocial experiences of LGBTQ populations; second, the differences in mental health among LGBTQ populations; third, LGBTQ experiences with health care; fourth, the effects of

oppression beyond mental health; and fifth, ways in which alternative health care services can enhance the mental and physical health of LGBTQ clients.

Review of Literature

The objective of this literature review was to gain knowledge about the LGBTQ experience and its relation to alternative health care systems. Through analyzing the biopsychosocial experience of LGBTQ populations and LGBTQ client experiences within mainstream health care, a pattern was detected, indicating a deficit in optimal care and support. Finally, alternative health care theory will be discussed in relation to the parallels existing between LGBTQ needs and integral health care benefits.

Throughout this paper, the term integral health care will be used interchangeably with holistic health, alternative health care, and complementary and alternative medicine (CAM). Integral health care is a client-centered approach to health care, which aims to view and treat the individual as an intricate whole, using interventions that address the mind, body and spirit as a connected entity. Through a review of the literature, enough exploration will have been done to conclude that there is a need to study LGBTQ clients' reactions to integral health care systems.

Psychosocial Experiences of LGBTQ Populations

Many studies have shown that LGBTQ populations are at a high risk for external stressors, such as: stigmatization, harassment, discrimination, and social isolation (Alexander, 2002; Israel, Gotcheva, Burnes, & Walther, 2008; McLaughlin, Hatzenbuehler, & Keyes, 2010; Ueno, 2005). In addition to increased external stressors, LGBTQ populations are also susceptible to internal stressors such as internalized homonegativity and stigma consciousness (Cox et al., 2010).

Homonegativity refers to the tendency for LGBTQ populations to internalize negative attitudes and stereotypes towards homosexuality; consequently, this phenomenon is “related to depression, self-esteem issues, and general psychological distress” (Cox et al., 2010, p. 1201). Stigma consciousness represents the extent to which a person expects to be stereotyped or judged by others, and this is also thought to be related to negative psychosocial functioning (Cox et al., 2010). Research shows that these external and internal stressors associated with LGBTQ populations increase the risk for developing a mental illness (Alexander, 2002).

LGBTQ populations experience higher rates of depression, anxiety, suicidal ideation, suicide attempts, substance abuse, sexual abuse, eating disorders, and obesity issues (Israel et al., 2008; Mayer et al., 2008; Meyer et al., 2008; Needham & Austin, 2010; Remafedi, 1987). Alexander (2002) demonstrates the seriousness of this problem by reporting that sexual minority youths are twice as likely to attempt suicide, and more likely to report suicidal ideation than their sexual majority peers (as cited in Russle & Joyner, 2001). In addition, sexual minority youth present with higher levels of alcohol abuse and depression than their sexual majority peers (Alexander, 2002). Remafedi (1987) provided similar findings through a study conducted with 29 GB males - results showed 58 percent met the DSM standards for substance abuse. In addition, all but one respondent reported suicidal ideation, and 34 percent of respondents had made a serious suicide attempt. Another study with 388 LGB respondents was done by Meyer et al. (2008) which yielded concurring results: 44 percent of respondents had an anxiety disorder; 30.7 percent had a mood disorder; 30.7 percent had Major Depressive Disorder; 38.4 percent had a substance abuse disorder;

69.8 percent had a mental illness of any kind; and 8.3 percent had made a serious suicide attempt. These findings show that there is a need for LGBTQ populations to develop healthy ways to cope with increased stress levels in order to prevent the risk of mental illness and comorbidity.

In addition to a higher rate of mental illness and societal stigmatization, LGBTQ populations are found to have a higher number of negative relationships with their peers and parents than their heterosexual, gender majority counterparts (Alanko et al., 2009; Needham & Austin, 2010; Remafedi, 1987; Ueno, 2005; Ueno, Gayman, Wright, & Quantz, 2009). It has also been found that sexual minorities tend to be less emotionally attached to others (Ueno, 2005). While positive peer relationships have been shown to decrease levels of psychological stress for LGBTQ people (Ueno, 2005), another study shows that close relationships between LGB populations may also have the potential to increase stressors, depression, substance abuse and suicide if they are unhealthy (Ueno et al., 2009). This research demonstrates that healthy relationships can serve as a protective factor for LGBTQ populations, while unhealthy relationships serve as a risk factor.

In terms of parental relationships, findings have shown that LG populations, particularly those who behave in a gender atypical manner, experience more negative parental relationships than heterosexual populations (Alanko et al., 2009; Needham & Austin, 2010). Moreover, a study conducted by Remafedi (1987) showed that 42 percent of 29 GB male respondents moved away from their parents because of issues related to their sexual orientation, and half of respondents had run away from home at least once. The familial relationship factor not only impacts youth and adults, it also

impacted LGBT elders (Mayer et al., 2008). It has been found that many LGBT elders lack strong ties to their parents and family connections (Mayer et al., 2008). The impact of these deficits in social support is discussed by Ueno (2005), reporting that peer and parental relationship quality highly impacts the level of psychological distress experienced by LGBTQ people. These findings suggest that familial relationships can be negatively impacted by one's sexual orientation, and the consequences of this can increase stress and associated mental and physical health issues.

Differences in Mental Health within LGBTQ Populations

While lesbian, gay, bisexual, transgender and queer populations are often lumped together as LGBTQ, these populations should additionally be studied independently of each other, as results show sexual and gender minorities suffer differently depending on the individual, age, sexual orientation, gender, social support levels, race, and residential legislation (Cox et al., 2010; Hatzenbuehler, Keyes & Hasin, 2009; McLaughlin et al., 2010; Meyer et al., 2008; Needham & Austin, 2010; Pachankis & Goldfried, 2006; Ueno, 2005). A study by Needham and Austin (2010) yielded results which indicate that lesbians had a higher rate of suicidal ideation than bisexual females, and female bisexuals had a higher rate of depression and heavy drinking than lesbians. Both lesbians and bisexual females showed higher rates of suicidal ideation and marijuana usage than gay and bisexual males (Needham & Austin, 2010). Additionally, gay males showed a higher rate of suicidal ideation than bisexual males; while, bisexual males showed a higher rate of depression (Needham & Austin, 2010). A study by Cox et al. (2010), supports these findings by reporting that male and female bisexuals have a higher rate of depression than gay, lesbian, or heterosexual

populations. Meyer et al. (2008) adds to this picture by reporting that bisexual people also show higher rates of substance abuse in comparison to LG populations. Though it has been shown that there are marked mental health differences among LGB populations, other factors should be further explored.

Mental health within the LGB population also differs according to race, age, level of internalization, and residential state legislation (Cox et al., 2010; Hatzenbuehler et al., 2009; McLaughlin et al., 2010; Meyer et al., 2008; Pachankis & Goldfried, 2006). According to a study conducted by Meyer et al. (2008), Black LGB respondents experienced lesser mental illness than White or Hispanic LGB respondents. This study also found that younger respondents had lesser mental illness prevalence than respondents over the age of 45 (Meyer et al., 2008). Additionally, McLaughlin et al. (2010) and Pachankis and Goldfried (2006) both found that LGB people who are not open with their sexual orientation and those unwilling to discuss their experiences with discrimination are at a higher risk for mental illness. Cox et al. (2010) supported these findings by reporting that youth who marginalized themselves or experienced internalized homonegativity presented a greater risk for mental illness, though it is important to remember this occurrence follows an individual experiencing marginalization and discrimination from the external world.

Another factor associated with mental illness in LGB populations was the existence of LGB protective state level policies (Hatzenbuehler et al., 2009). Hatzenbuehler et al. found that LGB populations living in states without protective policies were at a higher risk for mental illnesses, such as Anxiety Disorder, PTSD, and Dysthymia (2009). These findings indicate that preventative mental health services and

community and state advocacy measures are important tools for diminishing the high risk factors associated with LGBTQ populations.

Health Care Experiences within LGBTQ Populations

While the health care system (mental and comprehensive) has become increasingly accessible and sensitive to LGBTQ populations, many barriers to optimal service still exist (Mayer et al., 2008). According to Mayer et al. (2008) some prominent barriers currently existing are LGBTQ populations' unwillingness to self-disclose sexual or gender identity, lack of informed providers, and a lack of culturally sensitive prevention measures. Some important reasons for the avoidance of disclosure are related to lack of trust, fear of discrimination and stigmatization, and past negative experiences with providers (Mayer et al., 2008), which, although are not framed as such, may be systemic barriers within the health care system. Israel et al. (2008) reports some of the negative experiences LGBT clients have identified within mental health settings, including: assumption of heterosexuality, urging client to change sexual orientation, and focusing on the client's sexual orientation when it is not applicable to the pertinent issue. Furthermore, some of the negative outcomes of unhelpful mental health services have been feelings of betrayal, rejection, and hopelessness; moreover, 43 percent of these negative experiences led to increased symptoms, diminished quality of life and self-acceptance and damaged relationships (Israel et al., 2008).

Although LGBTQ clients have more reluctance to self-disclose within traditional health care settings, Israel et al. reports that LGBT clients have a higher rate of mental health service utilization, when compared with heterosexual clients (2008). A study by Remafedi (1987) illustrates this high utilization rate through findings that

indicate 72 percent of LGB respondents had sought out a psychologist or psychiatrist at least once in their lifetime for emotional problems. Israel et al. adds to these findings, indicating that LGBT clients rank social workers and psychologists as the most helpful mental health providers, and psychiatrists to be the least helpful providers (2008).

Exemplary practitioner initiatives, as reported by LGBT clients, include: recognizing and validating the importance of alternative families, helping clients to overcome internalized stigmatization, and countering bias views held by other professionals in the health care field (Israel et al., 2008). Results of this study indicate that the client-practitioner relationship and practitioner's counseling skills were the most indicative of positive experiences (Israel et al, 2008). Moreover, effects of a positive therapeutic experience include: increased insight, self-acceptance, confidence, and self-efficacy (Israel et al., 2008).

Additionally, clients reported that mental health service experiences are more helpful if homework and specific techniques such as imagery, dialectical behavioral therapy (DBT), and cognitive behavioral therapy (CBT) are used (Israel et al., 2008). Other interventions that have shown to increase the effectiveness of mental health support in LGBT populations are practitioners' ability to work with the larger LGBT community, increasing LGB clients' sense of belonging to the general community and the LGB community, and focusing on strengthening the bond between LGB youth and their parents (Israel et al., 2008; McCallum & McLaren, 2011; Needham & Austin, 2010). This research indicates that the client-practitioner relationship and the practitioner's LGBTQ knowledgebase and advocacy skills are very important for optimal treatment.

Effects of Oppression Beyond Mental Health

While optimal treatment for an LGBTQ client suffering from a mental health issue certainly involves a mental health service component, it is important for social workers and other mental health practitioners to be aware that oppression not only has the ability to affect the mind, but also the body (Johnson, 2007; Pert, Dreher & Ruff, 2005) – an area in which most social workers do not venture to treat. An oppressed individual is defined by Silverman (2012) as someone who's, “autonomy or... life prospects are burdened in systematic, social, and wrongful ways” (p. 41) More broadly, oppression is defined as a social occurrence in which ways of being are either privileged or marginalized, and with marginalization follows stigmatization and discrimination (Kumashiro, 2012). The psychological impacts of oppression have been an extensively researched topic within the social work field (Alexander, 2002; Cox et al., 2010; Hatzenbuehler et al., 2009); however, the physiological impacts of oppression have been paid much less attention within the context of research and practice.

Somatic theory addresses this unnecessary dichotomy between mind and body, which has acted as a barrier, preventing a greater understanding of health and illness. According to somatic theory, the mind is not separate from the body, and it is understood that the environment, body, and mind are affected by each other simultaneously, in a synergistic manner (Johnson, 2007). Somatics is derived from the Greek word “soma” meaning “living body” and this emphasizes the body's role in taking in and processing all of the information life has to offer - the good and the bad (Johnson, 2007). In more concrete terms, the body is a mediator between physical reality and the mind. Somatic theorists have argued that the trauma resulting from

oppression is felt most prominently within the body, rather than the mind, which can result in dissociation from the body and/or physiological manifestations, such as: "... headaches, stomach or digestive problems, immune system problems, asthma or breathing problems, dizziness, chest pain, chronic pain... and neurobiological changes" (Johnson, 2007, p. 85).

Pert, Dreher and Ruff (2005) support this notion by discussing research within behavioral medicine, which has shown that the health of our bodies is linked to our emotional state. Neuropeptide receptors, which are carriers and transmitters of molecular emotion, previously were thought to only have been located within the brain; however, recently these receptors have been identified within the gastrointestinal tract, kidneys, testis, pancreas, and immune system (Pert, Dreher, & Ruff, 2005). A study by Cole, Kemeny, Taylor and Visscher (1996) supports the link between body and mind through exploring the nature of sexual orientation concealment and its relation to disease progression among 222 homosexual, HIV positive men. Results indicated that men who masked their homosexual identity were significantly more likely to have developed cancer and other diseases, such as pneumonia, bronchitis, sinusitis, and tuberculosis (Cole, Kemeny, Taylor, & Visscher, 1996). These findings provide a biological demonstration of the complexity between the mind and body, and explain the necessity for an integral approach to health when treating LGBTQ populations as well as other populations that experience oppression.

Alternative Health Care Benefits

Alternative health care is based on an entirely different paradigm than the medical model: this paradigm is called integral health. Integral health is founded upon

the idea that health and healing is a life-long transformational process that, “exists in widening and deepening relationships with self, culture, and nature” (Schlitz, 2005, p. XL). It is a prevention-oriented process of treating the person as a whole, using natural and internal healing methods from a variety of systems (Howard, 2003). According to the National Center for Complementary and Alternative Medicine (NCCAM), alternative health care includes the following modalities: natural products, such as dietary supplements, herbs, and probiotics; mind and body medicine, such as meditation, yoga, acupuncture, breathing techniques, guided imagery, hypnotherapy, qigong, tai chi, Feldenkrais method, Alexander technique, and pilates; manipulative and body-based practices, such as chiropractic, and osteopathic, practices, as well as massage therapy and rolfing structural integration; energy therapies, such as healing touch, reiki, magnet therapy, and light therapy; and whole systems of integral theory such as ayurvedic medicine, traditional Chinese medicine, homeopathy, and naturopathy (2011).

Because many mental and physical health issues within LGBTQ populations stem from oppression and the lack of positive connection with the self, family and community, these populations could significantly benefit from integral health care modalities which aim to strengthen such connections. Moreover, alternative health care modalities such as massage, imagery, and meditation have been shown to reduce mental health symptoms within the general population, which LGBTQ clients are at a higher risk for, such as - stress, anxiety and depression (Campbell & Moore, 2004; McCann, 2009; Miller, Fletcher & Kabat-Zinn, 1998; Smith, Sullivan, & Baxter, 2010; Watanabe, Fukuda, Hara, Maeda, Ohira, & Shirakawa, 2006). Additionally, according

to Proulx (2008), meditation also has potential to affect other factors relevant to LGBTQ populations including self-awareness, self-esteem, interpersonal effectiveness, coping and problem solving. A study done by Russinova, Wewiorski, and Cash (2002) yielded results that support these ideas. It was shown that religious/spiritual activities, meditation, massage, and yoga all facilitate improvements in physical, social and emotional functioning (Russinova, Wewiorski, & Cash, 2002).

LGBTQ clients might be better served through the use of the integral paradigm because it assesses a person through many perspectives, resulting in a fuller picture – rather than fragmented pieces (Howard, 2003; Schlitz, 2005). The result of assessing a client through the integral model is a view that includes the bio-psycho-social-emotional-spiritual state of the client, their physical environment, and the bio-psycho-social-emotional-spiritual state of the larger community, city, state, and national environment (Schlitz, 2005). LGBTQ clients may not be best treated solely through the medical model's symptomology focus, but rather, through a more comprehensive integral approach which includes a combination of alternative health care, mental health support, biomedical health care and advocacy.

Research Question

A review of the literature shows that LGBTQ populations are at a higher risk for stress resulting from oppression, discrimination, marginalization, and stigmatization. This stress, consequently, creates a greater likelihood for members of the LGBTQ community to develop physical and mental illness. In addition, because of the mental and physical health issues LGBTQ populations encounter due to systemic oppression, it is important for them to have access to health care services, especially preventative

care; however, due to perceptions of health care professionals, lack of understanding, and a gender and heterosexual biased health care model, barriers may exist for such services within the traditional medical model systems. There is a lack of research on how well alternative health care modalities meet the unique needs of LGBTQ populations; therefore, the current research question proposed asks: What are the effects of integral health care modalities within LGBTQ populations?

