

INTEGRATIVE HEALTH COACHING:
A PHENOMENOLOGY OF CLIENTS' DISCOVERIES

By

Karen L. Goble

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Director of Thesis: Dr. Sharon Knight

Major Department: Health Education and Promotion

The field of health coaching has experienced significant growth in response to the social and economic burden of chronic disease. Integrative health coaching (IHC) applies the principles of integrative medicine and a motivational coaching process to engage clients with attaining self-determined goals. The literature at the time of this study had not examined clients' experiences and meanings in the developing health promotion practice. The purpose of this study was to describe the lived experience of IHC for adult clients who sought the coaching intervention to address a chronic health condition.

The researcher applied a phenomenological approach in the study. Nine participants voluntarily responded to a UMCIRB approved study announcement distributed to clients by integrative health coaches at Duke Integrative Medicine. The collection of qualitative data occurred through in-depth and photo-elicitation interviews. Analysis entailed Moustakas' process of phenomenological reduction and coding using qualitative software.

Study participants acknowledged the difficulty of lifestyle change and readiness to improve their health. Their participation in IHC involved building intrinsic motivation to attain self-defined goals with the support of the coach-client relationship. The essence of clients' IHC experience was engagement in transformational change. Study participants' descriptions

revealed four key structures: a) the integrative medicine framework; b) the health coaching process; c) the sense of transformational change; and, d) engagement. The study findings described client engagement in a health coaching process that uniquely applied mindfulness and integrative medicine practices.

This study contributes to an understanding of the dynamics of mindfulness and integrative medicine in the emerging health coaching practice. The nine IHC clients' experiences provide insights for health professionals who seek to engage persons living with chronic health conditions in a process that supports their self-determined efforts toward goal attainment and realizing health and well-being.

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DISCOVERIES

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Karen L. Goble

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Karen L. Goble

APPROVED BY:

DIRECTOR OF THESIS: _____ Sharon M. Knight, PhD

COMMITTEE MEMBER: _____ Sloane C. Burke, PhD

COMMITTEE MEMBER: _____ Hans H. Johnson, EdD

COMMITTEE MEMBER: _____ Lena W. Carawan, PhD

COMMITTEE MEMBER: _____ Ruth Q. Wolever, PhD

CHAIR OF THE DEPARTMENT OF HEALTH EDUCATION AND

PROMOTION: _____ Tim R. Kelley, PhD

DEAN OF THE GRADUATE

SCHOOL: _____ Paul J. Gemperline, PhD

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CHAPTER I: INTRODUCTION

Interest in health coaching among health promotion practitioners gained momentum in the last decade in response to the increasing burden of chronic disease (Olsen & Nesbitt, 2010). The literature identified a wide range of health coaching models including practices based in life coaching, health education, disease management, and psychology and behavioral health (Hayes, McCahon, Panahi, Hamre, & Pohlman, 2008; Lindner, Menzies, Kelly, Taylor, & Shearer, 2003; Linden, Butterworth, & Prochaska, 2010; Newnham-Kanas, Gorezynski, Morrow, & Irwin, 2009; Olsen & Nesbitt, 2010; Palmer, Tubbs, & Whybrow, 2003). Integrative Health Coaching (IHC) is an emerging model established in Integrative Medicine (IM) (Wolever et al., 2011). IHC builds upon prevailing coaching models yet is unique in the incorporation of central constructs of IM including mindfulness and a whole person approach to health and well-being (Wolever et al., 2011). Initial studies of IHC found that participants with identified risk for cardiovascular disease reduced their 10 year risk for coronary heart disease (Edelman et al., 2006) and participants with type 2 diabetes significantly lowered A1C, a standard measure of glycemic control (Wolever et al., 2010). This qualitative study sought to further understand the IHC model by describing clients' lived experience with the intervention.

In this chapter, the researcher introduces IHC and its relationship to the prevailing models of health coaching. The chapter describes the IM framework for IHC and introduces the construct of mindfulness. The researcher presents a brief overview of key elements of literature concerned with IHC and health coaching. This introductory chapter identifies subject matter that informs the proposed qualitative study of clients' lived experience of IHC and presents the theoretical approach to the phenomenological inquiry.

Background

The Centers for Disease Control and Prevention (CDC) reported an expected mortality of 1.7 million individuals from chronic disease in 2011 (2010). Almost half of the U.S. adult population suffered from at least one chronic health condition (CDC, National Centers for Chronic Disease Prevention, 2009). Chronic disease contributed to over two-thirds of U.S. deaths; the greater part of health costs issued from heart disease, cancer, stroke, diabetes, and arthritis (CDC, 2009). Research demonstrated the effectiveness of increased physical activity, improved nutrition, cessation of tobacco use, and limited alcohol consumption for chronic disease prevention (CDC, 2010). Changes in lifestyle and health behaviors effectively reduced risk for chronic disease (CDC, 2009). The search for evidence-based approaches to reverse the toll of chronic disease among Americans has gained momentum during the last decade (Guarneri, Horrigan, & Pechura, 2010; Linden et al., 2010; Olsen & Nesbitt, 2010; McCabe-Ruff & Mackenzie, 2009; Snyderman & Dinan, 2010).

At the same time, leadership in the field of health promotion called for a shift in principles and practice to promote health as a resource for well-being. The ecological and integrative paradigm envisioned by the World Health Organization and Institute of Medicine advocated a multidimensional approach that aligned with the principles of IM (Liburd & Sniezek, 2007; Snyderman & Weil, 2002; Weisfeld, 2009). The practice of IHC in the framework of IM demonstrated a promising practice that addressed both the call to prevent chronic disease and to promote well-being.

Development of Health Coaching

The practice of health coaching has drawn the attention of professionals and individuals affected by chronic disease as a response to the need for prevention and self-management

(Edelman et al., 2006; Hayes et al., 2008; Olsen & Nesbitt, 2010; Rimmer, Rauworth, Wang, Heckerling, & Gerber, 2009; Tidwell et al., 2004; Vale et al., 2003; Wolever et al., 2010; Young et al., 2007). Health coaching has been variously defined in terms of health education (Palmer, Tubbs, & Whybrow, 2003), nursing (Hayes et al., 2008; Tidwell et al., 2004), life coaching (Moore & Tschannen-Moran, 2010; Newnham-Kanas et al., 2009), and behavioral health and psychology (Linden et al., 2010; Pearson, 2011). Although Olsen & Nesbitt (2010) cited the absence of a standard definition for health coaching as a primary challenge for the field, Palmer, Tubbs, and Whybrow (2003) have provided a frequently used definition. They defined health coaching as “the practice of health education and health promotion within a coaching context, to enhance the well-being of individuals and to facilitate the achievement of their health-related goals” (2003, p. 92).

Programs employing health coaching have emerged in clinics, workplaces, through insurers, and in community settings. Nurses, life coaches, physicians, health educators, psychologists, and counselors have practiced health coaching. Wide-ranging methods and strategies have informed health coaching practice extending from clinical case management, education, and goal setting to behavioral intervention, skill building, and health risk assessment (Butterworth, Linden, McClay, & Leo, 2006; Lindner et al., 2003). Health coaches worked with clients in a variety of settings including in person, via email, and frequently by telephone (Adelman & Graybill, 2005; Olsen & Nesbitt, 2010).

Published literature pointed to the potential of health coaching for supporting individuals with chronic disease as well as for disease prevention and the promotion of wellness (Holland et al., 2005; Linden et al., 2010; Oliver, Kravitz, Kaplan, & Meyers, 2001; Rimmer et al., 2009; Vale et al., 2003; Whittemore, Melkus, Sullivan, & Grey, 2004). Frates (n.d.) provided a

presentation on the status of research and health coaching for the Institute of Coaching at Harvard University. Frates (n.d.) reviewed randomized clinical trials published between 2001 and 2009 that investigated health coaching and concluded there is evidence to suggest health coaching can benefit individuals living with five chronic health conditions: cardiovascular disease, diabetes, asthma, cancer (pain), and overweight/obesity.

Olsen and Nesbitt (2010) found a broad array of structures, settings, and interventions framed as health coaching and called for basic research to define health coaching and establish evidence-based standards of practice. Health sciences researchers reviewed 72 health coaching studies that applied the framework of life coaching (Newnham-Kanas et al., 2009). The researchers found an “operational definition” of health coaching missing in the majority of studies and variability in coaching schools and models among the studies identified (Newnham-Kanas et al., 2009, p. 99). Despite the formative stage of health coaching, programs employing health coaching have expanded in the private and public sectors (Olsen & Nesbitt, 2010).

Integrative Health Coaching

IHC is a model founded in IM that builds upon the life coaching framework (Wolever et al., 2011). This mindfulness-based coaching process applies a holistic approach to support people in their process of realizing optimal health and well-being. Integrative health coaches create a partnership with people who are actively seeking to bring their health in alignment with their own vision and values. IHC demonstrates a humanistic paradigm that is trans-theoretical and builds upon health behavior, learning, and psychological theories (Smith & Rychener, 2010; Wolever et al., 2011). Integrative health coaches apply skills supported by evidence-based practices in health behavior change such as facilitating incremental goal setting and working with ambivalence through the use of motivational interviewing (MI) practices (Linden et al.,

2010). IHC builds upon the core constructs of executive, life, and fitness coaching but is distinct in its knowledge and practice base of holism, wellness, mindfulness, and IM (Lawson, 2009; Wolever et al., 2011).

Integrative Medicine

IHC exemplifies IM in a coaching intervention. IM, frequently mistaken for Complementary and Alternative Medicine (CAM), provides a framework for a multidimensional approach to health that empowers individuals and aims to transform fragmented health systems. Central constructs identified in the IM framework include mindfulness, a whole person approach, person-centered care across the lifespan, collaboration, prospective health and wellness, and application of an array of evidence-based practices (Bell et al., 2002; Maizes, Rakel, & Niemiec, 2009).

IM adopts a humanistic perspective that emphasizes intrinsic well-being and wholeness and promotes patients' self-determination as opposed to the disease orientation of standard care. IM engages "patients and caregivers in the full range of factors known to be effective and necessary for the achievement of optimal health over the course of one's life" (Weisfield, 2009, p. 2). The practice of IM "makes use of the best conventional care and the latest advances in predictive, preventive, and personalized medicine" by applying "evidence-based prevention, treatment, and supportive approaches" (Weisfield, 2009, p.2). IM addresses the individual holistically and demonstrates a unique approach to health care and health promotion.

IHC Development

Centers for IM are developing IHC models, professional training in IHC, and IHC certification programs. Duke Integrative Medicine (Duke IM), for example, launched a working model for IHC in 2002 with a randomized controlled study that found IHC in conjunction with

personalized health planning was effective in reducing the ten-year risk of coronary heart disease (Edelman, et al., 2006). Duke IM began offering professional IHC training in August 2008 and IHC certification in July 2010 (“The History of IHC,” 2009).

IHC training and certification programs established minimum credentialing requirements that participants have a professional health degree such as an R.N. or a minimum of a bachelor level education and experience in an allied health field such as Health Education or Social Work. Professionals certified in a Complimentary and Alternative practice such as massage therapy or yoga therapy met requirements for admission to integrative health coaching programs. IHC training programs emerged in graduate and undergraduate nursing and health programs and provided the IHC skills to nursing and allied health students (“Center for Spirituality,” 2011; “Graduate Certificate,” n.d.). IHC training and certification for professionals developed in hospitals and university IM centers. Each IHC training and certification program has established site-specific admission requirements. National criteria for health coach training and credentialing were in development when the researcher conducted this study.

At the time of this study, multiple university medical programs and academic graduate programs had initiated IHC training or certification. The University of Minnesota, Center for Spirituality and Healing launched a graduate level IHC training and certification program in 2005 (“Center for Spirituality,” 2011). The California Institute for Integral Studies (CIIS) initiated an applied IHC program that addressed health disparities (“CIIS Integrative Health Coaching,” 2009). West Chester University of Pennsylvania (“Graduate Certificate,” n.d.) had begun to offer an IHC graduate certificate. Integrative medicine programs such as the Vanderbilt Center for Integrative Health provided IHC for people served by the university clinic

(“Health Coaching,” 2012). The researcher found an increasing number of IHC practitioners in medical practices or self-employed in their own business.

Minnesota IHC Model

The University of Minnesota’s Center for Spirituality and Healing is a partner in advancing the field of IHC (“Center for Coaching,” 2011). The Center at the University of Minnesota collaborated with the Center for Coaching in Healthcare at Harvard Medical School to coordinate what they referred to as a “National Team for Standards, Certification, and Research for Professional Health and Wellness Coaches” (Institute of Coaching, 2011). Stakeholders in the health coaching field have been actively engaged in the working groups launched by the University of Minnesota and the Center for Coaching in Healthcare.

Lawson (2009) identified four constructs central to the University of Minnesota IHC model: (a) mindful presence; (b) authentic communication (deep listening, curious inquiry, perceptive reflections); (c) self-awareness; and, (d) safe space. Integrative health coaches are process experts according to Lawson (2009). IHC viewed participants as experts in their health and empowered them to build skills, set goals, and take effective action based on their identified strategies and solutions that included recommendations from their physician(s) or other health care providers. The dyadic relationship between individual and coach is a core element of the IHC process. Lawson describes the IHC dynamic as “client-directed, relationship-centered practice to facilitate individuals shifting their lives and health from wherever they are to wherever they want to go at the speed at which they are ready to move” (2009, p. 17).

Duke IHC Model

Duke IM defines IHC as “dynamic partnerships that move clients toward satisfying and healthy lifestyles” (Smith & Rychener, 2010, p. 16). Duke IM faculty developed the Integrative

Health Coaching Process Model (IHCPM) that sets forth a framework for coaching and personalized health planning and defines the core constructs of IHC (Smith & Rychener, 2010). The IHCPM is a model that applies the central principles of IM in the coaching practice and concentrates on the process of health behavior change rather than content knowledge regarding specific conditions.

Smith and Rychener (2010) acknowledged the origins of the IHCPM in life and executive coaching. The International Coach Federation (ICF) and Coaches Training Institute (CTI) contributed foundational methods, skills, and ethics to IHC. Theoretical approaches applied in multiple disciplines informed IHC including health education and psychology. The Duke IM model put into practice constructs from Positive Psychology, Self-Determination Theory (SDT), MI, the Transtheoretical Model (TTM), Social Cognitive Theory (SCT), Cognitive Behavioral Therapy (CBT), and adult learning theories in the IHC process (Smith & Rychener, 2010; Wolever et al., 2011).

Mindfulness and IHC

A central construct of Duke's IM program and IHC model, like other IHC models, is mindfulness (Wolever et al., 2011). Mindfulness is a natural quality of attention accessed by letting go of critical thought and witnessing the present moment. Mindfulness describes a state of being present rather than doing. Brantley defines mindfulness as paying attention on purpose with non-judging openness to the experience of the present moment (2003). Mindfulness is the practice of maintaining an authentic and holistic presence with all the circumstances and conditions of life.

Mindfulness Based Stress Reduction (MBSR) practices set forth by Kabat-Zinn in a program for persons with chronic health conditions provided the foundation for the application

of mindfulness in IHC (2003, 2005). Kabat-Zinn (2003, 2005) systematically applied mindfulness practice in a medical setting in the MBSR program. Mindful Eating programs built upon Kabat-Zinn's program and applied MBSR practices to address overweight and obesity and eating disorders (Kristeller, Baer, & Quillian-Wolever, 2006). Numerous studies regarding mindfulness and chronic health conditions have related consistent health benefits to mindfulness practice (Greeson, 2009; Gross et al., 2010; Grossman, Niemann, Schmidt, & Walach, 2004; Kabat-Zinn, 2003). Duke IHC certification requires completion of an MBSR program and supports the application of mindfulness in the coaching process by encouraging the development of coaches' personal mindfulness practice (Smith & Rychener, 2010). The experience with personal mindfulness is prerequisite for facilitating the practices in IHC.

IHC Research

Key areas of literature reviewed for this IHC study were IM, health coaching, and mindfulness and health. The literature distinguished IM from traditional allopathic medicine in terms of vision, values, understanding of the person, and approach to health (Bell, et al, 2002). IM is concerned with the whole person and the individual's personal agenda regarding wellness rather than the absence of disease or symptoms (Verhoef, Mulkins, & Boon, 2005; Wolever et al., 2011). IHC applies IM values and approach and thus differs from conventional health coaching.

The early phase of IHC research has shown promise for the intervention in prospective health and health promotion. A randomized clinical trial involving persons living with type 2 diabetes, for example, found the IHC intervention to be a promising strategy for improving participants' glycemic indicators (Wolever et al., 2010). A randomized controlled trial involving participants with at least one identified cardiovascular risk factor that were recruited from

community medical practices provided evidence that personalized health planning and IHC could reduce ten year risk for cardiovascular disease among participants (Edelman et al., 2006).

The first qualitative study of Duke IHC described the intervention as it evolved during three foundational IHC studies (Wolever et al., 2011). The organizational case study drew on the experiences of the six original Duke IM coaches and Duke IM documents to identify the core elements of the IHC practice (Wolever et al., 2011). Study findings addressed both the definition and process of IHC (Wolever et al, 2011).

This organizational case study of the Duke IHC model described the defining qualities of IHC as “aligned with integrative medicine” (Wolever et al, 2011, p. 32). Participating integrative health coaches distinguished IHC from the medical model and life coaching as well as from health education and psychotherapy (Wolever et al., 2011). While distinct from life coaching, the study found that life coach training was an important foundation for IHC (Wolever et al, 2011).

The six founding Duke integrative health coaches who engaged in the study described the necessity for IHC participants to have time, motivation, and commitment in order to benefit from the IHC process (Wolever et al., 2011). The study found that the nature of the coach/client relationship empowered clients and created a partnership that supported self-discovery (Wolever et al., 2011). The coaches described an active process in which clients linked personal values to goals in order to sustain motivation and resolve ambivalence regarding change (Wolever et al., 2011).

Study Significance

Proceeding from the work of Wolever et al. (2011) that focused on the founding IHC coaches’ experience, a qualitative study of client experiences with IHC such as the currently

proposed study is a logical next step in investigating themes and structures that can contribute insight into the IHC process model. A dearth of literature exists regarding how clients perceive and experience IHC. Since individual clients drive the IHC process and define what is important to and for them in coaching, an unanswered question relates to the constructs that clients identify as central to IHC. A qualitative investigation of client experiences with IHC can contribute to an understanding of how individuals perceive, experience, and derive meaning from the IHC process. Qualitative research of client experiences can help identify the essential structures of integrative health coaching and inform future studies of IHC.

Problem Statement

Health coaching, in response to the need for chronic disease prevention, has gained momentum in the current health care arena. The literature identified a wide range of operational definitions, approaches, and methods under the umbrella of health coaching (Newnham-Kanas et al., 2009; Olsen & Nesbitt, 2010). The IHC model shares theoretical foundations and methods with many health coaching programs; however, IHC is unique in the application of health coaching in an IM framework. The Wolever et al. (2011) study has contributed to defining IHC by investigating how the integrative health coaches who established IHC at Duke IM understood the practice and implementation of the IHCPM. The findings suggest that IHC differs from the medical model and reflects core constructs of the IM foundation such as mindfulness and the whole person approach (Wolever et al., 2011).

IM and IHC embrace person-centered care that clarifies and acknowledges client values and understandings (Smith & Rychener, 2010). IHC views clients as the experts in their lives, health, and the strategies for achieving goals they define. Integrative health coaches collaborate with clients in creating the design of their working relationship. Clients actively shape their

individualized IHC process, therefore client perspective and understanding of IHC is necessary to contribute to knowledge of the field. The researcher has identified the need to describe clients' experiences from their perspectives in order to add to the knowledge of the IM-based process. The literature has not described the significant structures and qualities of IHC identified by clients. Research investigating client experience in IHC can elaborate upon the Wolever et al. (2011) organizational case study that examined coaches' understanding of the model and practice. From clients' descriptions, core constructs of the practice may emerge and data collected may contribute to the knowledge of the field of IHC and its application in health promotion and prevention.

Study Purpose and Research Question

The purpose of this study was to describe the meaning and lived experiences of IHC from the perspective of adult clients with chronic health conditions who participated in IHC for at least six sessions within the past year. Clients engaged as partners in defining their IHC experience and their descriptions contributed to the knowledge and conceptualization of the IM-based coaching practice. The research question asked, "What is the lived experience and meaning of IHC for adult clients with a chronic health condition and at least six sessions of IHC experience within the past year?"

Research Design

The purpose of the qualitative IHC study was to investigate co-researchers' lived experiences and meanings with a multidimensional IM intervention called IHC. Clients actively shaped their IHC experience. Client partnership in defining care was a key tenet of IM. Study participants' provided descriptions essential to identifying and understanding key themes and structures that elaborated previous findings about the model (Edelman et al., 2006; Wolever et

al., 2010; Wolever et al., 2011). The structures identified by study participants can contribute to the development of the IM-based practice and further areas for research.

Phenomenological studies described co-researcher experiences and identified core themes and structures of their lived experience that, in the case of this study, related to how individuals experienced IHC (Creswell, 2007; Moustakas, 1994; Patton, 2002). The researcher applied Moustakas' phenomenological approach articulated by Creswell (2007) in a pilot study she conducted in November 2010. The pilot study informed the design of the proposed IHC study sample, interview process, and methods of analysis.

The researcher identified Moustakas' (1994) descriptive method of phenomenological analysis for the IHC thesis study. Moustakas' (1994) method provided a systematic process to describe the lived experience of co-researchers that aligned with the study purpose and discovery-oriented qualities of IHC and mindfulness. The phenomenological approach, like IHC and mindfulness, worked with the elements of presence, attention, self-awareness, perspective, and insight. Moustakas' model of analysis involved the steps of phenomenological reduction, imaginative variation, structural description, and synthesis of the essence or "core meanings" of co-researchers' experiences (Moustakas, 1994; Patton, 2002, p.106).

Moustakas' phenomenological approach involved the researcher's engagement in a systematic process of epoche, bracketing, and reflexivity (1994). The researcher iteratively examined the experiences described by co-researchers and her own experience throughout the study process. The researcher implemented the MBSR model developed by Kabat-Zinn (2003) as a process to cultivate laypersons' mindfulness practice. Specifically, she used the MBSR model presented by Duke IM as an approach to epoche, bracketing, and reflexivity.

Descriptive phenomenological research entailed identifying the universal structures that emerged from textural description (content) and structural description (process) and fit this study that entailed exploratory research of phenomena involving complex dynamics and levels of experience (Creswell, 2007). Phenomenology engaged the researcher and co-researchers in a shared process of inquiry. The researcher directed attention to co-researchers’ experiences, perspectives, and meanings. Moustakas’ (1994) phenomenological approach suited the exploration and description of co-researcher experiences in IHC and addressed the proposed research question, “What is the lived experience and meaning of IHC for adult clients with a chronic health condition and at least three months of IHC experience?”

