Abstract

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Female health is a complex and dynamic component of the female lifecycle. It is not based on a single entity, rather it is holistic and comprised of several individual facets. Thus, female healthcare should be approached from a wellness perspective and treated in an integrative system. While an integrative approach to healthcare is optimal for all people, this research study explores female development holistically as it relates to wellness and integrated healthcare.

Integrative Medical Practice: A Proposed System for Women's Healthcare

by
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BIOGRAPHY

Brook Powers is a graduate student in the Counselor Education department at North Carolina State University. She received a Bachelor of Arts from North Carolina State University in Psychology in 2003. In congruent with her graduate education she has been working as a fitness professional. Her future career goals include counseling and educating women on healthcare. This includes teaching clients about the benefits of preventive healthcare through diet, exercise, and stress management. Her theoretical orientation is developed from humanistic, existential, and holistic theories.

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CHAPTER 1

INTRODUCTION AND LITERATURE REVIEW

Female health is a complex and dynamic component of the female lifecycle. It is not based on a single entity; rather it is holistic and comprised of several individual facets. Thus, female healthcare should be approached from a wellness perspective and treated in an integrative style. While an integrative approach to healthcare is optimal for all people, this paper is looking to explore the depth of female development as related to wellness and integrated medicine.

Female Development

Carol Gilligan paved the way for female development. Her ethics of care model is the cornerstone of why women are ideal candidates for integrative and holistic wellness approaches to health. There are three stages of her theory as presented in her book, *In a Different Voice,* (1982).

The first stage presents a conflict between selfishness and responsibility. In this early stage of development females adopt an attitude of selfishness. They are primarily concerned about themselves. They worry about how the implications of their decisions are going to affect them with little regard of how their decisions affect those around them. This stage is typically seen in children before they reach adolescence. Resolution of this stage involves the ability to come to a consensus in a crisis.

Stage two is a *conventional stage* where females learn to shift from selfishness to responsibility. In this stage females learn that their decisions have an impact on others and thus, feel a sense of responsibility to make rational decisions based on that level of

responsibility. A female's concern for herself is usually minimal, concerned only with pleasing others. This stage is inherent during adolescence. A female's identity is founded in care and when confronted with a choice of protecting herself or others, the female feels the responsibility to the other. Stage two presents a *limbo crisis*. If the female is at risk of hurting two people, she perceives a decision in either direction as immoral. Here, the female may opt to stay neutral or seek decision-making help from a third party.

Stage three is one of transcendence, the shift from goodness to truth. Females learn that they cannot be solely responsible for the well-being of others if they are not able to make responsible decisions for themselves. Reaching this stage requires acknowledging the full scope of a crisis. One must accept the truth of the dilemma, admitting all parties involved and consequences at stake. The woman also learns that a relationship is unable to reach a successful level until she can take care of herself. One may view herself as being selfish as in stage one. However, she also realizes that no other decision is acceptable unless she is true to herself.

The post-conventional *Truth stage* is when most women can find and maintain healthy and loving relationships. According to the ethic of care developmental theory, women striving towards stage three will view relationship formation and attachment as the path to maturity (Gilligan, 1982, p. 170). This theory proposes that women are socially developed to care for one another. Girls learn at an early age that they are like their mothers and begin to adopt the relationship styles and patterns of their mothers. The

relationship built between mother and daughter is the beginning of many support networks a girl continues to build (Borysenko, 1996).

Although Gilligan's theory of development is a starting point for female development it is lacking some essential features. Female development is based on more than socialization and relationship building (Borysenko, 1996). It also includes biological, psychological, and spiritual development. These three components are working together simultaneously to create female growth and experience. This concept is a more holistic theory of female development.

Gilligan's developmental theory is easily seen in interpersonal relationships but should be considered in every female social interaction, including healthcare choices. According to Gilligan's theory, women are developed socially to take care of one another. The highest stage of this theory is when a woman takes care of others after she learns to meet her own needs. The course of this developmental process is learning how to relate to others and reciprocate the caring relationships. Based on this theory, it would make sense that the female healthcare system would be comprised of these principles: allowing opportunity for women to care for and grow with one another with psychoeducational support.

Women's Health

Prior to the women's movement in the 1970's, healthcare for females was centered on reproductive healthcare (Sherr, L. & St. Lawrence, J., 2000). Women have been redefining health as it applies to their work, recreation, development, reproduction, and body image. Women are creating a standard that appropriates their beliefs,

appearance, and behaviors, (Fogel, C.I. & Woods, N.F., 1995). "From a twenty-first century perspective, what differentiates men and women is not their reproductive role per se or the assumption that all else is similar in men and women, but that the ability to reproduce has biological, psychological, and sociological impacts on women's health" (Sherr, & St. Lawrence, 2000, p.9).

Women are more likely to seek mental health care, receive a diagnosis, and be prescribed psychotropic medication (Crose, Nicholas, Gobble, and Frank, 1992, Fogel & Woods, 1995, and Sherr & St. Lawrence, 2000). Specifically, women are more likely to receive a mental health diagnosis of major depressive disorder, agoraphobia, obsessive compulsive disorders, panic disorders, and somatization disorders. The only diagnosis men consistently outnumber women is substance abuse.

The primary intervention for treating mental health in the biomedical field is with psychotropic medication, (Sherr, & St. Lawrence, 2000). Previously, physicians held the philosophy that the "biological key" in female health is the hormones, specifically, estrogen and progesterone. These hormones cause the reproductive syndromes premenstrual syndrome, post-partum depression, and menopause. While physicians are now acknowledging that there are social factors, such as marital status, employment, gender role socialization, sexuality, and violence that contribute to female health and illness, few consult with mental health care providers.

Reproductive health

The counseling literature on reproductive health concerns, such as post-partum depression, menopause, or infertility is limited (Pfost, Stevens, & Matejcak Jr., 1990).

Postpartum Depression

Postpartum depression (PPD) can begin days after childbirth and can last up to a year (Highet, & Drummond, 2004). Some symptoms include fatigue, anxiety, lack of interest in the baby, sad or depressive mood, and confusion. The onset of PPD may be caused by a hormonal change, and primarily is treated by medication. PPD affects ten to 15% of first-time mothers (Pfost, Stevens, & Matejcak Jr., 1990). Current counseling research on PPD is minimal.

Post-partum depression presents social consequences as well as physical. Feelings of guilt, sadness, and thoughts of being a bad mother are often present. Being able to carry a child and care for it is often thought to be an innate characteristic of a woman. Similar feelings are reciprocated by women experiencing problems of infertility.

Infertility

Infertility, defined as the inability to conceive a child after a year or more of intercourse without use of contraception or the inability to carry a pregnancy to full term, affects one in five couples (Fogel, & Woods, 1995). There are many emotional responses to infertility, such as lower self-esteem, depression, guilt and imbalance in the relationship of the couple trying to conceive. Even after pregnancy is achieved couples may experience unresolved relationship issues, self-image problems, and anxiety. In heterosexual relationships, both the man and woman tend to attribute more responsibility to the female, even if the biological concern is from the male, (Gibson, D.M. & Myers, J.E, 2000). Research did not report relationship issues for homosexual couples.