Conceptual Framework

This research is exploratory in nature, and its aim is to gather information about the effects of integral health care services when used within LGBTQ populations. Descriptive information about what modalities are used and the frequency of use will be gathered by anonymously surveying LGBTQ people within the general population. Additionally, more in-depth information about the link between LGBTQ oppression, mental health, physical health and integral health care services will be gathered by interviewing two practitioners who employ integral modalities with LGBTQ clients. This research is important because it can inform social workers about the importance of integral services, and increase referral practice when necessary, not only within LGBTQ populations, but within all oppressed populations. By understanding where oppression comes from and how it affects the body as well as the mind, therapists and practitioners will be better equipped to provide services that wholly support wellbeing. Because the nature of oppression extends from macro to micro entities through both occurrence and effect, integral health theory heavily informs this research. Additionally, because integral health operates under the assumption that the body and mind interact and

experience as one entity, somatic theory is the other prominent concept that guides this research.

Integral Health Theory

Integral health theory is a mode of extended understanding of health and illness, best illustrated through Ken Wilber’s Four-Quadrant Integral Model.

<p>Upper Left (Interior-Individual)</p> <ul style="list-style-type: none"> • Feelings • Meanings • Concepts • Beliefs 	<p>Upper Right (Exterior-Individual)</p> <ul style="list-style-type: none"> • Organs • Tissues • Cells • Behavior
<p>Lower Left (Interior-Collective)</p> <ul style="list-style-type: none"> • Shared meanings • Cultural beliefs • Shared worldviews • Value subcultures 	<p>Lower Right (Exterior-Collective)</p> <ul style="list-style-type: none"> • Social structures • Families, tribes • Ecosystems • Communities

Figure 1. Wilber’s Four-Quadrant Integral Model (Astin & Astin, 2005, p.23)

Wilber’s four-quadrant integral model serves as an excellent map to investigate all realms which contribute to states of illness, health, and wellness (Astin & Astin, 2005). This incredibly comprehensive model includes four aspects: the interior-individual (subjective), exterior-individual (objective), interior-collective (intersubjectivity), and exterior-collective (interobjectivity). The interior of the individual includes an abstract component as it explores personal beliefs, feelings, values, and meanings that affect the health of an individual. The exterior of the individual includes a more scientific component as it is comprised of cells, tissues, bones, organs, and behavior. This exterior-individual quadrant is currently the most relied upon in addressing mental and physical health issues. The interior-collective component describes how the community an individual resides in can affect their health through abstract ideas, such as: shared

world views, cultural beliefs, and inherent meanings. The exterior-collective quadrant also explains the environmental impact on health and wellness; however, it addresses the impact of the concrete, such as: social structures, families, physical environment, government legislation and communities. Although these quadrants are separated on a chart, they are all constantly affecting each other, hence the name “Integral Model.”

This theoretical model was chosen to inform the research on the role of integral health modalities within LGBTQ populations because its broadness addresses the effects of oppression in a comprehensive way. Integral health theory is similar to the ecological, systems and person-in-environment theories of social work; however, integral theory provides a truly comprehensive view of the ways in which health and illness can be defined. Social workers are traditionally concerned with the mental health of an individual, and while they are trained to take a systematic approach when addressing mental illness, integral theory incorporates this and goes one step further with its focus on the connections between systems and disciplines. By observing the four quadrants in Wilber’s model, it is possible to achieve a greater understanding of all the possible components contributing to physical and mental illness within LGBTQ populations – for example, the subjective quadrant could outline negative feelings about oneself or internalized homonegativity; the objective quadrant could outline anxiety and physical disturbances due to somatic experiencing; the intersubjective quadrant could outline a cultural homophobic environment; and the interobjective quadrant could outline the legislation which puts sexual minorities at a disadvantage in society. By outlining all potential components of all four quadrants, it becomes easy to see that

none of these components can be fully understood when looked at individually. Deep understanding can only emerge through an integral perspective.

Somatic Theory

Somatic theory is based on the idea that our body and mind interact as one; therefore, illnesses cannot be separated and viewed as either purely physical or mental. This concept is explained by Pert, Dreher and Ruff in their discussion on the psychosomatic network (2005). Neuropeptides and neuropeptide receptors are used to explain the mind-body connection. Neuropeptides, are chains of amino acids that carry information throughout the body. Research has shown that about 70 to 80 specific neuropeptides can be classified as “the biochemical substrates of emotion” (Pert, Dreher, & Ruff, 2005). Neuropeptide receptors, then, can be thought of as the nodes at which emotions are transmitted and received. Because neuropeptide receptors have been found in areas all over the body, including the brain, it has been assumed that emotions and traumatic experiences such as oppression can cause mental and physical illness.

Somatic theory was chosen to inform this research because it underlines the importance in considering physical health when serving a client who has experienced oppression. The effects of oppression on mental health within LGBTQ populations has been explored in the past, but studies have failed to connect oppression and mental health with the physical wellbeing of a client. Currently, medical institutions focus on physical health and social work practice focuses on mental health; however, this paper is written under the assumption that until physical health is viewed and treated within the context of Integral health theory (connecting physical health with mental health)

comprehensive and sustainable wellbeing cannot be attained. The bridge between mental and physical health is where integral health modalities may make the intended impact of comprehensive wellbeing.

Methods

Research Design

The research question, “What are the effects of integral health care modalities within LGBTQ populations?” has not yet been explored by past studies; therefore, exploratory and descriptive research was conducted through this cross-sectional study. The research was carried out by employing mixed methods: qualitative interviews, and surveys with both qualitative and quantitative measurements. The interviews were designed to be qualitative in order to get an in-depth look at the ways in which LGBTQ clients present mental and physical health concerns. Additionally, the interview provided insight on how LGBTQ clients respond to integral health modalities. The surveys were designed to be quantitative in order to gather descriptive data, which would provide information about the health of the respondents and the rate at which LGBTQ populations use integral health modalities, as well as which modalities they choose. The survey also included one qualitative measurement, intended to explore the benefits perceived from integral modality usage.

Sample

Interviewees. In order to obtain data for this study a nonprobability convenience sample was used by contacting multiple holistic practitioners who have extensive experience working with LGBTQ identified clients. I obtained possible interview participants through recommendations from knowledgeable community members and

contacted them through email. Of the potential participants contacted, the first two that responded and agreed to participate were selected to interview.

Survey Participants. Another sample of 63 LGBTQ identifying people were obtained by convenience and snowball sampling strategies for the online survey portion of this study. The participants obtained for this study were not necessarily LGBTQ clients, rather they were any person within the general population who identified as LGBTQ, had a willingness to complete an online survey, and had access to the internet. Because the survey was distributed through social media, the respondents could be from any location, including the possibility of other countries; although, it is probable that the majority of respondents lived in Minnesota, particularly the Minneapolis, St. Paul metro area.

Protection of Human Subjects

Interviewees. The two interviewees were recruited through the researcher's previous knowledgebase, and by referrals from the researcher's committee members. The potential participants were contacted by email, in order to inform them of the aim of my research, and inquire whether they were interested in participating. These participants were not a vulnerable population because they were practitioners, rather than clients. To ensure the safety of potential participants they were informed of the voluntary and confidential nature of the study. They were also reassured that their participation would not affect their current or future relationship with the University of St. Thomas or St. Catherine University.

Prior to the two interviews, the selected interviewees were each given a letter of informed consent to review and sign with the researcher before the data collection

began. The consent form was approved by the St. Catherine University Institutional Review Board (IRB) (See Appendix A). The consent form outlined the purpose of the study, and all the protective measures that would be taken to keep the respondent from potential harm. Some of the protective measures included anonymity, confidentiality, nonthreatening questions, and the choice to back out of the research process at any time. Additionally, the interviewees had the opportunity to choose the interview time and place. The interviews were audio recorded; however, the consent form outlined procedures that would be taken to destroy the audio data upon completion of the assignment. Further confidentiality measures were ensured by deleting any identifying information from the transcript, and keeping the audio data and notes locked within a file cabinet in the researcher's home.

Survey Participants. The survey participants were recruited through email and social networking websites. Messages and emails were sent out to potential volunteers, asking for anyone identifying as LGBTQ to consider taking a "health and wellness" survey. A link to the Qualtrics survey was included, as well as a suggestion to forward the message to anyone that might be willing to participate in the survey. The participants were not necessarily a vulnerable population because the intent of recruiting participants for this survey was not to contact LGBTQ clients, but rather LGBTQ identifying people within the general population. The researcher had no way of knowing who clicked on the link and who did not. Moreover, no identifying information was asked within the survey; therefore, anonymity and confidentiality were ensured. Additionally, due to the nature of online surveys, participation was completely voluntary and the process could have been exited at any time by closing the webpage.

When the participants clicked on the Qualtrics link, they were first directed to a page that contained an online version of the consent form (See Appendix B), which informed them of the nature of the study and outlined all the protective measures that would be taken to keep the respondent from potential harm. Some of the protective measures included anonymity, confidentiality, nonthreatening questions, and the choice to back out of the research process at any time. Upon agreeing to the consent form, the participant was directed to begin the survey.

Data Collection (Instrument and Process)

Interviews. Data collection was conducted through two semi-structured interviews, each lasting approximately 45 to 60 minutes. The interviews were held in a quiet confidential area, and they were audio recorded for the ease of transcription. Prior to the interviews, a list of 16 open-ended questions was developed by the researcher, based on both a review of the literature and the lack of information found within the current literature (See Appendix C). The quality and content of these questions were approved by the researcher's committee chair member. Furthermore, the validity of these questions was ensured through the clear and direct way in which the questions were worded and asked.

The interview questions explored the issues experienced by LGBTQ populations, the effect oppression can have on physical and mental health within LGBTQ populations, the role and effects of alternative health care within this population, and the interviewee's background and field experience. The questions were organized from simple to complex. In order to ease into the subject of research, the first question asked the interviewee to describe their journey to becoming a holistic

practitioner. The second question inquired about the practitioner's experience working with LGBTQ populations, and the third question inquired about more specific demographics of their LGBTQ client base, such as typical age, gender and sexual orientation. The fourth question explored special considerations for practitioners working with LGBTQ clients. The fifth question asked for a description of the oppression LGBTQ populations experience, and the sixth question asked about how this oppression can affect the physical and mental health of LGBTQ populations. Question seven explored psychosocial, biological, emotional and spiritual issues that may affect LGBTQ populations more prevalently than heterosexual populations. Question eight and nine asked why LGBTQ clients have sought out alternative treatments, and what modalities the interviewee has specifically practiced within this population. Question ten explored the positive and negative outcomes of the interviewee's interventions. Question eleven explored the differences between client experiences within alternative health care approaches and more traditional allopathic and psychological approaches. In order to ensure a discussion about possible oppression-related physical symptoms experienced by LGBTQ populations, question twelve inquired about a concept previously explored in question seven. Question thirteen asked for a possible validation of previous research, which has indicated that LGBTQ populations experience higher rates of mental illness than heterosexual populations, due to increased stress. Question fourteen explored the topic of how oppression can affect the body, specifically within LGBTQ populations. Question fifteen asked the interviewee to express their opinion about what the best combination of health care interventions seem to be and why. The

last question re-explored the benefits of alternative health care modalities when used or practiced by LGBTQ populations.

Surveys. Data was collected from 63 respondents, through a semi-structured, qualitative and quantitative online survey. The survey was facilitated through Qualtrics, an online survey software program, affiliated with the University of St. Thomas. The survey was developed by the researcher, and it included ten questions, nine of which were closed-ended and one that was open-ended (See Appendix D). Questions one through three measured demographics, including the respondent's age, gender, and sexual preference. Questions four through seven employed a 5-point Likert scale to measure the respondent's health, including physical, mental, spiritual, and overall health. Question eight measured the frequency at which the respondent participated in alternative health care practices, including ("never") as a possible answer. Question nine measured which types of alternative practices were being used. Finally, Question ten was open-ended and asked the respondents to describe the perceived benefits of engaging in alternative health care practices.

Data Analysis Plan

Interview analysis. An analysis of the interview transcript was completed by conducting a content analysis, which is a qualitative coding strategy. This strategy was completed through a systematic examination and interpretation of the data in order to identify categories, themes and corresponding codes (Berg, 2009). Inductive grounded theory was used to examine the data; therefore, the data was analyzed at the micro level, through the exact words and language within the transcript. The findings were then generalized to form larger concepts (Berg, 2009). The first step in data analysis was to

go through the transcript line by line and generate codes for every minute idea within the data – this is called open coding (Berg, 2009). After the open coding process, similarities and differences were noted and patterns for categories and themes emerged. If a code was found three or more times, it was classified as a theme.

In order to enhance the reliability of the data analysis, my research chair reviewed my content analysis and provided feedback. The research chair did not have access to the identity of the interviewees, as the transcript was made anonymous to ensure confidentiality. The categories, themes and codes discussed between my research chair and I were taken into consideration when finalizing the list of themes found through the content analysis. Reliability was supported through this process because a similar consensus was reached by both parties, in terms of which themes should be included and which should be collapsed and/or reframed.

Survey analysis. SPSS was used to run statistics gathered from the information provided by the surveys. Qualtrics, the online survey software, automatically recorded the data in SPSS, and the researcher then ran descriptive and inferential tests with selected data sets.

Descriptive statistics. In order to be knowledgeable about the sample characteristics, descriptive statistics were compiled through SPSS for age, gender, sexual orientation, frequency of engagement in alternative health practices, and level of health, including overall, physical, spiritual and mental. In addition, data was compiled concerning the types of modalities respondents used. Age characteristics of the sample were identified by conducting a frequency distribution for survey item (1). This variable was ordinal and operationalized by the item: “Age.” The responses were (“17

and younger”), (“18-22”), (“23-29”), (“30-39”), (“40-49”), (“50-59”), (“60-69”), and (“70 and older”). The research question for this study was: What are the respondents’ age characteristics?

Gender characteristics of the sample were identified by conducting a frequency distribution for survey item (2). This variable was nominal and operationalized by the item: “Gender.” The responses were (“Female”), (“Male”), (“Transgender”), (“Gender Queer”), and (“Other, (Please Specify)”). The research question for this study was: How many respondents identify as female, male, transgender, gender queer, and other?

Sexual preference characteristics of the sample were identified by conducting a frequency distribution for survey item (3). This variable was nominal and operationalized by the item: “Sexual Preference.” The responses were (“Lesbian”), (“Gay”), (“Bisexual”), (“Queer”), (“Heterosexual”), and (“Other (Please Specify)”). The research question for this study was: How many respondents identify as lesbian, gay, bisexual, queer, heterosexual, and other? The results are shown in a bar chart.

The respondents’ level of health was measured by conducting a frequency distribution and running measures of central tendency, including median and mode for survey items (4-7). These variables were ordinal and operationalized by the items: “Please rate: Your overall health; your physical (medical health); your spiritual health; and your mental health.” The responses included (“Very Unhealthy or Ill”), (“Unhealthy”), (“Could be Better, Could be Worse”), (“Healthy”), and (“Very Healthy”). These responses were arranged on a 5-point Likert scale. The research question for this study was: What are the levels of health (overall, physical, spiritual and mental) within the sample? The results are shown in corresponding histograms.

The rate at which respondents engage in alternative practices was measured by conducting a frequency distribution and running measures of central tendency, including median and mode for survey item (8). This variable was ordinal and operationalized by the item: “How often, if ever, do you use alternative health practices or interventions to support your wellbeing, such as: natural products, supplements, herbal remedies, yoga, meditation, massage, acupuncture, chiropractics, naturopathy, homeopathy, Ayurvedic medicine, Chinese medicine, energy therapies, tai chi, qigong, and creative arts?.” The responses included (“Never”), (“Rarely”), (“Sometimes”), (“Frequently”), and (“Every Day”). These responses were arranged on a 5-point Likert scale. The research question for this study was: How often do respondents engage in alternative health practices? The results are shown in a histogram.