Definition of Terms

| Term | Definition |
|--------------------------|--|
| Bracketing | In phenomenological inquiry, bracketing involves directing attention on purpose. The researcher [brackets] or directs attention to her mental model, schemas, and presuppositions in order to recognize them and be aware of the content and processes of her conscious mind (Bernard & Ryan, 2010). Bracketing is the process of concentrating attention and is an element of epoche (Moustakas, 1994; Thompson, 2007). |
| Chronic health condition | In the context of this study, a chronic health condition refers to a disease or health condition that persists for more than three months or one of the 97 Chronic Disease Indicators defined by the National Center for Chronic Disease Prevention and Health Promotion (CDC, 2009). |
| Epoche | In phenomenological study, epoche is the practice of cultivating open awareness and immediacy or presence that leads to insight. It describes |

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| | <p>the researcher’s stance toward the phenomenon that allows the researcher to perceive the phenomenon as it is and not through the filters of her mental model or natural and scientific attitudes. Epoche describes mindful awareness (Moustakas, 1994; Thompson, 2007).</p> |
| Health coaching | <p>A process in which a dyad of coach and client design a relationship to facilitate developing and achieving goals that support lifestyle and health behavior change with the purpose of specific disease prevention and overall health and well-being (Butterworth et al., 2006).</p> |
| Integrative health coaching | <p>A mindfulness-based IM process in which coach and client design a relationship that engages the client in clarifying values, setting goals, and acting to realize the client’s vision of well-being. The participating client defines IHC content and pace (Lawson, 2009; Wolever et al., 2011).</p> |
| Integrative medicine | <p>IM is a paradigm that embraces a collaborative approach to health and well-being. IM places clients in an active role in care and addresses the multiple domains of human life including mind, body, spirit, relationship, community, and environment. IM applies the evidence-based practices of conventional medicine and CAM and focuses on health promotion and well-being through the lifespan (Snyderman & Weil, 2002; Weisfeld, 2009).</p> |
| Life coaching | <p>A process that designs a partnership between coach and client and that facilitates the client in clarifying values and setting self-defined goals that support action toward realizing their vision and life purpose (Whitworth, Kimsey-House, Kimsey-House, & Sandahl, 2007; ICF, 2011).</p> |

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| <p>Mindfulness</p> | <p>Mindfulness is a natural mind/body state involving attention and awareness. Kabat-Zinn provides an operational definition of mindfulness: “the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment” (2003, p. 145).</p> |
| <p>Mindfulness-Based Stress Reduction (MBSR)</p> | <p>An eight week outpatient program, developed by Kabat-Zinn at the Stress Reduction Clinic of the University of Massachusetts Medical Center in the late 1980’s, that is now an evidence-based replicable model for participants to cultivate a personal mindfulness practice in a secular setting (2003, 2005).</p> |
| <p>Phenomenology</p> | <p>A philosophical and research paradigm founded by Husserl (1859 – 1938). Phenomenology is a research framework that investigates phenomena and their essential structures as directly experienced through the lens of the intentional conscious mind/body. Phenomenology entails self-awareness, presence, and attention. Phenomenology attempts to overcome the subject-object split and recognizes that scientific inquiry occurs in the context of relationships that must be clarified (Creswell, 2007; Moustakas, 1994; Thompson, 2007).</p> |
| <p>Practice</p> | <p>In this study, practice signifies engagement in an active and intentional process, particularly the process of cultivating mindfulness, rather than rote or rehearsed application of techniques (Kabat-Zinn, 2003).</p> |

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| Reflexivity | A systematic process applied in qualitative research whereby the researcher examines her actions and perceptions or mental constructs. The researcher observes and records her mind/body process as well as her reactions and responses in order to cultivate self-awareness in relationship to the study topic and process (Moustakas, 1994; Patton, 2002). |
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Delimitations

The researcher delimited this study to the experience of Duke IM health coaching clients who received coaching from eight formative Duke IHC coaches including the six IHC coaches involved as participants in the Wolever et al. organizational case study (2011). The study employed purposive sampling to identify nine co-researchers who reside in the U.S. and have proficiency in English language, in an effort to address the research question. The study recruited and enrolled adults, aged 18 years or older, who are former or current clients of eight Duke integrative health coaches with formative experience in the IHC model (Wolever et al., 2011). The co-researchers sought IHC to address a chronic health condition in order to emphasize the health domain, as distinguished from individuals who might have sought IHC as an integrative approach to life coaching. Co-researchers met the criteria that they engaged in a minimum of six IHC sessions in order to gather data from those who have experienced sufficient coaching sessions to progress through the IHCPM steps (Smith & Rychener, 2009; Wolever, et al., 2011). The co-researchers participated in IHC within the past twelve months in order to have sufficient recall of their experience to provide the detailed description necessary for phenomenological research.

Limitations

A limitation related to study design existed due to the parameter that the study recruited co-researchers from one program, Duke IM. The recruitment of co-researchers from other IHC programs was beyond the scope of the current study but limited the understanding of IHC to co-researcher experience of the Duke model.

IHC clients with strong responses to the coaching experience were more likely to respond to the research study announcement and commit to the time and effort involved in participating in a qualitative study (Patton, 2002). Participants were more likely to have had strong positive IHC experiences, as this was the case with volunteers for the pilot study conducted by the researcher prior to this study. Participants who had ambivalent, neutral, or negative IHC experiences were unlikely to volunteer for the study. The individual's relationship with her or his coach who sent the announcement could have influenced IHC participant response to the study announcement. IHC participants who did not respond to the study announcement could have experiences and perspectives essential to the understanding of the IHC model (Groger, Mayberry, & Straker, 1999).

The transcendental phenomenological approach is descriptive of the lived experience of the particular study participants at the time of the study and is not representative of or generalizable to a broader population (Creswell, 2007). The design of the qualitative approach elicits in-depth insight, meaning, and individual experience rather than addressing the scope of the IHC discipline. Universal themes and structures may emerge from the qualitative study that can inform further experimental investigation but the findings are specific to those who participated in this study (Creswell, 2007; Patton, 2002).

Assumptions

The IHC study design reflected the following researchers' assumptions. The eight Duke IHC coaches were likely to forward the study announcement to clients. Participants were likely to describe their IHC experiences honestly due to the voluntary recruitment process. The in-depth interview method of data collection assumed that participants could describe and articulate their IHC experience and meanings. The use of an open-ended interview guide with prompts and probes assumed that participants would describe the full range of experience with IHC (positive, neutral, difficult).

The IHC study design assumed that participants would have a degree of familiarity with open-ended telephone processes and questioning based upon their coaching experience. The telephone was the typical setting for the IHC process. The IHC study design assumed that the influence of a particular coach would not uniquely bear on participant recruitment and response. The study assumed that the researcher could identify and examine her knowledge and practice of IHC through a reflexive process. The researcher applied MBSR practices as a method of engaging in reflexivity.

Researcher Qualifications

The researcher was a graduate student in Health Education and Promotion at East Carolina University at the time of the study. She had completed prerequisite coursework for undertaking a thesis study. The researcher received IHC professional training and certification at Duke IM in 2010. The researcher's undergraduate studies in philosophy and an independent study of phenomenological foundations and Moustakas' (1994) approach contributed to her understanding of the method and its tenets. The researcher's experience during a pilot study she conducted in November 2010 as well as a review of published studies and supportive materials informed the design of the IHC study.

CHAPTER II: REVIEW OF LITERATURE

According to the Centers for Disease Control and Prevention (2010), chronic disease has exacted a significant personal and societal cost, and accounted for the majority of preventable deaths and disabilities in the United States. The IHC intervention emerged from IM, a paradigm for healthcare that takes a holistic approach to prevention and promotion (Snyderman & Weil, 2002). Published literature about IHC at the time of this study was limited but suggested that the intervention was effective in reducing risk and addressing chronic health conditions (Edelman, et al., 2006; Wolever et al., 2010). The purpose of this literature review was to present the current knowledge about IHC and clarify the gap in the literature that the current study addressed.

The aim of the study was to describe the lived experiences of IHC from the perspectives of adult clients with chronic health conditions who have participated in a minimum of six IHC sessions within the past year. These IHC clients informed the content and process of coaching in collaboration with their coaches (Wolever et al., 2011). Research that employed an experimental design to investigate IHC outcomes related to chronic disease has provided a partial understanding of the intervention and its applications (Edelman et al., 2006; Wolever et al., 2010). This qualitative research study will contribute to knowledge of IHC by investigating and describing the perspectives and experiences of IHC clients (Patton, 2002).

IHC has been firmly rooted in IM, an approach to medicine with a substantially different worldview than traditional allopathic medicine (Lawson, 2009; Wolever et al., 2011). Published literature described IHC as concerned with the whole person and their well-being rather than the absence of a disease or symptom (Lawson, 2009; Wolever et al., 2011). The client guided the IHC process and set goals based on what they found meaningful and important (Wolever et al., 2011). Unlike other forms of health coaching, the conceptual framework and IM model that

informed the development of IHC emphasized mindfulness (Lawson, 2009; Smith & Rychener, 2010; Wolever et al., 2011).

Mindfulness practices originated in Buddhist and ancient Vedic traditions but similar contemplative practices exist among the world religions. Kabat-Zinn (2005) established the application of mindfulness practice as a formal health intervention at the University of Massachusetts Medical Center in 1979. Mindfulness has been described as inquiry that involves qualities of attention, intention, and acceptance, notably self-acceptance (Kabat-Zinn, 2003). Kabat-Zinn (2003) noted that non-judgmental awareness of the present moment was central to mindfulness practice. Research has found that mindfulness benefitted individuals who experience health difficulties such as a chronic health condition (Greeson et al., 2008; Gross et al., 2010; Grossman et al., 2004; Kabat-Zinn, 2003; Shapiro, Oman, Thoresen, Plante, & Flinders, 2008). The Duke IHC model applied the mindfulness elements of attention, self-awareness, acceptance, non-judgment, inquiry, and presence to the coaching process (Smith & Rychener, 2010).

The literature review examined central topics relevant to IHC, with a focus on published studies addressing IM, approaches to health coaching, mindfulness in health coaching, and the IHC process model. The review sought to ascertain the current knowledge about IHC at the time of this study. The researcher identified IM, the role of the coach, and mindfulness as constructs in a sensitizing framework in the qualitative study (Patton, 2002).

Literature Review Method

The researcher conducted a search of published literature on IHC using relevant health-related electronic databases including CINAHL via EBSCO, Dyna Med, EBM Reviews, Medline via OVID, and Medline via PubMed. The researcher also searched Google Scholar.

The researcher considered theoretical and methodological literature. Search terms included: a) integrative health coaching; b) health coaching; c) mindfulness and health coaching; d) mindfulness and integrative medicine; e) integrative medicine and outcomes; f) qualitative research and health coaching; and, g) health coaching and outcomes.

IHC training materials and the program manual from the Duke IM IHC professional training program were included as supplemental materials (Brantley, 2009; Smith & Rychener, 2010). The supplementary material was consistent with the purpose of this review to identify considerations for qualitative study design rather than investigate outcomes. The researcher used a coding process with six identifiers to analyze the literature: a) IM elements; b) IHC elements; c) mindfulness elements; d) health coaching elements; e) health coaching outcomes research; and, f) research considerations. The researcher will use these elements to provide a framework for this review of the literature.

Foundations of Integrative Medicine

What makes health practice integrative? Kreitzer, Kligler, and Meeker (2009) reviewed definitions of integrative health and medicine for health practitioners. Common elements emerged from the leading definitions of integrative practice (Kreitzer et al., 2009). The researchers found that IM addressed the whole person and involved all dimensions of the individual including mind, body, and spirit. They noted that individuals' central and active role in designing their health care was fundamental to the IM approach.

IM prioritized interpersonal relationships across life domains (Bell et al., 2002). Significant relationship domains included patient and provider, collaboration among providers, the patient's personal relationships and support system, and the patient's relationship with their community and community support systems (Bell et al., 2002). Snyderman and Dinan (2010)

suggested that individualized and person-centered health planning plays a central role in IM and the practice accessed a range of appropriate and evidence-based therapies. Weisfield (2009) observed that IM focuses on prevention, wellness, and the individual's vision of health. IM leaders concurred with the WHO definition that health is more than the absence of disease (Bell et al., 2002; Weisfield, 2009). Bell et al., (2002) noted that achieving optimal health is not a linear process; attaining and sustaining wellness required returning to goals, health behaviors, therapies, and support in a complex and dynamic process.

Integrative health care encompassed a multidimensional, dynamic, and emergent system of care (Snyderman & Weil, 2002). Bell et al. observed that IM transcended the individual interventions of conventional as well as complementary and alternative medicine (CAM) (2002). An additive construct where a CAM therapy supplemented a conventional treatment plan did not represent IM (Bell et al., 2002). IM differed qualitatively from conventional medicine even though it involves allopathic practice (Bell et al., 2002).

Studies that have assessed outcomes of IM were promising in terms of prospective health and prevention (Guarneri et al., 2010). A literature review examined clinical research and the cost effectiveness of IM (Guarneri et al., 2010). The reviewers found a substantial body of published literature examining elements of IM as well as a number of randomized controlled trials that investigated multi-modal integrative interventions (Guarneri et al., 2010). Findings indicated that IM holds significant benefit for chronic disease management and prevention. The research showed that healthy lifestyle changes resulted in major improvements in reducing risk, alleviating symptoms, reversing progression, or even resolving chronic health conditions (Guarneri et al., 2010). The literature identified diabetes, cardiovascular disease, cancer,

arthritis, chronic pain, obesity, and depression as health conditions demonstrated to be responsive to an IM approach (Guarneri et al., 2010).

Review of Health Coaching

Health coaching has attracted attention among professionals and the public concerned with prevention and prospective health. A growing body of literature examined the applications, methods, and outcomes of health coaching (Newham-Kansas et al., 2009; Olsen & Nesbitt, 2010). Health coaching has received the most attention for chronic disease prevention and self-management as the individual and societal costs of chronic disease skyrocketed (Hayes & Kalmakis, 2007; Linden et al., 2010; Linder et al., 2003, Olsen & Nesbitt, 2010).

Health coaching outcomes. Health coaching outcomes and elements of coaching were the subjects of a systematic review of literature by Olsen and Nesbitt (2010). The review found health coaching efficacious for health behavior change, prevention, and disease management (Olsen & Nesbitt, 2010). Health coaching showed promise for addressing diet and nutrition, physical activity, weight management, medication compliance, and health risk factors such as blood glucose, lipids, and blood pressure (Olsen & Nesbitt, 2010). Frates (n.d.) presented a report on health coaching outcomes for the Institute of Coaching and identified twelve randomized controlled trials (RCT) that investigated health coaching outcomes. Similar to Olsen and Nesbitt (2010), Frates (n.d.) noted that the variability of coaching interventions limited the findings that indicated health coaching demonstrated effectiveness in prevention for asthma, cancer pain, cardiovascular disease, diabetes, and overweight/obesity.

Health coaching resulted in increased physical activity and weight loss in a study that involved predominantly African American women with severe obesity and mobility limitations (Rimmer et al., 2009). The researchers randomized 92 participants to three groups that received

information only, weekly phone coaching, or weekly phone coaching plus a physical activity support group. The health coaching with a support group experienced the most significant reduction in barriers to physical activity, increased activity, and decreased body weight (Rimmer et al., 2009). The health coaching only group also experienced a significant increase in physical activity according to standardized mobility measurements (Rimmer et al., 2009). The researchers found that the person-centered health coaching interventions held promise for engaging persons with transportation and mobility barriers and for providing ongoing support for increased physical activity and weight loss, factors important in addressing severe obesity among persons with mobility challenges (Rimmer et al., 2009).

The DIAL pilot study randomized participants to a self-directed weight loss program, ten sessions of telephone health coaching, or twenty health coaching sessions (Sherwood, Jeffrey, Welsh, VanWormer, & Hotop, 2009). The researchers found higher, but not significant, weight loss for coaching participants who engaged in a minimum of ten sessions and recommended further study to examine dose and time (Sherwood et al., 2009). Tucker, Cook, Nokes, and Adams (2008) found that telephone health coaching resulted in increased weight loss for adults who received eleven sessions over three months.

University students who lived with obesity reported lifestyle changes, increased self-acceptance, and improved self-care following nine sessions of a life coaching model applied to support health (vanZandvoort, Irwin, & Morrow, 2009). The researchers applied inductive content analysis to explore the experience of five university students coached by a certified Co-Active life coach (vanZandvoort et al., 2009). The participants described increased motivation that resulted in healthy choices regarding physical activity and nutrition (vanZandvoort et al., 2009).

Oliver, Kravitz, Kaplan, and Meyers (2001) investigated the effects of one health coaching session in reducing pain for 67 participants undergoing treatment for cancer and found that health coaching significantly improved reduction in pain severity at the two-week follow-up point. The Ca-HELP study expanded the health coaching RCT enrolling 265 patients receiving cancer treatment (Kravitz et al., 2009). Street Jr. et al. (2009) examined the effects of the Ca-HELP coaching intervention on patient-physician communication and analyzed audio-recorded physician sessions for 148 of the Ca-HELP participants. Street Jr. et al. (2009) found that the tailored health coaching intervention improved patient communication with their physician regarding cancer pain. Subsequently, Kravitz et al. (2011) found that communication did not predict pain control while increased self-efficacy for pain control in the Ca-HELP health coaching group significantly predicted improved pain control at 12 weeks. The Ca-HELP study found that health coaching improved pain control among participants undergoing cancer treatment. The single dose intervention limited comparison with health coaching studies that provided ongoing contact and a relationship with the health coach.

Nurses provided telephone health coaching in a randomized study that investigated outcomes related to cardiovascular disease for 792 participants referred from university hospitals (Vale et al., 2003). The Coaching patients On Cardiovascular Health (COACH) study found that participants who engaged in five sessions of health coaching over six months measured significant total cholesterol reductions compared to those randomized to usual care (Vale et al., 2003). Researchers found that the COACH participants exercised more, improved nutrition, and reported improved overall health (Vale et al., 2003).

Young et al. (2007) modified the COACH model to address the needs of participants with type 2 diabetes. The Patient Engagement and Coaching for Health (PEACH) randomized

controlled trial replicated the COACH study with modifications that employed practice nurses as health coaches and provided one face to face and eight telephone coaching sessions over an 18 month period. At the time of this study, researchers had not published outcomes of the PEACH study. Researchers employed a grounded theory approach to analyze transcripts of PEACH health coaching sessions and found coaches displayed two distinct styles in working with the multidimensional challenges of study participants (Walker et al., 2011). The researchers described the working relationships that the nurse coaches developed with participants as “personalized care” or “treat to target” (Walker et al., 2011, p. 420). Analysis of the effects of the two styles has not been determined. The differing approaches illustrated a significant difference in health coaching interventions. Clients established the focus of the coaching session and addressed concerns across life domains in the person-centered approach. Health coaching that maintained the session focus on specific targets defined by the program represented a disease management approach.

Scope of health coaching. The literature reported a wide range of interventions and contexts applicable to health coaching (Hayes et al., 2008; Lindner et al., 2003; Olsen & Nesbitt, 2010). Professionals, paraprofessionals, and peers have served as health coaching providers either independently or in the context of a program. Researchers reported a number of professional training and certification programs for health coaching (Olsen & Nesbitt, 2010; Wolever et al., 2010). Professionals provided health coaching under their existing licensure; for example, insurance companies employed registered nurses as health coaches who deliver coaching as a part of nursing (Butterworth et al., 2006). In the absence of licensure, paraprofessionals provided health coaching (Olsen & Nesbitt, 2010). Paraprofessionals and

peers often received training in the context of a grant or targeted program that delivered health coaching such as that offered by the American Cancer Society (Olsen & Nesbitt, 2010).

Health coaching settings varied from face to face meetings, telephone, internet, home, medical office, and community locations, with a wide variation in the frequency and duration of sessions (Olsen & Nesbitt, 2010). Initial studies found health coaching to be efficacious for health behavior change across settings (Kravitz et al., 2011; Linder et al., 2003; Olsen & Nesbitt, 2010; Sherwood et al., 2008; Tidwell et al., 2004, Vale et al., 2003). Opdenacker and Boen (2008) conducted a randomized trial that compared outcomes of two different types of coaching delivery: telephone and face-to-face. The study findings were consistent with that of previous research in that no significant difference existed between the two coaching settings (Opdenacker & Boen, 2008).

Health coaching interventions. A review of conventional health coaching revealed a broad range of coaching methods. Lindner et al. (2003) identified three categories of coaching interventions including health education, behavior change interventions, and psychosocial support. Hayes and Kalmakis (2007) reviewed cross-disciplinary literature related to health coaching and they identified common elements that characterized health coaching. These elements included a relationship between coach and client designed to elicit trust, motivation to set and achieve goals, acknowledgment of client successes and concerns, feedback that is empathic and holds the client accountable, and support for the client as they navigate a process of lifestyle or health behavior change (Hayes & Kalmakis, 2007).

Research studies that investigated health coaching presented a variety of health coaching interventions including goal setting, education, skill building, planning, monitoring, counseling and consultation, and assertiveness training (Adelman & Greybill, 2005; Kravitz et al., 2009,

2011; Lindner et al., 2003; Olsen & Nesbitt, 2010; Sherwood et al. 2010). The two areas of intervention important to health coaching according to a review of published studies by Olsen and Nesbitt (2010) were goal setting and motivational interviewing.

Motivational interviewing has become an important method in conventional and integrative health coaching. Miller and Rollnick defined motivational interviewing as a “collaborative, person-centered form of guiding to elicit and strengthen motivation for change” (2009, p.137). Huffman (2009) described five core elements of motivational interviewing based health coaching. The motivational interviewing process relied on active listening, the client’s agenda, identifying beliefs and values, change talk, and clarifying readiness to change (Huffman, 2009).

Linden, Butterworth, and Prochaska (2010) conducted a quasi-experimental design study of the outcomes of motivational interviewing based health coaching for university employees with chronic health conditions. Participants improved on six variables related to health behavior change including: a) tobacco use; b) stress management; c) social support; d) sleep; e) physical activity; and, f) nutritional choices (Linden et al., 2010, p. 171). Butterworth provided an overview of motivational interviewing based health coaching that applied health behavior theory in a patient-centered model (2010).

Theoretical approaches. Several theoretical models have informed health coaching. Hayes et al. (2008) described the application of communication and behavior change models in a literature review that examined health coaching conducted by Nurse Practitioners to improve outcomes for persons living with type 2 diabetes. One theoretical model frequently applied in health coaching is the Transtheoretical Model (TTM) articulated by Prochaska and DiClemente and also known as the Stages of Change (Linden et al., 2010). Health coaches assessed

participant readiness to change and applied interventions appropriate to the stage such as education for the contemplation stage or goal setting for the preparation and action stages (Linder et al., 2010).