Gibson and Meyers (2002) suggest a relational model of development to treat the stresses associated with infertility. The relational model of development suggests that women develop through relationships with others and is based on the concepts of empathy and mutuality. This model is a continuation of Gilligan's ethics of care developmental theory. When women are able to relate to other women encountering similar experiences, possible in a group setting, they are more likely to feel like they are not alone, have a more accurate view of themselves, and feel a sense of energy and empowerment. Infertility will affect 2.1 million couples every year, but other developmental processes, such as menopause will affect more than 52.5 million women (Gibson & Myers, 2002, and Huffman & Myers, 1999).

Menopause

Menopause, also referred to as climacteric is a biological stage in a woman's life when menses cease (Huffman, & Myers, 1999). There are three stages of this process, perimenopause, menopause, and early postmenopause. Most common symptoms of menopause include hot flashes, night sweats, depression, vaginal dryness, decreased libido, decreased self-esteem, irritability, headaches, forgetfulness, and fatigue. Hot flashes are reportedly experienced by 85% of women by the onset of menopause. However, in a study of menopause symptoms and African American women, hot flashes and night sweats were not in the list of top ten symptoms (Huffman, & Myers, 1999 & Bond, 2005).

The most common treatment for menopause is hormone replacement therapy (HRT), more often supplementing estrogen, but also progesterone. HRT has been

demonstrated to aid in the prevention of common post-menopausal diseases, such as osteoporosis and coronary heart disease. Another common disease in menopausal women is breast cancer. Research is inconsistent with the findings on breast cancer and HRT (Huffman and Myers, 1999). Alternative treatments, such as balanced diet, exercise, nutritional supplements, and the plant hormone- phytoestrogens have shown success in decreasing menopausal symptoms. Huffman and Myers (1999) suggest that HRT and alternative treatments, in combination with psychosocial therapy may be of the greatest success in treating women through menopause.

The symptoms experienced by menopause are culturally relative (Huffman & Myers, 1999). For many women in the United States, a women's worth is determined by her age, beauty, and sexuality. In other cultures, such as Native American culture, a woman is valued more as she ages. These women are less likely to acquire the negative symptoms of menopause. Cultural values have many social implications. Society creates a framework for how we live and interact with one another. Thus, there are social outcomes that have a profound impact on health.

Social Factors

Women's health is affected beyond the scope of reproductive and biological concerns. Society also plays a significant role in women's overall health. One recurring theme in counseling and female health literature is the role that media plays on body image and self-esteem (Sinclair & Myers, 2004). Body image is a growing problem among teenage girls. Ninety percent of White and 30 percent of African American adolescent females are dissatisfied with her weight (Borysenko, J., 1996). Body image

problems are the catalyst for mental, physical, and social problems including, eating disorders, low self-esteem, depression, anxiety, and unrealistic self-comparisons (Sinclair & Myers, 2004).

Eating Disorders

Eating disorders are a current physical and mental health concern affecting females in the United States. Eating disorders are defined into two major categories with each having two subtypes. The first disorder listed by the Diagnostic and Statistical Manual of Mental Disorders, *DSM-IV-TR,* is Anorexia Nervosa (American Psychiatric Association, 2000, p. 587). This disorder is reported to be predominately experienced by females (90% of cases) with a "lifetime prevalence…among females [being] approximately 0.5%". Anorexia is also most common in industrialized cultures. The second eating disorder included in the *DSM-IV-TR* is Bulimia Nervosa. The prevalence rates for this disorder are similar to those of Anorexia Nervosa with 90% of reported cases occurring in females, but the lifetime prevalence for this disorder is higher with 1%-3% individuals experiencing Bulimia Nervosa over their lifetime. Several modalities, including cognitive-behavior therapy, family therapy, and pharmacology are usually employed when treating patients with eating disorders (Stein, et al., 2001).

Current Healthcare

Women, more than men, are showing up in the American healthcare system, yet this system is not guided by an ethics of care (Gilligan, 1982). The current model of health care practice is based on a design from the mid-nineteenth century. "Women's health has inherited a model of health care that reflects both the Cartesian duality of mind

and body, and a philosophy of medical science based on biological reductionism that views the body as a machine and the whole as merely the sum of its parts," (Sherr & St. Lawrence, 2000, p. 3). Medical research to date is dominated by information related to men, while cardiovascular disease, for example, is the leading cause of death for both men and women.

From a systems perspective women tend to be the decision makers for their own health care as well as for the members of their family (Correa-de-Araujo, R. & Clancy, C.M., 2006). Between 16-32 percent of women are dissatisfied with the quality of healthcare they are receiving and are more likely to perceive discrimination based on race, gender, and ability to pay. Women more than men, report difficulty understanding doctors instructions, thus are less likely to follow doctors' advice. However, women are found to seek and use more sources of health information including social support networks, trusted healthcare providers, and independent research (Brown, et al., 2002).

The American College of Women's Health Physicians has seven guiding principles: (a) Women-centered care: Possess the biological, psychological, and sociological knowledge and skills based on women's experiences; (b) Respectful use of power: To provide positive and empowering change; (c) Diversity: To be comprehensively representative in research and care; (d) Activism: Promote advocacy and action; (e) Eclectic healing practices: Support the safety and effectiveness of alternative medicine; (f) Complexity: Realize that health factors are biological, psychological, familial, ethnic, social, cultural, environmental, occupational, spiritual and chance; and (g) Individual and organizational well-being: Informed care should be

dedicated to practices that empower or enable others' achievements, encourages one's own personal and professional growth, and enhances team spirit and collaboration (Sherr & St. Lawrence, 2000). These principles are in line with the proposed integrative approach to female health care.

A Wellness Model

Witmer and Sweeney (1992) define wellness as the "total person approach to improving the quality of life in proactive and positive ways" (p. 140). The Indivisible Self model of wellness (ISWEL) emphasizes holism as the highest order with sub-components identified as second-order factors (Meyers & Sweeney, 2005). There are five second-order factors each divided further with meta-components. The first second-order factor is the *Essential Self,* which includes spirituality, self-care, cultural identity, and gender identity. Second, the *Creative Self* is "a combination of attributes that each individual forms to make a unique place among others in his or her social interactions" (p. 273). The components here are thinking, emotions, control, positive humor, and work. Third, realistic beliefs, stress management, self-worth, and leisure make up the *Coping Self*. Fourth, the *Social Self* includes friendship and love. Finally, the *Physical Self,* includes exercise and nutrition. Extensive research has shown the positive impacts of these second-order factors on health (Myers, Sweeney, & Witmer, 2000).

Wellness treatment has been shown to benefit patients with various symptoms. Traditional medicine combined with mental health counseling and wellness consulting was revealed to decrease headaches among migraine sufferers, (Deggers-White, Myers, Adelman, & Pastoor, 2003). Recent studies on exercise have demonstrated positive

effects on the treatment of breast cancer patients (Mustian, Katula, & Gill, 2002), as well as contributing to the goals of feminist therapy (Chrisler & Lamont, 2002). A positive relationship also exists between one's belief that she can control her appearance and aspects of wellness among college females (Sinclair & Myers, 2004).