The types of modalities used were identified by conducting a frequency distribution for survey item (9). This variable was nominal and operationalized by the item: “If you have participated in alternative health practices, indicate which ones you have experienced.” The responses were (“Supplements”), (“Herbal Remedies”), (“Yoga”), (“Meditation”), (“Guided Imagery”), (“Massage”), (“Acupuncture”), (“Tai Chi”), (“Qigong”), (“Reiki”), (“Healing Touch”), (“Light Therapy”), (“Magnet Therapy”), (“Hypnotic Therapy”), (“Chiropractic Services”), (“Naturopathy”), (“Homeopathy”), (“Ayurvedic Medicine”), (“Chinese Medicine”), (“Creative Arts”), and (“Other (please specify)”). The research question for this study was: What types of alternative modalities have the respondents experienced? The results are shown in a bar chart.

Association. Seven different chi-square tests were run to check for associations between data. Four chi-squares were run between respondents' self-reported health status and frequency of engagement in alternative health practices. The same independent variable was used for all four tests - frequency of alternative practice, which was operationalized by survey item (8): "How often, if ever, do you use alternative health practices or interventions to support your wellbeing, such as: natural products, supplements, herbal remedies, yoga, meditation, massage, acupuncture, chiropractics, naturopathy, homeopathy, ayurvedic medicine, Chinese medicine, energy therapies, tai chi, qigong, and creative arts?." The responses included ("Never"), ("Rarely"), ("Sometimes"), ("Frequently"), and ("Every Day") and they were arranged on a 5-point Likert scale; however, for the purpose of this test the responses were recoded so that there were three categories. The response ("Never") and ("Rarely") were combined and recoded as (1), ("Sometimes") was recoded as (2), and responses ("Frequently") and ("Every Day") were combined and recoded as (3). The responses indicating level of health, items (4-7), were also recoded for all of the chi-square tests. Responses ("Very Ill or Unhealthy") and ("Unhealthy") were combined and recoded as (1), ("Could be better, could be worse") was recoded as (2), and ("Healthy") and ("Very Healthy") were combined and recoded as (3).

The dependent variable for the first test, overall health, was operationalized by survey item (4): "Please rate your overall health." Responses ranged from ("Very Unhealthy or Ill") to ("Very Healthy") on a 5-point Likert scale. The research question for this study was: Is there an association between respondents' frequency of alternative health engagement and the overall health of the respondents? The hypothesis was:

There is an association between respondents' frequency of alternative health engagement and the overall health of the respondents. The null hypothesis was: There is not an association between respondents' frequency of alternative health engagement and the overall health of the respondents.

The dependent variable for the second test, physical health, was operationalized by survey item (5): "Please rate your physical (medical) health." Responses ranged from ("Very Unhealthy or Ill") to ("Very Healthy") on a 5-point Likert scale. The research question for this study was: Is there an association between respondents' frequency of alternative health engagement and the physical health of the respondents. The hypothesis was: There is an association between respondents' frequency of alternative health engagement and the physical health of the respondents. The null hypothesis was: There is not an association between respondents' frequency of alternative health engagement and the physical health of the respondents.

The dependent variable for the third test, spiritual health, was operationalized by survey item (6): "Please rate your spiritual health." Responses ranged from ("Very Unhealthy or Ill") to ("Very Healthy") on a 5-point Likert scale. The research question for this study was: Is there an association between respondents' frequency of alternative health engagement and the spiritual health of the respondents. The hypothesis was: There is an association between respondents' frequency of alternative health engagement and the spiritual health of the respondents. The null hypothesis was: There is not an association between respondents' frequency of alternative health engagement and the spiritual health of the respondents.

The dependent variable for the fourth test, mental health, was operationalized by survey item (7): “Please rate your mental health.” Responses ranged from (“Very Unhealthy or Ill”) to (“Very Healthy”) on a 5-point Likert scale. The research question for this study was: Is there an association between respondents’ frequency of alternative health engagement and the mental health of the respondents. The hypothesis was: There is an association between respondents’ frequency of alternative health engagement and the mental health of the respondents. The null hypothesis was: There is not an association between respondents’ frequency of alternative health engagement and the mental health of the respondents.

The association between two ordinal variables, respondents’ self-reported physical health and mental health was tested. The independent variable, mental health, was operationalized by survey item (7): “Please rate your mental health.” The dependent variable, physical health, was operationalized by survey item (5): “Please rate your physical (medical) health.” Both of these variables had the same recoded response options that ranged from (“Very Unhealthy or Ill”) to (“Very Healthy”) on a 5-point Likert scale. The research question for this study was: Is there an association between respondents’ mental and physical health? The hypothesis was: There is an association between respondents’ mental and physical health. The null hypothesis was: there is not an association between respondents’ mental and physical health.

The association between two ordinal variables, respondents’ self-reported spiritual health and mental health was tested. The independent variable, spiritual health, was operationalized by survey item (6): “Please rate your spiritual health.” The dependent variable, mental health, was operationalized by survey item (7): “Please rate

your mental health.” Both of these variables had the same recoded response options that ranged from (“Very Unhealthy or Ill”) to (“Very Healthy”) on a 5-point Likert scale. The research question for this study was: Is there an association between respondents’ spiritual and mental health? The hypothesis was: There is an association between respondents’ spiritual and mental health. The null hypothesis was: there is not an association between respondents’ spiritual and mental health.

The association between two ordinal variables, respondents’ self-reported spiritual health and physical health was tested. The independent variable, spiritual health, was operationalized by survey item (6): “Please rate your spiritual health.” The dependent variable, physical health, was operationalized by survey item (5): “Please rate your physical health.” Both of these variables had the same recoded response options that ranged from (“Very Unhealthy or Ill”) to (“Very Healthy”) on a 5-point Likert scale. The research question for this study was: Is there an association between respondents’ spiritual and physical health? The hypothesis was: There is an association between respondents’ spiritual and physical health. The null hypothesis was: there is not an association between respondents’ spiritual and physical health.

Qualitative analysis. A qualitative analysis was conducted through gathering the respondents’ answers to survey item (10): “If you participate in any of the above alternative health practices, please describe the benefits you perceive from such activities.” Similarly to the interview data, a content analysis was conducted through coding strategy. First, the data was systematically examined, and categories were then identified. Next, themes and corresponding codes were identified. Using inductive

grounded theory, the researcher processed the respondents' responses and formed general concepts and themes through observed patterns within the findings.

Findings

Interviews: Qualitative Analysis

Two interviews were conducted with holistic practitioners that had experience working with LGBTQ identifying clients. It was the researcher's intent to gather practitioners with different modality emphasis; however, both of the participants were holistic chiropractors. While they share the same type of career, they demonstrated to some degree different approaches and opinions, as well as experience with differing populations, which has enriched the content of these findings. For confidentiality reasons, pseudonyms were given to the two interviewees.

The first interviewee, Sam, did not disclose their gender or sexual preference. The researcher did not ask for this information, and does not wish to make assumptions concerning gender or sexual orientation. They seemed to have a deep understanding of the challenges and oppressive experience that LGBTQ populations face, yet also spoke of hope and the potential for recovery from these experiences. This interviewee reported to have experience working with youth and young adults, mainly ages 18 to 23 who identify as trans males and gender queer. They estimated that their LGBTQ client base was about 75 percent "trans guys" and 25 percent "gender queer" individuals. The second interviewee, Amy, disclosed that she was a lesbian, and seemed to have a much different personal outlook on the LGBTQ experience. She mentioned many times, her surprise when she remembered that many LBGTQ identifying individuals have struggles related to their sexual orientation and/or gender affiliation. As a confident

person, successful business owner, mother, and partner, she identified that she may live in a bubble where she does not experience blatant oppression, but acknowledged that many of her clients remind her that oppression within the LGBTQ population still exists. She reported that her client base is predominantly women, ages 30 to 60, and about 20 percent of her clients identify as LGBTQ.

Through conducting a content analysis of the two interviews, seven intersecting themes began to emerge:

- 1.) LGBTQ Experience of Oppression
- 2.) Barriers to Health
- 3.) Bio-Psycho-Social Effects of Oppression within LGBTQ Community
- 4.) Holistic Perspective
- 5.) Client-Practitioner Relationship
- 6.) Multiple Avenues Towards Health
- 7.) Special Considerations for Working with Clients that Identify as LGBTQ

LGBTQ experience of oppression. Both Sam and Amy seemed to touch on how oppression causes barriers within the individual and also within the systems in which they are connected. Sam focused on the life of an LGBTQ identifying person and how is it threatened and questioned because of lack of understanding within the heteronormative world and specifically mainstream healthcare, suggesting a barrier to feeling understood and accepted. Sam specifically emphasized the difficulty of those who will never fit into the binary world we live in – transgender and gender queer individuals. Amy emphasized fear and oppression in the form of being closeted, specifically at work in the professional world.

Being closeted at work, suggests an exterior barrier and an interior barrier within the individual to express themselves, and the fear of doing so indicates a possible barrier to acceptance within their work system. Additionally, Amy mentioned the emotional battery and loss of familial support this population faces. The overall concept within this theme is fear and a lack of perceived and/or actual acceptance and understanding within the general community.

Sam. The following quote discusses how difficulties or barriers can arise when one is not accepted or understood by mainstream society.

...watching someone who has been marginalized, looking for care, who has realized that they don't want to go to mainstream because they're not accepted, because their gender is questioned, there's so many barriers to receiving that care.

The next quote takes the idea of being threatened and goes further by explaining that for transgender people, this experience can be even more acute, because if they do not “pass” as their gender within society, this sets them up for even more notice of being different, and therefore more readily apt to experience oppression.

...a person is stared at, questioned, their life is threatened... for your very life to be threatened, is oppression, and people as LGBT, and I have to say, specifically, the T experience that every day, unless you “pass” in the eyes of what the heteronormative community thinks... in the binary world, they are really ostracized because you're different...

This next quote connects to the previous one, in that Sam goes into a more deep conversation about binary gender norms and the prolonged anxiety and/or exacerbated symptoms of oppression this binary creates. Sam explains that these negative symptoms of oppression will continue to manifest until these issues are politically addressed.

...there's a part that for the trans community always will be different from the non-trans community because they do not fit in the binary, what it is to be a man and a woman. And queer gender community will never fit, so their issues are going to be completely... there might be anxiety, but it's going to come from a different source and they're going to stay with the anxiety a lot longer because until those bigger political things change and the way people view people differently, that's when it's going to change...

Amy. Conversely, Amy approached the idea of oppression from a different perspective. She identified that she is often taken aback upon meeting LGBTQ people and re-realizes that oppression still exists within this community. She attributes this to her own life, where she is open, and successful, in terms of owning a business, having a partner and two children, and a circle of wonderful friends. She personally feels very safe, but acknowledges within the next two quotes that oppression can be seen when people chose to stay closeted within the corporate world.

...but then I'm often surprised to find how much some people might be closeted because they're in the ummm, you know, corporate world, and I find it shocking.

...I do get people that come in who are afraid to come out at work...

Amy also discusses the lack of family support this population can experience and links it to a way this population experiences oppression.

...their families disown them, and they just don't have family support

This last quote gives examples of a couple of the consequences created through oppression, including emotional battery and creating walls, which is similar to creating barriers for oneself.

I mean it is an emotionally battered population and you can see that because they have their walls up...

Barriers to health. Both Sam and Amy emphasized the lack of familial and/or general support, which causes a barrier to health through prolonging the recovery time

of an individual. Sam mentioned that people who do experience a high level of support, recover much faster than those that do not. Additionally, they mentioned that LGBTQ clients sometimes experience barriers because they are marginalized in jobs, which leads to lack of financial security, access to food, insurance, and healthcare – mainstream and alternative. Amy discussed very different aspects of barriers, emphasizing the tangled emotional and physical issues these populations experience - frequently referring to LGBTQ clients who identify with their illnesses, because of fear and an unwillingness to explore and express themselves. Without naming it, Amy discusses resistance as a barrier throughout her interview.

Sam. Sam discusses access to food as a barrier for the client, which also acts as a barrier to the successful outcome of their services.

So, I think, I mean my experience has been there are challenges because of access to food, so the experience has been challenging...

This next quote goes into more detail about how all of the barriers compound upon one another, discussing access to insurance and healthcare, which are related to a lack of money and job opportunities.

...[this population experiences barriers] through access, obtaining insurance, access to healthcare, being marginalized in jobs, so not having the money even if they don't have insurance and then to have the money to pay for a holistic practitioner.

Sam's final quote reports that people with less support experience longer recovery times, and in this case Sam is referring to LGBTQ clients.

I see [physical and psychological issues] in non-trans communities, but the way they have paths to healing – that's what's different and that's how they get better quicker, because they have the access and people are more empathetic and supportive of healing and I don't think that [access and support] happens as often in LGBTQ.

Lack of support is a concept that Amy also discusses, but Sam makes an important link here between lack of support and recovery time and Sam does not limit this to familial support, but rather any kind of support that offers empathy.

Amy. Amy discusses barriers to health in broader terms, including the idea that the LGBTQ population is a more difficult one to serve because there are so many emotional issues, which create a milieu of other physical issues. The quote below indicates that the barrier to health is not only impacting the client, but also the practitioner. It may take more than just talk therapy to get at the physical manifestations of emotional issues.

...but it is a harder population to serve because I think the emotional issues that they carry create a lot of physical problems for them, and they are a harder population to treat, they truly are.

Amy echoes Sam's statement about lack of support within the LGBTQ community; although, Sam goes a step further in discussing how much a lack of support can affect recovery time.

...their families disown them, and they just don't have family support...

This next quote illustrates what social workers might term resistance or avoidance.

Amy discusses this concept frequently throughout the interview, often connecting it to clients with chronic pain.

I mean you see a lot of chronic pain, and then they start identifying through their pain. People come in and you know that their life is about their pain and their sickness, and they don't know how to let go of that, and they don't get well because they don't know how to be otherwise – they don't know how to be in the world, so they become their illness and you know that's all emotional stuff ...and interestingly they will drop off when they think they're getting better because that's their identity...

The barrier to health identified in this quote is client resistance, which can be interpreted as a fear of expressing themselves or finding out who they are in the world, apart from their illness. It is easy to understand this as a survival mechanism – when one feels that they are not safe or that they will not be accepted for who they are, they may begin to take on a different way of identifying. Pain, being a universal concept, seems as though a logical route to gain acceptance or understanding of one's self.

Bio-psycho-social effects of oppression and stress within LGBTQ

community. Both participants responded similarly to the effects of oppression within the LGBTQ population. They discussed oppression in terms of its ability to trigger a stress response, thereby increasing cortisol levels which affect every tissue, organ and system in the body. Amy went on further to explain what happens in the body when the stress response is triggered, noting that it causes systems in the body to shut down, such as the reproductive system, digestive system, and immune function. Furthermore, the stress response causes inflammation and increased insulin, which is connected to the development of disease. Both Sam and Amy mentioned the increased level at which they see mental health issues within their clients, including anxiety, depression, addiction, alcoholism, suicide, and PTSD. Other issues were also noted within their discussion, such as chronic pain, obesity, gastrointestinal issues, allergies, migraines, and skin problems. Within previous themes of the holistic perspective and the client-practitioner relationship, the participants had mentioned treating every client as an individual and that every individual reacts to stress differently - the findings contained in this particular theme demonstrate the cyclical inner-workings of this phenomenon.

Sam. The first quote illustrates the biological affects of oppression, specifically relating to stress and the increased amount of cortisol in the body as a result of it.

...[oppression and consequential stress] produces a significant amount of cortisol and that overloads the brain, hypothalamus, pituitary, the whole HP axis, which is going to affect the adrenal glands, thyroid, pancreas - it affects everything and that continuum of interactions with hormones... there ends up being a lot of collateral damage.

The next quote discusses different symptoms of oppression-induced stress. Sam also emphasizes the prevalence of gastrointestinal problems that occur due to stress.

Oh all of those [GI issues, allergies, decreased immune function, migraines, skin conditions], all of those... stress and anxiety are, I would say 9, 9.9 out of 10 times I see that... GI issues. Whenever you have brain issues you're going to have gut issues, they go hand in hand because of serotonin, so 80% of serotonin is produced in the gut, so it it's increased because of the anxiety and there's a cortisol overload...they're all interactive...