Spence, Cavanagh, and Grant (2008) presented a cognitive-behavioral, solution-focused (CB-SF) model for health coaching. While initial outcome studies were promising, the model has drawn criticism that the cognitive-behavioral approach excluded the emotional level of experience important to health behavior (Spence et al., 2008). In response, the authors applied a randomized crossover design in a study supplementing CB-SF health coaching with mindfulness training to address emotional regulation. The Spence, Cavanagh, and Grant (2008) study found that the important factor for health coaching outcomes as measured by goal attainment scaling was a facilitative and non-directive coaching process.

The wide range of approaches to health coaching identified in the literature reflected the emergent qualities inherent in the coaching process. Multiple definitions and approaches also denoted the recentness of the field. Reviews established the need for further quantitative and qualitative research to identify core constructs of health coaching (Frates, n.d.; Lindner et al., 2003; Olsen & Nesbitt, 2010). The differences found in health coaching definitions also suggested the need for developing a model of health coaching that retains flexibility and responsiveness to varied settings while providing a coherent structure and skill set. The literature called for studies to identify essential competencies, to establish standards for professional training, and to create a national credentialing process (Institute for Integrative Health, n.d.; Olsen & Nesbitt, 2010). Olsen and Nesbitt (2010) recommended research to develop an operational definition of health coaching and identify the skill sets essential to the service. The lack of a consistent and coherent theoretical approach and methodology that says

“this is health coaching” presented barriers for health coaching program design and for research (Olsen & Nesbitt, 2010).

Elements of IHC

What distinguishes IHC from conventional health coaching? IM incorporates allopathic medicine yet is qualitatively different in purpose, values, methods, and outcomes. Similarly, IHC contains elements of conventional coaching practice but differs in purpose, values, methods, and outcomes.

IHC values and qualities. Leaders in the field have defined the purpose of IM and IHC as a partnership designed to support participants aspiring to realize their unique vision of well-being (Bell et al., 2002; Lawson, 2009; Wolever et al., 2011). This contrasts with the disease management or symptom and risk reduction purpose of conventional health coaching. The distinction is vital to the understanding of IHC and to research.

The literature identified IM values such as being client-centered, holistic, facilitative, and focused on well-being as central to IHC practice (Lawson, 2009; Wolever et al., 2011). IHC was described as oriented toward client optimal well-being, mindfulness, and a coach-client relationship designed to build trust and client self-efficacy (Lawson, 2009; Wolever et al., 2011). A central IHC value holds that each person is “intrinsically healthy, whole, wise, and the ultimate expert in his or her healing journey” (Lawson, 2009, p.17; Wolever et al., 2011). Essential qualities of IHC articulated by the Duke IM model included a designed relationship that is client-centered, mindfulness that facilitates insight, articulation of optimal health vision and values, personalized health planning, self-determined goal-oriented action, and appreciative inquiry (Smith & Rychener, 2010). Published literature examining the Duke IHC model has begun to define core elements of the intervention (Wolever et al., 2010; Wolever et al., 2011).

Core constructs of IHC. Wolever et al. presented ten *Principles of Integrative Health Coaching* in a randomized controlled study of Duke IHC for individuals with type 2 diabetes (2010, p. 637). Core IHC constructs described in the study included coach support for the client's change process, connecting goals with vision and values, and establishing a relationship that promotes client trust and self-direction (Wolever et al., 2010, p. 637). One of the IHC principles identified by Wolever (2010) was the view of clients as the expert regarding their health and process of lifestyle change.

Lawson identified four key constructs of IHC as “mindful presence, authentic communication, self-awareness, and safe space” (2009, p. 17). In support of these key constructs, clients direct the change process and determine the preferred outcomes of IHC (Wolever et al., 2010, 2011). Goals and outcomes identified by the clients form the basis for individual measures of efficacy rather than symptom relief or risk reduction (Bell et al., 2002; Smith & Rychener, 2010). Clients clarify values that inform goal setting and link the values to outcomes thereby increasing motivation (Verhoef et al., 2005; Wolever et al., 2010). Individualized plans developed collaboratively by clients, their coaches, and health care providers span life domains (Smith & Rychener, 2010). It is important to note the non-linear process of lifestyle and health behavior change in the IHC framework that reflected the holistic qualities of IM and human experience (Bell et al., 2002; Smith & Rychener, 2010).

IHC research. Clinical research that has involved IHC has been limited but promising. A controlled randomized trial with participants at risk for cardiovascular disease utilized IHC in the development and implementation of a personalized health plan (Edelman et al., 2006). The researchers found a reduction in ten-year risk that accompanied both increased exercise and weight loss among the study group (Edelman et al., 2006). A randomized clinical trial

conducted by Wolever et al. (2010) investigated the outcomes of IHC as an intervention for psychosocial factors and blood sugar control for participants living with type 2 diabetes.

Participants in the coaching group not only significantly reduced levels of A1C, a glycemic control indicator, but also had higher scores on measures of well-being including perceived health status (Wolever et al., 2010).

Snyderman and Dinan (2010) discussed the outcomes of the Duke Prospective Health project initiated in 2003 for university employees experiencing or at high risk for cardiovascular disease or diabetes. Personalized health planning and health coaching were central interventions in an array of interventions that had demonstrated benefits in prevention and cost reduction (Snyderman & Dinan, 2010). Participants who received IHC had significant reductions in inpatient admissions (25.4 percent) in comparison to those who did not and whose inpatient admissions increased 6.4 percent (Smith & Rychener, 2010, p. 24).

The first qualitative study of Duke IHC described the intervention as applied in three foundational IHC studies (Wolever et al., 2011). The organizational case study drew from the experiences of six founding coaches using in-depth interviews to examine IHC coaches' understanding of the process (Wolever et al., 2011). The study included a review of Duke IM documents related to IHC (Wolever et al., 2011). The organizational case study distinguished IHC from the medical model and life coaching (Wolever et al., 2011).

The study identified seven essential IHC components including establishing trust and support, knowledge of health risks, connecting vision and values with health behavior, SMART goals, and starting and maintaining new health behaviors (Wolever et al., 2011). The integrative health coaches described the necessity for IHC participants to have time, commitment, and motivation to benefit from the process (Wolever et al., 2011). Duke formative coaches viewed

IHC as a “good fit between the assumptions of life coaching and integrative medicine” (Wolever et al., 2011). Mindfulness is an important element of IM and IHC (Wolever et al., 2011).

IHC and mindfulness. The Wolever et al. randomized clinical trial articulated the Duke IHC model and defined mindfulness as “nonjudgmental self-awareness” (2010, p. 632). The qualitative organizational case study identified mindfulness as an element of IM that is an area of “focus” of IHC (Wolever et al., 2011, p. 32). At the time of this review, studies were underway to investigate the benefits of mindfulness and IHC for cardiovascular disease and weight loss according to personal communication with R. Wolever (October 18, 2011).

The practice model identified mindfulness as a core element of IHC and the basis for the dyadic coaching relationship (Lawson, 2009; Smith & Rychener, 2010; Wolever et al., 2011). Mindfulness supported other-focused listening and effective communication (Lawson, 2009). Mindfulness provided a foundation for skillful inquiry. Practicing mindfulness strengthened emotional regulation, attention, and awareness that support action and lifestyle change (Kabat-Zinn, 2003). The significance of mindfulness to IHC warrants investigation of the application of mindfulness in IHC practice and the experience of IHC participants with mindfulness.

Elements of Mindfulness

Lawson (2009) identified mindfulness as an IM value central to the practice of IHC. Kabat-Zinn (2003) noted that mindfulness upholds the intrinsic well-being and capacity for transformation that resides within each person. Duke integrative health coaches considered this understanding a shared central tenet in IM and IHC (Wolever et al., 2011). That there is inherently “more right than wrong” with a person no matter what their condition is a worldview that tends to be unfamiliar to those associated with conventional medicine and western culture (Kabat-Zinn, 2005).

Mindfulness practices in health care. Mindfulness was defined by Kabat-Zinn as “moment to moment awareness...cultivated by purposefully paying attention to things we ordinarily never give a moment’s thought to” (2005, p. 2). Mindfulness directs attention to the workings of our mind and body without judgment or latching on to the content or trying to change what we find. Kabat-Zinn developed the Mindfulness-Based Stress Reduction (MBSR) protocol at the University of Massachusetts Medical Center (2005). Kabat-Zinn sought to offer a secular yet authentic process for persons with chronic medical conditions to access traditional Buddhist practices (Kabat-Zinn, 2005). Kabat-Zinn established MBSR as an eight-week program that serves as the foundation for developing a personal mindfulness practice. Kabat-Zinn described MBSR as “an intensive training...in the art of conscious living” (2005, p. 1).

Kabat-Zinn (2003, 2005) established central elements of mindfulness as adopting a mind/body approach, attention, acceptance, reflexive consciousness, and presence. The literature described elements of mindfulness as non-judgment, non-attachment to outcomes, observation of thoughts and emotions, recognition of impermanence and the nature of change, and openness to inner and outer experience (Kabat-Zinn, 2003, 2005). Mindfulness practice was not goal and outcomes oriented. While mindfulness did not seek outcomes, research has documented the benefits of mindfulness practice across health and life domains (Baer, 2003; Brown, Ryan, & Creswell, 2007; Kabat-Zinn, 2003). The theoretical and empirical foundations for applications of mindfulness practice in medicine have been articulated by Baer (2003), Brown, Ryan, and Creswell (2007), Davidson (2010), Greeson (2009), and Kabat-Zinn (2003, 2005).

Mindfulness and health benefits. Brown, Ryan, and Creswell (2007) examined the benefits of mindfulness practice of significance for IM and IHC. Research has identified self-

regulation or emotional regulation an important aspect of health supported by mindfulness practice (Brown et al., 2007; Greeson, 2009). The literature found increased attention and awareness to have multiple health benefits including supporting self-regulation and supporting interpersonal relationships (Brown et al., 2007; Kabat-Zinn, 2003). At a physical level mindfulness practice supports working with pain, reducing stress and inflammatory processes, reducing hypertension, and working with overweight and obesity (Baer, 2003; Brown et al., 2007; Gross et al, 2010; Kabat-Zinn, 2003, 2005).

Spence, Cavanagh, and Grant (2008) conducted a randomized study using a crossover design to investigate the outcome of mindfulness training and health coaching. The mindfulness training was not an integral component of the health coaching intervention but a separate training provided either before or after the coaching component. The researchers used goal attainment as the outcome measure. Although mindfulness training did not have a statistically significant bearing on goal achievement, the authors noted a trend toward improved goal attainment and recommended further study (Spence et al., 2008). The authors suggested that the mindfulness-training component of the study was too short to realize a significant benefit. The Spence et al. (2008) study involved a mindfulness intervention of four weeks duration, a period of time that was about half the amount of time associated with demonstrated effectiveness in MBSR studies (Kabat-Zinn, 2005).

Mindfulness and phenomenology. A scholarly discourse has developed examining the similarities in consciousness studies, phenomenology, and mindfulness (Brown & Cordon, 2009; Thompson, 2007; Varela & Shear, 1999). Three methods of first-person inquiry identified by Varela and Shear are introspection, phenomenological reduction, and contemplative methods including mindfulness practice (1999). A central area of scientific investigation and a core

teaching of traditional Buddhist practice has been the role of attention in strengthening awareness (Davidson, 2010; Greeson, 2009; Kabat-Zinn, 2003). The ability to purposefully direct and sustain attention represented an element shared by mindfulness practice and phenomenological reflexivity. Core skills applied in mindfulness and phenomenological inquiry involved presence, meta-awareness, and emotional regulation. Thompson stated, “features of the epoche closely parallel the basic mental skills cultivated in Buddhist mindfulness” (2007, p. 445). Mindfulness and the application of MBSR practices can support bracketing, epoche, and the reflexive activities of a phenomenological study.

Conclusion: IM and IHC Research Considerations

The nature of IM presented a challenge for outcomes research. Bell et al. (2002) investigated the problems standard biomedical research encountered when studying IM and described the need for an alternative research paradigm. The article set forth considerations for research design (Bell et al., 2002). Integrative medicine research design must address the complex, emergent, and multidimensional nature of health, persons, and holistic approaches to care (Bell et al., 2002). Bell et al. (2002) found that a research design appropriate for an emergent process is necessary for IM. The article suggested a role for observational and qualitative research that can examine actual integrative practice (Bell et al., 2002).

Participants have a role in IM research design. Verhoef, Mulkins, and Boon (2005) analyzed qualitative data from the evaluation of an integrative health clinic and found that client language, meanings, and values were central to outcomes research design and analysis. The research framework incorporated and mirrored the core elements of IM (Verhoef et al., 2005). The IM client occupied a central and active role in the health care process and the authors

recommended that IM outcomes research replicate this approach (Bell et al., 2002; Verhoef et al., 2005).

The investigation of IM research design conducted by Bell et al. identified an important role for qualitative study (2002, p. 139). Qualitative research lends itself to the participatory approach and voice advocated by Verhoef et al. (2005). Qualitative studies identify variables and outcomes important to participants and for the subsequent design of quantitative research (Patton, 2002). Qualitative approaches have the flexibility necessary to work with an emergent process such as IHC. Qualitative studies observe the whole picture and the integral parts. Qualitative research methods provide a way to ask, “What is this?” about a complex, evolving, and collaborative intervention like IHC. The advancement of knowledge of client experience in IHC will benefit from a qualitative research design that examines client perspectives and experiences.

CHAPTER III: RESEARCH METHODS AND DESIGN

The purpose of the study was to describe participants' lived experiences with an integrative health coaching (IHC) process that was characteristically complex and multidimensional. A review of health coaching literature found varied approaches for the health education and promotion practice including the IHC model distinguished by the IM framework (Olsen & Nesbitt, 2010; Wolever et al., 2011). While early studies investigating IHC suggested the IM-based approach offered clients a unique experience distinguished by the application of mindfulness and the holistic approach (Wolever et al., 2010, 2011), research had not investigated the lived experiences of IHC clients at the time of this study. The description of how clients perceived, experienced, and derived meaning from engagement in the process was necessary to identify key structures that can expand the knowledge of IHC. This phenomenological study described participant experiences in an effort to reveal core themes and structures essential to the research topic (Creswell, 2007; Moustakas, 1994; Patton, 2002).

The researcher conducted a pilot study in November 2010 that informed the study design. The pilot study entailed in-depth interviews with two IHC clients who responded to an announcement forwarded by integrative health coaches enrolled in the Duke IM 2010 certification program. The researcher applied Moustakas' (1994) phenomenological approach and used in-depth interviews, photo-elicitation, and member checking to gather data from pilot study participants who sought IHC to address a chronic health condition. The researchers' mindfulness practice provided a supportive framework for bracketing, epoche, and reflexivity during data collection and analysis.

Theoretical Description

Epistemology. Qualitative inquiry has its basis in a social constructivist paradigm whereby phenomena and meanings are not absolute and isolated in occurrence but constructed by human interaction with the world (Bentz & Shapiro, 1998; Creswell, 2007, 2009; Patton, 2002). Moustakas' (1994) descriptive phenomenological approach provided the framework for this IHC study. Moustakas sought to understand “meaningful concrete relations implicit in the original description of experience” and therefore placed the researcher and study participants, who will be referred to as co-researchers in this study, in the center of the field of phenomenological inquiry (1994, p. 14). The researcher chose to use the term co-researcher in reference to study participants as a means of acknowledging the reciprocity and partnership with participants that characterizes the qualitative inquiry process. Moustakas' (1994) phenomenological approach encouraged the researcher to direct her attention toward the co-researchers and the description of their lived experience of IHC with an intentional, open, and aware presence that facilitated a discovery-oriented process.

The researcher pragmatically drew from the mindfulness-based approaches articulated by Bentz and Shapiro (1998), Brantley (2003, 2009), Kabat-Zinn (2003, 2005), and Varela and Shear (1999) to design this IHC study. Mindful inquiry applies a holistic and inter-subjective approach to research (Bentz & Shapiro, 1998; Patton, 2002). Authors described the Buddhist Vipassana or Insight tradition as concerned with seeing things as they really are through mindfulness practices (Bentz & Shapiro, 1998; Kabat-Zinn, 2005; Thompson, 2007; Varela & Shear, 1999). The application of a mindfulness-based approach to this study placed the researcher as a witness to the dynamics of her subjective experience and the research question, qualitative inquiry process, and data collected.

Qualitative research. Qualitative inquiry offered a suitable approach to describing IHC clients' experiences in an effort to contribute to the IHC knowledge base. The researcher deemed the qualitative methods of phenomenology and photo-elicitation as appropriate for an IHC study that was exploratory, particularly in the areas of client IHC experiences where previous studies had not developed and tested hypotheses or identified factors and areas for investigation (Creswell, 2007; Holloway & Wheeler, 2010; Patton, 2002). A naturalistic setting provided the context for this study. The study focused on the voices and experiences of co-researchers who had direct experience and thus crucial insight into the IHC process (Creswell, 2007; Holloway & Wheeler, 2010; Patton, 2002).

The emergent design of qualitative inquiry supported detailed and in-depth data collection in a discovery-oriented process. A flexible and responsive design made a qualitative approach appropriate for a study focused on a developing field such as IHC. Qualitative methods identified thematic and structural elements that contributed to describing the defining features of client experience in IHC and pointed the way for future experimental research (Creswell, 2007; Holloway & Wheeler, 2010; Patton, 2002).

Phenomenology. Edmund Husserl (1859-1938) articulated phenomenology as a philosophical approach that sought to overcome the problem of Cartesian dualism in epistemology and philosophical inquiry (Moustakas, 1994). The phenomenological framework set forth by Husserl and developed by successors with branching epistemologies has been a predominant influence in twentieth century philosophy and human science research (Dowling, 2007; Creswell, 2007; Holloway & Wheeler, 2010; Patton, 2002). Scholars referred to Husserl's phenomenology as descriptive phenomenology because it described universal structures evidenced in the lived experiences of participants and did not seek to draw interpretations from

those experiences, as did the hermeneutic branch developed by Heidegger (Creswell, 2007; Dowling, 2007). Descriptive phenomenology, applied in a qualitative research framework, investigated the researcher's and study participants' direct experiences of a phenomena and their essential structures as experienced through the lens of the intentional conscious mind (Moustakas, 1994). The phenomenological approach sought to overcome a dualistic perspective by bringing the whole of the researcher's consciousness to encounter the experience while in a state of presence that involved intention, attention, and awareness (Creswell, 2007; Holloway & Wheeler, 2010; Moustakas, 1994). In this study, descriptive phenomenology brought to light the essential elements and structures of the co-researchers' experiences with IHC. The resulting conceptual framework presented clients' lived experiences with IHC.

The descriptive phenomenological research framework called for the researcher to bracket her own IHC experience and engage in collaborative inquiry to gather in-depth descriptions by co-researchers (Creswell, 2007; Moustakas, 1994). Additional constructs of descriptive phenomenology entailed the exploration of horizons, themes and structures in the data and identification of universal constituents and essences. The experience of immediacy and insight into the data in a descriptive phenomenology issued from the researcher's open, focused, and reflexive process (Creswell, 2007; Moustakas, 1994).

The researcher engaged in reflexivity and bracketed her experience as an integrative health coach by conducting a self-interview using the study interview guide and by writing a personal reflection. The bracketing process resulted in the identification of the following assumptions held by the researcher: a) mindfulness practice on the part of the coach contributed to the qualities of presence and non-judgment experienced by clients; b) co-researchers would describe varied experiences and levels of satisfaction with IHC; c) coaching skills would be a

prominent element of co-researchers' experiences; and d) the client-coach relationship would serve as an essential structure in the IHC process. The researcher applied her personal mindfulness practice to observe and bracket the assumptions throughout study implementation.

In order to support co-researchers' in-depth description of their IHC experiences, the researcher designed the research setting and data collection process using several strategies. The researcher selected telephone interviews as the vehicle for data collection in this study since the telephone is the primary setting for IHC coaching process. Thus, the researcher provided co-researchers with a familiar setting for engaging in the in-depth, open-ended interviews associated with this study. The researcher invited co-researchers to open the interview process with a moment of mindfulness to support their presence and epoche. This kind of opening was typical of the IHC coaching they had experienced. The informed consent process potentially supported co-researchers' perceptions of safety and autonomy during the interview process. The researcher facilitated a discovery-oriented process by asking open-ended questions and invited co-researchers to assume an active stance in articulating matters of importance to them regarding their IHC experiences. The integration of a photo-elicitation process during an interview in this study engaged co-researchers in a self-directed process in which they applied their intention, attention, and reflexive awareness in the act of identifying and discussing a visual image that illustrated their IHC experience.

The researcher's analysis of data from this study entailed a process of phenomenological reduction in an effort to identify essences and universal structures and present an exploratory conceptualization of client experience in IHC. Reflexivity denotes a skill in scientific inquiry that researchers have found to be particularly critical when employing qualitative approaches such as phenomenology. Reflexivity is a process in which the researcher becomes self-aware of

personal biases and assumptions that may influence the study process and research environment (Moustakas, 1994; Patton, 2002). Epoche, reflexivity, and bracketing describe crucial elements of phenomenological inquiry (Moustakas, 1994). Epoche refers to the researcher's establishment of a state of open awareness and immediacy or presence in encounters with study participants. The researcher engaged in bracketing, or purposefully directing attention to, in this case, IHC and to her thoughts and feelings regarding the IHC experience in order to not only recognize her assumptions, but also set those assumptions aside. The process of bracketing helped the researcher be more fully present to her co-researchers' perspectives. The researcher's engagement in reflexivity involved her in an iterative process of discerning inter-subjective influences and identifying personal responses and reactions to IHC and the co-researchers who shared their experiences and views with her. The researcher applied epoche and bracketing to increase awareness and attention in the reflexive process (Moustakas, 1994).

Methods such as phenomenological reduction and reflexivity, the psychological process of introspection, and contemplative practices such as mindfulness have a common foundation in intentionally directing attention to the processes of the mind (Thompson, 2007). Mindfulness practices provided a supportive process for cultivating reflexive awareness. The researcher applied mindfulness-based stress reduction (MBSR) practices in the activities of researcher reflexivity in this phenomenological study.

Researcher's Personal Statement, Biases, and Assumptions

Moustakas' (1994) approach involved developing a personal statement that described my own lived experience with IHC. To facilitate exploration of my cognitive map of IHC, I completed a self-reflection using the study interview guide to identify assumptions and biases that I brought to the study. My professional training as an integrative health coach and my

personal experience with recovering from a chronic health condition carried meanings and understandings that warranted reflexive attention and bracketing. I engaged in the ongoing practices of mindful inquiry, reflexive journaling, and bracketing in an effort to continually identify and reflect upon my instrumental role in the qualitative study. My personal aim in this study was to contribute to the continuing development of IHC and ultimately benefit individuals who sought well-being through the process.