An Integrative Approach

Integrative medicine is a scientifically researched approach to healthcare (Gaudet & Snyderman, 2002). It is a philosophy of wellness, rather than illness and designed to treat the whole person rather than the specific diagnosis. Further, it recognizes the relationship between mind and body and the power to heal. This system is referred to as the bio-psycho-socio-spiritual dimensions of the entire person (Bell et al., 2002). The goal of integrative medicine is for the patient and group of practitioners to develop a health plan that will supersede the chief complaint and extend to preventive healthcare.

While integrative medicine is not the same as complementary and alternative medicine (CAM), it does employ the services of CAM if appropriate for the patient (Bell et al., 2002). Integrative medicine will use techniques from conventional Western medicine and CAM to find the best solution for treating a patient, while concurrently working with the patient in a person-centered approach.

Integrative care is beginning to be used in conventional medical practices. For example, psychiatric practitioners adopting this modality may incorporate social support, mental health services, and medication, while health psychologists may incorporate behavioral theory to assist clients with diabetes (Bell et al., 2002).

Summary and Research Question

Carol Gilligan's research on female development demonstrates that females develop by a principle known as the *Ethics of Care*. Females relate uniquely to one another in a social environment as they are raised to take care of one another and respond positively to similar care. Female healthcare today does not comprehensively incorporate developmental principles or life experiences particular to female development over the lifespan. The literature does, however, present a model informed by wellness and holism that provides an enhanced standard for female healthcare. This study seeks to answer the following research question. Is there is a difference in the level of wellness for women that receive traditional healthcare services compared to women who receive integrative healthcare services?

CHAPTER 2

METHOD

This chapter describes the purpose of the study, participants, survey, data collection, data analysis, and limitations.

Purpose of the Study

The purpose of this study was to determine if there was a difference in the level of wellness for women that receive traditional healthcare services compared to women who receive integrative healthcare services.

For the purposes of this study a traditional healthcare practice is defined as one or more health practitioner(s) specializing in women's reproductive health, such as a gynecologist, obstetrician, or nurse practitioner. Integrative healthcare practices include a health practitioner, such as gynecologist, obstetrician, or nurse practitioner and one or more of the following: (a) complimentary alternative medicine (CAM), (b) mental health professional, or (c) nutrition and exercise specialist.

Research question: Is there a difference in the level of wellness for women that receive traditional healthcare services compared to women who receive integrative healthcare services?

Participants

Criteria for participation in this study included: (a) self-identification as a female, (b) between 18-25 years old, and (c) patient at the same healthcare practice for more than one year.

Participation in this study was voluntary. Participants were recruited via email and myspace.com (http://myspace.com). One email was sent to peers, colleagues, and personal friends and family of the researcher (See Appendix A). Peers and colleagues were notified through a departmental listserv that included the faculty and staff at a university counselor education department. Emails were also sent to individuals working at a university women's center and counseling center. Personal contacts included coworkers, personal training clients of the researcher, and members of a local health club where the researcher is employed part-time. Participants were encouraged to forward the email to other prospective participants. All email addresses were blind copied for confidentiality.

Myspace.com is a social networking website that allows individuals to share pictures, blogs, and other information on their personal profile page with friends and members. Mass messages can be sent to all of the myspace user's *friends* as a bulletin. *Friends* are other myspace users that have been permitted to view a myspace user's profile and receive bulletins. The researcher posted the email for participation in the study as a bulletin message.

One of the researcher's friends has a myspace profile page titled *Ladies of the South*. *Ladies of the South* is a profile page that befriends women living in the southern region of the United States. This page had 11,461 friends at the time the bulletin was posted. The *Ladies of the South* reposted the original email message for participation in the study as a bulletin for all of their friends with permission from the researcher.

Instrument

The Holistic Wellness Inventory is a two page, online survey (see Appendix B). Page one of the Holistic Wellness Survey included twelve demographic variables. Page two consisted of thirty questions seeking to measure wellness characteristics. The inventory was made available to participants through an online survey creator, Surveymonkey.com (http://surveymonkey.com).

General demographic information of the survey included: (a) age, (b) marital status, (c) sexual orientation, (d) race, (e) religious affiliation, and (g) if the participant has children. Health demographics collected by the Holistic Wellness Inventory included: (a) participant perception of her overall health, (b) if the participant is currently seeing a mental health professional, (c) how long the participant has been a regular patient of their healthcare practice, (d) if the participant is getting yearly mammograms (age applicable), (e) if the participant is receiving yearly pelvic exams, and (f) whether the participant was a patient at an integrative or traditional practice.

The Holistic Wellness Inventory (Appendix B) was adapted from the Integrative Yoga Therapy (IYT) Whole Person Wellness Survey (http://www.adventure-yoga.com). The IYT Whole Person Wellness Survey is a 100 question scale divided equally into four sections: (a) My connection to my physical being, (b) My connection to my breath and levels of wellness, (c) My connection to my mind and emotions, and (d) My connection to my spiritual being. Questions were selected from the IYT Whole Person Survey to be representative of the Indivisible Self model of Wellness (ISWEL, Meyers & Sweeney, 2005). Specifically, the Holistic Wellness Inventory reflects the ISWEL second order factors of wellness, referred to as the essential self, creative self, coping self, social self,

and physical self. The following survey questions are examples that correspond with each second order factor of wellness: (a) essential self: "I am comfortable with myself as a woman"; (b) creative self: "I am able to share my feelings and emotions," (c) coping self: "I participate in activities that I find enjoyable," (d) social self: "I feel love and joy in my life," (e) physical self: "I am conscious of the health effects of the foods I eat and understand how to read a food label."

Subscales exist within each second order factor. The subscales for each second order factor include: (a) *essential self*: spirituality, self-care, cultural identity, and gender identity, (b) *creative self:* thinking, emotions, control, positive humor, and work, (c) *coping self:* realistic beliefs, stress-management, self-worth, and leisure, (d) *social self*: friendship and love, and (e) *physical self:* exercise and nutrition. No questions examining tenets of gender and cultural identity were on the IYT Whole Person Wellness Survey. Because gender and cultural identity were independent from the other variables, they were created by the researcher. Representation of the whole self is identified as the highest order of the ISWEL. A question for the highest order was also created by the researcher and added to the Holistic Wellness Inventory: "I see my life as an inseparable part of the whole self."

Participants used a four-point likert scale to respond the questions on the Holistic Wellness Inventory: 1-almost always, 2- usually, 3-sometimes, 4-almost never. The participants were asked to choose the number that would represent their response to each item.

Procedure

A proposal for the study was submitted to and approved by the university institutional review board (IRB). Following approval, notification of this study was sent via email to prospective participants. The email detailed the description of the study as well as instructions for completing the survey (Appendix A). Participation in this study was voluntary.

The participants were referred to a web address hosted by SurveyMonkey.com, an online survey creator (http://surveymonkey.com). SurveyMonkey.com allows you to create an online survey with your own questions and variables and collects the results. SurveyMonkey is confidential, allowing access of the data only to the subscriber. SurveyMonkey tabulates the scores. Results were downloaded into a spreadsheet and uploaded into SAS statistical software.