Mental health is also affected by oppression-induced stress. Within these last two quotes, Sam mentions the mental health issues that they have seen most prevalently within the LGBTQ population.

I mean, 1 in 3 attempt suicide and 1 in 7 actually commit suicide...

...the [mental health issues] I've seen, have been depression, addiction...alcoholism, anxiety... on some level probably all of the 5 years I've been treating [LGBTQ] youth... I've experienced that mental health issues occur at a high rate.

Amy. Similar to Sam, Amy discusses the biological inner-workings of stress, and the damaging effects that can occur because of this process. The two quotes below discuss this phenomenon, along with a comment that connects this process with the occurrence of food and drug addiction.

...[oppression]is going to cause stress, and cortisol, a stress hormone, which affects every system in the body, you see it in food addictions or drug addictions,

ummm, but I would say definitely for the LGBTQ community. I would say stress is the biggest cause of disease, stress and toxins, but on the physical body, absolutely...

...if you're being threatened, you're going to have a stress reaction, so what happens with stress is cortisol comes up and then that's telling the body that you have to fight or flight... so what happens is, all necessary systems shut down - reproduction system shuts down, immune system shuts down, digestion shuts down, so that's where you get the GI effects, and all the blood is shunted to the extremities...

Amy also discussed her belief that the LGBTQ population suffers from increased rate of PTSD because of the difficulties they face..

I would say there's a lot more posttraumatic stress in the LGBTQ populations... they're just having this reaction over and over because of being triggered.

Again, similar to Sam, Amy discusses the physical and mental health symptoms that occur within the LGBTQ population because of oppression-induced stress, which include gastrointestinal issues, allergies, decreased immune function, migraines, skin conditions, obesity, chronic pain, and addictions.

Obesity is a big one... obesity, and chronic pain and addictions... I mean there's chronic pain... I mean I see it all (GI issues, allergies, decreased immune function, migraines, skin conditions)... first thing I would say is obesity and addiction.

Holistic perspective. Both interviewees emphasized that taking a holistic perspective is different than an allopathic (mainstream) approach to medicine, identifying that allopathy tends to put people “into boxes” or tends to employ quick, go-to solutions for certain issues, such as depression. Sam mentioned that a holistic approach means treating someone without separating the symptoms from the person - looking at the whole person - mind, body and spirit - stressing that there are multiple ways to treat one illness. Amy emphasized that everyone reacts differently to stress

and illness, therefore a holistic approach includes treating every client as a unique individual, with an individualized treatment plan and journey to health.

Both Sam and Amy stressed that having a holistic perspective means being mindful of the mind-body connection, recognizing that emotional traumas can manifest as physical issues – Amy specifically notes that emotional trauma can be a catalyst for disease or cancer. They both focused on the interconnectedness of health systems. Sam discussed how one’s biochemistry can be altered just by the amount of love and acceptance they experience, and Amy began a discussion about how emotions, hormones, neurotransmitters and toxicity levels are all connected and effected by each other. The mind-body connection is a concept which shapes the holistic notion that one cannot be healed by treating symptoms as if they are separate from the person.

Sam. In the first quote Sam discusses the difference between the allopathic approach to health and the holistic approach to health, pointing out that there are many ways to understand and treat an illness.

What I do is functional medicine – it’s actually looking at the whole body, the interactions that go on in the whole body, rather than separating one thing from another. So, if someone comes in to me with depression, an allopathic or psychological approach might be to use the Prozac right away or the antidepressant. I’m going to look at thyroid, adrenal glands, ummm, remove the stressors and then feed the body.

So, depression is one of those umbrella terms that can come from many sources.

The next quote illustrates the root of holistic practices – “looking at the whole picture.”

Sam likens this idea to social work’s environmental perspective.

...I’m looking at the whole picture – it’s kind of like social work, I think... social work looks at the environment, right?

The following two quotes emphasize the mind-body connection that the holistic perspective honors and explores.

Well, feelings are buried alive, not dead, so they're going to come out somehow, and in the body, it may manifest in migraines or the back or chest pain...

...there are hormones that are produced when a person is in love for who they are, oxytocin for one, that is produced in higher quantities – it's mood stabilizing, it's rejuvenating, and if a person is not loved and supported there is a decrease in the production of oxytocin, amongst other hormones...

Sam's thoughts on holistic health offer an understanding of what the word holistic entails, by describing the mind-body connection and offering a discussion about the difference between traditional allopathic health practices and holistic health practices

Amy. Similar to Sam, Amy discusses the mind-body connection, emphasizing how emotions affect physical health and how all systems in the body are affected by one another. In the two quotes below, she indicates that stress and illness manifest differently in every person; therefore, being a holistic practitioner means treating every client as an individual.

...everyone reacts a little differently to stress...

...so, depending on the history of the person and how they present, I might work with brain chemistry, and that affects the adrenal response, or I might do adrenal stuff, which affects brain chemistry, or I might do both, depending...

This next quote continues to discuss the importance of treating every client as an individual, and it also emphasizes how important this individualized approach is for healing and the client-practitioner relationship.

...it's all very individual I would say, because it's such an individual thing and that's how alternative is, you know allopathic medicine just really puts people into boxes, so you really have to take every individual as a whole, and I think that alone is – ok, you're going to be treated differently because this is your set of circumstances, and just acknowledging that is very helpful for people to move beyond it a bit because they have been frustrated for so long, and not been able to find any answers, and I think they feel heard here because they feel they're different from every other person who comes through

The following two quotes discuss the mind-body link that is understood by holistic practitioners.

...what's happening in the internal environment is often expressed on the outside of the body...

I think the emotional issues that they carry create a lot of physical problems for them...

The last quote demonstrates the complexity that is involved when practicing through a holistic lens. Amy discusses the interconnectedness of systems, and biochemical ways to understand and treat emotional issues.

...so what's your hormone, neurotransmitter, toxicity level, all of that, and this is really the emotional side, um, and you can't affect one without affecting the other and we do a lot of structure and a lot of biochemistry, this is where I am hung up (points to the emotional side.)

The knowledge provided by Sam and Amy creates a complex picture of what a holistic perspective entails. In the quotes provided, it is understood that practicing in a holistic way means understanding complexity and the interconnectedness of emotions and the physical body, and remembering that all individuals should be approached, understood, and treated as individuals.

Client-practitioner relationship. Both Sam and Amy emphasized the client-centered approach to healthcare and the importance of education, facilitated through the client-practitioner relationship. Furthermore, Sam specifically referred to the empowerment that follows from client education. They also both stressed the importance of clients being heard and understood within the client-practitioner relationship - Amy specifically referring to the increased amount of comfort LGBTQ clients experience with a holistic practitioner and/or a gay provider.

Sam. In the following quote Sam emphasizes the importance of listening to the client and meeting the client where they are. Sam also treats the client as the expert.

The most powerful [intervention for this population] would be to listen and honor their story and then meet them where they're at and let them lead the way because they know better than [we] know. They've been in their bodies.

The next two quotes discuss the importance of education within the client-practitioner relationship, and the empowerment that a client can experience through education about their health.

I'm going to educate them with, you know, food, what is this, what does it do, what doesn't it do... but if they're not ready to do that yet than we're not going to do that...

...so [a benefit of using alternative modalities] is empowerment through knowing how their body works...

Sam's last quote demonstrates his belief that responsibility and the ability to control one's health is a direct benefit of educating clients about their health.

...the mind, body, spirit – you can take the tangents of all those things, as far as empowering a person with knowledge to make different choices for themselves. To me, that's bringing the responsibility back to the person and know that they have control over what choices they make to get healthier – there are more choices than they may even know about.

Amy. The following quote demonstrates a client-centered approach, where Amy emphasizes the importance of the client feeling heard within the relationship, and how that is a part of being a holistic/alternative care provider, whereas this is not always the case for the client-practitioner relationship within an allopathic setting. When Amy refers to “being just a number,” she is referring to being treated within an allopathic setting informed by the medical model.

It's all about safety, health is about safety... also, they want to be heard and umm, so, I think it's safer and they feel like they will be heard more, instead of being just a number.

Within the next quote Amy discusses the openness and comfort within the client-practitioner relationship, while admitting that she is unsure of whether these things are inherent for a holistic/alternative practitioner, or if the openness and comfort can be attributed to identifying as a lesbian.

I think they feel comfortable coming to somebody who is a gay provider, because then their family can come in and they can be open about their life... there is a comfort about being able to be open, and I don't know if that's alternative therapy or if that's going to a gay provider.

The last quote is a phrase that again demonstrates an important aspect of the client practitioner relationship – the importance of education.

...we can educate them about it...

Multiple avenues towards health. Both Sam and Amy emphasized that their practices incorporate an in-depth look at the client including (but not limited to) biology, the nervous system, brain, and adrenal glands. They employ interventions that include dietary recommendations, supplements, hormonal adjustments, back adjustments, and other practices that change neurological responses. Sam discussed interventions that specifically support the surgical procedures that trans clients experience. Amy discussed her practice of referring clients to other modalities when she felt her chiropractic background would not wholly facilitate a client's healing journey – some of the modalities she mentioned include homeopathy, hypnosis, acupuncture, massage, Hoffman process, and traditional mental health therapy. The overarching concept within this theme underlines the idea that having a holistic perspective when practicing healthcare means that there are many ways to approach and explore one's journey toward health – in other words, there is not one right answer. Furthermore, if a

practitioner is knowledgeable about different modalities and feels comfortable referring their clients when appropriate, they may be an even more valuable resource for their clients.

Sam. The following quotes demonstrate some of the interventions that Sam uses beyond his chiropractic skills, including nutrition counseling, hormone balancing, working with adrenal glands and recommending supplements.

...a lot of stuff on nutrition, preparing for hormones, or surgery...

Well, I've done hormonal interventions, working with adrenal glands... what I do is to try to help them figure out how to support their liver and gallbladder better, which will help their hormone metabolism.

...organic whole food supplements, which helps with all of the interventions around hormone balancing, getting ready for surgery, post surgery, and the also stuff for scarring...

Amy. Amy takes a different approach with this theme, discussing, not only what she does as a chiropractor, but also other types of therapies that she refers clients to when she feels it is necessary. The following quotes mention different modalities Amy practices beyond chiropractic, often employing nutrition and supplements within her practice. These quotes also describe and/or name other modalities to which she has referred clients - acupuncture, homeopathy, hypnosis, mental health therapists. Other modalities that Amy mentioned during her interview that are not reflected by the quotes were the Hoffman process and massage therapy.

...I'm a certified clinical nutritionist as well, because I just think that's the foundation of disease.

I like homeopathy – that's something to get to the emotional considerations, but I've noticed that homeopathy is not always as powerful, because I've noticed, if we are so deficient in our nutrient status, homeopathy just doesn't work very well.

I use hypnosis - that might help for some people. I had somebody with PTSD and hypnosis was really helpful, because it's not easy to change that reaction. You can change with supplements, you can sort of change or stop it in certain places, but the reaction is still there, but you can blunt the reaction to the body by doing supplements and different things, so we do a lot...

I mean, it's very individual. I've seen some powerful things with supplements, I've seen some powerful things with hypnosis, some powerful things with certain therapists, umm, acupuncture...

The final quote for this theme is important because it names the pharmaceutical avenue toward health, but also illustrates that there is a population that does not seem to be happy with this traditional medical model approach to health.

People come in and they say, "I want to be off my meds," and they don't know all of the options...

Special considerations for working with clients that identify as LGBTQ.

Sam and Amy took different approaches to this question; although, they both briefly mentioned the importance of meeting the client where they are, which is a familiar concept within the field of social work. Sam discussed the importance of not making assumptions and making it a point to ask the clients about their gender and what pronoun they would prefer. Sam also noted that younger populations are more amenable to this question, and that asking it has the power to provide some relief to the client because it lets them know that they are in an accepting environment.

Additionally, Sam believed that being open, honest and vulnerable causes clients to feel more comfortable. Amy discussed the possibility that clients who identify as LGBTQ may be more comfortable going to a practitioner who also identifies as LGBTQ.

Furthermore, she discussed the importance of outreach activities, such as marketing one's services within LGBTQ oriented events or publications.

Sam. In the quote below Sam discusses the importance of asking transgender clients what pronoun they prefer for themselves. Sam goes on to describe the relief a client will feel when asked this question.

...the gender I do [ask them about] because I want to get the pronouns right - what pronoun do you go by? I mean you, it's actually very acceptable [to ask that] in the GLBTQ [community]... as far as the gender queer trans community. That's like breath... a breath of relief, because it's ok you want to know this... it's not an insult.

The next quote emphasizes the practitioner's responsibility to remain open and make no assumptions with the client, which in some cases means allowing oneself to be vulnerable with the client.

...making no assumptions, keeping open communications, being direct and honest, and being vulnerable within the parameters of the practitioner that you are. Being vulnerable to a degree helps a client who comes in as GLBT also be vulnerable... the more honest you are with your vulnerability... the better it's going to go, because you start with honesty.

Amy. In the quote below Amy takes a different approach to this theme, discussing her own personal account of her experience of living “on the fringe.” This quote demonstrates that not all people who identify as LGBTQ feel and experience oppression in the same way or even at all, which is important to remember when working with this population.

...so, I don't, I guess I haven't really thought about [special considerations for working with LGBTQ clients] because I just think it's the norm, until I stop and think and say, “wow, my life is really on the fringe of society (laughs)” ummm, so maybe that's comforting [for LGBTQ identifying clients] to come here..

The last quote demonstrates the power of marketing and advertising one's services within LGBTQ oriented events and publications.

...market at the PRIDE Festival... [LGBTQ clients] are much more comfortable coming to [a practitioner] who is family, basically.

Survey: Qualitative Analysis

The online survey conducted, yielded responses that complement and support the interview findings. Additionally, the results provide a more positive outlook on the health and wellbeing of the LGBTQ populations. There were four themes found through conducting a content analysis of the qualitative responses to the survey question: If you participate in any alternative health practices, do you perceive any benefits? If so, what are they? While there were 63 survey respondents, 46 chose to respond to this open-ended question.

- 1.) Mind-Body Connection
- 2.) Relaxation/Stress Relief
- 3.) Alternative to, or Relief from Pharmaceuticals
- 4.) Increased Overall Wellbeing: Energy, Balance, Mental, Physical, and Spiritual Health

Mind-body connection. The three quotes that were chosen to represent this theme demonstrate that the survey respondents felt a link between their mind and body after engaging in alternative health care modalities. This mind-body connection was referred to as a benefit of such practice. The first quote reports that mental health is connected to physical health.

I believe that a healthy mind leads to a healthy body.

The second quote discusses alternative therapies as a means to connecting the mind and body, which produces benefit for the survey respondent.

I believe they connect my body to the rest of me in a more beneficial way than traditional health practices.

The third quote implicitly seems to discuss the power of the placebo effect, as well as meditation, which seems to be a practice that is held in the mind but spread throughout the body, connecting them and making the respondent feel, “at ease.”

Supplements make me feel like I'm actively helping my body. Creative arts are a necessary outlet that I use. Tapping into my right brain is a form of meditation that leaves me feeling at ease.

Relaxation/stress relief. This theme formed because many of the qualitative responses mentioned that relaxation and stress relief were benefits that the respondents found through practicing alternative therapies. The five quotes below were chosen to represent the theme of relaxation and stress relief because they mention the modalities that were most frequently reported to cause relaxation within the qualitative responses: massage, acupuncture, Reiki, meditation, and yoga.

I always am more relaxed.

[I use] massage/acupuncture to relieve stress and feel great.

Reiki and massage have relaxed and soothed me...

Meditation and yoga provide me with relaxation and clearer thinking

I find that with regular massages, my stress level goes down. My mind and body work better.

The last quote in this theme not only discusses the ability massage has to decrease stress, but it also mentions that this practice allows the mind and body to work better, which intersects with many of the other themes.

Alternative to or relief from pharmaceuticals. This was a surprising theme that emerged from responses to the question: If you participate in any alternative health practices, do you perceive any benefits? If so, what are they? An overwhelming number of respondents commented on their distaste for pharmaceutical products, and

saw a benefit in that these products are not always necessary when one is aware of the natural alternatives that exist, and uses them appropriately. These first two quotes discuss the “crazy” side-effects that pharmaceutical medications can have, and report that there is a benefit in natural remedies because one does not have to endure these side-effects.