At the time of this study, I had completed the Duke IHC certification program. Engagement in the IHC training program led to my interest in how clients experienced IHC and the meaning that the process held for them. I was curious about what IHC was like for clients with chronic health concerns and questioned what elements of the IHC process clients found beneficial and challenging. I was interested in gaining insight into IHC clients' experiences with mindfulness during the coaching process. I recognized that my training in IHC would present a challenge to me as a researcher and would require moving beyond the professional understanding of IHC language, terms, and process in order to see and be clear about study participants' meanings and lived experiences. The need for bracketing the assumptions that comprised my mental map of IHC accompanied my interest in and curiosity about IHC clients' experiences and views. My experience as an IHC coach and client as well as with mindfulness practice necessitated that I engage in the rigorous and systematic practice of reflection, reflexivity, and bracketing.

When I decided to undertake this study, I did not anticipate the challenges I would face in the course of cancer treatment and recovery or the difficulties my "new normal" would pose for me while conducting the study. I engaged in reflection at many points during the course of the study regarding my ability to realize my goal of completing the research as I experienced

complications and limitations following treatment. My lived experience as the researcher involved personal discovery and increased awareness of factors influencing my health and well-being that led to a different approach to balancing work and self-care. The essence of my lived experience with the study deepened my understanding that as a practitioner and researcher I am an instrument in the process and thus must authentically seek well-being.

I personally experienced the supportive presence of a physician who listened, communicated a sense of presence, respected my values, and collaborated in the decision-making process. The characteristics of my physician reflected IM principles and had a significant effect on the quality of my experience in treatment. My experiences with both conventional and integrative medicine throughout the course of this study provided an area for reflexive inquiry and bracketing.

Holistic health and IM have been longstanding personal interests. I valued a humanistic paradigm that empowered participants and recognized people's intrinsic capacity for well-being. I discovered mindfulness practice two decades ago and have started, drifted, and returned many times. Mindfulness is a horizon that helps me make sense of the world. I attended the Mindfulness for Professionals training in MBSR held at Duke IM in 2009. My personal practice of mindfulness supported me throughout the course of this study as I repeatedly found myself striving to push forward, my habitual and unhealthy drive related to academic work. I was grateful for the practice that guided me as I navigated a different approach.

The phenomenological approach I used in this study aligned with the study purpose and fit the personal qualities and skills that I brought to the study process (Creswell, 2007; Patton, 2002). Creswell (2007) has suggested that researchers who apply a phenomenological approach must have a solid understanding of the philosophy and its tenets. I studied phenomenology as an

undergraduate student majoring in philosophy. I also engaged in an independent study of phenomenological foundations and Moustakas' (1994) approach prior to developing the design for this study. My experiences during a pilot study I conducted in November 2010 as well as a review of published studies and supportive materials informed my design of the IHC study and my interactions with the co-researchers who participated in the study.

Methods

Moustakas (1994) outlined a methodology for phenomenological research that instructed the IHC study procedures. This section described the study methods and implementation including the recruitment, purposive sampling, data collection, and analytical procedures that the researcher applied in this study. Methods to seek rich descriptions of co-researchers' experiences included in-depth interviews, photo-elicitation interviews, and member checking. The discussion of methods reviewed ethical considerations addressed during the design and implementation of the study. The researcher incorporated methodological considerations from her experience conducting a November 2010 pilot study.

Sample recruitment. In order to recruit study participants, the researcher emailed a Research Study Announcement (Appendix F) approved by the East Carolina University Medical and Institutional Review Board (UMCIRB) to the Duke IM Research Director. The Research Director then forwarded the announcement to the eight formative Duke IM health coaches with a request that the coaches forward the document to coaching clients with whom they had worked within the past year. The announcement briefly described the study and invited interested prospective participants to contact the researcher directly. Two of the eight IHC coaches reported that they had reduced the number of coaching clients over the past year, thus reducing the potential study population.

After distribution of the initial e-mail, the researcher received feedback from one of the IHC coaches who recommended sending a second announcement. The researcher drafted a revised study announcement that changed the layout to be more appealing to the target population. Upon receipt of UMCIRB approval (Appendix B) for the revised Research Study Announcement (Appendix G), she sent the announcement to the Duke IM Research Director who then forwarded it to the eight formative coaches.

The selection criteria for study co-researchers included the following: a) adults aged 18 years or older; b) former or current clients of Duke IM health coaches; c) clients of eight formative IHC coaches including the six coaches who participated in the Wolever et al. (2011) study; d) sought IHC for the purpose of addressing a chronic health condition; e) received a minimum of six IHC sessions within the past year; f) resided in the U.S. at the time of the study; and, g) had proficiency in the English language.

Sampling strategy. The researcher employed purposive sampling to identify individuals with a diversity of demographic and chronic health issues from those who responded to two announcements about the study distributed eight weeks apart (Creswell, 2007; Patton, 2002). The researcher designed the recruitment strategy to maximize the privacy and confidentiality of IHC clients and anonymity of the IHC coaches in the sampling process. The study sample consisted of current and former IHC clients of Duke IM coaches. The coaches had participated in the Wolever et al. study (2011).

Twelve IHC clients voluntarily responded to the study announcements over a three-month recruitment period. The researcher conducted a two-step sampling and enrollment interview. The researcher both emailed and mailed via U.S. Postal Service the informed consent document (Appendix D) and the consent to publish artwork or photographs (Appendix H) to

each respondent prior to the sampling and enrollment interview. The first step involved sampling. In a telephone “sampling and enrollment interview” with each potential participant, the researcher described the expectations of study participation, gathered demographic information, affirmed that the respondent met inclusion criteria, and ascertained that the respondent was not a member of a vulnerable population. Two respondents declined study participation when the researcher informed them about the estimated 90 minutes that study participation entailed. When the researcher and respondent confirmed enrollment in the second step of the sampling and enrollment interview, she then conducted the informed consent process. The length of the sampling and enrollment interview averaged 30 minutes.

During the sampling and enrollment interview, the 12 initial respondents volunteered the information that they had a highly satisfactory experience with IHC. Clients who experienced a range of satisfaction with IHC had an opportunity to respond to the study announcement sent by coaches to all clients they coached within the past year. The sampling strategy did not entail a specific process to recruit a disconfirming case or respondents who experienced a range of satisfaction. Co-researchers’ comments during the sampling interview indicated their knowledge of IHC clients who had experienced a range of satisfaction. A study design revision to include a snowball sampling strategy might have effectively recruited study participants with a range of satisfaction. The researcher determined that the revision was beyond the scope of the present study and that revising the study design and requesting participation in snowball sampling after enrollment presented ethical concerns (Patton, 2002).

Based on pilot study findings, the researcher determined that gathering demographic information during initial contact was necessary to understand the diversity and characteristics of the pool of respondents. The researcher benefitted from the pilot study experience during which

she did not collect demographic data that might be important to purposive sampling until the end of the initial interview.

The researcher emailed and mailed by U.S. Postal Service each of 12 respondents, prior to conducting the sampling and enrollment interview, the UMCIRB approved informed consent (Appendix D) and the optional Permission to Publish Study Participant's Art Work or Photographs (Appendix H). She included three self-addressed stamped envelopes (one each for the informed consent document, photograph or image, and member checking comments) in the event the respondent enrolled in the study. The researcher provided potential study participants with the option to review, address concerns and questions, and sign the informed consent immediately prior to the initial telephone interview. One respondent selected the above option that entailed faxing the signed consent to a secure and confidential fax in the researcher's office. Nine respondents chose to proceed with the informed consent at enrollment following the sampling interview. The co-researcher conducted the informed consent and reviewed the permission to publish and then the co-researcher signed the documents and returned them in the self-addressed stamped envelope. Upon receipt of the original consent, the researcher scheduled the in-depth interview.

Sample size. The researcher sought a sample size of approximately 10 to 12 co-researchers in an effort to address the scope and depth of insights appropriate for a phenomenological study (Creswell, 2007; Patton, 2002). Ten respondents contacted the researcher in a four-week period following the distribution of the first Research Study Announcement (Appendix F). Two additional respondents contacted the researcher in response to the second Research Study Announcement (Appendix G).

The researcher assigned a study number to each of the 12 respondents and entered their corresponding demographic data into a sampling matrix (Appendix L). The researcher conducted a sampling interview with 10 respondents who expressed an interest in participation following the initial contact. She enrolled 10 purposefully sampled respondents who met study inclusion criteria and who voluntarily agreed to participate in the study. The 10 co-researchers who enrolled in the study had engaged in the minimum duration and number of IHC sessions in order to progress through the steps of IHC process (Wolever et al., 2010, 2011). Thus, all participants indicated both direct and sufficient experience with the IHC process to address the entire process during subsequent data collection.

The nine co-researchers who completed data collection reported diverse demographics, health conditions, and coaching settings. They lived in regions across the continental U.S. The two men and seven women varied in age ranging from 18 to 34 years of age to over 70 years of age. Co-researchers described differing professions including accounting, education, medicine, nursing, management, and customer service. Their educational backgrounds ranged from completing high school to holding professional or advanced degrees.

Co-researchers sought IHC for differing health conditions. Many reported living with more than one health risk or condition. They described living with obesity, high cholesterol, chronic stress, arthritis, type 2 diabetes, cancer, and an autoimmune condition. The duration of co-researchers' IHC experience ranged from 10 individual sessions in the course of 10 weeks to approximately 100 sessions over three years. Co-researchers engaged in individual coaching ranging from 25 minute to one- hour duration. Six experienced both individual and group coaching. Three accessed IHC through a clinic and six through a worksite program.

The sample size of nine co-researchers allowed for variation in the data and exploration of themes as well as data saturation (Creswell, 2007; Patton, 2002). The researcher recognized data saturation as a process of collecting data until no new descriptions of a particular theme emerged, no new themes or categories emerged, and new data consistently reflected the essential elements of data collected to that point in the study (Creswell, 2007). The researcher reviewed transcripts and interview notes to assess saturation. She suspected saturation after the seventh interview. She had planned to conduct three additional interviews to confirm the redundancy of the new information collected, but one co-researcher withdrew from the study in August 2011 due to an emergent health issue. The researcher determined that the two interviews conducted after the researcher suspected saturation adequately confirmed that data saturation had occurred.

Setting. A key characteristic of qualitative phenomenological studies is that they occur in naturalistic settings. The telephone interview process was a naturalistic setting for individuals who had participated in IHC. The nine co-researchers who completed the interviews had participated in IHC by telephone and shared with the researcher that they were familiar and comfortable with a telephone setting. The study setting consisted of telephone interviews, with the researcher viewing mailed or emailed photographs and other visual images. Telephone interviews maximized the co-researchers' privacy and confidentiality. The researcher had emphasized to co-researchers that photographs or images that contained information such as landmarks or pictures of individuals could identify them or others and thus would not be included in publication of study findings. The researcher retained or returned the visual images as per co-researcher request following the photo-elicitation interview and analysis. Three co-researchers sent self-portraits that the researcher returned or retained but did not publish in the study findings.

Data collection. Data collection consisted of one in-depth telephone interview and one photo-elicitation interview with each of nine co-researchers (Creswell, 2007; Patton, 2002). Member checking of the draft findings with feedback provided by means of e-mail or written response mailed in the self-addressed stamped envelope provided a third strategy to gather data. The researcher maintained awareness that in a phenomenological study, meaning emerged from the interaction of the researcher and co-researcher as well as from the interaction of co-researcher and IHC experience. In keeping with a phenomenological orientation, she sought detail and depth in co-researchers' descriptions of their IHC experiences (Patton, 2004).

The researcher obtained informed consent for study participation and audio recording the telephone interviews prior to data collection. She conducted the informed consent process in a scheduled phone call with co-researchers and then reviewed the informed consent prior to each interview. The researcher confirmed consent prior to initiating the audio recording. The researcher reminded co-researchers immediately prior to each interview that they could choose to end the interview at any point and that she would respect and support their decision as an indication of empowerment and the voluntary nature of the process. The researcher checked for co-researchers' comfort with the process and approval to continue during natural breaks in the interviews and listened carefully for any signs of discomfort. The researcher supported participants' preference to email or use the US Postal Service to send a copy of the photographic image that they took or selected. The researcher had sent a self-addressed stamped envelope for the image to all participants. Two participants chose to mail the image and seven emailed a digital image to the researcher.

In-depth interviews. During phenomenological interviews conducted in this study, the researcher aimed to establish a safe and comfortable setting for participants to openly and

comprehensively explore and describe their experiences (Moustakas, 1994). The researcher scheduled in-depth interviews that ranged from 40 to 60 minutes duration with co-researchers at times convenient to their schedules. After reviewing and confirming informed consent as well as checking co-researcher comfort, safety, and privacy prior to each telephone interview, she confirmed consent to audio record the interview prior to activating the recording mechanism.

The researcher invited co-researchers to engage in a brief, 10-second mindfulness practice prior to the interview. The nine co-researchers agreed to a centering pause that brought their attention to the present and to the interview process. This process was consistent with the phenomenological process of epoche (Moustakas, 1994). The researcher guided co-researchers' attention to the phenomenon (bracketing) by stating the study purpose at the beginning of the interview. Co-researchers reported familiarity with mindfulness practices because of their participation in IHC. During the interview process, the researcher provided pauses and silence for co-researchers' reflection. The researcher used probes and reflections to encourage the nine IHC clients to elaborate or further explore particular aspects of their experience. The researcher listened attentively for co-researchers' ease and safety throughout the interview process and checked their comfort with proceeding with the interview at intervals during the process. The researcher requested co-researchers' feedback regarding the interview process at the conclusion of each interview. Co-researchers stated that the interview process reminded them of their IHC experience due to the open-ended questions and non-directive, facilitative process. They shared their appreciation for the insights they gained about their IHC experience from the interview and study process.

The researcher used an interview guide (Appendix E) for both the in-depth interview and the photo-elicitation interview. Open-ended questions, probes, and a non-directive style helped

the researcher establish an interview dynamic intended to provide a sense of safety and empowerment and encouragement for detailed description (Patton, 2002). Open-ended questions presented an effective method for obtaining the detailed descriptions and authentic experiences that comprised the data in this phenomenological study (Creswell, 2007; Moustakas, 1994; Patton, 2002).

The use of the interview guide assisted the researcher with inviting participants to describe a consistent range of their IHC experiences including both the content and the process of their coaching experience. The researcher used an interview guide that applied sensitizing concepts identified through a review of the literature (Patton, 2002). Sensitizing concepts included: a) integrative; b) coach's role; c) client's role; d) mindfulness; and, c) IHC structure.

Phenomenological interviews are flexible and emergent (Creswell, 2007; Moustakas, 1994; Patton, 2002). The phenomenological in-depth interview conducted in this study focused on two areas: the content (texture) and process (structure) of co-researchers' experiences in IHC (Moustakas, 1994). The researcher identified the need to prompt participants to consider challenges or barriers as well as successes with IHC based upon her experience with a November 2010 pilot study that she conducted. She designed a question that opened the opportunity to explore potential challenges and barriers with IHC. The nine co-researchers, similar to the two participants in the pilot study, were eager to describe the beneficial aspects of their IHC experience but needed the prompt and silence to consider and explore potential challenges and barriers they experienced with IHC.

The process of data analysis began during the first interview and involved the researcher in writing jotted notes during phone contacts and the interview process (Patton, 2002).

Interview notes detailed the content of the interview, documented influences on the setting, and

described the researcher's observations about the process (Patton, 2002). The researcher noted the time and date on interview notes. She recorded in jotted interview notes such information as the time of specific observations such as interruptions, shifts in tone, or transitions in the conversation. She wrote expanded interview notes immediately following the interviews and engaged in reflexive journaling.

The researcher established a toll-free conference call account to ensure that study participants incurred no costs associated with the study. The conference call service had a secure mechanism to record interview data and to download it in mp3 format to a personal computer. The researcher made a back-up recording of the interview on a digital recorder. She deleted the interviews from the conference call service after downloading and from the digital recorder after transcribing the interviews. Accessibility to the recordings was limited to the researcher on a password-protected computer in a password-protected file.

Photo-elicitation interviews. Photo-elicitation has emerged as a strategy to engage and empower participants in the qualitative research process (Harper, 2002). In such interviews, participants take or respond to photographs that represented the study phenomenon (Bignante, 2009; Harper, 2002). In this study, the participants' use of representations in the form of visual images they selected or photographs they took, "evoked deeper elements of human consciousness than did words" and provided co-researchers with access to other levels of their experience not readily articulated by words (Harper, 2002, p.13). The photo-elicitation interviews with co-researchers provided a means for them to view their IHC experiences from another variant perspective (Bignante, 2009; Patton, 2002).

The research study announcement requested that co-researchers take or identify a photograph or image that represented their experience with IHC and participate in a photo-

elicitation interview (Appendix F). Co-researchers had the option to engage in the second interview immediately following the first or schedule a separate photo-elicitation interview that explored their perceptions about their image and its reflection of their IHC experience. Five of the nine co-researchers elected to complete the two interviews in one session due to personal time considerations.

The researcher reviewed and re-confirmed informed consent prior to the photo-elicitation interview and re-confirmed consent to audio record the interview. She reviewed the Permission to Publish Study Participant's Art Work or Photographs and confirmed that images that contained identifying representations would remain confidential and not be published (Appendix H). The researcher used the UMCIRB approved interview guide for the photo-elicitation interview (Appendix E).

The photo-elicitation strategy in this study involved an interview during which the co-researcher's visual image or photograph served as a catalyst for discussion about her or his IHC experiences. Consistent with the phenomenological step of epoche, the researcher intended the photo-elicitation process to encourage co-researchers to take a new look, to bring open awareness to their views of their IHC experiences. Co-researchers described their photograph or image and shared its meaning related to the perspective it provided on their IHC experiences. All co-researchers stated that the photo-elicitation component of the study contributed to their interest in study participation. They articulated that they appreciated the opportunity to be creative in taking a new view of their IHC experiences.

The second interview provided an opportunity for the researcher to ask participants questions or to clarify data shared during the initial in-depth interview. The researcher asked co-researchers for feedback regarding the interview process at the conclusion of each interview.

The researcher maintained jotted notes during the photo-elicitation interviews and wrote expanded notes immediately following the interview.

Following the interview sessions, regardless of whether the photo-elicitation interview was combined with the initial interview or conducted at a separate time, the researcher downloaded the audio recordings from the secure toll-free telephone conferencing service to a password-protected computer located in the researcher's home office and maintained them in a password-protected file. She then deleted the audio recordings from the telephone conferencing service and back up digital recorder. After transcribing the photo-elicitation interviews verbatim, she incorporated the transcribed photo-elicitation data into the phenomenological analysis process and included the photo-elicitation invariants in the composite textural and structural descriptions. The researcher analyzed the photo-elicitation data as a separate data set and as data integrated into the entire data set.

Member checking. As an essential component of the descriptive phenomenological approach (Creswell, 2007; Holloway & Wheeler, 2010), member checking contributed to the credibility of the study and the process of data collection. It provided an opportunity for co-researchers to review the researcher's written research findings and provide feedback regarding the representation of their experiences and perspectives in the findings (Creswell, 2007; Holloway & Wheeler, 2010). The study findings that co-researchers reviewed included the synthesis as well as the textural description, structural description, and composite textural and structural description. The researcher invited co-researchers to a) verify that their perspectives and experiences were adequately and accurately represented in the findings; b) clarify or confirm the accuracy of particular aspects of the findings of concern to the researcher; and c) provide additional insights or descriptions in response to reviewing the findings.

In order to conduct the process of member checking, the researcher canvassed co-researchers about their preferences regarding the method by which they received a copy of draft findings (email or USPS). In response to co-researchers' preferences, the researcher emailed the draft findings to six co-researchers and mailed the findings to three co-researchers. The latter group of co-researchers also received a self-addressed stamped envelope for use in returning their written comments. Seven of the nine co-researchers participated in member checking by replying to the researcher's request for feedback within a three-week period. One co-researcher replied that she would provide feedback only if she found a correction or had something to contribute and did not reply further. One co-researcher did not reply to the invitation to provide feedback.

Without exception, the seven co-researchers who participated in member checking confirmed that the draft findings adequately and accurately represented their IHC experiences and perspectives (Appendix T). The researcher invited and encouraged co-researchers to express variant or contrasting views and provide feedback that might contribute to understanding the essence of the themes in the synthesis and draft findings (Creswell, 2007). At the conclusion of the photo-elicitation interview, the researcher reviewed member checking with co-researchers as the next step in the study. While on the telephone call, she encouraged and invited co-researchers to express variant or contrasting views as well as clarifications when they received the draft findings. The researcher reiterated the invitation in the email or memo that she sent to co-researchers with the findings (Creswell, 2007).

Transcription. The researcher developed a transcription guide (Appendix M) that she adapted from Bailey (2008) and tested during the pilot study. The guide served to specify how she: a) noted elements of verbal interaction such as pauses or laughter; b) documented events

that occurred in the interview setting such as noises and phone connection problems; and , c) represented the transcribed data (Bailey, 2008). The researcher transcribed the audio-recorded data verbatim, documenting all utterances including (uh, eh, hmm) in order to capture the context of the interview in terms of tone and the cadence of co-researchers' speech.

Researcher reflexivity. The researcher drew upon her experiences of working with reflexive inquiry in the pilot study and her personal mindfulness practice in order to inform the reflexive process for this study. The researcher drew from her personal mindfulness practice and recent training she received by engaging in the eight-week MBSR curriculum developed by Duke IM (Brantley, 2009) to inform her reflexivity efforts throughout this study. Mindfulness is a paradigm that the researcher found beneficial for understanding her inner landscape and schemas. Mindfulness practices offered her a “language” to examine the structures of her sensory, cognitive, and emotional experiences. Adopting a friendly witness perspective helped the researcher to discover nuances of the study experience she might have otherwise lost to habit. Her mindfulness practice supported the process of reflexive inquiry and was itself a mental model that the researcher bracketed for this study. The researcher's reflexivity data consisted of the MBSR practice log, the researcher's journal, and the research time and activity log (Brantley, 2009; Moustakas, 1994; Patton, 2002). The researcher maintained the personal reflexive journal from the development of the study proposal to the conclusion of the study.

Data analysis. The process of data analysis began with the researcher's jotted notes during the first interview and continued recursively by repeatedly reading interview transcriptions, coding data, categorizing and segmenting data, identifying themes, and writing textural and structural descriptions of the data. The researcher employed both NVivo-9 software (QSR International, 2011) and the manual analysis of data that involved using paper transcripts

during the processes of coding, phenomenological reduction, and thematic analysis. She maintained a reflexive journal and wrote analysis and interpretation memos throughout the data collection and analysis process.