Analysis

Three statistical analyses were used to analyze the results. All data was entered into SAS statistical software to compute statistical output (http://sas.com). Wilcoxon Two-Sample test was used to measure a difference in means of wellness scores for participants that seek traditional healthcare and participants that seek integrative healthcare. Fisher's Exact Test was used to test for differences in each question on the Holistic Wellness Inventory for traditional healthcare and integrative healthcare. Finally, Pearson's correlational analysis was calculated for each second order-factor (Meyers & Sweeney, 2005).

Wilcoxon Two-Sample test

A Wilcoxon Two-Sample Test was performed to calculate an overall wellness score for each participant. Assumptions for the Wilcoxon Two-Sample Test are: (a) the paired differences are independent; (b) each paired difference comes from a continuous distribution that is symmetric; (c) the paired differences all have the same median; and (d) the test to be performed are those relative ranks for the paired differences (http://basic.northwestern.edu). The Wilcoxon Two-Sample Test was the statistical analysis chosen because of the ranked scores, thus meeting assumption *d* stated above. Numbers were assigned for each of the answer choices. Number 1 was assigned for each answer of *almost always;* number 2 was assigned for each answer of *usually;* number 3 was assigned to each answer of *sometimes;* and a number 4 is assigned to each answer of *almost never.* The difference in means was calculated for the categories *Integrative* and *Traditional.*

Fisher's Exact Test

Fisher's Exact Test was used to test for differences in categories *Integrative* and *Traditional* for each wellness question. Fisher's Exact Test is an analysis between two categorical data (Weisstein, 2008). For example, the question, "I balance the time I spend in service to others with experiences that nurture me," a test for differences was done for participants that selected *Integrative* and participants that selected *Traditional*.

Pearson's correlational analysis

Pearson's correlation was used to test for a relationship for the questions that lie within each second order factor. For the second order factors: essential self, creative self,

coping self, social self, and physical self, the corresponding questions for these factors were tested to determine if participant responses were related.

For example, there were five questions that corresponded to *Coping Self*. These questions were: (1) *I like the way my body looks and feels,* (2) *I balance the time I spend in service to others with experiences that nurture me,* (3) *I participate in activities that I find enjoyable,* (4) *I possess tools and skills such as relaxation techniques that allow me to keep my stress in balance,* and (5) *My actions and decisions are based on overall visions of my life's goals meaning and goals rather than momentary fears and desire.* These five questions were tested for a relationship in participant response.

Limitations

The limitations of this study included sampling and instrument used. The sample used in this study was a convenience sample and not a random sample. In order to have a fair and representative sample of the population, a random sample is preferred. Time and finding contributing participants were the primary concerns that necessitated the use of a convenience sample.

The survey for this study has not been statistically validated. It was adapted from the IYT Whole Person Wellness Survey (http://www.adventure-yoga.com). No testing for validity or reliability of the IYT Whole Person Survey has yet been conducted. The researcher attempted to contact the creator of the survey in effort to examine validity and reliability, however, no response was received.

CHAPTER 3

RESULTS

This chapter reports the results of the study including participant demographics, data analysis for the Wilcoxon Two-Factor Test, Fisher's Exact Test, and the correlational analysis.

Participants

The total sample size was 390 participants completing the inventory. General demographics for this inventory include: *race, religion, age, marital status, sexual orientation, and if one has children* (Table 1). Racial identification of participants included 93.5% Caucasian (365), 1.4% African American (6), 1.3% Hispanic (5), 0.2% Asian American or Pacific Islander (1), 0.2% Native American (1), and 2.8% defined race as mixed or other (12). Participants identified religious affiliation as Christian (82.9%), Agnostic (7.0%), Atheist (2.3%), Jewish (1.6%), Buddhist (0.5%), Islam or Muslim (0%), and other (5.6%). Most of the participants were ages 18-35 years (85.1%). The remaining participants were between the ages 36-45 years (9.1%) and 46-55 years (5.8%). Marital status for participants was single (48.9%), partnered or married (40.8%), divorced (9.9%), and widowed (0.5%). For sexual orientation, 95.5% of the sample identified as heterosexual with the remainder identifying as bisexual (3.1%), lesbian (0.9%), and unsure (0.5%). More than half of participants reported not having children (58.5%).

Table 1

Demographic Information for Holistic Wellness Inventory

General Background Information	n	Percentage of Participants
Race		
Caucasian	365	93.5%
African American	6	1.4%
Hispanic American	5	1.3%
Asian/Pacific Islander	1	0.2%
Native American	1	0.2%
Mixed race or Other	12	2.8%
Religion		
Christian	323	82.9%
Agnostic	27	7.0%
Atheist	9	2.3%
Jewish	6	1.6%
Buddhist	2	0.5%
Islam/Muslim	0	0%
Other	23	5.6%
Age Range		
18-25 years	157	40.3%

26-35 years	175	44.8%
36-45 years	35	9.1%

Table 1 (continued).

General Background Information		Percentage of Participants
Age Range		
46-55 years	23	5.8%
Marital Status		
Single	147	37.6%
Partnered	44	11.3%
Married	159	40.8%
Divorced	38	9.9%
Widowed	2	0.5%
Sexual Orientation		
Heterosexual	372	95.5%
Bisexual	12	3.1%
Lesbian	3	0.9%
Unsure	2	0.5%
Has Children		
Yes	162	41.5%
No	228	58.5%

Demographic questions representing general healthcare practice were also included (Table 2). Women reported overall health as *good* (82.4%), overall health as *moderate* (17.2%), and overall health as poor (0.5%). In this sample, 13.6% of women reported being in the recommended age to receive yearly mammograms. Of the 13.6%, 9.0% report getting yearly mammograms. Most women of this sample reported getting yearly pelvic exams (87.8%).

Two demographic questions inquired about healthcare providers: (a) *do you currently see a mental health care professional?* and (b) *how would you describe the gynecological practice where you seek service: Integrative or Traditional?* Few participants reported seeing a mental health professional (8.1%). Most participants reported that they would describe their gynecological practice as traditional (85.0%).

Table 2

Healthcare Demographic Information

General Healthcare Information	n	Percentage of Participants
Overall Health Rating		
Good	321	82.4%
Moderate	67	17.2%
Poor	2	0.5%
Annual Mammograms		
Yes	46	9.0%
No	18	4.6%
Not Applicable	336	86.3%
Annual Pelvic Exams		
Yes	342	87.8%
No	48	12.2%
Mental Health Professional		
Yes	32	8.1%
No	358	91.9%
Gynecological Practice		
Traditional	332	85.0%
Integrative	58	15.0%

Results of Analyses

Wilcoxon Two-Sample Test

The Wilcoxon Two-Sample Test was used to test a significant difference in wellness scores for women going to integrative healthcare practices versus traditional healthcare practices. For the Wilcoxon Two-Sample Test with the significance level set at $p < .05$, the resulting p-value was 0.8559. This result suggested that there is not a significant difference in overall wellness for healthcare practices, since 0.8559 is greater than .05.

Fisher's Exact Test

Fisher's Exact Test is a statistical analysis used to test for differences in categorical data. The categories for this study are *Integrative* and *Traditional.* Fisher's Exact Test was used to test for differences in the individual questions based on if the participant selected integrative or traditional healthcare. For example, is there a significant difference in responses for participants that selected *Integrative* and *Traditional* to the question: *My joints are pain free and support me well?* At significance level $p<.05$, the p-value for Fisher's Exact Test was 0.532, suggesting no significant differences for this test.