Overall, I feel a lot better than when I take prescription medication – [I] don't have all the side effects.

I get to heal myself naturally, no use of chemicals with crazy side effects

The next quote discusses the propensity for alternative health care practices to provide palliative care, while one is damaged or “poisoned” by taking pharmaceutical medications.

It lessens the “poisoning” of my body using pharma products...

The next quote also reports the benefit of living life without pharmaceutical products, including anti-depressants. This respondent also reported that alternative health practices and practitioners assisted them in ending their use of pharmaceuticals.

I no longer take anti-depressants because I weaned off of them with help from homeopathy and acupuncturist.

The last quote emphasizes the benefit of safety that natural supplements and practices provide, as an effective way to manage infrequent or long-term seasonal ailments, such as seasonal allergies.

Safe alternatives to infrequent ailments and seasonal ailments...

Increased overall wellbeing: energy, balance, mental, physical, and spiritual health. The quotes below contain a myriad of different ways respondents’ wellbeing is enhanced through engaging in alternative health practices. The first two quotes discuss benefits related to increased energy.

More energy after meditation and yoga. Rarely get sick.

Relaxation, energy, wellbeing, stamina, able to get a good night's rest...

The next few quotes describe benefits relating to increased sense of clarity and balance. Some of these feelings included feeling more grounded, having a clear head and heart, finding inner balance, realigning thoughts and priorities, and becoming more aware of oneself. The specific modalities that were mentioned to support the benefit of clarity and balance were meditation, art, yoga, and guided imagery. Reiki was also mentioned to support balance in a quote that was not included in this theme.

A clearer head and heart, a general feeling of wellbeing.

Meditation – done daily, reminds me of the control I have over my feelings/life.

Helps to find an inner balance, helps me realign my thinking and focus on what is important to me and within my relationship with my partner.

I feel more grounded. I have a more full sense of the world and my place within it. It sometimes provides me an outlet for stress or other strong emotions.

Guided imagery helped me to know and like myself.

The next two quotes discuss benefits of movement practices, in terms of becoming more physically fit and firming the core. One of the quotes also connects the physical exercises of tai chi and qigong to feeling calm and facilitating emotional softening.

Specifically with yoga, I believe that this particular practice allows me to physically work my core...

Tai Chi and Qi-Gong help firm up my physical core, achieve better balance, provides my body with gentle stretching and calms me emotionally, making me softer in my responses to external stimulation (noise, anger, ect.)

The next quote is very nondescript; however, it demonstrates a powerful way of knowing and feeling of wellbeing. One may not be acutely aware of what exact

biological process is going on when they are engaging in an alternative health practice, but when a practice makes the body feel noticeably better, it is a benefit.

My body feels better.

The next three quotes discuss the benefits of many modalities, including supplements, chiropractic, yoga, massage, reiki, acupuncture and herbal remedies. The benefits of some of these practices include an increased sense of wellbeing, pain relief, hormonal balance, weight management, digestive function, immune support, anxiety relief, stress relief and support for mental health.

Supplements help my mood/depression when taken regularly... Chiropractic helps pain from spinal/back injury, helps anxiety. Yoga helps everything (back pain, anxiety, stress, sense of wellbeing.) Massage helps back pain.

Acupuncture – HUGE benefits! Better sleep, digestion, energy, concentration, hormonal balance, menstrual cycle, weight management, blood sugar control. Also, overall more emotionally consistent and happy. Herbal remedies for immune support... Massage/shiatsu – stress relief.

Reiki and massage... I believe have aided my mental wellbeing

The last quote to represent this theme demonstrates an all-encompassing, integrative wellbeing by mentioning benefits that touch the physical, mental and spiritual aspects of the respondent's life.

...seeing alternative health care practitioners as needed keeps me healthy and physically active and spiritually and mentally more balanced.

Survey Respondents : Quantitative Analysis

Descriptive statistics. The first three questions of the survey asked for demographic information including age, gender and sexual orientation. The first research question measured respondents' age. Data was collected from all 63

respondents and results are shown in Figure 2. Data indicate that the majority of respondents were in their 20s, 30s and 50s.

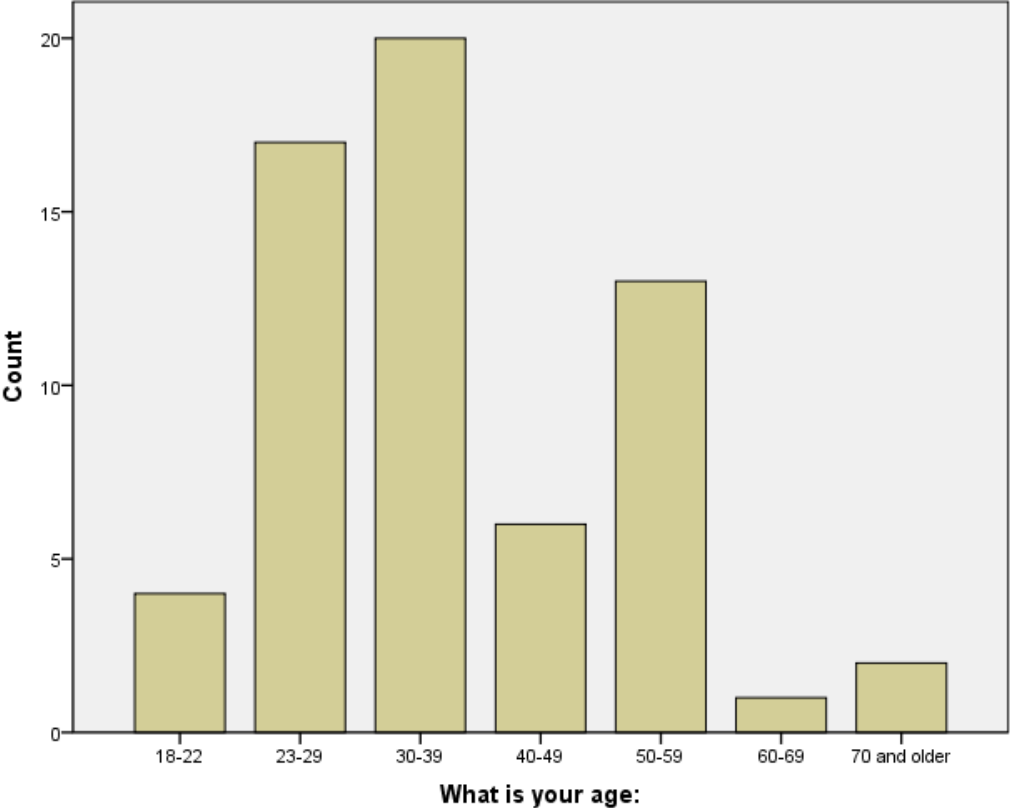


Figure 2. Age

The second research question examined the gender characteristics of the sample. Data for this question was gathered from 63 respondents. Results show that of the 63 respondents, 50 respondents (79.4%) identified as female, 11 respondents (17.5%) identified as male, 1 respondent (1.6%) identified as gender queer, and 1 respondent (1.6%) identified as “other,” specifying, “both male and transgender” in the text box. These findings show that the majority of respondents identified as female.

The third research question explored the respondents’ sexual orientation through conducting a frequency distribution and creating a bar chart (Figure 3). Data for this question was collected from all 63 respondents who participated in the survey. Results

show that of the 63 respondents, 24 respondents (38.1 %) identified as lesbian, 11 respondents (17.5%) identified as gay, 14 respondents (22.2%) identified as bisexual, 10 respondents (15.9%) identified as queer, 3 respondents (4.8%) identified as heterosexual, and 1 respondent (1.6%) identified as “other,” specifying pansexual in the test box provided.

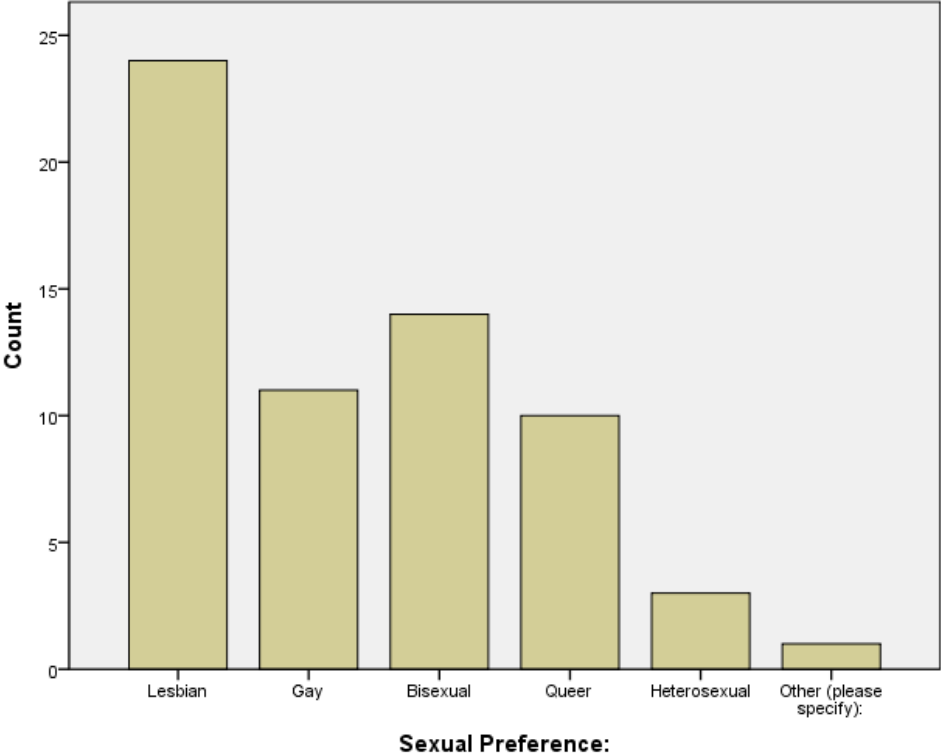


Figure 3. Sexual Orientation Distribution

Questions 4 through 7 measured the health of the respondent, including measures for overall health, physical health, spiritual health and mental health. These items were measured by conducting a frequency distribution and running measures of central tendency. The respondents were asked to rate these four aspects of health using a 5-point Likert scale. The responses included (“Very Unhealthy or Ill”),

(“Unhealthy”), (“Could be Better, Could be Worse”), (“Healthy”), and (“Very Healthy”).

Question 4 specifically measured respondents’ overall health. Of the 63 survey respondents, 61 provided data for the overall health category. The possible range of health was 1-5, and results show the minimum score selected was 2 and the maximum was 5. Additionally, of the 61 respondents, the mean was 3.89 with a standard deviation of .709. The median and mode were both 4. Results show that 3 respondents (4.8%) were unhealthy, 10 respondents (15.9%) could be better/could be worse, 39 respondents (61.9%) were healthy, and 9 respondents (14.3%) were very healthy. The histogram in Figure 4 shows that the responses were negatively skewed. These means, on average, respondents view themselves as more healthy than not.

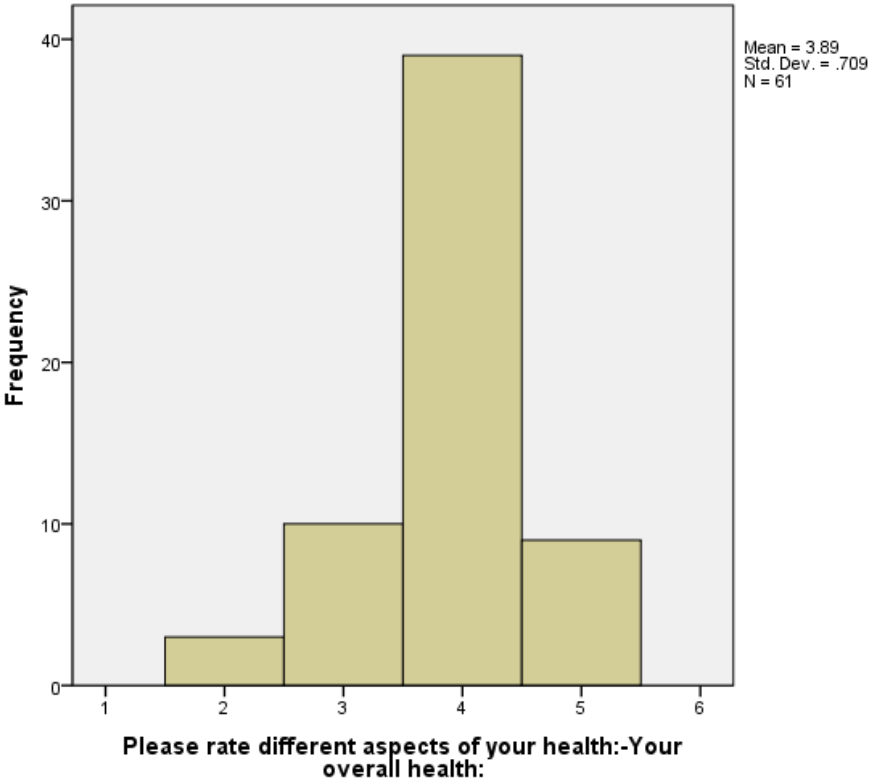


Figure 4. Overall Health

Question 5 specifically measured respondents’ physical health. Of the 63 survey respondents, 63 provided data for the physical health category. The possible range of health was 1-5, and results show the minimum score selected was 2 and the maximum was 5. Additionally, of the 63 respondents, the mean was 3.73 with a standard deviation of .865. The median and mode were both 4. Results show that 4 respondents (6.3%) were unhealthy, 22 respondents (34.9%) could be better/could be worse, 24 respondents (38.1%) were healthy, and 13 respondents (20.6%) were very healthy. The histogram in Figure 5 shows that the responses were negatively skewed. This means, on average, respondents view themselves as more physically or medically healthy than not.

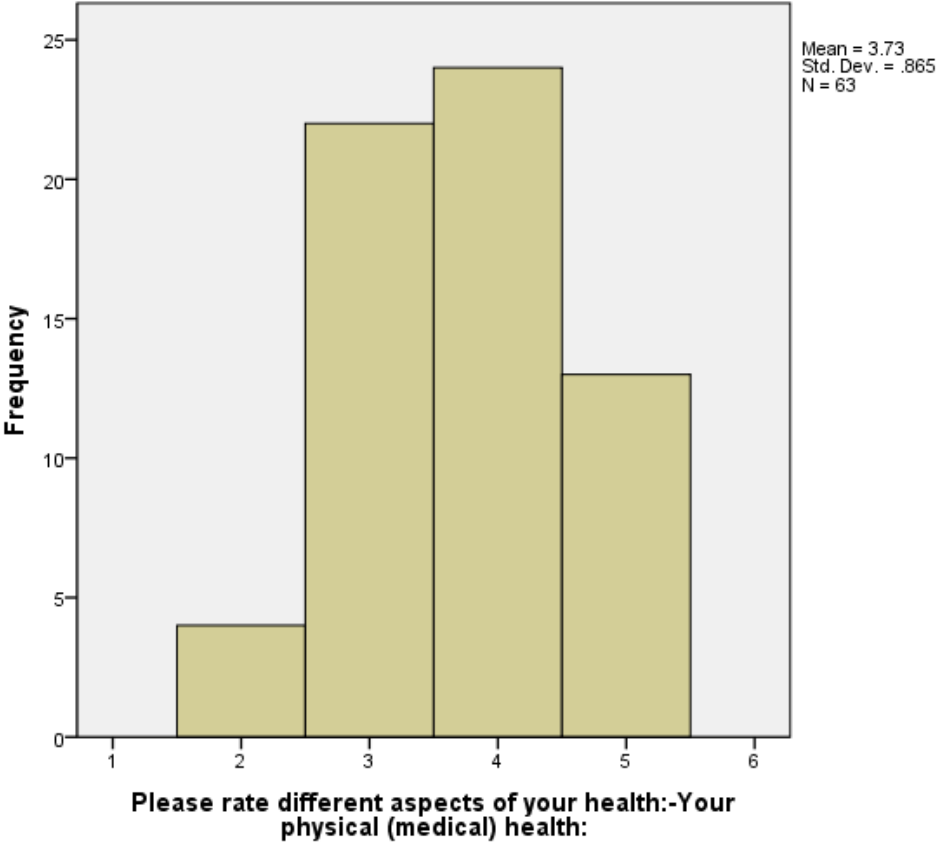


Figure 5. Physical Health

Question 6 specifically measured respondents’ spiritual health as seen in Figure 6. Of the 63 survey respondents, 62 provided data for the physical health category. The possible range of health was 1-5, and results show that the minimum score selected was 2 and the maximum was 5. Additionally, of the 62 respondents, the mean was 3.79 with a standard deviation of .771. The median and mode were both 4. Results show that 1 respondent (1.6%) was unhealthy, 23 respondents (36.5%) could be better/could be worse, 26 respondents (41.3%) were healthy, and 12 respondents (19.0%) were very healthy. This means, on average, respondents view themselves as more spiritually healthy than not.