Phenomenological reduction. In accordance with Moustakas' (1994) phenomenological approach, the researcher engaged in a phenomenological reduction process that entailed what Moustakas (1994) referred to as horizontalizing the data, which ensured that she viewed all data as having equal value. The researcher identified invariant horizons that included non-overlapping statements in which the co-researchers' described qualities of their IHC experience (Appendix S). Since Moustakas' (1994) method of phenomenological reduction did not entail a specific process for coding data, the researcher used an iterative process of coding based on identifying and labeling meaning segments that emerged from the data. Codes consisted of units of meaning that signified the texture or context of participant IHC experiences and perspectives. The researcher developed a codebook (Appendix Q) with definitions for each code and inclusion and exclusion criteria that clarified the application of the code to the narrative data, thus ensuring consistency and accuracy in the coding process (Creswell, 2007; Moustakas, 1994). The QSR NVivo-9 (2011) software supported linking the text, units of meaning, and the annotated memos that documented the researcher's thoughts, observations, and decisions during the coding process (Bernard & Ryan, 2010; Creswell, 2007). The QSR NVivo-9 software enabled the researcher to sort and retrieve data according to code for use during a continuing data analysis process. The codes that the researcher developed for this study ultimately revealed concepts, categories, themes, as well as textural descriptions (Moustakas, 1994).

Consistent with the analytical process described by Moustakas (1994), the researcher engaged in the next step in phenomenological reduction that involved clustering and identifying

themes, and developing individual textural descriptions. Her textural descriptions addressed the content of co-researchers' lived experience. The researcher used the individual textural descriptions (Appendix R) to write a composite textural description from which central understandings or themes emerged (Appendix J) (Creswell, 2007).

Structural description. The researcher explored alternative views of the coded units of meaning and co-researchers' descriptions by engaging in what Moustakas (1994) referred to as imaginative variation in order to understand the process or "how" of the IHC experience. Imaginative variation entailed the researcher's consideration of participants' descriptions in terms of structures that were universal or found generally in human experience in order to develop structural themes. The researcher applied universal structures of "being in, being for, and being with" in facilitative relationships described by Moustakas (1986) in the process of imaginative variation to explore how these relationship stances might contribute to understanding co-researchers' descriptions of the client-coach relationship. The researcher also viewed mindfulness as a universal structure in the process of imaginative variation (Moustakas, 1994). Moustakas described the process of imaginative variation as "systematic varying of the possible structural meanings that underlie" co-researcher descriptions of IHC (1994, p. 99).

Structural description addressed the dynamics of the co-researchers' experience with a focus on how the IHC process operated for them. In the process of developing the structural description, the researcher identified structural elements and themes for individual co-researchers. She then applied the insights gleaned from imaginative variation (Appendix K) to the development of a composite structural description. The description presented the central elements of the dynamics of co-researchers' experiences as IHC clients (Appendix J).

The final steps of phenomenological analysis involved developing the findings. The researcher utilized a thematic framework to present the composite textural statement, imaginative variation, and the composite structural statement. A synthesis of findings described the essence of co-researchers' lived experience as IHC clients (Appendix J). The researcher considered the photo-elicitation images and interviews as a unique horizon or perspective within the body of data. She applied the phenomenological reduction process to the photo-elicitation images, titles, and interviews both as an individual data set and as a part of the whole body of data.

Study rigor and credibility strategies. Qualitative research demands strategies to ensure the rigor of the study as an element of design, including the process of study implementation and data analysis (Morse et al., 2002). Patton stated that the credibility of qualitative studies entailed three areas of focus: a) methods that demonstrate rigor; b) the skillfulness of the researcher; and, c) fidelity to the qualitative approach (2002, p. 584). Creswell offered eight “validation strategies” that distinguish the approach to credibility in qualitative research from the positivist understanding of validity (2007, p. 207). He encouraged qualitative researchers to employ a minimum of two strategies among those recognized in the field such as member checking, triangulation, ensuring the quality of the data, and peer review (Creswell, 2007). Wojnar and Swanson (2007) identified member checking as an essential verification and credibility strategy for a descriptive phenomenological approach.

In this study, efforts to address credibility entailed designing a research process that involved incorporating the understandings gained at each turn and applying those understandings to the next step (Morse et al., 2002; Patton, 2002). The insights gained from the November 2010 pilot study informed the study design. Strategies that the researcher used to address study

credibility included methodological congruence and using purposive sampling, in-depth interviews, and saturation of the data to contribute to quality data. The researcher maintained an audit trail, including a research log, the researcher's reflexivity journal, analytical and interpretation memos. She developed and utilized a codebook and ensured accuracy in data collection by means of audio-recording and taking handwritten notes during interviews. She demonstrated knowledge of the theoretical orientation and skills necessary to implement the study. The researcher applied triangulation and member checking as strategies for validation that contribute to study credibility.

Methodological congruence. Morse et al. described strategies for building reliability and validity into the study design (2002), proposing that the design be responsive to the study purpose and question. A phenomenological approach such as Moustakas' transcendental method aligned with the IHC study purpose to describe the lived experience of clients with a chronic health condition who engaged in IHC for a minimum of six sessions within the past year. The descriptive phenomenological method supported the study aim to identify structures that clients described as central to their IHC experience.

Quality data. The researcher employed purposive sampling in order to enroll a study sample that met inclusion criteria and had variation in their chronic health conditions, coaching settings, and personal demographics that would contribute to the quality of the data. Study participants engaged in in-depth telephone interviews in order to provide the rich description that contributes to the quality of the data. The researcher conducted purposive sampling, in-depth interviews, and data analysis until she observed saturation and then conducted two additional interviews to confirm saturation (Morse et al., 2002). Morse et al. observed that saturation

contributed to replication and “replication verifies, and ensures comprehension and completeness” of the data (2002, p. 18).

Audit trail. Maintaining an audit trail provided a process for verification and “integrity in analysis” (Creswell, 2009; Patton, 2002, p. 553). The researcher maintained a portfolio that included three components: a) a research log; b) analysis and interpretation memos; and, c) a reflexive journal (Creswell, 2009; Patton, 2002). In the research log, the researcher documented study activities and decision points by time and date (Appendix P). She wrote analysis and interpretation memos to explicate her thought processes, questions, intuitions, and decisions during study implementation (Appendix O). In the reflexivity journal, she documented her experience with epoche, bracketing, and her schemas and mental model during the study (Appendix N). The researcher engaged in a mindfulness-based process for reflexivity.

Codebook. The development and application of a codebook in the analytic process contributes to study credibility and verification (Attachment Q). The researcher developed a codebook based upon the sensitizing concepts that emerged from the literature that formed the basis for the interview guide and the themes that emerged in initial analysis (Patton, 2002). She applied the codebook in her analysis of the transcribed interview data manually with paper transcripts and with NVivo-9 software (QSR International, 2011).

Accuracy in data collection. Creswell (2007) discussed strategies for credibility specific to phenomenological studies. The first three qualities concerned ensuring the accuracy of the data and transcriptions. The researcher took multiple steps to ensure the accuracy of the data. She audio recorded interviews and took jotted notes during the interview. The researcher wrote expanded interview notes immediately following the interview. The researcher downloaded the interviews into a password-protected file and listened to each interview to ensure the quality of

the recording. The researcher utilized a transcription guide and transcribed each interview verbatim to support accuracy of the data.

Researcher's knowledge and skill. Study credibility strategies in this study involved the researcher as a skillful research instrument who was engaged in a systematic process that Creswell characterized as explicit, ethical, and able to apply multiple views or “levels of abstraction” (2007, p. 46-47). Creswell stated the need for the researcher to know the “philosophical tenets of phenomenology” (2007, p. 215). The researcher conducted a review of the philosophical foundation and lineage of Moustakas’ phenomenological method and the applications in health research prior to this study.

The researchers drew from previous experience as an interviewer and her coaching skills to create a safe interview environment and ask open-ended questions and probes that supported co-researchers’ rich descriptions and engagement in the study process. The researcher engaged in a mindfulness-based process for reflexivity and bracketing in order to identify assumptions and biases that might influence the study. The researcher monitored and considered her health considerations that might have had an effect on study implementation.

Triangulation. Triangulation of data is a credibility strategy that involved the researcher viewing the phenomenon from different horizons subsequent to incorporating multiple data sources and by applying multiple approaches in data collection (Patton, 2002). In this study, the researcher used four strategies for triangulation: a) multiple participants provided a variety of data sources; b) three methods of data collection (one in-depth interview, one photo-elicitation interview, and data provided by member checking); c) two methods of data analysis; and, d) independent investigators. The researcher applied multiple approaches to data analysis. She developed a codebook and used QSR NVivo-9 (2011) software as a method for coding, sorting,

and retrieving data. She applied Moustakas' phenomenological reduction process in which she identified and grouped significant statements and then used an imaginative process to identify themes (Moustakas, 1994). Members of the thesis committee provided a mechanism for investigator triangulation (Patton, 2002). Thesis committee members reviewed, supervised, and contributed to the design and implementation of the study as well as the findings and final report. The researcher met with the thesis director and university research faculty throughout the study process to seek supervision and feedback.

Member checking. Wojnar and Swanson (2007) identify member checking as the central validation strategy for the descriptive phenomenological approach. The researcher explained the process and importance of member checking to co-researchers during the study enrollment interview, at the end of the photo-elicitation interview, and in the invitation to provide feedback that accompanied sending the findings to each co-researcher. She specifically encouraged researchers to identify areas where the findings diverged or did not reflect the essence of their experience and shared that she welcomed such feedback, that it would be treated as data, and would contribute to the quality of the study. The researcher sent each co-researcher the three page composite synthesis of essences and meanings as well as the document containing the draft study findings so that they could view the photo-elicitation images and accompanying discussion. Seven co-researchers replied in writing by e-mail or letter and confirmed that the findings accurately reflected their experience (Appendix T).

Ethics

Ethical considerations with the proposed IHC study included ensuring respect for study participants, minimizing risks and maximizing benefits, and justice in participant selection (Crosby, DiClemente, & Salazar, 2006; Patton, 2002). The researcher obtained CITI training

certification (Appendix I) and obtained UMCIRB approval for study (Appendix A) and revisions (Appendices B, C).

Beneficence. Beneficence ensured the safety of participants and guided the researcher to ensure that benefits outweighed potential harm (Patton, 2002). The researcher established that there was minimal risk to participants in the study design and implementation (Richards & Schwartz, 2002). The researcher monitored participant comfort and safety during the interview process. She reminded participants that they could elect to stop an interview or decline to respond to a question at any point in the process (Patton, 2002). The interview process focused on the participants' IHC experience and entailed minimal risk of evoking strong emotional content. Co-researchers did not evidence or describe emotional distress during the interview process.

The researcher submitted a UMCIRB proposal to the Behavioral and Social Sciences Chair for expedited review on October 25, 2010 and received UMCIRB approval for the proposed IHC study on November 7, 2010 (Appendix A). The researcher revised the UMCIRB proposal to include the Duke IM coach recruitment strategy, a re-wording of the Research Study Announcement, and the inclusion of member checking as a third component of data collection and a credibility strategy (Appendix A). The researcher submitted a revised UMCIRB proposal for the thesis study on December 8, 2010 and received UMCIRB expedited approval on December 23, 2010 (Appendix A). The researcher submitted a second IRB revision on April 1, 2011 that incorporated thesis committee recommendations (Appendix C), the option for participants to combine the photo-elicitation and initial interviews, and the Permission to Publish Study Participant's Art Work or Photographs (Appendix H). The UMCIRB approved the second revision on April 13, 2011. She revised the Research Study Announcement and

requested UMCIRB expedited approval to send a second announcement on June 20, 2011 that the UMCIRB approved July 1, 2011 (Appendix B). She received the UMCIRB approval on July 11, 2011. The researcher completed the UMCIRB Continuing Review on September 22, 2011 (Appendix A). The researcher will retain the study data for three years in a locked file cabinet with access restricted to the researcher at her home office. The researcher will refrain from use or distribution of data outside the proposed thesis study without a new consent and UMCIRB approval.

Justice. The principle of justice in research entailed that persons who received IHC from the Duke IM coaches had fair access to participation in the study and that the design distributed the benefits and risks of the study across the study population (Patton, 2002). Justice applied specifically to the study sampling design. The design entailed the researcher sending the UMCIRB approved Research Study Announcement to the Duke IM Research Director. The Duke IM Research Director forwarded the announcement to the six Duke IM coaches with a request that the coaches send the Research Study Announcement to their IHC clients who they coached within the past year. The study design entailed that the Duke IM coaches would send the Research Study Announcement to all IHC clients in the study population at two points in time that occurred eight weeks apart.

Respect for persons. The principle of respect for persons addressed each co-researcher's privacy and confidentiality as well as autonomy in co-researchers' decision making throughout the study process (Patton, 2002). The researcher protected co-researchers' privacy and autonomy by designing the recruitment processes so that participants volunteered for the IHC study and elected to contact the researcher directly based upon their interest in participation. The researcher confirmed such autonomy by asking respondents if they perceived pressure to

participate and confirmed that each individual participated by choice. Respondents and those selected as co-researchers were not members of vulnerable populations. The researcher observed the screening process in order to identify potential vulnerability. She asked each co-researcher if she or he needed special considerations or accommodations in order to participate in the study. One co-researcher withdrew from study participation due to an emergent health issue and the researcher communicated support and respect for her decision.

Privacy entailed autonomy and minimized study impact on co-researchers and their personal and social domains (Patton, 2002). The researcher maintained co-researcher privacy by providing a toll-free call-in number for the interviews and reminding co-researchers of their freedom to end the interview or not to respond to a specific interview question. The researcher maintained co-researcher privacy by using pseudonyms and deleting or changing all personal or identifying information.

Confidentiality pertained to privacy; confidentiality defined the researcher and co-researcher relationship through a specific agreement regarding participant information (Patton, 2002). The researcher facilitated the informed consent process that included both the IHC study co-researchers and the researcher in signing a UMCIRB-approved document that addressed the protection of personal information and the security of data (Appendix D). The researcher maintained anonymity by assigning a study number and pseudonym to each co-researcher. The researcher maintained demographic information, personal information such as name and address, and study data separately in a locked file cabinet in her private office.

The researcher mailed each co-researcher the informed consent, reviewed the consent during a scheduled telephone session prior to data collection, and provided self-addressed stamped envelopes for co-researchers to return their signed consent documents. The researcher

provided co-researchers with a copy of the signed consent documents for their records. The researcher provided an option for co-researchers to fax the consent to a private fax in her office immediately prior to the interview. One co-researcher elected this option. The researcher reviewed and confirmed consent at the beginning of each telephone interview and prior to activating the audio recording.

Other ethical considerations. The IHC study involved the experiences of individuals who live with chronic health conditions. Thus, the researcher anticipated minimal risk regarding the emergence of strong emotions or sensitive topics (Dickson-Swift, James, Kippen, & Liamputtong, 2008). The anticipated minimal risk was born out in the collection of data; co-researchers reported a positive experience and did not express concern or distress during the interviews. The researcher used an interview guide to reduce the risk to researcher and participants. The researcher had the option to contact the thesis chair or designated member of the thesis committee to debrief any difficulty arising from the research but this step was not necessary (deMarrais & Tisdale, 2002).

The researcher considered a concern regarding potential appearance or actual conflict of interest due to her enrollment in the Duke IHC certification program and personal practice as an integrative health coach. The researcher discussed the concern with faculty and determined a conflict of interest did not exist for the study.

Pilot Study Findings

The researcher applied Moustakas' phenomenological methods as described by Creswell (2007) in a pilot study conducted in November 2010. The researcher sent a Research Study Announcement to all Duke 2010 certification program coaches with a request that they forward the announcement to clients. The researcher enrolled the first two participants who responded to

the Announcement. She conducted in-depth interviews using an open-ended interview guide to gain detailed description of IHC from participants' perspective and experience. The interviews were audio recorded with participants' permission and the researcher transcribed the interviews verbatim.

The researcher identified 180 significant statements and identified structural and textural elements in the significant statements. The researcher grouped data through a process of multiple iterations of coding and identifying themes and textural description. Six themes or units of meaning related to participant experience with IHC emerged from the coding and analysis process: (a) forward moving, (b) recognizing the whole person, (c) dynamics of health, (d), qualities of attention, (e) role of the coach, and (f) self-directed approach. The researcher conducted a final grouping of transcript data applying the six units of meaning (Creswell, 2007).

The researcher wrote composite textural and structural descriptions for each theme using participants' words from interview transcripts as evidence in support of the researcher's analysis and interpretation. The researcher conducted photo-elicitation interviews with each participant using an interview guide and images the participants sent to the researcher in self-addressed, stamped return envelopes. The photo-elicitation interview data was not included in the pilot-study analysis nor did the researcher conduct member checking. The researcher presented the synthesis of textural and structural descriptions from the in-depth interviews in the preliminary findings.

According to data from the pilot study, participants revealed that IHC was a transformational process that was dynamic and engaged the whole person. A sense of "moving forward" and experiencing a sense of "freeing" were prominent themes for both participants. Participants described experiencing the sense of freedom from patterns and limiting beliefs that

prevented them from achieving health and lifestyle goals. Freedom entailed “making progress...in my mind and body and health.” One participant described freedom as working through “serious health issues” and making “very hard decisions.”

Participants described forward movement as “being able to make a change.” Insight and awareness of self-judgment and blame were cultivated through mindfulness in the coaching process; participants identified letting go of self-judgment as central to supporting change. Participants also cited reducing stress as a benefit of mindfulness in IHC that supported moving forward “into the next thing or healing.” Both participants identified mindfulness as the essence of “forward movement” and the IHC experience. One participant stated, “Mindfulness is what allows us to move forward.”

Participant “attention” and “intention” opened possibilities for a restored sense of personal power and health across multiple areas of life including health, finances, work, and relationships. Artistic expression and creativity played a significant role in the IHC experience for both participants. The role of the coach was facilitative and supportive. Participants were empowered in the process and clear that they personally directed the IHC process. Both participants recognized that coaches have “expertise” that contributes to the IHC experience. Participants acknowledged that their IHC experience contributed to the healing of their physical conditions (back injury, depression, fatigue, and overweight); but the significance of IHC for participants was in creating the process for healing the whole person.

The November 2010 pilot study of participant experience with IHC described the potential of IHC for supporting individuals in realizing their vision of well-being and achieving success in areas they defined as priorities. The essences of the IHC dynamic identified in the pilot study were mindfulness, personal power, and responsibility. Participants described IHC as helping

them “move forward” in addressing specific health conditions as well as in restoring the whole person, their “hope” and “dreams.” Participants described IHC as connecting them with a sense of “wisdom,” restored “trust” in their abilities, and confidence “that they have the power” to shape all aspects of their lives.

Summary

The purpose of the study was to describe the lived experience of clients aged 18 years or older who live with a chronic health condition and who participated in at least six IHC sessions within the past year. The study applied a qualitative phenomenological approach and examined the structures and essences co-researchers described as essential to their IHC experience (Moustakas, 1994). The IHC study contributed to the identified need for research to describe IHC core structures (Olsen & Nesbitt, 2010). Wolever et al. (2010) advanced the understanding of IHC with a qualitative study that described the perspectives of formative Duke IM coaches. The IHC study added to the understanding by describing the lived experience of nine IHC clients.

The researcher applied Moustakas phenomenological method in the IHC study design and implementation (1994). The study employed purposive sampling to identify ten co-researchers, nine who completed the study process, who received IHC from six formative Duke integrative health coaches (Wolever et al., 2011). The researcher sought detailed description of co-researcher lived experience with IHC by conducting two in-depth interviews, one of which involved photo-elicitation. She transcribed the interviews verbatim.

The researcher utilized the four-step phenomenological analysis process described by Moustakas (1994). The researcher used NVivo-9 software (QSR International, 2011) and manual coding of the data and developed textural and structural descriptions of significant

themes. Co-researchers had the opportunity to review and provide feedback on the composite textural and structural description and study findings and seven confirmed that the findings represented their experience. The researcher developed a final composite textural and structural description supported by co-researchers' comments that served as evidence (Attachment J). The concluding step in analysis synthesized the findings and presented the structures and essences of co-researchers' experiences of IHC. The researcher wrote a manuscript to submit for publication in an effort to disseminate findings via a peer-reviewed journal. The study presents the manuscript as Chapter IV.

CHAPTER IV: MANUSCRIPT

Background: Integrative health coaching (IHC), an emerging approach to health promotion founded in integrative medicine, uniquely brings mindfulness, a holistic client-centered approach, and a supportive coaching relationship to facilitate clients' attainment of self-defined goals. The purpose of this study was to describe the lived experience of adult clients who sought IHC to address a chronic health condition and engaged in at least six sessions within the past year.

Method: The researcher applied a descriptive phenomenological approach in the UMCIRB approved study. The collection of qualitative data occurred through in-depth and photo-elicitation interviews with nine IHC clients who voluntarily responded to a study announcement.

Results: Participants engaged in a holistic and self-determined coaching process resulting in transformative change characterized by health and well-being. The integrative medicine approach distinguished IHC from other coaching models and applied mindfulness-based practices that fostered participants' self-awareness, self-acceptance, and internal motivation.

Conclusions: Client experiences contributed to the understanding of IHC as a process of realizing health and well-being in an integrative medicine-based coaching model. The integrative medicine framework, most notably mindfulness, promoted client autonomy and engagement in goal attainment and resulted in the experience of transformative change.

Keywords: Integrative health coaching, health education and promotion, integrative medicine, mindfulness, engagement

Introduction

Integrative health coaching (IHC) offers an emerging model for health promotion. Established in integrative medicine, IHC demonstrates promise for chronic disease prevention,

self-management, and the promotion of well-being (Edelman et al., 2006; Lawson, 2009; Wolever et al., 2010, 2011). The IHC process has incorporated prevailing coaching models, particularly the professional standards and competencies defined by the International Coach Foundation (ICF) (ICF, 2011; Wolever et al., 2011). IHC differs from other coaching models in that it applies an integrative medicine paradigm that includes mindfulness and a holistic approach to health oriented toward well-being (Wolever et al., 2011). Kabat-Zinn (2005) described mindfulness as a natural process that involves bringing attention to the experience of the present moment with a sense of friendly curiosity. IHC establishes the coach as a supportive partner in a person-centered integrative medicine process that activates and engages clients in realizing self-defined goals (Edelman et al., 2006; Lawson, 2009; Maizes, Rakel, & Niemiec, 2009; Wolever et al., 2010; 2011). The active role of clients suggested the importance of adding their voice and conceptualization of the health coaching process to the knowledge about the integrative medicine-based model. This qualitative study sought to contribute to the knowledge of IHC by describing the lived experience of clients with chronic health conditions who participated in IHC for at least six sessions within the past year.