Pearson's Correlational Analysis

Pearson's correlational analysis is used to test for a relationship between items. Each question for the Holistic Wellness Inventory was categorized within a second-order

factor, as specified in the ISWEL (Meyers & Sweeney, 2005). The second-order factors are essential self, creative self, coping self, social self, and physical self.

Pearson's correlational analysis was used to measure if the answers within each of these second-order factors were related. No significant relationships were found for correlation analyses ($p<.05$). The results of the correlational analyses are presented in Appendix C. The questions analyzed within each second order factor are as presented in Table 3.

Table 3

Holistic Wellness Inventory Questions by Second Order Factor

Survey Question
Essential Self
3. I am able to maintain a healthy, balanced body weight
12. I avoid tobacco and excess alcohol
13. I receive 7-9 hours of sleep each night and maintain a regular sleep schedule
16. When I become psychologically or emotionally overloaded, I take rest before I become exhausted
17. I dream regularly and take time to reflect on my dreams when I recall them
24. My skin is healthy and problem free
28. I am comfortable with myself as a man or a woman

29. I am connected with the world around me and aware of adversities that affect of nations, races, and genders

Table 3 *(continued).*

Creative Self

18. I take time to laugh and experience the lighter side of life

20. I am able to share my feelings and emotions

21. I am able to express myself with all my feelings within my intimate relationships

25. I am mentally challenged and stimulated by my work

27. I have a sense of control of the direction of my life

Coping Self

2. I like the way my body looks and feels

22. I balance the time I spend in service to others with experiences that nurture me

23. I possess tools and skills such as relaxation techniques that allow me to keep my stress in balance

26. I participate in activities that I find enjoyable

30. My actions and decisions are based on overall visions of my life's goals meaning and goals rather than momentary fears and desire.

Social Self

15. I approach other human beings with an open heart and from a place of compassion

19. I feel love and joy in my life.

Physical Self

1. I feel connected to my body and listen to it for signals and messages

4. I am conscious of the foods I eat and understand how to read a food label

5. I drink adequate amounts of water

Table 3 *(continued).*

6. My body receives all the nutrients, such as vitamins, minerals, and fiber necessary for optimal functioning

7. My blood pressure is balanced and healthy

8. My heart is strong and healthy

9. My joints are pain-free and support me well

10. My muscles provide adequate strength and flexibility for all my usual activities

11. I participate in energizing aerobic activity (walking, running, swimming, etc.) regularly (at least 1.5 hours weekly).

DISCUSSION

This chapter discusses the results of the study, implications for healthcare professionals, suggestions for future research, and summary.

Results

No significant differences in wellness for survey participants using integrative healthcare and those using traditional healthcare were found in this study with the Holistic Wellness Inventory. There are several possibilities for this outcome. First, the percentage of participants currently going to traditional healthcare gynecologists (85%) was disproportionate to individuals using integrative healthcare (15%). Integrative healthcare is a relatively new concept in comparison to the traditional healthcare system (Gaudet & Snyderman, 2002). An individual may have to make a conscious choice to find an integrative healthcare practice. Some of the services offered at integrative healthcare facilities, such as health coaching, a preventive measure of healthcare, is often not covered by insurance companies (http://dukeintegrativemedicine.org). Many of the participants of this study were recruited from a counseling department and a health club. It is possible that many of these individuals are already practicing a healthy lifestyle, even if they are cared for by traditional gynecological practices.

Women over age 40 are recommended to get yearly mammograms (Zieve, 2007). In this sample, 13.6% of women reported being in the recommended age to receive yearly mammograms. Of the 13.6%, 9.0% report getting yearly mammograms. For pelvic exams, it is recommended that women receive a pelvic exam within three years of first having sexual intercourse, or by age 21, and then yearly after that. Sexual activity was

not measured in this study, but all women had to be over 18 years to participate in this study. Most women of this sample reported getting yearly pelvic exams (87.8%).

Limitations

The limitations noted in this study were response scale options, demographic response option error, and convenience sample. The likert-scale responses (a) *almost always,* (b) *usually,* (c) *sometimes,* and (d) *almost never* were used on the Holistic Wellness Inventory . The difference in response levels may be too minimal for individuals to distinguish between them.

For the demographic question '*What is your sexual orientation?'* the responses included (a) *straight,* (b) *homosexual,* (c) *bisexual,* and (d) *unsure*. Response option (a) *straight*, should be changed to heterosexual. The term *straight* implies that the opposite is *crooked* and can be offensive to individuals. This may have led to individuals reporting incorrectly or not reporting at all.

A limitation of this study was defining integrative healthcare for the purpose of research. The tenets of integrative healthcare were set by the researcher to help participants define integrative healthcare. The requirements to meet the definition of integrative healthcare may have included other general healthcare practices that were not integrative by the true definition.

A large number of individuals participating in this study identified race as Caucasian (93.9%) and religion as Christian (82.9%). Myspace.com is a social networking website that allows users to create profile pages to display personal information and pictures (http://myspace.com). Users can "befriend" other users and

share information and post messages for friends to see. The myspace.com profile, *Ladies of the South* assisted in recruiting participants for this study. *Ladies of the South* is a profile page that befriends women living in the southern region of the United States. The demographics of the women who are friends with *Ladies of the South* are unknown. However, the pictures of the women displayed on the webpage are mostly Caucasian women or women with light skin color. This study originally sought a more representative sample that would include women of color and various religious and faith backgrounds. The chance of getting a diverse sample was also limited by using a convenience sample.

Implications for Counselors

When treating clients, counselors need to be knowledgeable of the ISWEL model of wellness. This model illustrates 17 subscales of wellness under each second order factor (Meyers & Sweeney, 2005). The subscales for each second order factor include: (a) *essential self*: spirituality, self-care, cultural identity, and gender identity, (b) *creative self:* thinking, emotions, control, positive humor, and work, (c) *coping self:* realistic beliefs, stress-management, self-worth, and leisure, (d) *social self*: friendship and love, and (e) *physical self:* exercise and nutrition. Counselors should assess each part of the whole person and help clients create a balance between them. .

Counselors are encouraged to work with clients from a whole person philosophy. If counselors are not working with a practice or agency that provides an integrative model of healthcare, referrals to the specialized healthcare professionals may be required. Counselors should build an alliance with other healthcare professionals to consult and

collaborate when it is appropriate for the client. Finally, an integrative model, like counseling, seeks seek to work with clients from a wellness, rather than illness philosophy.

Implications for Women's Heath Practitioners

Treating female health should no longer be divided into sectors. All health specialists, including but not limited to mental health professionals, gynecologists, and nutritionists should be partnering and consulting with one another. They should evaluate the client as a whole person and consider the female's social development while building a trusting relationship with the client. Health practitioners should be mindful that women in today's society have a variety of responsibilities that include choosing the health care providers for the family and building the relationships with the health care providers (Sherr & St. Lawrence, 2000).

Research on female social development suggests that women come from an ethics of care (Gilligan, 1982). As women progress through life they make moral decisions based on the impact the decision may have on other people. Creating relationships and learning to care for others is how a woman grows socially. Women are taught from an early age to act like her mother and to care for others.