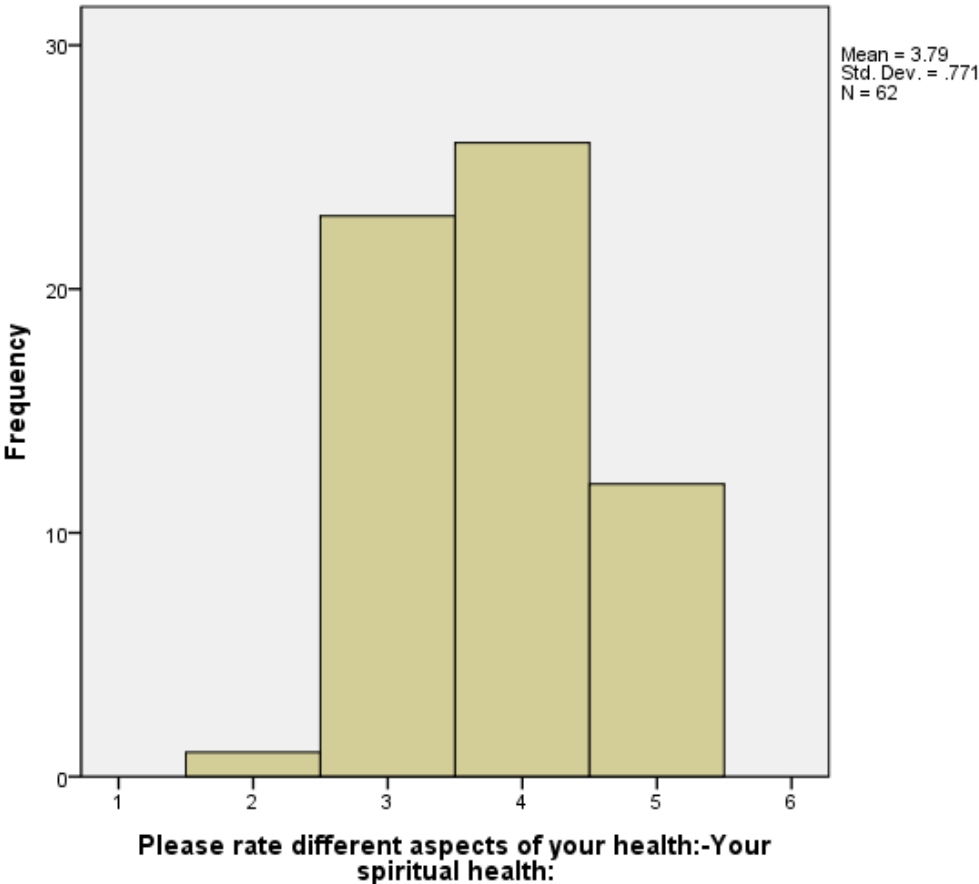


Figure 6. Spiritual Health

Question 7 specifically measured respondents’ mental health as seen in Figure 7. Of the 63 survey respondents, 63 provided data for the mental health category. The possible range of health was 1-5, and results show that the minimum score selected was 2 and the maximum was 5. Additionally, of the 63 respondents, the mean was 3.67 with a standard deviation of .803, and the median was 4. Results show that 3 respondents (4.8%) were unhealthy, 25 respondents (39.7%) could be better/could be worse, 25 respondents (39.7%) were healthy, and 10 respondents (15.9%) were very healthy. This means, on average, respondents view themselves as more mentally healthy than not, but about 40 percent saw themselves as neither healthy nor unhealthy, but in the very middle of the spectrum.

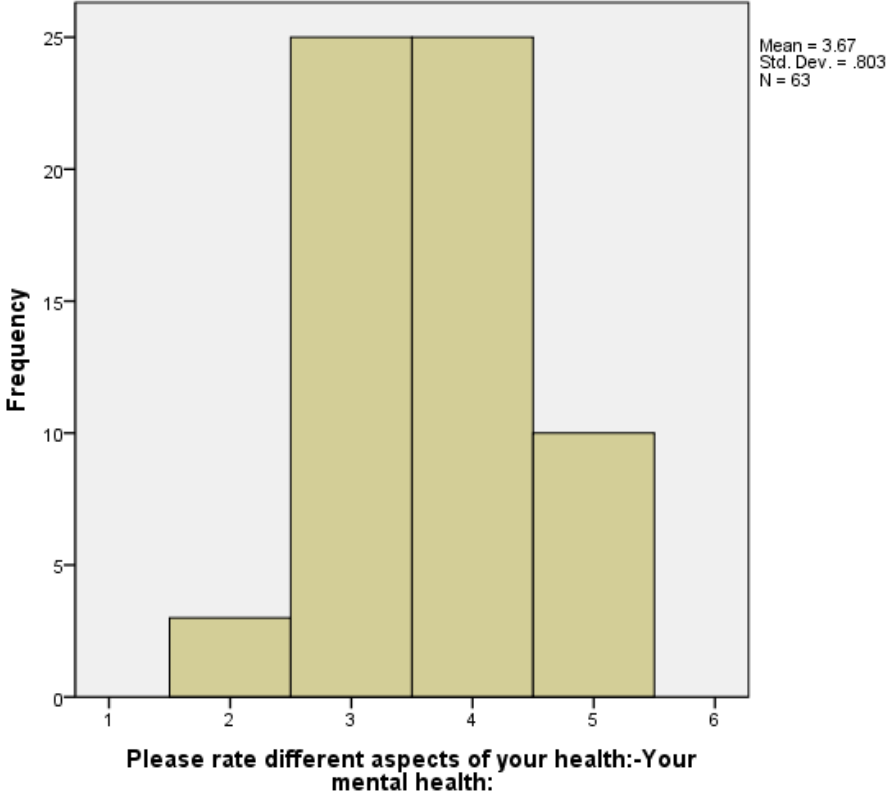


Figure 7. Mental Health

The eighth question examined the rate at which respondents engage in alternative health practices through conducting a frequency distribution and creating a histogram (Figure 8). Of the 63 respondents who participated in the survey, 62 responded to this question. Results show that 2 respondents (3.2%) reported they “Never” use alternative health practices, 8 respondents (12.7%) reported they “Rarely” use alternative health practices, 20 respondents (31.7%) reported they “Sometimes” use alternative health practices, 21 respondents (33.3%) reported they “Frequently” use alternative health practices, and 11 respondents (17.5%) reported the use alternative health practices “Every Day.” The mean was 3.5 with a standard deviation of 1, indicating that the average frequency of use was between “Sometimes” and “Frequently.” This analysis suggests that 96.8 percent of respondents engage in alternative health practices and a majority of the respondents engage in alternative health practices at frequencies ranging from “Sometimes” to “Every Day.” The histogram in Figure 8 shows that the responses are negatively skewed.

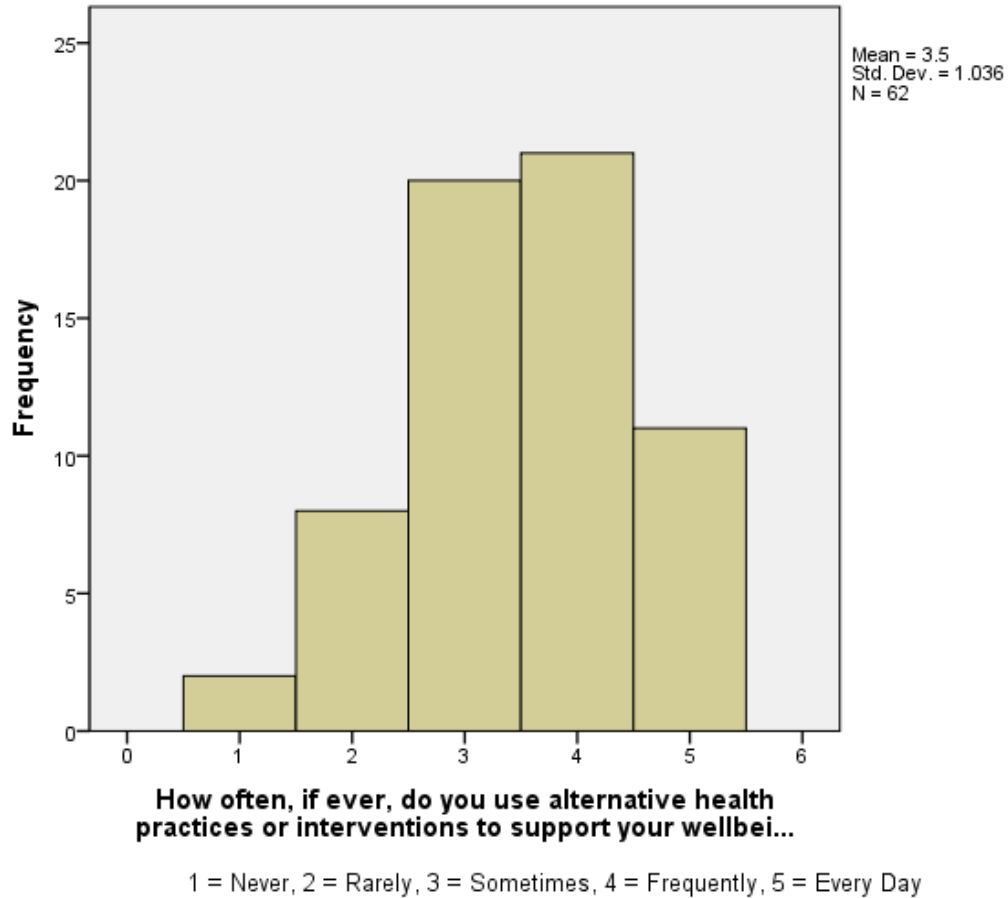


Figure 8. Frequency of Alternative Health Care Engagement

Question 9 asked respondents to indicate which types of alternative health practices they engage in, or have engaged in, and were provided with a list to choose from, and a bar chart was created to reflect this data (Figure 9). As results from question 8 show that 96.2 percent of respondents engaged in some type of alternative practice, data from question 9 provides deeper insight on which health modalities are being practiced. Results show that massage therapy (74.6%) was the most frequently used modality, taking supplements (68.3%) was the second most frequent, and both herbal remedies (60.3%) and meditation practice (60.3%) were the third most frequent modalities. The remaining modalities are listed in order of frequency: yoga (54%),

chiropractic services (46%), creative arts (38.1%), acupuncture (38.1%), guided imagery (38.1%), homeopathy (25.4%), reiki (17.5%), Chinese medicine (14.3%), tai chi (12.7%), healing touch (9.5%), qigong (7.9%), naturopathy (7.9%), light therapy (7.9%), ayurvedic medicine (6.3%), hypnotic therapy (4.7%), and magnet therapy (1.6%). There was an option to choose “other” - 3 respondents (4.7%) chose this option and listed alternative health practices: theatre, Buddhist practice, and aromatherapy.

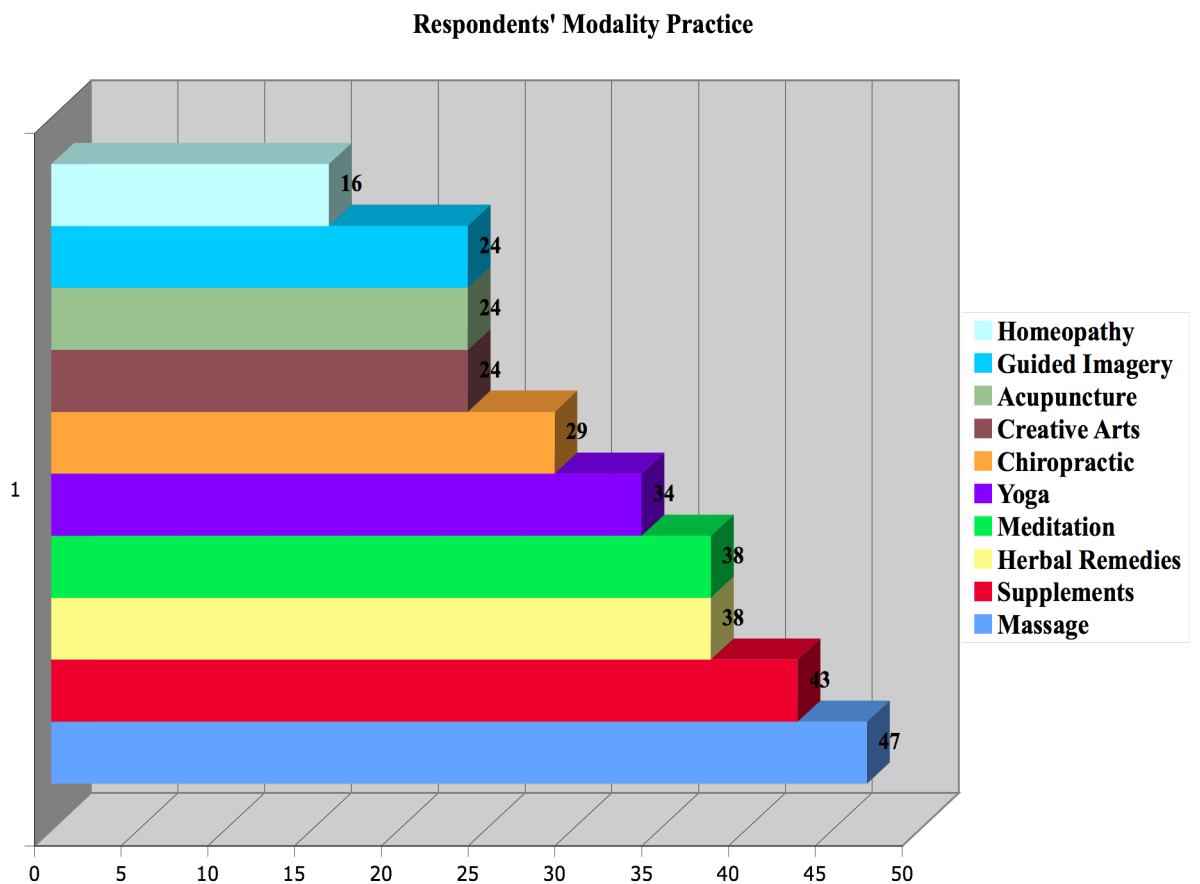


Figure 9. Engagement of Modalities

Associations. Seven different associations were explored through the use of a chi-square test. Four of these tests shared the same independent variable: frequency of alternative health engagement. The four dependent variables that were tested include

level of overall health, medical health, spiritual health and mental health. The first hypothesis was: There is an association between respondents' frequency of alternative health engagement and the overall health of the respondents. The null hypothesis was: There is not an association between respondents' frequency of alternative health engagement and the overall health of the respondents. The p-value for this chi-square for this test is .024, and because this value is less than .05, we can reject the null hypothesis. Therefore, this data supports the hypothesis that there is an association between respondents' frequency of alternative health engagement and the overall health of the respondents.

The second hypothesis was: There is an association between respondents' frequency of alternative health engagement and the physical health of the respondents. The null hypothesis was: There is not an association between respondents' frequency of alternative health engagement and the physical health of the respondents. The p-value for this chi-square test is .450, and because this value is more than .05 we fail to reject the null hypothesis. Therefore, this data does not support the hypothesis that there is a significant association between respondents' frequency of alternative health engagement and the physical health of the respondents.

The third hypothesis was: There is an association between respondents' frequency of alternative health engagement and the spiritual health of the respondents. The null hypothesis was: There is not an association between respondents' frequency of alternative health engagement and the spiritual health of the respondents. The p-value for this chi-square test is .244, and because this value is more than .05 we fail to reject the null hypothesis. Therefore, this data does not support the hypothesis that there is a

significant association between respondents' frequency of alternative health engagement and the spiritual health of the respondents.