Literature Review

The research literature includes studies focused on health coaching approaches and outcomes, but few studies have addressed how clients experienced health coaching and none described the perspectives of clients in IHC. The body of evidence supporting an array of interventions termed health coaching has grown (Newnham-Kanas, Gorezynski, Morrow, & Irwin, 2009; Olsen & Nesbitt, 2010). Evidence exists for health coaching as an intervention to support individuals living with chronic illness (Linden, Butterworth, & Prochaska, 2010), coronary heart disease (Vale et al., 2003), type 2 diabetes (Walker et al., 2011; Whittemore,

Melkus, Sullivan, & Grey., 2004) and cancer associated pain (Kravitz et al., 2011). Researchers have linked health coaching with the promotion of increased physical activity (Holland et al., 2005; Rimmer, Rauworth, Wang, Heckerling, & Gerber, 2009) and weight loss (Sherwood, Jeffrey, Welsh, VanWormer, & Hotop, 2010; Tucker, Cook, Nokes, & Adams, 2008).

Two experimental studies have documented the positive impact of IHC on the course of chronic disease. Initial experimental research, for example, found that IHC participants reduced their ten-year risk for coronary heart disease (Edelman et al., 2006). A randomized clinical trial revealed that IHC participants with type 2 diabetes significantly lowered their A1C levels, a standard measure of glycemic control (Wolever et al., 2010).

Olsen and Nesbitt's (2010) review of the published literature identified the issue that health coaching in general entailed varied interventions across multiple disciplines, and cited the need for a conceptual model and organizational framework for such coaching. Health coaching has been variously defined in the context of health education (Palmer, Tubbs, & Whybrow, 2003), nursing (Whittemore et al., 2004; Young et al., 2011), life coaching models (Moore & Tschannen-Moran, 2010; Newnham-Kanas et al., 2009), and behavioral health and psychology (Linden et al., 2010; Spence & Oades, 2011).

Two qualitative studies have explored clients' experiences with both life coaching and nurse coaching interventions. Parry et al. (2006) described the patient-centered health coaching experiences of 32 hospitalized older adults living with chronic illness. The health coaching intervention intended to support self-management in their care transition. Study findings revealed that clients' perceptions about the existence of a caring relationship with the coach contributed to their engagement in self-management and an improved sense of well-being (Parry et al., 2006). Similarly, Newnham-Kanas, Morrow, and Irwin (2011) investigated the

experiences of eight adult females living with obesity who received life coaching that applied motivational interviewing. The researchers identified key elements of the coaching process that included a client-driven approach encompassing multiple life domains, the application of life coaching skills, and the significance of the supportive relationship with the coach (Newnham-Kanas et al., 2011).

Researchers examined the organizational framework and the six Duke Integrative Medicine original coaches' description of IHC and found that the integrative medicine context distinguished IHC from the existing array of health coaching models (Wolever et al., 2011). Wolever et al. (2011) called for further research to understand the integrative medicine context and core elements of IHC. Descriptive research that explored IHC from the experience of clients would contribute to the knowledge of the integrative medicine-based approach.

Research Question

The purpose of this study was to gain an understanding of IHC from the perspective of clients' with chronic health conditions who had actively engaged in the IHC process. The research question asked, "What is the lived experience of IHC for adult clients with a chronic health condition and at least six sessions of IHC experience within the past year?"

Method

The qualitative approach employed in this study engaged the researcher and study participants in a discovery-oriented process in an effort to describe clients' lived experience in IHC. Phenomenology, set forth by Edmund Husserl (1856-1938) and developed by successors with branching epistemologies, has emerged as an important approach to human sciences research in the twentieth century (Moustakas, 1994; Wojnar & Swanson, 2007). The researcher applied Moustakas' (1994) approach to facilitate participants' descriptions of the structure and

essence of their lived experiences as IHC clients. A photo-elicitation data collection strategy provided study participants additional opportunity to express themselves and essences of their IHC experiences (Bignante, 2009; Harper, 2010; Patton, 2002).

Wojnar and Swanson (2007) identified three necessary elements of descriptive phenomenology: a) the state of openness by the researcher and study participants to the phenomenon; b) the engaged encounter of the researcher and study participants; and, c) the description of the universal structures and essences of the phenomenon. The researcher addressed the first element by describing her experience as an integrative health coach in order to identify and set aside preconceptions (bracketing) and encounter the phenomena with an open awareness (epoche). She applied mindfulness practices to support the phenomenological researcher's iterative process of bracketing, epoche, and reflexivity. The researcher engaged nine clients in in-depth and photo-elicitation interviews to describe the themes and structures of their lived experience with IHC (Creswell, 2007; Moustakas, 1994; Patton, 2002). She applied Moustakas' (1994) method for qualitative analysis that used phenomenological reduction, imaginative variation, and structural description to identify textural and structural themes and essences from which she developed a synthesis that presented the conceptual framework of client experience in IHC.

The qualitative approach required strategies to ensure credibility (Creswell, 2007; Patton, 2002). The researcher obtained institutional review board approval for the study. The phenomenological approach suited the purpose of the study and the research question. The researcher utilized NVivo-9 software (QSR International, 2011) to code the verbatim transcripts. She maintained an audit trail that included a dated and timed log of researcher activities, analysis and interpretation memos, and the researcher's reflexive journal (Patton, 2002). Photo-

elicitation and member checking provided varied horizons for gathering data (Patton, 2002).

Seven study participants confirmed that the synthesis and composite textural-structural description captured their lived experiences in IHC (Creswell, 2007; Wojnar & Swanson, 2007).

The researcher employed purposive sampling to recruit clients of eight formative Duke IHC coaches including the coaches who participated in the Wolever et al. (2011) organizational case study. The sample sought IHC to address a chronic health condition and engaged in at least six coaching sessions within the past year. Respondents voluntarily contacted the researcher in response to a study announcement that IHC coaches e-mailed to their clients. The researcher conducted an informed consent process and confirmed consent throughout study implementation. Nine study participants completed the in-depth and photo-elicitation interviews ranging from 60 to 90 minutes combined.

The characteristics of study participants varied by coaching context (clinic, worksite, individual, group), demographics, and the health conditions for which they initially sought coaching including arthritis, type 2 diabetes, cardiovascular disease, cancer, overweight, and obesity. To protect anonymity, the researcher assigned a study ID number and pseudonym to each participant. While participants varied by age range, location, educational status, coaching context, and health conditions, they all reported high satisfaction with their IHC experience. The limitation of the small sample size ($n=9$) as well as the limitation that the sample did not represent clients with a range of satisfaction suggested caution with generalizing the findings.

Findings

Analysis of the data through a process of phenomenological reduction revealed four textural themes: a) the unique integrative approach to realizing self-defined goals; b) the supportive relationship with the skilled health coach; c) mindfulness as a foundation for change;

and, d) a transformative change to “a new me” who experienced health and well-being. A structural description of findings identified the dynamics of a) the integrative medicine approach, particularly the application of mindfulness; b) the supportive coaching relationship; and, c) the IHC coaching process that led to the essential experience of empowerment and engagement in the change process. The exploratory conceptualization of nine clients’ lived experience with IHC identified the essential structures of integrative medicine and health coaching. The synthesis of clients’ experiences described the phenomenon as coach-supported whole person engagement in a mindfulness-based coaching practice established in integrative medicine and resulting in transformative change characterized by health and well-being.

Unique integrative approach to goal attainment. Study participants expressed that IHC was “different” from the health interventions they had previously experienced. They described qualities of the integrative approach that distinguished IHC from care they had received through their primary medical practice or other prevention programs and that contributed to their success in making crucial lifestyle changes. Participants observed that “integrative” meant considering the whole person as well as multiple life domains. They recognized that IHC approached health and well-being from an “overarching” perspective that included domains such as exercise, rest, nutrition, self-awareness, emotions, relationships, personal and professional growth, physical environment, and spirituality. Ida’s photo-elicitation interview illustrated that by reclaiming and transforming her physical environment to express her creativity and reflect her personal interests, she experienced the health benefit of a sense of well-being and improved quality of life.

Study participants quickly learned that they were “the players” (Bill) in the IHC process. They recognized themselves as active agents who were responsible for determining the focus,

goals, action steps, and pace of health coaching. In the integrative medicine framework that informed IHC in this study, client and coach designed a supportive partnership in which the coach facilitated the IHC process, but the client defined the emphasis and content. Study participants said they found their active role in IHC empowering. They described feeling ownership, responsibility, and engagement in realizing their self-determined goals. Danny noted that the concept of “integrative” entailed “different ways of getting you to participate as well as possible.” The following excerpt illustrates the ownership and engagement that Danny experienced in IHC process of whole person activation and integration:

Had she [coach] said, ‘Well, go do this,’ then I might have done it once. But would I have done it the second time because it wasn’t a part of me? Making it part of me allowed me to see how it was important to me and to do it again and again.

Study participants noted their integrative partnership extended to an integrated network of providers that included conventional as well as complementary and alternative care. They described experiences such as the use of guided imagery, yoga, or mindful eating as unique, engaging, and change evoking. The IHC clients emphasized the importance of resources, education, and collaboration. Claudette noted, “she [coach] will always say, ‘Well what resources do you know, what could you think of to help yourself with this?’” Participants described an approach to building knowledge and skills that relied on their strengths, resourcefulness, and sense of discovery.

Supportive relationship. The supportive relationship with their coach formed a central element of the nine clients’ IHC experience. Study participants described the role of IHC coaches as partner, guide, cheerleader, and educator who empowered and engaged them in a self-defined process of change. Ana reflected, “It was like doing it together...having that

partnership...I thought it was pretty incredible she [coach] could know who I am just from my 25 minute sessions.” The client-coach relationship involved a joint endeavor in which study participants experienced the coach as present and invested but not directive.

IHC coaches incorporated mindfulness into the coaching process by leading mindfulness practices and demonstrating qualities of mindfulness during interactions with participants. Study participants described that qualities of mindfulness displayed by their coaches were tangible. Presence, non-judgment, attunement, listening, openness, awareness, loving kindness, and a calm voice reflected the features study participants valued in their coaches. Ana shared that her coach had, “that voice that is very soothing, very easy to listen to, very calming...I felt very safe that I could share anything and I felt like I had a partner.” The coaches’ attuned, uncritical presence contributed to the client-coach relationship feeling personal, friendly, safe, and comfortable. Ida’s statement represented the qualities of friendliness and non-judgmental presence that participants experienced with their coaches:

It’s really the sense that I have this outside person who knows a lot about me, who listens and who is interactive and encouraging...It’s like having a friend who’s, well, I was going to say a friend who’s not a friend.

Coaching expertise. Study participants described IHC coaches as “crafted, very skilled” and emphasized the importance of proficiency in coaching in the outcomes they achieved. Bill noted that, “You’ve got to have good coaching.” Participants identified as pre-requisites for IHC coaches the elements of personal experience and skill in mindfulness and knowledge of integrative medicine. They described the importance of IHC coaches having professional training, credentials, and the resources afforded by an integrative health network. “I would

imagine that if you go with a health coach, you should definitely check their certifications and where they studied,” advised Grace.

Mindfulness as a foundation for change. The nine clients identified mindfulness as a basis for the IHC process and a foundation for change. Qualities of mindfulness threaded throughout the clients’ IHC experience: presence, attention, increased self-awareness, non-judgment, loving-kindness, insight, letting-go of control, and equanimity. Ericka described mindfulness as, “opening to your thoughts. It’s listening to your body. It’s slowing down.” Study participants described mindfulness as a central element supporting their activation and engagement in their lifestyle change process. The self-awareness clients experienced through mindfulness empowered them, as Ericka noted, to “identify the why of your choices and your actions.” They observed that the IHC process reflected a basis in mindfulness that facilitated client insight and self-awareness in order for them to make intentional choices aligned with their personal values. Ida described that mindfulness operated in her coaching sessions by increasing her awareness of, “What reactions do I have to something?”

Clients learned mindfulness practices such as mindful eating, body scan, and awareness of breathing either as an element of IHC sessions or in a collaborative mindfulness-based program. They applied mindfulness skills in their daily lives to support the realization of their goals. Mindy illustrated how mindfulness while eating supported her change process:

The thing is when I’m aware of what’s going on, I don’t pig out. I don’t go for the extra big plate. I don’t go for seconds. I eat ‘til I actually feel like I’m getting full and then I stop and then I’m like, I know I’m full. I don’t stress and over eat.

Study participants attributed mindfulness to supporting their new sense of health and well-being and, ultimately, to their experience of personal transformation. Seven participants described

mindfulness related to their photo-elicitation images. Kate shared, “I picked a lady that’s meditating and I chose that image because that’s where it starts.” The image depicted her experience that, “My coach was a support system to help me be mindful.”

Transformative change to “a new me.” “I think that integrative health coaching is life changing,” Kate shared. “Sometimes you can be yourself all your life and not really know yourself. So I’m starting to get to know me.” The nine IHC clients used change-focused words that described the essence of their IHC experience as transformative change: *metamorphosis, baking a cake, a new me, refined, freedom, blooming, transformative, lifesaver, and soaring*. Study participants recounted experiencing changes in their health, most notably in the areas of weight loss, improved physical fitness, lowered blood pressure and cholesterol, reduced stress, improved mood and less negative thoughts, and improved glycemic control. Their lifestyle changes included increased exercise, healthier nutrition and eating behavior, stress-management, and taking time for self-care. Such changes encompassed multiple life domains including their physical environment, professional development, communication skills, education, personal growth, and relationships.

The experience of transformation surpassed health and lifestyle changes and entailed whole person change characterized by happiness, a sense of well-being, and improved quality of life. Ida shared, “Health is such a small part of it in a way.” Transformative change denoted integration of the changes so that they became a part of the client’s life. Ana described:

I guess the new me...that’s what it [her image] means, it’s a whole new way of awareness. I would have to say that it’s a happier me with myself...I physically and emotionally feel so much better...it’s a whole new way of thinking, a whole new way of living my life.

The photo-elicitation images and interviews centered on the experience of transformative change as shown the photo-elicitation image titles presented in Table 1. Three study participants sent self-portraits that depicted “the new me.” Ericka’s collage, titled “Metamorphosis,” illustrated her IHC experience that “the coaches had acknowledgement and understanding of our transformation process, and so the caterpillars turned into butterflies.” The image of a blooming rose captured Grace’s experience:

I guess the fact that you can blossom...Everybody has that flower inside of them and you can, with assistance, with the health coaching, you can actually become what you were meant to become.

Table 1
Photo-Elicitation Image Titles

| Co-Researcher | Photograph or Image Title |
|---------------|--|
| Ana | The New Me |
| Bill | Before and After |
| Claudette | My Health Coach: The Wind Beneath My Wings |
| Ericka | Metamorphosis |
| Grace | A Blooming Life |
| Ida | The Tea Room |
| Kate | Refined |
| Mindy | Mini-me |
| Danny | Empowerment |

Empowerment and whole person engagement. IHC engaged the whole person in taking self-identified steps toward realizing health and well-being. Study participants expressed that they benefited from IHC to the extent that they engaged in the process. Mindy emphasized the need to, “be one hundred percent active in it.” The clients found that engagement in IHC involved intrinsic motivation based on values and their personal vision such as a long healthy

life to be with grandchildren (Bill, Mindy). Grace shared that her coach, “open[ed] my heart and mind to be able to figure out what I wanted to do.”

Study participants observed that IHC engagement involved attributes such as readiness to change, self-awareness, presence, and empowerment that contributed to autonomy and competence. They described that skillful coaching supported engagement by helping them build a sense of “self-reliance,” success and competence. Claudette shared how her coach helped her stay engaged by taking small steps that led to success, “she’ll [coach] have me think through what might make it easier to begin, how it might again be broken down into smaller, manageable parts, what support I might need to get started.”

Study participants expressed that having personal knowledge and skills as well as the ongoing support and accountability of a skilled coach contributed to the sustained effort involved in engagement in change. They emphasized the significance of self-determination to engagement in IHC. Bill stated, “I was the player. I was the one that had to produce the results...The bulk of it was on my back.” Engagement in IHC entailed increased self-confidence and autonomy that participants described as empowering.

Study participants noted that the self-regulation skills they learned through mindfulness and health education in IHC, particularly working with negative thoughts and self-judgment, played a significant role in sustaining engagement. Accountability and strategies to overcome obstacles contributed to engagement. Mindfulness, the coaching relationship, the coaches’ interventions, and the integrative medicine approach worked together to empower clients and engage them in the IHC process. Study participants described time and competing demands as barriers to engagement in IHC. Danny focused on his experience of “Empowerment” in IHC

that he depicted in his photo-elicitation image of an eagle “looking inward to doing outward.”

Danny observed:

The other weight loss’s [programs] say do this and you’ll lose weight. Not change yourself and you’ll have control over that...It’s [IHC] changed me. It’s changed me to looking at things differently and looking at myself differently.

Summary. The nine IHC clients who contributed to this study had initially sought coaching assistance for managing their chronic illnesses and reducing health risks and thus understood the difficulties involved in making and sustaining lifestyle and health behavior changes. Their experience with IHC engaged them in realizing self-defined goals that were connected to their personal vision and values. The integrative medicine framework that informed the coaching process contributed to their self-described experience of success by bringing mindfulness, a whole person approach, a facilitative relationship, and an integrative medicine resource network to the person-centered coaching process. All study participants described a personally transformative journey that originated with intentions to use IHC to address a particular health concern, but that culminated in self-discovery, empowerment, and change. Their integration of mindfulness and holistic changes not only resulted in improved and sustainable health and well-being, but also a “new me.”

Discussion

Study findings revealed the paramount importance of the integrative medicine context and principles for the IHC practice. Study participant data underscored the significance of two overarching IHC structures: the integrative medicine context and the coaching process. Their experiences supported the findings by Wolever et al. (2011) that the integrative medicine framework was a distinguishing feature of IHC and one that differentiated IHC from medical

models of health coaching, health education that involved coaching, and from life coaching. The researcher observed that the dynamic integrative medicine context and the coaching operated seamlessly for clients, a finding consistent with the literature that integrative medicine is not a separate silo but encompasses the entire experience of care (Bell et al., 2002; Maizes et al., 2009). Study findings revealed that the key elements of the integrative medicine context that were significant to study participants corresponded to the elements identified by the IHC coaches in a previous study (Wolever et al., 2011).

The study added to understanding of similarities and differences with IHC and varied health coaching approaches. Consistent with the research literature, study participants identified health coaching practices that applied individual constructs found in the integrative medicine paradigm such as a facilitative relationship, person-centered approach, and focus on self-determined goals and strategies (Hayes, McCahon, Panahi, Hamre, & Pohlman, 2008; Linden et al., 2010; Newnham-Kanas et al., 2009, 2011; Parry, Kramer, & Coleman, 2006). Elements significant to participants' IHC experiences corresponded to constructs identified in qualitative studies of varied health coaching models. These constructs included the facilitative relationship, client engagement, the coaching skills, and the person-centered process (Parry et al., 2006; Newnham-Kanas et al., 2011).

Similar to findings reported by IHC participants in this study, clients in a study conducted by Parry et al. (2006) described the experience of improved quality of life resulting from the coaching intervention. Consistent with Wolever et al. (2011), the application and central role of mindfulness in IHC emerged as an element that differentiated IHC from other coaching processes. Study findings suggested that the integrative medicine framework

contributed to study participants' IHC experiences and empowered them to change their lives and realize well-being (Maizes et al., 2009; Wolever et al., 2011).

The IHC coaching process engaged the nine study participants in transformative change, an experience associated with client outcomes in integrative medicine and indicative of that paradigm's understanding of the person as self-actualizing (Bell et al., 2002; Verhoef, Mulkins, & Boon, 2005). A growing body of evidence addresses the significance of engagement (Hibbard et al., 2004, 2005) and motivation for health behavior change (Ryan, Patrick, Deci, & Williams, 2008; Linden et al., 2010). Researchers identified health coaching involving a facilitative relationship that encouraged clients to step into an active role as agents of change increased client motivation and engagement (Hibbard et al., 2004, 2005; Linden et al., 2010; Parry et al., 2006; Wolever et al., 2010).

When IHC study participants focused on self-defined goals tied to intrinsic values, their motivation and engagement increased. This finding was consistent with the theoretical framework of Self-Determination Theory (SDT) set forth by Deci and Ryan (2008). SDT addresses the dynamics of motivation in health behavior change and the natural human propensity toward self-actualization (Deci & Ryan, 2008; Ryan et al., 2008). According to this theoretical approach, the initiation and maintenance of health behavior change requires autonomous, internal motivation based upon an individual's values and self-defined goals (Ryan et al., 2008). Interventions that focused on meeting the need for autonomy, competence, and relationship increased autonomous motivation and demonstrated effectiveness for changing and maintaining health behaviors (Ryan et al., 2008). The theoretical approach of SDT offers support for this exploration of study participants' experiences with IHC. The elements of

integrative medicine identified by study participants as key structures in their IHC experience frame the following discussion of findings.

Whole person engagement. This study found that IHC focused on the well-being of the whole person in contrast to targeted, disease-oriented approaches often applied in health education and coaching programs (Olsen & Nesbitt, 2010; Wolever et al., 2011). Study participants reported that IHC promoted their intrinsic capability to realize well-being, a finding consistent with the integrative medicine paradigm (Maizes et al., 2009), the IHC literature (Wolever et al., 2010, 2011), and life coaching models (ICF, 2011; Newham-Kanas et al., 2011). Participants' descriptions of the whole person IHC approach that encompassed mind, body, spirit and multiple life domains aligned with the principles of integrative medicine (Maizes et al., 2009).

The study added to the understanding of elements supporting client activation and engagement in IHC. Findings revealed the significant role of the integrative medicine context for engagement. The whole person approach supported client autonomy and active engagement in the change process (Ryan et al., 2008). Study participants expressed autonomy or self-direction and perceived responsibility in the IHC process, a finding consistent with SDT concept that increased autonomy promotes engagement in the change process (Ryan et al., 2008). The clients' experiences reported in this study supported findings by Wolever et al. (2010) that patients with type 2 diabetes who received IHC had higher measures of engagement for self-management. IHC clients discovered what mattered most to them and defined goals connected to their values and personal vision, thus building autonomy and increasing motivation and engagement (Ryan et al., 2008; Wolever et al., 2010).

Mindfulness-based health coaching. Findings from this study support the role of mindfulness in IHC. The practice of mindfulness threaded throughout the IHC process including within the client-coach interactions and through participants' personal practice. The multidimensional role of mindfulness in IHC reflected the integrative medicine paradigm in practice (Bell et al., 2002; Maizes et al., 2009).