Current healthcare practices in the United States do not reflect women's development model (Correa-de-Araujo, R. & Clancy, C.M., 2006). Yet, women tend to be the decision makers for their own health care as well as the health care for family members. Women seek and use more sources of health information including social

support networks, trusted healthcare providers, and independent research (Brown, et al., 2002).

Integrative medicine is a philosophy of wellness, rather than illness and designed to treat the whole person rather than the specific diagnosis (Gaudet & Snyderman, 2002). The goal of integrative medicine is for the patient and group of practitioners to develop a health plan that will supersede the chief complaint and extends to preventive healthcare (Bell et al., 2002). The philosophy of integrative medicine is representative of a women's model of development. The practitioners are tuned in to the whole person, building relationships, and treating the woman as expert while developing the health plan.

Recommendations for Future Research

Deggers-White, et al (2003) found that religion was not positively correlated with feelings of spirituality. Future researchers may further examine the relationship between the variables religious affiliation and questions included in *essential* self, which include spirituality, self-care, cultural identity, and gender identity.

The criteria for integrative healthcare include a health practitioner, such as gynecologist, obstetrician, or nurse practitioner and one or more of the following: (a) complimentary alternative medicine (CAM), (b) mental health professional, or (c) nutrition and exercise specialist. A demographic question asking participants if they were currently seeing a mental health professional was posed in the Holistic Wellness Inventory. Individual questions about if a participant uses complimentary alternative medicine or nutrition and exercise specialists should also be asked. Future researchers can then test for differences in traditional health care alone versus traditional health care

plus the use of mental health, complimentary medicine, and/or exercise and nutrition. This may help health care professionals determine if wellness is positively related to consulting with additional healthcare professionals. A test for differences may also be done with individuals seeking several healthcare professionals independently and those seeking integrative services. Researchers and clinicians may be able to determine if the collaborative model of integrative healthcare is more beneficial for their clients than referring clients to seek these services in the community.

The Holistic Wellness Inventory asks participants to report their perceived level of health. Future research may test the relationship of perceived level of health with level of wellness to examine if participants' perception of personal health is accurate. If a difference between participants' perceived health and actual wellness exists, then healthcare providers may need to evaluate education in the community.

Summary

Women in the United States are relational beings. Wellness is preventive health that includes many levels of physical, psychological, and spiritual components. Integrative healthcare is the philosophy that you treat the total person from a wellness, rather than an illness stance while building relationships with the client. Integrative healthcare is a model that would be ideal for every human being, but especially for women who are making healthcare decisions for herself and her family.

This study looked for differences of wellness in women seeking traditional healthcare and women seeking integrative healthcare services. The researcher created a survey based on the Indivisible Self Wellness Model, (Myers & Sweeney, 2005).

Three tests for significance were conducted. The Wilcoxon Two-Sample Test was used to test a significant difference in wellness scores for women going to integrative healthcare practices versus traditional healthcare practices. Fisher's Exact Test was used to test for differences in the individual questions based on if the participant selected integrative or traditional healthcare. For example, is there a significant difference in responses for participants that selected *Integrative* and *Traditional* to the question: *My joints are pain free and support me well?* Pearson's correlational analysis was used to measure if the answers within each of the second-order factors were related. The second-order factors are essential self, creative self, coping self, social self, and physical self (Meyers & Sweeney, 2005). No significant relationships were found for any test for $p<.05$.

In the future, researchers may want to investigate how different healthcare practitioners or wellness specialists influence the levels of wellness in a person's life. Is a person's level of wellness influenced by working with a mental health care professional, nutritionist, or a complimentary alternative medical specialist? Does the collaboration of these professionals play a role on the level of wellness in a woman's life? Also, how do individual tenets of wellness impact our lives, like religion and spirituality? More research should be done on wellness to further explore the breadth.

REFERENCES

American Psychiatric Association. (2004). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.

Bell, I.R., Opher, C., Schwartz, G.E.R., Grant, K.L., Gaudet, T.W., Rychener, D., Maizes, V., & Weil, A., (2002). Integrative medicine and systemic outcomes research. *Archives of Internal Medicine, 162,* 133-140

Borysenko, J., (1996). *A woman's book of life: the biology, psychology, and spirituality of the feminine life cycle.* New York, NY: Riverhead Books.

Chrisler, J.C., & Lamont, J.M., (2002). Can exercise contribute to the goals of feminist therapy? *Women and Therapy,* 9-22.

Correa-de-Araujo, R. & Clancy, C.M., (2006). Catalyzing quality of care improvements for women. *Women's Health Issues, 16,* 41-43.

Crose, R. Nicholas, D.R., Gobble, D.C., and Frank, B., (1992). Gender and wellness: a multidimensional systems model for counseling. *Journal of Counseling and Development, 71,* 149-156.

Deggers-White, S., Myers, J.E., Adelman, J.U., Pastoor, D.D., (2003). Examining counseling needs of headache patients: an exploratory study of wellness and perceived stress. *Journal of Mental Health Counseling, 25,* 271-290.

Fogel, C.A., & Woods, N.F., (1995). *Women's health care.* Thousand Oaks, CA: Sage Publications.

Gaudet, T.W., & Snyderman, R., (2002). Integrative medicine and the search for the best practice of medicine. *Academic Medicine, 77,* 861-863.

Gibson, D.M., & Myers, J.E., (2000). Gender and infertility: a relational approach to counseling women. *Journal of Counseling & Development, 78,* 400-410.

Gilligan, C., (1982). *In a different voice.* Cambridge, MA: Harvard University Press.

Highet, N. & Drummond, P., (2004). A comparative evaluation of community treatments for post-partum depression: implications for treatment and management practices. *Australian and New Zealand Journal of Psychiatry, 38,* 212-218.

Huffman, S.B., & Myers, J.E., (1999). Counseling women in midlife: an integrative approach to menopause. *Journal of Counseling and Development, 77,* 258-266.

Huffman, S.B., & Myers, J.E., Tingle, L.R., & Bond, L.A., (2005). Menopause symptoms and attitudes of african american women: closing the knowledge gap and expanding opportunities for counseling. *Journal of Counseling and Development, 83,* 48-58.

Mustian, K.M., Katula, J.A., & Gill, D.L., (2002). Exercise: complementary therapy for breast cancer patients. *Women and Therapy,* 105-118.

Myers, J.E., Sweeney, T.J., (2005). The indivisible self: an evidence-based model of wellness. *The Journal of Individual Psychology, 61,* 269-279.

Myers, J.E., Sweeney, T.J., & Witmer, J.M., 2000. The wheel of wellness counseling for wellness: A holistic model for treatment planning. *Journal of Counseling and Development, 78,* 251-266

Pfost, K.S., Stevens, M.J., Matejcak Jr., A.J., (1990). A counselor's primer on post-partum depression. *Journal of Counseling and Development, 69,* 148-152.

Sherr, L., & St. Lawrence, J. (2000). *Women, health and the mind.* West Sussex UD, England: John Wiley and Sons, Ltd.

Sinclair, S.L., & Myers, J.E., (2004). The relationship between objectified body consciousness and wellness in a group of college women. *Journal of College Counseling, 7,* 150-161.