The fourth hypothesis was: There is an association between respondents' frequency of alternative health engagement and the mental health of the respondents.

The null hypothesis was: There is not an association between respondents' frequency of alternative health engagement and the mental health of the respondents. The p-value for this chi-square test is .954, and because this value is more than .05 we fail to reject the null hypothesis. Therefore, this data does not support the hypothesis that there is a significant association between respondents' frequency of alternative health engagement and the mental health of the respondents.

The fifth hypothesis was: There is an association between respondents' level of mental health and level of physical health. The null hypothesis was: There is not an association between respondents' level of mental health and level of physical health. The p-value for this chi-square test is .094, and because this value is more than .05, we fail to reject the null hypothesis. Therefore, this data does not support the hypothesis that there is a significant association between respondents' level of mental health and level of physical health.

The sixth hypothesis was: There is an association between respondents' spiritual health and mental health. The null hypothesis was: There is not an association between respondents' spiritual health and mental health. The p-value for this chi-square test is less than .001, because this value is less than .05, we can reject the null hypothesis. Therefore, this data supports the hypothesis that there is a significant association between respondents' spiritual health and mental health.

The seventh hypothesis was: There is an association between respondents' spiritual health and physical health. The null hypothesis was: There is not an association between respondents' spiritual health and physical health. The p-value for this chi-square test is less than .001, because this value is less than .05, we can reject the null hypothesis. Therefore, this data supports the hypothesis that there is a significant association between respondents' spiritual health and physical health.

Discussion

The overarching research question for this study was: What are the effects of integral health care modalities within LGBTQ populations? The findings from the interviews and surveys show some consistency as well as discrepancies with past research, in terms of the LGBTQ experience of oppression and consequential bio-psycho-social effects, integral health care benefits, and the meaning of holistic practice. The following discussion will compare the results of the interviews with the surveys, and then compare these findings with past literature. Finally, implications for social work, policy, future research and strengths and limitations will be discussed.

LGBTQ experience of oppression. Findings from the interviews are consistent with past research; however, the qualitative findings provided by the interviews give a more in-depth understanding, and offer a discussion that suggests more hope than provided by past research. Sam and Amy both discussed their experience of LGBTQ clients who endure oppressive circumstances, emphasizing the fear, marginalization and discrimination that this population faces due to the general population's lack of awareness and understanding. This supports past literature, which suggests that

LGBTQ populations experience increased discrimination, stigmatization, isolation and marginalization (Alexander, 2002). Sam took this further by discussing the increased struggles the transgender and gender queer population experience in comparison to other sexual minorities who appear to fit better into binary gender norms. Amy discussed the prevalence of oppression in the “corporate world,” in comparison to the less mainstream lifestyle. In addition, she discussed oppression as a contributing factor for LGBTQ identifying people who remain closeted.

In contrast, it seems that it is very possible for LGBTQ identifying individuals to experience a life free of the extreme stress and negative health effects caused by oppression. Amy offered her own personal account as a lesbian, asserting that she personally, is mostly unaware of and unaffected by oppression. She does not explicitly say that this is due to her successful career, self-esteem, and family support through having a long-term partner with whom she has children; though, it is a possibility that these factors protect her from experiencing the negative effects of oppression. Past literature supports this assumption because it suggests that positive relationships decrease the level of psychological distress experienced by LGBTQ identifying individuals (Ueno, 2005).

Findings also suggest that the oppression LGBTQ populations experience causes barriers to health and security. Amy and Sam both discuss the barriers that occur for this population, including lack of social support, lack of employment opportunities, financial security, access to food, insurance, and healthcare. Amy takes this topic further by framing resistance within this population as a barrier to health. She mentions several times that her experience has been that many LGBTQ clients cling to their

illnesses such as chronic pain because it is how they identify with themselves and express themselves to the world. It may be easier for some clients to identify as their illness than with their gender or sexuality. This is framed as fear of accepting oneself and fear of acceptance from others, and this fear has developed because of oppressive circumstances. Past research is largely consistent with these findings, because it particularly emphasizes barriers to health care, including lack of culturally sensitive and informed care for LGBTQ clients, in addition to clients' lack of trust, reluctance to self-disclose gender or sexual orientation, and past negative experiences (Mayer et al., 2008).

The lack of social support experienced by this population is also a consistent finding throughout past literature. Many studies have shown that the LGBTQ population experiences a higher level of negative relationships with family and that this circumstance increases levels of psychological stress (Alanko et al., 2009; Mayer et al., 2008; Remafedi, 1987; Ueno, 2005; Ueno et al., 2009). Sam reports that when clients have less social support, they heal more slowly, even when receiving adequate health care. This suggests that barriers stemming from oppressive circumstances are likely to create a cyclical pattern, which has the power to seriously impact health and wellbeing.

Bio-psycho-social effects of oppression. Results from the interviews are fairly consistent with past research; however, the survey results offer some inconsistency, and challenge the overwhelmingly negative experience depicted by the interviews and previous literature. Both Sam and Amy discuss the increased stress level that LGBTQ populations tend to experience due to oppression. Findings from the interviews also assert that the cause of prevalent mental and physical health issues found within the

LGBTQ population can be attributed to the biochemical effects of stress. Alexander (2002) supports this idea by reporting that the LGBTQ population is at a higher risk for increased stress levels, which contribute to and increased risk of experiencing a mental illness. Johnson (2007) and Pert et al. (2005) add to this idea by indicating that oppression significantly impacts both the mind and the body.

Findings indicate that there are mental health issues that seem to be more prevalent within the LGBTQ population: anxiety, depression, addiction, alcoholism, suicide, and PTSD. In addition, there are physical health issues that seem to be more prevalent within this population: chronic pain, obesity, gastrointestinal issues, allergies, migraines, and skin problems. Results from past literature support Sam and Amy's discussion of the specific mental and physical health issues found within their clients, indicating a higher prevalence of anxiety, depression, substance abuse, suicidal ideation and attempts, eating disorders, physical and emotional abuse, and obesity (Israel et al., 2008; Johnson, 2007; Mayer et al., 2008; Meyer et al., 2008; Needham & Austin, 2010; Remafedi, 1987). In addition, it was found that oppression in any population can cause dissociation and/or physiological problems such as headaches, digestive problems, immune function, asthma, chronic pain and neurobiological changes (Johnson, 2007). These findings seem to suggest that both creating a less oppressive environment and reducing stress levels could offer a path of increased wellness for those within the LGBTQ population who are suffering from an illness of any kind.

The survey results offer an interesting contrast to previous findings because they indicate a fairly healthy group of LGBTQ identifying individuals. While the survey did not ask respondents to report their stress level, or level at which they experience

oppression, they were asked to report their health status including overall health, physical health, spiritual health and mental health. Responses for all four categories indicate that a majority of the respondents were healthy to very healthy. The overall health category yielded results that show 76.2 percent of respondents were healthy to very healthy, and 15.9 percent of respondents reported that they, “could be better, could be worse.” The physical, spiritual and mental health levels reported by the survey respondents were similar to that of overall health, providing a positive outlook on the health status of LGBTQ identifying individuals.

Interestingly, none of the respondents within the current study reported to be “very unhealthy” in any of the possible health categories, and the percent of respondents who reported to be “unhealthy” ranged from 1.6 percent to 6.3 percent. In contrast, past research indicates a much higher level of illness. Meyer et al. (2008) conducted a study with 388 LGB respondents which showed that 44 percent of respondents had an anxiety disorder; 30.7 percent had a mood disorder; 30.7 percent had Major Depressive Disorder; 38.4 percent had a substance abuse disorder; 69.8 percent had a mental illness of any kind; and 8.3 percent had made a serious suicide attempt. However, the current study yielded results indicating that only 4.8 percent of respondents were “unhealthy” in terms of mental health. Therefore, the survey results suggest a more healthy population than the interviews or past research, which could potentially be due to the high level of alternative healthcare engagement reported within the sample.

Effects of integral health care modalities. Results from both interviews and surveys show that the benefits of integral health care include: comfort with practitioner, individualized care, education and increased awareness of the mind-body connection.

In addition, the content analysis of survey findings indicate benefits of overall wellbeing, including stress relief, relaxation, increased energy, clarity, balance, self-awareness, and mental, physical and spiritual health. Survey respondents also mentioned the benefit of having a safe, healthy, and natural alternative to pharmaceutical health solutions, which are often associated with negative side effects. All of the benefits of integral health care are important; however, stress relief/relaxation seems to be the benefit which is most relevant to the past and present research involving oppression and related mental and physical health symptoms within LGBTQ clients. Interview findings and past research report that the LGBTQ population is more vulnerable to experience increased stress due to oppression which can cause an increased risk for mental and physical illness; therefore, it seems that stress relief/relaxation could be a catalyst for increased mental, physical and spiritual health.

Findings from both the interviews and survey respondents support the notion that stress relief has a positive impact on health, and that alternative health care modalities provide a means for stress relief. Amy and Sam discuss the biochemical inner-workings of stress, and how their chiropractic, nutritional and supplement practice facilitates stress relief and/or blunting of the biochemical stress process. Survey respondents also report that the alternative health practices they engage in provide stress relief, most often associating stress relief specifically with massage, acupuncture, Reiki, meditation, and yoga. Past research supports these claims, suggesting that meditation facilitates coping and problem-solving, interpersonal effectiveness, increased self-awareness, and self-esteem (Proulx, 2008). In addition, meditation, yoga, and massage

facilitate improvements in physical, emotional and social functioning (Ruscinova et al., 2002).

Findings from the survey suggest that the frequency of alternative health care engagement is associated with one's level of overall health. In addition, associations were found between spiritual health and mental health, as well as spiritual health and physical health. The survey results indicate that a majority of the respondents reported to be either healthy or very healthy in terms of overall, physical, spiritual and mental health. In addition, 96.8 percent of respondents reported to engage in alternative health practices: 12.7 percent rarely, 31.7 percent sometimes, 33.3 percent frequently, and 17.5 percent use alternative health practices every day. In contrast, past research shows that in 2007, close to 38 percent of U.S. adults had engaged in some type of alternative health care modality (Barnes, Bloom & Nahin, 2008). This is a much lower rate than the 96.8 percent of LGBTQ respondents who reported to engage in some type of alternative health care practice. It is possible that either LGBTQ identifying people engage in alternative health care at a higher rate than the general population, or that people who engage in alternative health care were more likely to be willing to participate in the researcher's survey. It is also possible that the rate at which the general population engages in alternative health care has drastically increased over the last five years.

Other surprising findings include the prevalence of survey respondents who engage in alternative health care practices as a way to either stop engaging in pharmaceutical interventions or to alleviate the side effects that they experience while consuming pharmaceutical medications. Respondents seemed to have strong negative

feelings towards pharmaceutical medications, one specifically referring to it as “poison.” Amy supported these findings, as she reported that many clients come in asking for help to get them off their pharmaceutical medications. She also mentioned that many of her clients do not feel safe taking pharmaceutical medications because of all the side effects the medications produce.

Holistic practice. Amy’s words describe the foundation of the holistic client-practitioner relationship – “health is about safety.” There is safety found within the client-practitioner relationship, and that is where good practice begins. When clients have trust in their practitioner, they are likely to benefit more from the treatment. Because holistic practice is client-centered, it is likely that clients have negative experiences at a lesser rate than within mainstream health care, where research suggest many barriers exist due to past negative experiences (Mayer et al., 2008). Therefore, when any practitioner, holistic or mainstream, approaches a client with care, gentle curiosity, openness, and validation, barriers to health care crumble, and increased health and prevention will likely follow.

Past research shows that 43 percent of negative experiences led to increased symptoms, diminished quality of life, decreased self-acceptance and damaged relationships (Israel, et al., 2008). The factors that were found to be the most indicative of a client’s positive experience were the client-practitioner relationship and the practitioner’s counseling skills (Israel et al., 2008). Because of these statistics, it is easy to see why the survey respondents had overwhelmingly positive things to say about alternative practices, and negative things to say about pharmaceutical-based practices. Moreover, the passion with which Amy and Sam spoke about their clients

and their practice serves as a testament to the positive outcomes they report to have with clients, as both skills and relationships are the most indicative of a positive experience. This also aligns with past research that indicates LGBTQ clients find social workers and psychologists to be more helpful than psychiatrists (Israel et al., 2008), because social workers and psychologists are able to lend themselves to more of a relational, client-centered, ecological approach to treatment than psychiatrists.

This research found that 96.8 percent of respondents engaged in some type of alternative health practice, which indicates that there is a desire and need for alternative treatment. The top 10 treatments utilized by the respondents were massage, supplements/herbal remedies, meditation, yoga, chiropractic, creative arts, acupuncture, guided imagery, homeopathy, and reiki. The past research reports similar findings, in terms of the top 10 modalities practiced: natural products, deep breathing, meditation, chiropractic, massage, yoga, diet-based therapies, progressive relaxation, guided imagery, and homeopathy (Barnes et al., 2008). Although these lists are similar, there are some important differences to note. Previous research seems to have categories that were not included in the current researcher's survey, such as deep breathing and progressive relaxation. Additionally, it should be noted that the current research yielded high rates of creative arts practice as a therapy, which was not included in the previous research. This difference could either mean that LGBTQ populations find more benefit in engaging in creative arts as a therapeutic practice or that the previous research did not include that as a category of alternative therapy. Because oppression causes an inability to express oneself without facing the possibility of discrimination and stigmatization,

people who experience oppression may find that creative art therapy provides a powerful avenue for self-expression and release.

Half of the top 10 alternative modalities listed in the current research are practices that one can easily do on their own with some education, which suggests client-empowerment – another important part of holistic health care. These practices include supplements/herbal remedies, meditation, yoga, creative arts, and guided imagery. Both Amy and Sam discuss the client empowerment they hope to facilitate through the education they provide within their practice. Sam and Amy also discuss the role of education in creating client-awareness of the mind-body connection, which is similar to self-awareness. Survey respondents also reported to experience similar things by engaging in alternative practices: self-knowledge, self-love, clarity and balance. This supports the theory that alternative health care facilitates healing by repairing or building the relationship with self, culture, and nature (Schlitz, 2005). Holistic health care emphasizes the importance of treating the client as expert, and handing them the power in the client-practitioner relationship; similarly, practices that do not require a practitioner facilitate this same concept because the user is the expert by default.

Implications for Social Work Practice

This topic has many implications for social work practice, including education about alternative therapies, incentive to practice referral, and suggestions about how to approach a beneficial alliance with any client, but specifically a client that identifies as LGBTQ. Interviews suggest that alternative health care offers a safe and beneficial environment for LGBTQ clients. Sam and Amy emphasized the openness, understanding, acceptance, validation, comfort and vulnerability with which they

approach a client. These ways of being are all characteristics that social workers probably intend to approach their clients with, but burn-out can take a negative toll on practice, resulting in a lack of these empathetic characteristics, and therefore decreased quality of service. Alternative health care can act as self-care, so it is something that social workers and their clients can equally benefit from, leading to an increase in both the wellness of the social worker and client.

Social work traditionally focuses on mental health, which is something that is changing as people are becoming more aware of how much the mind and body are linked. Although the NASW does not currently allow social workers to jointly provide other alternative therapy practices to their clients, social workers do have the opportunity to refer clients to resources they deem as beneficial. However, it is impossible to refer clients to resources that we are unaware of. Because of this, social workers should make an effort to become more informed about alternative health care modalities and their specific benefits. This research is important because it can inform social workers about the importance of integral services, which has the ability to increase referral practice, not only within LGBTQ populations, but within all oppressed populations. By understanding where oppression comes from and how it affects the body as well as the mind, therapists and practitioners will be better equipped to provide services that wholly support wellbeing.