The SDT theoretical approach articulated by Deci & Ryan (2008) provides a helpful framework to examine the application of mindfulness in IHC. Mindfulness played an instrumental role in cultivating self-awareness and insight that increased study participants' ability to make intentional choices (Kabat-Zinn, 2005). Increased self-awareness helped study participants notice and shift habitual behavior to behaviors aligned with their personal goals such as stopping snacking at work when bored (Kabat-Zinn, 2005; Deci & Ryan, 2008; Wolever et al., 2011). The findings concurred with Deci and Ryan's (2008) discussion of mindfulness as a way to increase self-awareness that builds intrinsic motivation for health behavior change.

Study participants' descriptions suggested that mindfulness contributed to their experience of engagement, a dynamic central to initiating and sustaining health behavior change (Deci & Ryan, 2008; Hibbard, 2004, 2005). The experience of presence, such as awareness of their inner state, empowered participants to make choices and take purposeful action consistent with the SDT concept of the importance of autonomy in health behavior change (Ryan et al., 2008). The resulting successes, along with skills for self-management augmented by mindfulness practices, contributed to study participants' experience of competence. A sense of competence helped sustain participants' motivation and engagement (Ryan et al., 2008).

The IHC process helped study participants apply insights and self-awareness cultivated through mindfulness to goal-directed action. Consistent with the SDT approach to health

behavior change, the translation of insight into action increased engagement and resulted in the integration of a change process that study participants described as transformative (Deci & Ryan, 2008; Wolever et al., 2011). Study findings suggested that the application of mindfulness in IHC increased motivation and engagement and contributed to participants' experiences of transformative change.

Facilitative relationships and empowerment. Consistent with the integrative medicine framework, study findings revealed that IHC entailed a facilitative relationship that empowered IHC clients as active agents in the change process (Maizes et al., 2009; Wolever et al., 2011). The researcher found that the IHC coaching relationship contrasted with didactic health coaching often applied in disease-focused approaches (Maizes et al., 2009; Olsen & Nesbitt, 2010; Wolever et al., 2011). IHC coaches facilitated study participants' sense of autonomy and competence by supporting their agenda and inviting them to draw from their resources and knowledge to develop strategies to meet their personal goals. The study found that IHC coaches demonstrated proficiency with coaching skills that empowered and engaged the study participants. According to participants, coaches asked open-ended questions, offered complex reflections, and acknowledged client successes. Their coaches actively listened and communicated attuned presence, non-judgment, and acceptance.

Study participants described a coaching relationship in which qualities of mindfulness demonstrated by IHC coaches, such as their capacity for presence, non-judgment, and attunement, created the sense of safety and support essential to relationships that facilitate change (Moustakas, 1986; Ryan et al., 2008). The researcher found the coaches' skillfulness in facilitating mindfulness essential to study participants' experiences of the IHC process; study participants' descriptions of the role of mindfulness in their client-coach relationship concurred

with that of the IHC coaches in the study conducted by Wolever et al. (2011). Findings from the present study suggested that the IHC coaches required training, experience, and personal practice with mindfulness.

This study revealed that participants considered the legitimacy and skills of IHC coaches as significant in their client-coach relationship. The coaches' affiliation with a trusted institution contributed to legitimacy, safety, and trust. Study participants emphasized the importance of training and proficiency that their IHC coaches demonstrated. Such coaches' attributes and interventions were consistent with the literature addressing health coach training (Adelman & Graybill, 2005; Wolever et al., 2010, 2011). Study findings supported the need for IHC coach credentialing such as that developed by Duke Integrative Medicine and the national initiative to develop standardized credentials for health coaching practice (Institute of Coaching, 2011; Wolever et al., 2011). The findings suggested that IHC coaches needed authentic experience and knowledge of integrative medicine practices in addition to a coaching skillset. IHC coaches required knowledge of practices that supported holistic, mind and body involvement in the change process such as the use of guided imagery or knowledge of yoga and mindful eating (Maizes et al., 2009; Wolever et al., 2011).

Collaborative network. The study found that the integrative medicine context provided a network of care and resources that supported the nine IHC clients in their change process. Three study participants specified that communication and collaboration among health care providers and coaches signified an essential element of their IHC experience. This observation was consistent with the integrative medicine framework (Maizes et al., 2009; Verhouf et al., 2005; Wolever et al., 2011). Access to a network of resources including health education and complementary and alternative practices supported individualizing participants' change process

and contributed to clients' experience of autonomy and competence that increased engagement (Deci & Ryan, 2008; Hibbard et al., 2004, 2005; Maizes et al., 2009; Wolever et al., 2011).

The study found that health education played a consequential role in study participants' change process (Olsen & Nesbitt, 2010; Palmer et al., 2003). Participants valued the knowledge and skills they accessed through their health coach and the integrative medicine network. The findings suggested that the practice of health education in the IHC process differed substantially from the didactic style found in a medical model. The IHC process entailed a facilitative approach that encouraged study participants' discovery and engagement in gaining the knowledge and skills they deemed necessary to accomplish their goals (Maizes et al., 2009; Ryan et al., 2008; Wolever et al., 2011). The IHC approach applied health education as a tool for empowerment and integration of the change process (Maizes et al., 2009; Ryan et al., 2008; Wolever et al., 2011).

Conclusions

Health coaches and health promotion practitioners can look to these study findings for an exploratory conceptualization of nine clients' experiences with the integrative medicine framework for coaching. The study participants who engaged in IHC described the difficulty involved with making and sustaining health and lifestyle changes. They needed more than physician recommendations and information. This study suggested that clients' experiences with IHC reflected health promotion practice that involved a paradigm shift as opposed to the adoption of an ancillary skill or intervention. While IHC had elements in common with varied health coaching approaches, participants described that the integrative medicine context, as a whole, contributed to their experience of transformative change characterized by health and well-being. Clients found that mindfulness played a significant role in their IHC experience.

The IHC coaches demonstrated skill with practices that supported personal qualities of mindfulness such as presence and self-awareness that clients found significant to their coaching relationship and the coaching process. Coaches facilitated mindfulness during the coaching process and supported their clients' own mindfulness practice. The application of mindfulness in IHC required that coaches receive training in the practice. Mindfulness-based Stress Reduction (MBSR) provided one approach to the application of mindfulness in IHC (Kabat-Zinn, 2005). Study participants' experiences suggested that IHC provided varied approaches that took into account individual preferences for how to cultivate mindfulness. Their descriptions of mindfulness in IHC illustrated the potential benefits of the practice as a transformative agent and for empowerment and engagement in the change process.

IHC coaches required proficiency with coaching interventions such as the competencies defined by the ICF (2011). The study suggested that IHC coaches required additional training, credentials, and skills unique to the integrative medicine foundation, including training and personal experience with mindfulness and the principles applied in the integrative medicine paradigm. The IHC role required a reorientation from a directive coaching relationship to an attuned and authentic presence and the personal skills for "being in, being for, and being with" their clients that Moustakas (1986) found in relationships that facilitated change. Study findings revealed that IHC offered a model for health promotion practice that can meet the challenge of chronic disease prevention and support individuals in a process of realizing well-being and improved quality of life.

Recommendations

The study described the lived experience of nine clients who voiced satisfaction with IHC. The researcher recommends that future qualitative study examine the IHC experience of

clients who represent a range of satisfaction and outcomes, including clients who withdrew from IHC. This exploratory study demonstrates that gaining insight into clients' experiences contributes to understanding IHC. Study participants described the experience of transformative change and their integration of new behaviors. Outcomes research that builds upon an SDT framework could focus on measuring the maintenance of lifestyle or behavioral change. This study pointed to the need for future investigation of the role of the integrative medicine framework, possibly through experimental research that compares IHC to motivational interviewing –based health coaching.

This study contributed to the knowledge base of IHC by presenting an exploratory conceptualization of what mattered most to the nine clients who sought IHC to address a chronic health condition and realized improved health and well-being in the process. Their experience of health coaching applied in an integrative medicine framework can inform the shift to a new paradigm for health promotion practice that is patient-centered, holistic, facilitated by supportive relationships, and recognizes each client's potential for transformative change.

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CHAPTER V: DISCUSSION

Integrative medicine (IM) centers launched integrative health coaching (IHC) to help clients realize their personal vision of health and well-being. At the time of this research, two experimental studies had found evidence that IHC reduced the ten-year risk for cardiovascular disease (Edelman et al., 2006) and supported clients who lived with type 2 diabetes in improving their glycemic management (Wolever et al., 2010). One qualitative study had described IHC based upon an organizational case study and the experience of IHC coaches (Wolever et al., 2011). Since the researcher identified no published literature that described the experience of clients with IHC practice, she designed this study to address that gap in knowledge. The researcher employed Moustakas' (1994) transcendental phenomenological approach to address the research question, "What is the lived experience and meaning of IHC for adult clients with a chronic health condition and at least six sessions of IHC participation in the past year?"

This phenomenological study described the lived experience of IHC from the perspective of nine IHC clients. Findings emerged from an analysis of transcribed qualitative data collected by means of in-depth and photo-elicitation interviews. Study findings revealed a conceptualization of clients' lived experience of IHC as a mindfulness-based IM coaching process that engaged them as whole persons in transformative change and resulted in a sense of health and well-being.

In this chapter, the researcher presents a study summary and discusses the findings related to the research literature and Self-Determination Theory (SDT) (Deci & Ryan, 2008). SDT provides a theoretical framework applicable to IHC in that it informs the process of personal growth and change, including health behavior change, in terms of motivation and the human needs for autonomy, competence, and relationship (Deci & Ryan, 2008; Ryan, Patrick,

Deci, & Williams, 2008). Following the discussion of findings, the researcher presents conclusions based on the themes and structures of co-researcher descriptions. She then identifies study limitations, addresses implications for the practice of health promotion and IHC, and concludes the chapter with recommendations for future research.

Summary of Study Findings

The researcher employed purposive sampling to recruit clients of the eight formative Duke IM coaches including the six coaches who participated in the Wolever et al. (2011) organizational case review. Nine participants, referred to as co-researchers in this study, voluntarily engaged in the in-depth and photo-elicitation interviews that the researcher facilitated in an effort to elicit co-researchers' perspectives about IHC. Co-researchers' characteristics varied by coaching context, personal demographics, including a wide dispersion of geographic residence, and the health conditions for which they initially sought coaching. These health conditions included arthritis, type 2 diabetes, cardiovascular disease, cancer, overweight, and obesity.

Consistent with Moustakas' (1994) recommendations for phenomenological analysis, the researcher presented the textural and structural themes that emerged from analysis of the verbatim interview transcripts as well as the photo-elicitation images. The textural themes pointed to the significance of the IM approach and the skilled coaching that resulted in co-researchers' experience of self-perceived transformative change. Imaginative variation explored how the co-researchers' experience of IHC might have differed without the inclusion of mindfulness as an integral part of the coaching process. In exploring imaginative variation, the researcher applied Moustakas' (1986) conceptualization of presence in relationships that facilitated change.

Structural themes that emerged from the data reflected the interrelated dynamics of the IM framework and the specific elements of mindfulness, the supportive relationship, and attributes of the coaching process that enhanced co-researchers' engagement in IHC. The synthesis of essences and meanings derived from the data revealed co-researchers' lived experience with IHC as coach-supported whole person engagement in a mindfulness-based coaching practice established in IM and resulting in transformative change. Seven of the nine co-researchers reviewed a draft of the study report and confirmed the presence and accuracy of their perspectives and experiences in the findings.

Discussion

The researcher applied Moustakas' (1994) phenomenological approach to describe the experience of nine co-researchers living with chronic health conditions who engaged in at least six sessions of IHC within the past year. The researcher used a qualitative approach in this study to give voice to co-researchers, describe what they experienced in the coaching process, and present an exploratory framework of essential structures related to their experience. In the context of the SDT framework for human growth and behavior change (Deci & Ryan, 2008; Spence & Oades, 2011; Ryan et al., 2008) four key structures formed the conceptual framework of the co-researchers' IHC experience: a) the IM framework; b) the coaching process facilitated by a skilled coach; c) co-researcher engagement; and d) the experience of transformative change. The essential structures of the IHC experience described by the nine co-researchers comprise an exploratory conceptualization of IHC (Supplemental Material, Figure S1). A small sample size ($n=9$) allowed the researcher to provide rich description specific to the co-researchers' experience. Though readers must use caution in generalizing study findings, inclusion of thick, rich description affords opportunity to assess the study for transferability.

IM framework distinguished IHC. The nine co-researchers' perspectives revealed that IHC differed from other health care and health promotion experiences to which they had been exposed. They described IHC as “innovative” and based in an IM framework. This finding supported the Wolever et al. (2011) organizational case study that found IHC applied IM principles in coaching practice. The application of IM demonstrated a facilitative and non-didactic style that supported clients in connecting their values to self-defined goals and emphasized their role as the agents of change (Maizes et al., 2008; Wolever et al., 2011).

The research literature indicated similarities between IHC and life coaching and motivational interviewing-based health coaching approaches in that these approaches implemented multiple constructs consistent with IM principles (Hayes et al., 2008; Linden et al., 2010; Newham-Kanas, Morrow, & Irwin, 2011). IHC, life coaching, and motivational interviewing-based coaching recognized the importance of a supportive partnership between coach and client as well as client autonomy and self-determination in the coaching process (Hayes et al., 2008; Linden et al., 2010; Newham-Kanas et al., 2011; Spence & Oades, 2011; Wolever et al., 2011). The three coaching approaches shared the view of clients as intrinsically whole, resourceful, and able to realize well-being (Hayes et al., 2008; Linden et al., 2010; Newham-Kanas et al., 2011; Spence & Oades, 2011; Wolever et al., 2011). Life coaching and motivational interviewing aligned with the IM principle of employing a person-centered approach and empowering the participant (Hayes et al., 2008; Linden et al., 2010; Newham-Kanas et al., 2011; Spence & Oades, 2011; Wolever et al., 2011). The researcher's observation that co-researchers' experience of IHC differed from other coaching approaches in that mindfulness and IM principles established the basis for the coaching relationship and IHC process was consistent with prior research findings (Wolever et al., 2011).

The researcher found that the SDT concepts of the role of intrinsic motivation and the need for autonomy, competence, and supportive relationships in order to realize personal change contributed to understanding co-researchers' experience of the IM framework (Deci & Ryan, 2008; Maizes, Rakel, & Niemiec, 2009; Ryan et al., 2008; Wolever et al., 2011). The SDT approach, consistent with co-researchers' experience and the IM paradigm, holds that people have an innate tendency to seek self-actualization and well-being (Deci & Ryan, 2008; Ryan et al., 2008; Spence & Oades, 2011; Wolever et al., 2011). The role of health behavior change interventions in SDT involves providing a supportive relationship that promotes clients' autonomy, increases their sense of competence, and engages them by connecting self-defined goals to intrinsic motivators such as their personal values and aspirations (Deci & Ryan, 2008; Ryan et al., 2008; Spence & Oades, 2011). Co-researchers in this study described a similar experience with IHC. The IM framework promotes autonomy and intrinsic motivation by means of holistic, person-centered practice (Maizes et al., 2009). Deci & Ryan (2008) recognized the potential role of mindfulness in building personal autonomy and competence. The significance of a supportive and facilitative relationship in health behavior change that is advocated in SDT (Deci & Ryan, 2008; Maizes et al., 2009) was reflected by co-researchers' perspectives about IM and IHC. The SDT approach to health behavior change supported co-researchers' contention that the IM framework played a key role in their process of transformative change.

Data shared by co-researchers revealed five themes consistent with the literature addressing IM principles and practices (Bell et al., 2002; Guarneri et al., 2010; Maizes, Rakel, & Niemiec, 2009; Snyderman & Dinan, 2010; Verhouf et al., 2005; Weisfeld, 2009). The five themes included a: a) focus on health and well-being; b) whole person approach; c) person-centered process; d) mindfulness; and, e) supportive partnership with the coach. Co-researchers

also identified the coaching-specific attributes of training, credibility, and access to an integrative network as significant elements of IHC related to the IM framework.

IHC focused on health and well-being. Co-researchers sought IHC to address chronic health conditions or risk factors for chronic disease. They reported prevention benefits from IHC that, depending on the individual, included weight loss, improvements in eating behavior, increased exercise, and stress reduction as well as increased efficacy for health promoting behaviors. This finding agreed with published findings regarding health coaching interventions in general (Holland et al., 2005; Linden et al., 2010; Lindner et al., 2003; Newnham-Kanas et al., 2011; Olsen & Nesbitt, 2010; Tucker et al., 2008). Co-researchers described improvements in their chronic health conditions and self-management of those conditions, which were also consistent with the general health coaching literature (Edelman et al., 2006; Hayes et al., 2008; Holland et al., 2005; Kravitz et al., 2011; Linden et al., 2010; Newnham-Kanas et al., 2011; Oslen & Nesbitt, 2010; Wolever et al., 2010; Vale et al., 2003). Their experience of prevention and self-management supported prior research that revealed that IHC improved health outcomes for adults at risk for cardiovascular disease and adults living with type 2 diabetes (Edelman et al., 2006; Wolever et al., 2010).

The primary benefit of IHC emphasized by the nine co-researchers came from their descriptions of subjective well-being beyond disease management or the improved chronic health condition (Deci & Ryan, 2008; Maizes et al., 2009; Verhouf et al, 2005; Wolever et al., 2011). The IHC focus on health and well-being distinguished IHC from conventional medical approaches that co-researchers had previously experienced. Such a focus clearly aligned with the IM paradigm (Maizes et al., 2009; Verhouf et al, 2005; Wolever et al., 2011). Eight co-researchers described how their sense of well-being resulted from the internal changes they had

experienced such as increased self-awareness and self-acceptance. They had made such changes through IHC and the practice of mindfulness in IHC, a finding consistent with literature addressing mindfulness and the SDT framework (Brown, Ryan, & Creswell, 2007; Deci & Ryan, 2008; Greeson, 2009; Kabat-Zinn, 2005; Spence & Oades, 2011).

Co-researchers' characterized their experiences of well-being using such terms as *happier, calm and centeredness, comfort, empowerment, strength, feeling healthy and vital, peacefulness, being energized, soaring, illumination and self-awareness*, and having a sense of *looking forward to each day*. The IHC focus on health and well-being concurred with literature addressing IM approaches to care (Bell et al., 2002; Guarneri et al., 2010; Maizes et al., 2009; Snyderman & Dinan, 2010; Verhouf et al., 2005; Weisfeld, 2009). The importance of an IM focus on client health and well-being supported findings from preliminary IHC studies (Wolever et al., 2010, 2011). Co-researchers' experience of well-being also reflected the SDT concept that people moved naturally toward optimal health and well-being as their autonomy and intrinsic motivation increased through a self-determined process (Deci & Ryan, 2008; Spence & Oades, 2011). For co-researchers, the IHC process increased their autonomy and intrinsic motivation and consequent experience of well-being.

IHC engaged the whole person. Co-researchers observed that IHC activated the whole person in defining and realizing personal aspirations and goals. They noted the importance of IHC interventions such as mindful eating that acknowledged the interrelatedness of mind and body, a practice consistent with an IM framework (Bell et al., 2002; Guarneri et al., 2010; Liburd & Sniezek, 2007; Maizes et al., 2009; Snyderman & Dinan, 2010; Verhouf et al., 2005; Wolever et al., 2011). Co-researchers' self-defined goals addressed multiple life domains including personal growth, education, professional development, relationships, and physical

environment. IHC demonstrated a multidimensional approach articulated in the IM paradigm as well as the IOM model for health promotion (Bell et al., 2002; Guarneri et al., 2010; Liburd & Sniezek, 2007; Maizes et al., 2009; Snyderman & Dinan, 2010; Verhouf et al., 2005; Wolever et al., 2011). The whole person approach, for example, validated Ida's experience of moving toward realizing optimal health and well-being by creating a nurturing home environment for herself.

Co-researchers' experiences reflected IM principles that IHC practice is holistic and based upon clients' unique vision for their lives and the values they identified as meaningful and motivating (Bell et al., 2002; Guarneri et al., 2010; Maizes et al., 2009; Snyderman & Dinan, 2010; Verhouf et al., 2005; Wolever et al., 2011). The IM focus on co-researchers' core values across life domains aligned with the SDT premise that intrinsic motivation engaged and sustained clients in health behavior change (Deci & Ryan, 2008; Ryan et al., 2008; Spence & Oades, 2011). The whole person approach contributed to co-researchers' perceptions that their coach had a stake in "me" as a unique person, a positive perception about their coaches' investment in them furthered the supportive client-coach relationship (Bell et al., 2002; Guarneri et al., 2010; Maizes et al., 2009; Verhouf et al., 2005; Wolever et al., 2011). Data from co-researchers confirmed their application of the IM perspective that a disease or a health condition did not define them as individuals. Consistent with SDT, the nine co-researchers found that their individual strengths, values, aspirations, and life purpose increased their personal motivation for change and engaged them as whole persons (Deci & Ryan, 2008; Spence & Oades, 2011; Wolever et al., 2011) in the IHC-facilitated change experience.

IHC demonstrated person-centered practice. Findings from this study revealed that IHC demonstrated person-centered practice in coaching and health education for individuals

living with chronic health conditions. Co-researchers emphasized their role as agents of change. The coaches supported co-researchers' "self-reliance" in the change process, which was consistent with the IM paradigm and the understanding of the importance of autonomy in the SDT approach (Deci & Ryan, 2008; Hibbard et al, 2004; Maizes et al, 2009; Spence & Oades, 2011; Wolever et al., 2010, 2011). SDT provided evidence that client autonomy increased engagement and maintenance of health behavior change consistent with the co-researcher's comment that IHC "taught them to fish" in the change process (Deci & Ryan, 2008; Ryan et al., 2008; Spence & Oades, 2011).

Person-centered health education. Consistent with literature that defined health education as an element of health coaching (Lindner et al., 2003; Olsen & Nesbitt, 2010; Palmer, Tubbs, & Whybrow, 2003; Parry, Kramer, & Coleman, 2006), co-researchers valued the health education component of IHC. Coaches provided access to prevention and self-management materials such as guides for eating healthy in restaurants, information regarding specific diets, or how to stretch and exercise at your desk. Key to the application of health education practices for the nine co-researchers in this study was that they played an active role in determining their need for and acquisition of knowledge and skills, a dynamic that supported client autonomy and competence emphasized in SDT-based interventions (Deci & Ryan, 2008; Ryan et al., 2008; Spence & Oades, 2011; Wolever et al., 2011).

Consistent with IM principles, co-researchers noted the uniqueness of the IHC approach in which the coaches encouraged and empowered clients to build upon their own resources, skills, and knowledge as a step in health education (Maizes et al., 2009; Wolever et al., 2010, 2011). Coaches inquired about what co-researchers knew, what resources they had available to help them explore and identify strategies to meet their self-defined goals, and recognized the

contributions of co-researchers as viable expertise. This finding reflected a difference in the application of health education among the various health coaching approaches. Health coaching that applied a didactic approach to health education contrasted with co-researchers' descriptions of IHC in which the process of facilitating health education supported the person-centered, partnership process consistent with IM principles (Hayes et al., 2008; Linden et al., 2010; Maizes et al., 2009; Parry, Kramer, & Coleman, 2006; Wolever et al., 2010, 2011).