Stein, R.I., Saelens, B.E., Dounchis, J. Z., Lewczyk, C.M., Swenson, A.K., & Wifley, D.E., (2001). Treatment on eating disorders in women. *The Counseling Psychologist, 29,* 695-732.

Unknown Author. (1997). *Profit statguide*. Retrieved February 2, 2008. http://www.basic.northwestern.edu/statguidefiles/srank_paired.html

Unknown Author. (nd). *Adventure Yoga's online wellness survey*. Retrieved November, 6, 2007 from http://www. http://www.adventure-yoga.com/WholePersonWellnessSurvey.pdf

Weisstein, E.W. nd. Fisher's exact test. *Mathworld.* Retrieved February 2, 2008. http://mathworld.wolfram.com/FishersExactTest.html

Witmer, J.M., & Sweeney, T.J., (1992). A holistic model for wellness and prevention over the lifespan. *Journal of Counseling and Development, 71,* 140-148.

Zieve, D. (2007). Medline Plus. Retrieved March 13, 2008. http://www.nlm.nih.gov/medlineplus/ency/article/002125.htm

Appendices

APPENDIX A

Email to Prospective Participant

Dear Prospective Participant,

My name is Brook Powers and I am graduate student in the Counselor Education department at North Carolina State University. I am currently studying the effects of female healthcare on levels of wellness for my master's thesis.

Wellness is a holistic term that includes mental, physical, and social health. The benefits of wellness range from an overall increase in daily productivity to a form of preventive healthcare over a lifespan. I am looking to see if the philosophy of a healthcare practice plays a role in our level of wellness.

If you are a female between the ages of 18-55 and have been seeing the same female healthcare provider for more than one year, your participation in this study is greatly appreciated. This wellness inventory should take between 10-15 minutes to complete.

Continue to this link (surveymonkey.com) Please read the informed consent on page 1 and complete the survey on the subsequent pages.

Thank you for your time and contribution.

Sincerely,
Brook Powers

APPENDIX B

Name_____ Date_____

Age_____

1. What is your current marital status?
___Single
___Married
___Partnered
___Divorced
___Widowed

2. What is your sexual orientation?
___Straight
___Lesbian
___Bisexual
___Unsure

3. What is your race?
___Asian/Pacific Islander
___African American
___Caucasian
___Hispanic
___Native American
___Mixed
___Other

4. What is your religion?
___Agnostic
___Atheist
___Buddhist
___Christian
___Islam/Muslim
___Jewish
___Other

5. Do you have children? Yes No

6. How would you rate your overall health?

Good Moderate Poor

7. If over age 40, do receive yearly mammograms?

Yes No

8. Do you receive yearly gynecological exams?

Yes No

9. How would you describe the gynecological practice where you seek service?
For the purpose of this study an integrative practice is defined as a gynecologist that also incorporates services of a mental health care provider, an expert in nutrition or exercise, or specialist of Contemporary Alternative Medicine (i.e. massage therapist, accupuncturist, or chiropractor). A traditional pracitice is defined as gynecological services only.

Traditional Integrative

Holistic Wellness Inventory

Note: The second order factors are noted in green. If a subscale directly exists within the second order factor, it is included parenthetically.

Directions: This survey is designed to measure the overall level of one's *wellness*. It is based on several variables that comprehensively define the concept of wellness. Answer each question to the best of your ability and choose the response that is most like you.

1. I feel connected to my body and listen to it for signals and messages
   a. Almost Always b. Usually c. Sometimes d. Almost Never
   Physical Self

2. I like the way my body looks and feels
   a. Almost Always b. Usually c. Sometimes d. Almost Never
   Coping self (self worth)

3. I am able to maintain a healthy, balanced body weight
   a. Almost Always b. Usually c. Sometimes d. Almost Never
   Essential self (self care)

4. I am conscious of the health effects of the foods I eat and understand how to read a food label
   a. Almost Always b. Usually c. Sometimes d. Almost Never
   Physical Self (nutrition)

5. I drink adequate amounts of water
   a. Almost Always b. Usually c. Sometimes d. Almost Never
   Physical Self (nutrition)

6. My body receives all the nutrients, such as vitamins, minerals, and fiber, necessary for optimal functioning
   a. Almost Always b. Usually c. Sometimes d. Almost Never
   Physical Self (nutrition)

7. My blood pressure is balanced and healthy
   a. Almost Always b. Usually c. Sometimes d. Almost Never
   Physical Self

8. My heart is strong and healthy
   a. Almost Always b. Usually c. Sometimes d. Almost Never
   Physical Self

9. My joints are pain-free and support me well
   a. Almost Always b. Usually c. Sometimes d. Almost Never
   Physical Self

10. My muscles provide adequate strength and flexibility for all my usual activities
    a. Almost Always b. Usually c. Sometimes d. Almost Never
    Physical Self (exercise)

11. I participate in energizing aerobic activity (walking, running, swimming, etc.) regularly (at least 1.5 hours weekly)
    a. Almost Always b. Usually c. Sometimes d. Almost Never
    Physical Self (exercise)

12. I avoid tobacco and excess alcohol
    a. Almost Always b. Usually c. Sometimes d. Almost Never
    Essential Self (self care)

13. I receive 7-9 hours of sleep each night and maintain a regular sleep schedule
    a. Almost Always b. Usually c. Sometimes d. Almost Never
    Essential Self (self care)

14. I see my own life as an inseparable part of the whole self

a. Almost Always b. Usually c. Sometimes d. Almost Never
Highest Order

15. I approach other human beings with an open heart and from a place of compassion
a. Almost Always b. Usually c. Sometimes d. Almost Never
Social Self (love)

16. When I become psychologically or emotionally overloaded, I take rest before I become exhausted
a. Almost Always b. Usually c. Sometimes d. Almost Never
Essential Self (self Care)

17. I dream regularly and take the time to reflect on my dreams when I recall them
a. Almost Always b. Usually c. Sometimes d. Almost Never
Essential Self (Spirituality)

18. I take time to laugh and experience the lighter side of life
a. Almost Always b. Usually c. Sometimes d. Almost Never
Creative Self (Positive humor)

19. I feel love and joy in my life
a. Almost Always b. Usually c. Sometimes d. Almost Never
Social self (love)

20. I am able to share my feelings and emotions
a. Almost Always b. Usually c. Sometimes d. Almost Never
Creative self (emotions)

21. I am able to express myself with all my feelings inside my intimate relationships
a. Almost Always b. Usually c. Sometimes d. Almost Never
Creative self (emotions)

22. I balance the time I spend in service to others with experiences that nurture me
a. Almost Always b. Usually c. Sometimes d. Almost Never

Coping Self (self worth)

23. I possess tools and skills such as relaxation techniques that allow me to keep my stress in balance
    a. Almost Always b. Usually c. Sometimes d. Almost Never
    Coping Self (stress management)

24. My skin is healthy and problem free
    a. Almost Always b. Usually c. Sometimes d. Almost Never
    Essential Self (self care)

25. I am mentally challenged and stimulated by my work
    a. Almost Always b. Usually c. Sometimes d. Almost Never
    Creative Self (work)