Finally, this research provides some education about oppression that the LGBTQ population still encounters today, as well as some suggestions about how to support a client who identifies as LGBTQ. Amy discusses her experience, which specifically suggests that the corporate world can be oppressive and cause LGBTQ

people to remain closeted. Sam specifically discusses the struggles that transgender and gender queer people face due to their inability and/or reluctance to fit into binary gender norms. This can exacerbate oppression because the world is not organized in a fashion that makes life easy for people who are not simply male or female. There are typically only male and female bathrooms available, male and female university dormitories, female colleges, male colleges, and male/female choices on forms. In addition, doctors may not be educated about how to treat someone who does not fit neatly into the male or female category. Sam recommends that therapists get into the habit of asking transgender and gender queer clients what pronoun they prefer, as a way to show that you accept them, understand and respect them. Most importantly, Sam recommends that therapists meet every client, but specifically an LGBTQ client with a blank slate, do not make assumptions and do not be afraid to show your vulnerability to a client. In other words, if you have not worked with a transgender client before, let the client know that, and allow your curiosity and vulnerability indicate that you are open and accepting; however, at the same time, be mindful that the client may not want the burden of having to educate everyone about their gender or sexuality.

Implications for policy

Though things seem to be changing, we currently live in a country where there is a dominant culture, and within this culture there is a reliance on binary concepts as a way of learning and understanding our world. While this way of thinking may have had a place in prior decades and lifestyle patterns, it no longer serves our lives in a positive way. Our society has continuously diversified since it has been born, and at this moment in time we are a more diversified population than has ever previously existed.

Consequently, binary concepts no longer serve as the best way to help us understand one another or our world. Instead, they serve as a model for oppression. Binary thinking structures contribute to the potential for everyone to experience oppression, both within and outside of the dominant culture.

Social work is a profession which has been built to address oppression in terms of putting a stop to its occurrence and helping those who have experienced oppression to heal. There are, however, a few problems with this aim. First, oppression is thought to have a profound impact on the body as well as the mind. While social work takes a broad ecological perspective, the profession is not currently set up to provide body-centered holistic approaches, as evidenced by the Code of Ethics. Therefore, policy should take this discrepancy into consideration and amend social work policies to fill this gap in treatment. Education trainings on CAM therapies would be beneficial within schools of social work and medical settings, because referrals are an important part of a social worker's and doctor's job, and education about CAM would enrich their referral arsenal. Additionally, NASW should begin to rethink a few of the rules outlined by the Code of Ethics, related to banning a social worker's right to practice alternative therapies within their social work practice. As these therapies are undergoing an increasing amount of research, and we are more able to understand the effectiveness of CAM practices, the NASW should allow itself to become more open and interested in holistic possibilities. In other words, NASW should support social workers in gaining certifications in various CAM services, and applying this knowledge within their practice.

This research has many implications for general policy as well, including promoting education about diverse populations and amending or creating laws that provide LGBTQ populations with the same rights that heterosexual populations experience, for example the right to marry and the 515 laws in Minnesota that discriminate against same-sex couples. Education is an essential step in creating policy changes; because of this, education about diverse populations in the form of trainings and workshops should be conducted within schools, medical settings and other professional organizations. Many large corporations do have diversity trainings; however, if this were required by law, a larger audience would be reached and impacted. If more education about diverse populations were disseminated, increased understanding and acceptance would follow, leading to less oppression and consequently happier and healthier people.

Implications for Research

Very few, if any, studies have researched the effects of integral health care when practiced within LGBTQ populations, and the results of this study warrant further research on this topic. Some things that would be beneficial to explore further include: Social workers' propensity to make use of alternative health care within their practice; LGBTQ populations' frequency of alternative health practice engagement; clients' views on the differences and similarities within the relationships they have with mainstream health providers, therapists, and CAM practitioners; and investigation about the relationships between spiritual, mental and physical health, as well as the frequency of alternative health care engagement and overall health. The current study found that LGBTQ populations engage in alternative health practices more prevalently than the

general population, so it would be beneficial to duplicate this to test its reliability, and conduct qualitative, exploratory research about this trend in health care preference.

Another research question that surfaced through this study was: Do LGBTQ populations practice creative arts as a therapeutic tool at a higher rate than the general population and why? Finally, more in-depth short-term and long-term research should be done with the individual modalities, involving their ability to decrease stress and alleviate mental and physical illness, which could be conducted by measuring the level of cortisol within a participant's body before, during and after they have participated in an alternative health care practice.

Strengths and Limitations

The strengths of this research lie in its support, and its aim to explore uncharted territory. While the mental health status of LGBTQ populations has been heavily researched, it has not often been tied with physical health of the respondents. Furthermore, it seems that research exploring the effects of alternative health care modalities has not been specifically facilitated within LGBTQ populations. Because this research was conducted through both qualitative interviews and quantitative and qualitative surveys, a much greater scope of information was available to assess. Thus, this research provides multiple perspectives. Another strength of this study was the number of resources available for this project. The researcher had many friends, faculty, supervisors, and acquaintances that offered support for this research by referring potential interviewees, and providing contacts and strategies to gather potential online survey respondents. This support created a greater ease in conducting and accomplishing this research.

There were many limitations within this research, including lack of time, funding, and limited sampling, in terms of number of respondents, control of respondents and a representative sample. Because of the lack of time and funding, the size of the sample was small, including two interviewees and 63 online survey participants. This small sample size may affect the reliability of the results, particularly reliability of the chi-square tests. Additionally, a representative sample was difficult to maintain, due to the snowball sampling technique. It is possible that LGBTQ identifying people who engage in alternative health care services were more likely to participate in this survey, thereby skewing the results. Moreover, because of the nature of online surveys, the researcher did not have an ability to control the number of times one respondent took the survey, or even that the survey was being taken seriously and honestly by an LGBTQ identifying individual.

Conclusion

The purpose of this study was to explore the effects of integral health care modalities when practiced or used within LGBTQ identifying populations. In broader terms, the overarching goal was to assess the bio-psycho-social effects of oppression, and the ways in which integral health care modalities can be available to support healing within the LGBTQ population, and also potentially for anyone beyond this particular population who experiences oppression of any kind. Findings indicate that those identifying as LGBTQ are more likely to engage in alternative health care modalities than the general population. Furthermore, it was found that benefits of utilizing alternative health care services include: overall wellbeing, stress relief, increased energy, clarity, balance, self-awareness, and mental, physical and spiritual

health. Findings also show that alternative health care modalities emphasize education, and they facilitate an increased awareness of the mind-body connection.

Integral health care meets the needs of those who feel alienated within the mainstream health care system by providing an accepting, open environment and individualized care. Findings also show that alternative modalities had provided a support system for the respondents who expressed a desire to reduce their consumptions of pharmaceuticals, or lessen the negative side-effects that pharmaceuticals have caused. This research indicates that integral health modalities serve many beneficial roles within the LGBTQ population. In the future, it will be important for social workers and other mental health professionals to become attuned to this knowledge, in order to better meet the needs of their clients.

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Appendix A

(For Interviewees)

Effects of Integral Health Modalities Used within LGBTQ Populations INFORMATION AND CONSENT FORM

Introduction:

You are invited to participate in a research study investigating the effects of integral health modalities used within LGBTQ populations. This study is being conducted by Megan Gramlow, a graduate student at St. Catherine University and the University of St. Thomas under the supervision of Professor Richa Dhanju, an assistant professor in the School of Social Work. You were selected as a possible participant in this research because you have been recommended as a holistic healing professional who has experience in working with clients that identify as LGBTQ. Please read this form and ask questions before you agree to be in the study.

Background Information:

Previous research has indicated that people who identify as LGBTQ are at a higher risk to develop mental health issues; furthermore, research suggests that people identifying as LGBTQ face barriers to support and health care. This study is designed to explore the role of integral health modalities when used within LGBTQ populations. Integral health modalities are at the center of this research because they emphasize the connection between mind and body in a way that medical and social work professionals have not yet fully embraced. The purpose of this study is to investigate the potential effects of practicing or providing integral modalities within a population that experiences oppression. Two people are expected to participate in the interview portion of this research.

Procedures:

If you decide to participate, you will be asked to participate in a 45-minute, audio-recorded interview with the researcher. This interview will take place in a quiet, private area such as a conference room at a library or an office suite. This interview will be conducted to get practitioners' views on the effects of integral modalities when used within LGBTQ populations. The interview will then be transcribed by the researcher and used to identify themes, concepts and quotes, which will then be used to write the research paper. The research will be completed in May 2013; however, the only active participation required by you, as the interviewee, would be the one-time 45-minute interview.

Risks and Benefits of being in the study:

There are minimal risks in this study. Respondents may feel uncomfortable during some questions, but they will have the right to skip any question or back out of the survey or interview at any time, without consequence.

There are no direct benefits to you for participating in this research; however, the results may help advance both the field of holistic health and the field of social work, as results will be published. Specifically, this research may facilitate social workers' understanding of integral, holistic health services. This is a benefit because it can serve to increase referral practice when necessary, not only within LGBTQ populations, but within all populations. By understanding where oppression comes from and how it affects the body as well as the mind, therapists and practitioners will be better equipped to provide and/or refer services that wholly support wellbeing.

Confidentiality:

Any information obtained in connection with this research study that can be identified with you will be disclosed only with your permission; your results will be kept confidential. In any written reports or publications, direct quotes will be used, but no one will be identified or identifiable. This research will be published through St. Catherine University. Results that protect confidentiality may also be published in a local magazine.

I, the researcher, will keep the research results in a locked file cabinet in my room and only my research chair, Richa Dhanju and I will have access to the records while we work on this project. I will finish analyzing the data by May 10th. I will then destroy all original audio recordings, transcripts, reports and identifying information that can be linked back to you.

Voluntary nature of the study:

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

Contacts and questions:

If you have any questions, please feel free to contact me, Megan Gramlow, at (701) 238-4355. You may ask questions now, or if you have any additional questions later, the faculty advisor, Richa Dhanju (651) 690-6755, will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researchers, you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739.

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

Statement of Consent:

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

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

Signature of Participant Date

Signature of Researcher Date

Appendix B

(For Survey Respondents)

Effects of Integral Health Modalities Used within LGBTQ Populations INFORMATION AND CONSENT FORM

Introduction:

You are invited to participate in a research study investigating the effects of integral health modalities used within lesbian, gay, bisexual, transgender, and queer (LGBTQ) populations. Integral health is an umbrella term for all holistic health practices – for example, acupuncture, meditation, massage, chiropractic care and many other modalities. This study is being conducted by Megan Gramlow, a graduate student at St. Catherine University and the University of St. Thomas under the supervision of Professor Richa Dhanju, an assistant professor in the School of Social Work. You are invited to participate in this research if you identify as LGBTQ, because your insight on health and wellness will help to further develop this research. Before you agree to be in this study, please read this form, and feel free to email or call with questions if you would like.

Background Information:

Previous research has indicated that people who identify as LGBTQ are at a higher risk to develop mental health issues due to increased stress factors, including oppression; furthermore, research suggests that people identifying as LGBTQ face barriers to support and health care. This study is designed to explore the role of integral holistic health modalities when used within LGBTQ populations. Integral health modalities are at the center of this research because they emphasize the connection between mind and body in a way that medical and social work professionals have not yet fully embraced. The purpose of this study is to investigate the potential effects of practicing or providing integral modalities within populations that identify as LGBTQ.

Procedures:

If you decide to participate, you will be asked to fill out the following 10-question survey. After all of the data is compiled, I will run statistical analyses on the results. The research will be completed in May 2013; however, the only active participation required by you, as a survey respondent, would be this one-time survey.

Risks and Benefits of being in the study:

There are minimal risks in this study. Respondents may feel uncomfortable during some questions, but they will have the right to skip any question or back out of the survey or interview at any time, without consequence.

There are no direct benefits to you for participating in this research; however, the results may help advance both the field of holistic health and the field of social work, as results will be published. Specifically, this research may facilitate social workers' understanding of integral, holistic health services. This is a benefit because it can serve to increase referral practice when necessary, not only within LGBTQ populations, but within all populations. By understanding where oppression comes from and how it affects the body as well as the mind, therapists and practitioners will be better equipped to provide and/or refer services that wholly support wellbeing.

Confidentiality:

Any information obtained in connection with this research study that can be identified with you will be removed and kept confidential. In any written reports or publications, direct quotes may be used; however, no one will be identified or identifiable. This research will be published through St. Catherine University. Results that protect confidentiality may also be published in a local magazine.

I will keep the research results in a locked file cabinet in my room and only my research chair, Richa Dhanju and I will have access to the records while we work on this project. I will finish analyzing the data by May 10th. I will then destroy all reports and identifying information that can be linked back to you.

Voluntary nature of the study:

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

Contacts and questions:

If you have any questions, please feel free to contact me, Megan Gramlow, at (701) 238-4355. You may ask questions now, or if you have any additional questions later, the faculty advisor, Richa Dhanju (651) 690-6755, will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researchers, you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739.

Statement of Consent:

Even after beginning this survey, please know that you may withdraw from the study at any time.

Please check the box that reflects whether or not you consent to participate in the study:

- Yes, I understand and agree with the rules of consent, and I wish to begin the survey.
 No, I do not agree with the rules of consent, and I do not wish to begin the survey.

Appendix C

Interview Questions

- 1.) How did you come to be a holistic practitioner?
- 2.) Could you describe the experience you have working with people who identify as LGBTQ.
- 3.) What is your client base in terms of age, sexual orientation and gender?
- 4.) What are some special considerations for working with LGBTQ clients?
- 5.) Can you describe the ways in which this population experiences oppression?
- 6.) How does the oppression that these populations experience affect mental and physical health?
- 7.) Are there specific kinds of psychosocial, biological, emotional and spiritual issues that affect LGBTQ populations more than people who are not LGBTQ?
- 8.) What are some reasons that LGBTQ clients seek out alternative therapies?
- 9.) What interventions have you employed with LGBTQ populations?
- 10.) Can you describe the success of these interventions?
 - 10a.) Are there any negative outcomes you have seen?
- 11.) Based on client reports, how do these approaches differ from more traditional allopathic and psychological approaches?
- 12.) Have you noticed a prevalence of any specific stress or anxiety reactions within these populations such as: gastrointestinal issues, allergies, decreased immune system function, migraines, skin conditions?
- 13.) Research suggests that stress associated with stigmatization, discrimination, and reduced social support within the LGBTQ population may lead to higher rates of mental disorders. Has your experience as a practitioner validated this idea?
- 14.) Research also suggests that oppression can have an affect on the physical body. Do you have a professional opinion on this phenomenon and how it relates to LGBTQ populations?
- 15.) Through your experience as a practitioner, what kind of intervention or combination of interventions seems to be the most powerful for LGBTQ clients and why? i.e. individual work, group work, family counseling, alternative therapies, allopathic methods?
- 16.) In your experience, what kind of support or benefits do alternative therapies provide for LGBTQ clients?

Appendix D

Survey

Place and “X” in the appropriate box.

1.) Age:

- 17 and younger
 18-22
 23-29
 30-39
 40-49
 50-59
 60-69
 70 and older

2.) Gender:

- Female
 Male
 Transgender
 Gender Queer
 Other (Please specify): _____

3.) Sexual Preference:

- Lesbian
 Gay
 Bisexual
 Queer
 Heterosexual
 Other (Please Specify): _____

	Very Unhealthy or Ill				Very Healthy
Please rate:	1	2	3	4	5
4.) Your overall health:	_____	_____	_____	_____	_____
5.) Your physical (medical) health:	_____	_____	_____	_____	_____
6.) Your spiritual health:	_____	_____	_____	_____	_____
7.) Your mental health:	_____	_____	_____	_____	_____

8.) How often, if ever, do you use alternative health practices or interventions to support your wellbeing, such as: natural products, supplements, herbal remedies, yoga, meditation, massage, acupuncture, chiropractics, naturopathy, homeopathy, Ayurvedic medicine, Chinese medicine, energy therapies, tai chi, qigong, and creative arts?

- Never
 Rarely
 Sometimes
 Frequently

___ Every Day

9.) If you have participated in alternative health practices, indicate which you have experienced.

- ___ Supplements
- ___ Herbal Remedies
- ___ Yoga
- ___ Meditation
- ___ Guided Imagery
- ___ Massage
- ___ Acupuncture
- ___ Tai Chi
- ___ Qigong
- ___ Reiki
- ___ Healing Touch
- ___ Light Therapy
- ___ Magnet Therapy
- ___ Hypnotic Therapy
- ___ Chiropractic Services
- ___ Naturopathy
- ___ Homeopathy
- ___ Ayurvedic Medicine
- ___ Chinese Medicine
- ___ Creative Arts
- ___ Other (please specify): _____

10.) If you participate in any alternative health practices, do you perceive any benefits? If so, what are they?