26. I participate in activities that I find enjoyable
    a. Almost Always b. Usually c. Sometimes d. Almost Never
    Coping Self (leisure)

27. I have a sense of control of the direction of my life
    a. Almost Always b. Usually c. Sometimes d. Almost Never
    Creative Self (Control)

28. I am comfortable with myself as a man or a woman
    a. Almost Always b. Usually c. Sometimes d. Almost Never
    Essential Self (gender identity)

29. I am connected with the world around me and aware of adversities that affect other nations, races, and genders
    a. Almost Always b. Usually c. Sometimes d. Almost Never
    Essential Self (Cultural identity)

30. My actions and decisions are based on an overall vision of my life's meaning and goals rather than on momentary fears and desires
    a. Almost Always b. Usually c. Sometimes d. Almost Never
    Coping self (realistic beliefs)

APPENDIX C

Pearson Correlation Output for Essential Self

Question Number				
Regression line P-value				
	Q3	Q12	Q13	Q16
Q3	1.00000	0.04990	0.19335	0.23166
Q3		0.3244	0.0001	<.0001
Q12	0.04990	1.00000	0.21499	0.12974
Q12	0.3244		<.0001	0.0101
Q13	0.19335	0.21499	1.00000	0.31362
Q13	0.0001	<.0001		<.0001
Q16	0.23166	0.12974	0.31362	1.00000
Q16	<.0001	0.0101	<.0001	
Q17	-0.00475	-0.03912	0.11844	0.34814
Q17	0.9253	0.4393	0.0190	<.0001
Q24	0.14010	-0.00135	0.16980	0.17359
Q24	0.0055	0.9788	0.0007	0.0006
Q28	0.28544	0.09983	0.20893	0.27625
Q28	<.0001	0.0482	<.0001	<.0001
Q29	0.04216	0.07941	0.06447	0.15599
Q29	0.4058	0.1165	0.2033	0.0020

Pearson Correlation Output for Essential Self (continued).

	Question Number			
Regression line P-value				
	Q17	Q24	Q28	Q29
Q3	-0.00475	0.14010	0.28544	0.04216
Q3	0.9253	0.0055	<.0001	0.4058
Q12	-0.03912	-0.00135	0.09983	0.07941
Q12	0.4393	0.9788	0.0482	0.1165
Q13	0.11844	0.16980	0.20893	0.06447
Q13	0.0190	0.0007	<.0001	0.2033
Q16	0.34814	0.17359	0.27625	0.15599
Q16	<.0001	0.0006	<.0001	0.0020
Q17	1.00000	0.10015	0.10842	0.23637
Q17		0.0473	0.0319	<.0001
Q24	0.10015	1.00000	0.28311	0.10716
Q24	0.0473		<.0001	0.0339
Q28	0.10842	0.28311	1.00000	0.20217
Q28	0.0319	<.0001		<.0001
Q29	0.23637	0.10716	0.20217	1.00000
Q29	<.0001	0.0339	<.0001	

Pearson Correlation Output for Creative Self

	Question Number				
Regression line P-value					
	Q18	Q20	Q21	Q25	Q27
Q18	1.00000	0.28711	0.20009	0.11446	0.18927
Q18		<.0001	<.0001	0.0238	0.0002
Q20	0.28711	1.00000	0.65125	0.22582	0.41399
Q20	<.0001		<.0001	<.0001	<.0001
Q21	0.20009	0.65125	1.00000	0.20899	0.38859
Q21	<.0001	<.0001		<.0001	<.0001
Q25	0.11446	0.22582	0.20899	1.00000	0.42016
Q25	0.0238	<.0001	<.0001		<.0001
Q27	0.18927	0.41399	0.38859	0.42016	1.00000
Q27	0.0002	<.0001	<.0001	<.0001	

Pearson Correlation Output for Coping Self

Question Number

Regression line
P-value

	Q2	Q22	Q23	Q26	Q29
Q2	1.00000	0.35810	0.29209	0.32384	0.12229
Q2		<.0001	<.0001	<.0001	0.0154
Q22	0.35810	1.00000	0.37080	0.36765	0.22183
Q22	<.0001		<.0001	<.0001	<.0001
Q23	0.29209	0.37080	1.00000	0.35016	0.28312
Q23	<.0001	<.0001		<.0001	<.0001
Q26	0.32384	0.36765	0.35016	1.00000	0.24336
Q26	<.0001	<.0001	<.0001		<.0001
Q29	0.12229	0.22183	0.28312	0.24336	1.00000
Q29	0.0154	<.0001	<.0001	<.0001	

Pearson Correlation Output for Social Self

Question Number

Regression line
P-value

	Q15	Q19
Q15	1.00000	0.13782
Q15		0.0064
Q19	0.13782	1.00000
Q19	0.0064	

Pearson Correlation Output for Physical Self

Question Number

Regression line
P-value

	Q1	Q4	Q5	Q6	Q7
Q1	1.00000	0.19362	0.08419	0.26054	0.07546
Q1		0.0001	0.0956	<.0001	0.1364
Q4	0.19362	1.00000	0.23299	0.42329	0.03974
Q4	0.0001		<.0001	<.0001	0.4333
Q5	0.08419	0.23299	1.00000	0.42962	0.04448
Q5	0.0956	<.0001		<.0001	0.3804
Q6	0.26054	0.42329	0.42962	1.00000	0.16711
Q6	<.0001	<.0001	<.0001		0.0009
Q7	0.07546	0.03974	0.04448	0.16711	1.00000
Q7	0.1364	0.4333	0.3804	0.0009	
Q8	0.05381	0.14336	-0.01039	0.15812	0.45791
Q8	0.2885	0.0045	0.8377	0.0017	<.0001
Q9	-0.04454	0.06405	0.06153	0.08593	0.25915
Q9	0.3798	0.2063	0.2248	0.0897	<.0001
Q10	0.04679	0.07458	0.09868	0.13551	0.18659
Q10	0.3561	0.1410	0.0512	0.0073	0.0002
Q11	0.06594	0.31692	0.31015	0.40096	0.14209
Q11	0.1927	<.0001	<.0001	<.0001	0.0049

Pearson Correlation Output for Physical Self (continued).

	Question Number			
Regression line P-value				
	Q8	Q9	Q10	Q11
Q1	0.05381	-0.04454	0.04679	0.06594
Q1	0.2885	0.3798	0.3561	0.1927
Q4	0.14336	0.06405	0.07458	0.31692
Q4	0.0045	0.2063	0.1410	<.0001
Q5	-0.01039	0.06153	0.09868	0.31015
Q5	0.8377	0.2248	0.0512	<.0001
Q6	0.15812	0.08593	0.13551	0.40096
Q6	0.0017	0.0897	0.0073	<.0001
Q7	0.45791	0.25915	0.18659	0.14209
Q7	<.0001	<.0001	0.0002	0.0049
Q8	1.00000	0.21457	0.17232	0.15648
Q8		<.0001	0.0006	0.0019
Q9	0.21457	1.00000	0.47020	0.16384
Q9	<.0001		<.0001	0.0011
Q10	0.17232	0.47020	1.00000	0.27026
Q10	0.0006	<.0001		<.0001
Q11	0.15648	0.16384	0.27026	1.00000
Q11	0.0019	0.0011	<.0001	