IHC demonstrated a mindfulness-based approach. Co-researchers described the experience of mindfulness and mindfulness practices as basic elements of IHC. The study found that the central role of mindfulness in co-researchers' lived experience was consistent with IM principles and the IHC model (Bell et al., 2002; Lawson, 2009; Wolever et al., 2010, 2011). The co-researchers' perspective revealed mindfulness as an intrapersonal and interpersonal dynamic in the IHC process, adding to the understanding of the dynamics of mindfulness in IHC. Mindfulness in IHC operated in three key areas: the coaching relationship, the coaching process, as well as in the co-researchers' personal practices such as the body scan or loving-kindness practice that IHC supported.

Co-researchers described participation in mindfulness practices such as body scan, breath awareness, loving-kindness, and yoga consistent with formal practices applied in MBSR programs (Brantley, 2009; Kabat-Zinn, 2005). One co-researcher preferred not to engage in formal mindfulness practices during coaching but described using an MBSR practice for centering and observed that mindfulness operated in IHC through the coaching process that promoted her self-awareness and insight. Co-researchers' accounts of the role of mindfulness in IHC concurred with the depiction of mindfulness offered by IHC coaches (Wolever et al., 2011).

Brown, Ryan, and Creswell (2007) analyzed both experimental and descriptive studies that examined the potential health promotion benefits of mindfulness and found that the state of mindfulness measured by standardized instruments correlated with established indicators of well-being. Co-researchers' experiences that mindfulness supported their sense of well-being and contributed to improved health conditions concurred with Brown et al.'s (2007) findings that mindfulness leads to better physical health, subjective well-being, and improved mind/body functioning. Brown et al. (2007) identified mechanisms published research studies associated with the salutary effects of mindfulness. Their findings corresponded to the descriptions of increased self-awareness, acceptance, self-regulation, stress-reduction, and the ability to observe physical, emotional, and mental states with non-judgment that characterized co-researchers' experiences with mindfulness in IHC (Brown et al., 2007). Consistent with Brown et al.'s (2007) analysis of published studies and with MBSR practice models (Brantley, 2009; Kabat-Zinn, 2005), co-researchers' described the significance of quieting self-criticism with mindfulness practices in IHC. Co-researchers found themselves open and present to the coaching process as well as taking intentional action they described as "making choices" rather than acting based on habit or routine. Their descriptions of attention and enhanced behavioral control aligned with Brown et al.'s analysis (2007) of the role of mindfulness in facilitating health-promoting behavior.

In work related to SDT, Deci & Ryan (2008) stated that research provided evidence that self-awareness gained through mindfulness practices played a role in autonomous motivation. Consistent with the SDT framework (Deci & Ryan, 2008; Spence & Oades, 2011), co-researchers in this study indicated that the dynamics of mindfulness in the coaching process helped them develop new insights into themselves and their habits of behavior as well as initiate

and sustain action toward realizing their goals. Co-researchers noted that presence, self-awareness, and self-regulation associated with mindfulness contributed to their experience of engagement in IHC. Their observations concurred with the literature that addressed the benefits of mindfulness for supporting awareness, autonomous motivation, and competence associated with increased self-regulation (Brown et al., 2007; Deci & Ryan, 2008; Kabat-Zinn, 2005; Greeson, 2009).

Qualities supported by mindfulness such as presence, self-awareness, self-regulation, openness, and non-judgment aided co-researchers' reflexivity in the coaching process that led to meaningful insights regarding themselves and their habits of thought and behavior (Brown et al., 2007; Deci & Ryan, 2008; Kabat-Zinn, 2005; Silsbee, 2004). The insights informed and motivated their change process (Brown et al., 2007; Deci & Ryan, 2008; Kabat-Zinn, 2005; Wolever et al., 2011). An enhanced ability to witness internal states of hunger, thirst, boredom, worry, or tiredness associated with mindfulness (Kabat-Zinn, 2005) gave co-researchers an increased ability to overcome habitual behavior and make decisions that aligned with their vision and values (Wolever et al., 2011). One co-researcher described this aspect of mindfulness as "empowerment."

As noted in literature describing mindfulness practices and relationships that facilitate change (Brown et al., 2007; Kabat-Zinn, 2005; McCabe-Ruff & Mackenzie, 2009), mindfulness enhanced the coaching relationship (Silsbee, 2004; Wolever et al., 2011). Co-researchers observed that they could "feel and see" their health coaches' foundation in mindfulness. Five co-researchers described in detail the coaches' calm voice and presence that contributed to their IHC experience in general and coach-client relationship in particular. They expressed that they wanted to record sessions to hear the soothing voice repeatedly, having found the mindful

presence of the coaches to be centering, safe, and supportive. Co-researchers observed that IHC coaches demonstrated authenticity and skillfulness in guiding mindfulness practice during their coaching sessions. Their description of how IHC coaches exhibited mindfulness concurred with literature that addressed mindfulness and coaching including the importance of coaches developing a personal mindfulness practice (Brantley, 2009; Lawson, 2009; Silsbee, 2004; Wolever et al., 2011). Co-researchers described a relationship characterized by qualities of presence, attunement, deep listening, kindness, non-judgment, openness, safety, and acceptance that reflected mindfulness (Brown et al., 2007; Kabat-Zinn, 2005; Ruff & Mackenzie, 2009; Siegel, 2007; Silsbee, 2004). The qualities of mindful presence that co-researchers experienced with their IHC coaches aligned with Moustakas' (1986) description of the kinds of relationships that facilitated change.

IHC coaches facilitated a supportive partnership. Co-researchers found the coaching relationship central to their IHC experience. They characterized the coach as a partner, facilitator, guide, cheerleader, and friend (“that’s not a friend”). They described the supportive partnership with their coach as a cornerstone of their IHC experience, a relationship quality found in the IM paradigm (Bell et al., 2002; Guarneri et al., 2010; Maizes et al., 2009; Verhouf et al., 2005; Wolever et al., 2011). Their description was consistent with IHC coaches’ understanding of the client-coach relationship (Wolever et al., 2011). The literature identified supportive relationships that facilitated autonomy and empowered clients as an essential component of the SDT framework (Deci & Ryan, 2008; Ryan et al., 2008; Spence & Oades, 2011). The nature of the client-coach relationship described by co-researchers in this study supported findings from prior research that the relationship differed from the role typically found in prevention and health promotion interventions (Wolever et al., 2010, 2011).

Co-researchers' descriptions of the significance of the relationship with their coach agreed with the literature that distinguished health coaching that established a partnering relationship from health coaching that delivered targeted health education (Hayes et al., 2008; Linden et al., 2010; Lindner et al., 2003; Parry et al., 2006; Walker et al., 2011; Wolever et al., 2010, 2011). Consistent with the literature, co-researchers in this study identified the supportive client and coach relationship as a fundamental element of the coaching process (Newnham-Kanas et al., 2011; Parry et al., 2006; Wolever et al., 2011). The coaching relationship described by co-researchers in this study reflected an approach that supported client autonomy held in common by practices informed by SDT, IM, life coaching, and MI (Hayes et al., 2008; Hibbard et al., 2004; Linden et al., 2010; Lindner et al., 2003; Maizes et al., 2009; Newnham-Kanas et al., 2011; Spence & Oades, 2011; Wolever et al., 2011).

Co-researchers' descriptions of their IHC experiences concurred with the SDT concept that a supportive relationship preceded the acquisition of knowledge and skills for health behavior change (Deci & Ryan, 2008; Ryan et al., 2008; Spence & Oades, 2011). Consistent with the SDT framework and literature addressing the role of relationship in client activation, co-researchers in the present study noted that increased knowledge such as a specific dietary plan was not sufficient to achieve their goals (Deci & Ryan, 2008; Hibbard et al., 2004; Lindner et al., 2003; Ryan et al., 2008). They needed a supportive relationship for goal attainment. IHC provided a facilitative relationship dynamic that supported, activated, and motivated co-researchers in the process of realizing self-defined goals (Deci & Ryan, 2008; Hayes et al., 2008; Hibbard et al., 2004; Linden et al., 2010; Lindner et al., 2003; Maizes et al., 2009; Newnham-Kanas et al., 2011; Spence & Oades, 2011; Wolever et al., 2011).

IHC coaches established credibility. Co-researchers noted that the IHC coaches' personal experience and knowledge of IM and mindfulness contributed to their credibility and the coaching experience. They recommended that IHC coaches have personal experience with yoga, mindful eating, healthy nutrition, and complementary and alternative medicine (CAM) practices such as acupuncture accessible in an IM network. Three co-researchers emphasized the necessity for IHC coaches to affiliate with an IM network. Four co-researchers noted the importance of their IHC coaches' affiliation with a trusted institution such as Duke University. One co-researcher noted that the vetting of IHC by their employer contributed to the credibility of the worksite program. Co-researchers stated that having a sense of the coaches' legitimacy through their institutional affiliation, credentials, references, and extensive training in both coaching and IM established a level of credibility that was a necessary foundation for the coaching relationship. Their descriptions of the importance of coaches' proficiency and coaches' need for training in both coaching and IM supported prior findings regarding the training needs for IHC coaches (Wolever et al., 2010, 2011). The significance of coaches' credibility aligned with the IM principle that the array of practices in IM be evidence-based (Bell et al., 2002; Maizes et al., 2009; Verhoef et al., 2005; Wolever et al., 2011).

The focus on well-being, the person-centered and holistic approach, a basis in mindfulness, the supportive client-coach partnership, and credibility of the coach described the central IM constructs that provided the framework for co-researchers' IHC experience. The significance of the IM context distinguished IHC from other coaching models. Mindfulness played a prominent role in the IHC experience and the application of mindfulness in IHC suggested a primary differentiating factor. The IM paradigm formed an essential structure of co-

researcher experience in the coaching process that they described as “innovative” and “transformative.”

IHC coaches demonstrated proficiency with coaching. Co-researchers found the IHC coaches’ proficiency with coaching techniques important to their change process. The nine IHC clients described a coaching skillset similar to techniques applied in life coaching that were consistent with the coaches’ perspective in the IHC organizational case study (ICF, 2011; Wolever et al., 2010, 2011). Co-researchers described skills applied by IHC coaches that were consistent with motivational interviewing processes including non-judgmental reflective listening and efforts to explore differences between self-assessment of their current state and their vision and values (Linden et al., 2010; Wolever et al., 2011). Asking powerful open-ended questions, listening, attunement, reflection, non-judgment, and acknowledgment represented coaching skills identified by the IHC clients considered core competencies in life and motivational interviewing-based coaching (Hayes et al., 2008; Linden et al., 2010; Newnham-Kanas et al., 2011; Wolever et al., 2011). Co-researchers descriptions of their coaches’ ability to provide meaningful reflections of both what they said and of their person so that they felt “seen and known”, was a key life and motivational interviewing skill that was documented in the literature (ICF, 2011; Linden et al., 2010; Newnham-Kanas et al., 2011; Wolever et al., 2011). This study supported findings by Adelman & Graybill (2005) that the ability to listen attentively and to establish a non-judgmental, supportive relationship comprised essential coaching competencies that required training and supervision to master.

As reflected in the study by Wolever et al. (2011) co-researchers observed that their IHC coaches asked questions that invited inquiry and that often led to insights, new perspectives, and increased self-awareness. Skillful facilitation of guided imagery, the use of metaphors, and the

ability to probe for values and deeper meaning supported co-researchers process of visualizing their optimal health and clarifying values was consistent with practices applied in life coaching (Hayes et al., 2008; Linden et al., 2010; Newnham-Kanas et al., 2011; Wolever et al., 2011).

Coaches acknowledgment of co-researchers' successes was consistent with life coaching models reported in the literature (Hayes et al., 2008; Linden et al., 2010; Lindner et al., 2003; Newnham-Kanas et al., 2011; Wolever et al., 2011). Co-researchers characterized IHC coaches as proficient with coaching skills. Their view that "good" coaching contributed to their IHC experience was an observation supported by the coaches in the organizational case study (Wolever et al., 2011). IHC coaching techniques identified by co-researchers comprised a skill set that was comparable to skill sets applied in life coaching and standard competencies identified by the ICF (2011).

IHC increased engagement. Engagement played an essential role in co-researcher IHC experience. The study found that IHC activated and engaged the whole person in taking self-identified steps toward realizing health and well-being, which was consistent with the study conducted by Wolever et al. (2010). Co-researchers described their sense of personal responsibility, autonomy, empowerment, competence, and energy that accompanied engagement, a characterization of engagement that pointed to literature addressing SDT (Deci & Ryan, 2008; Ryan et al., 2008; Spence & Oades, 2011). SDT underscored the importance of intrinsic motivation and autonomy for behavior change and particularly for engagement and integration of change, themes emphasized by co-researchers (Deci & Ryan, 2008; Ryan et al., 2008). The Behavior Change Consortium of the National Institutes of Health identified SDT as an important theoretical framework for health-behavior change interventions (Ory, Jordan, & Bazzarre, 2002). Consistent with SDT (Ryan et al., 2008; Spence & Oades, 2011), the nine co-

researchers described engagement in IHC as an active process that required commitment and sustained effort until they integrated the change and it became a part of them.

Co-researchers' reported that all the structures of their IHC experience contributed to their engagement in the IHC process, including the IM framework that entailed mindfulness, the coaching relationship, and coaching techniques. The significance of co-researcher activation and engagement in the IHC change process supports literature that addressed patient activation in prevention and self-management of chronic disease (Gruman et al., 2010; Hibbard et al., 2004, 2005). Co-researchers' descriptions concurred with published findings that IHC participants had higher measures of patient activation that coincided with self-reported changes in health behaviors including medication compliance (Wolever et al., 2010). IHC activated and engaged co-researchers in self-management and increased compliance with care, including preventative screenings, which led to changes in risk and health condition, a finding that supported an observation and area for further investigation identified by Edelman et al. (2006).

According to co-researchers, the IHC process increased their knowledge, skills, and self-efficacy, findings that were consistent with factors identified in a behavioral framework for patient activation (Gruman et al., 2010). Hibbard et al. (2004, 2005) recognized the importance of relationships to engagement and developed a standardized instrument to measure patient activation. The SDT framework supports of co-researchers' experience with engagement in IHC (Deci & Ryan, 2008; Ryan et al., 2008; Spence & Oades, 2011). IHC coaches helped co-researchers identify what mattered most about engaging in change; gain the knowledge, resources, and self-efficacy for change, and coaches provided the supportive partnership necessary to achieve goals (Hibbard et al., 2004; Wolever et al., 2011). Co-researchers' experience of engagement in IHC supported the literature addressing patient activation in self-

management and health promotion. Co-researchers identified two additional elements of their experience with IHC engagement: activation of the whole person and mindful self-awareness.

Co-researcher experience of whole person activation and engagement aligned with the literature on IM that described a holistic approach to care (Bell et al., 2002; Maizes et al., 2009; Verhoef et al., 2005; Wolever et al., 2010, 2011). The IHC process activated internal and external domains of client experience including physical and sensory experience, the mind, imagination and creativity, emotion, relationships, and sense of place. Co-researchers described the coach facilitating the mindfulness practice of the body scan and noted that observing sensory experience helped them distinguish between hunger, thirst, and boredom and increased their activation and engagement in mindful eating.

The experience of client engagement in IHC concurred with literature from the field of positive psychology, particularly SDT (Deci & Ryan, 2008; Ryan et al., 2008; Spence & Oades, 2011). Spence and Oades (2011) suggested that SDT provided a theoretical foundation for coaching. Co-researchers' descriptions of elements of the IHC process that contributed to engagement in change and goal attainment were similar to SDT constructs of autonomy, competence, and relatedness (Ryan et al., 2008). The construct of autonomy pointed to IM principles of self-direction and focus on individual strengths and values (Deci & Ryan, 2008; Ryan et al., 2008; Spence & Oades, 2011). The SDT construct of competence involved self-awareness, skill, and confidence (Deci & Ryan, 2008; Ryan et al., 2008; Spence & Oades, 2011), all elements of IHC experience described by co-researchers. The construct of relatedness (Deci & Ryan, 2008; Ryan et al., 2008; Spence & Oades, 2011) concurred with the supportive partnership with the coach. These findings suggested that SDT could provide a theoretical

framework for future research that investigates the role of IM principles, mindfulness, and the coaching relationship in IHC client engagement.

Co-researchers indicated that increased self-awareness and skills for self-regulation developed through mindfulness practices helped them stay engaged and maintain the change process despite encountering barriers and difficulties. Their descriptions aligned with findings that mindfulness supported engagement in change discussed by Brown et al. (2007). Deci and Ryan (2008) also noted the role of mindfulness practice and increased self-awareness for persons' engagement in change. Co-researchers noted that increased awareness and attention strengthened their ability to make healthy choices. They described qualities of mindfulness that amplified engagement in IHC including self-awareness, presence, acceptance, self-regulation, attention, and decreased self-judgment and negative beliefs consistent with literature addressing the role of mindfulness in health behavior change (Brown et al., 2007; Deci & Ryan, 2008).

IHC led to transformative change. Co-researchers experienced transformative change. They described the sense of “new me” and the experience of “metamorphosis.” Their experience of transformation issued from holistic change rather than a change in a specific health behavior or risk factor. Verhoef, Mulkins, and Boon (2005) conducted a qualitative study of the lived experiences of 42 persons living with cancer who engaged in integrative health care. Study participants described the experience of “personal transformation” characterized by changes in mindful awareness, relationships, and “inner growth” (Verhoef et al., 2005, p. S-61). The researchers identified the whole person approach as central to their experience of transformative change, an observation that was similar to co-researchers' description of transformative change (Verhoef, Mulkins, & Boon, 2005).

Five co-researchers found that changes in mindfulness, particularly self-awareness resulting from mindfulness, contributed to their experience of transformative change. By increasing self-awareness, they experienced multiple lifestyle changes that contributed to the sense of transformative change. Linden, Butterworth, and Prochaska (2010) hypothesized that changes in a single higher-order construct such as self-awareness or activation could result in changes in multiple associated behaviors. This hypothesis fit with co-researchers' indication that IHC helped them make internal changes that resulted in a new lifestyle and the sense of a "new me."

Changes in quality of life and subjective well-being contributed to co-researchers sense of transformative change, which is consistent with the SDT framework (Deci & Ryan, 2008; Ryan et al., 2008; Spence & Oades, 2011). Co-researchers' description of internalizing the coaching skills and relationship qualities represented by the development of an "inner coach" suggested growth in confidence and increased self-efficacy or competence for self-managing change. The SDT theoretical framework (Deci & Ryan, 2008; Ryan et al, 2008; Spence & Oades, 2011) supported understanding co-researchers' description that internalization of the IHC change process led to integration of new behaviors in which they incorporated the change and the new behavior became a part of them. The co-researchers' experiences of transformative change agreed with the SDT understanding of self as dynamic and evolving toward wholeness and optimal well-being (Deci & Ryan, 2008; Ryan et al., 2008; Spence & Oades, 2011).

Summary. The researcher discussed the exploratory conceptualization of client experience in IHC in relation to published literature that addressed IM, mindfulness, health coaching, and health education and promotion. The study of co-researcher experience supported the key findings of previous IHC research including the significance of mindfulness and the IM

framework as distinguishing factors, the importance of coaching skills and competencies, and the finding that IHC increased client engagement (Wolever et al., 2010, 2011). The discussion pointed to the applicability of SDT as a theoretical framework for investigating factors contributing to client experience in IHC (Ryan et al., 2008; Spence & Oades, 2011). Co-researchers' perspectives and experiences add to the understanding of factors associated with client engagement, particularly the role of mindfulness as a factor supporting client engagement in IHC (Wolever et al., 2010). The discussion of study findings suggest that the IM framework and IHC coaching process demonstrated a paradigm and practice shift for health education and promotion (Liburd & Sniezek, 2007).

The nine co-researchers did not represent the experience of all IHC clients, but rather reflected the lived experience of nine clients who had high satisfaction and a seemingly optimal experience in IHC. Although representativeness was not the purpose of this study, co-researchers' insights and experiences contribute a significant initial conceptualization of client experience in IHC.

Study Limitations

Co-researchers described the discovery-oriented interview process and the opportunity for creative expression with photo-elicitation as strengths of the study. Their familiarity and comfort with telephone-based coaching and a supportive and partnering inquiry process contributed to the rich description of their IHC experience. Six co-researchers observed that the interview process reminded them of IHC; they noted that the open-ended questions and inquiry helped them gain new insights regarding their coaching experience. Seven co-researchers valued the brief mindfulness practice at the beginning of the interview and commented that it

helped them pause, shift their attention to the interview, and feel more relaxed. One co-researcher shared that she found mindfulness practice in sessions a challenge.

The researcher identified limitations in the study design and implementation. She applied purposive sampling to enroll ten co-researchers who experienced IHC within the past year; one co-researcher withdrew due to an emergent health issue. Consistent with the study design, the study findings were limited to the lived experience of the co-researchers with IHC. The small sample size ($n=9$) is clearly aligned with a phenomenological approach that sought rich description of the lived experience of IHC clients. The small purposively selected sample size limits the generalizability of the findings to IHC clients who participated in this study. Transferability of finding to other similar research participants and settings, however, may be possible.

The researcher recruited co-researchers from the clients of eight formative integrative health coaches who were instrumental in the development of the practice at Duke IM including the six who participated in the Wolever et al. (2011) organizational case study. In order to protect the privacy of coaches and clients, the study design did not provide a mechanism to track the distribution of the recruitment announcement. The recruitment of co-researchers from other IHC programs was beyond the scope of this thesis study. Two of the eight coaches reported that they had decreased the number of clients they coached in the past year which limited the pool of potential participants and might have contributed to a relatively limited client response ($n=12$). The estimated time requirement for study participation of between one and one and one half hours may have limited potential participant response, particularly since the anticipated time commitment was the identified factor in two respondents deciding not to participate.

Six co-researchers received IHC through a worksite program that was part of a larger Duke IM research study. The worksite study design could have shaped IHC experience for the six participating co-researchers but the consistency of their description with that of the other three co-researchers who received IHC through the Duke IM clinic suggested that the setting did not significantly influence their IHC experience. Clients who received IHC in other settings did not respond to the study announcement. The homogeneity of the coaching contexts potentially limits study findings.

The study findings represented the experience of nine co-researchers who reported high satisfaction with their IHC experience and outcomes. A limitation of the study design was that it did not include additional steps to recruit participants who had differing IHC experiences or a disconfirming case. IHC clients who had dropped out of the coaching programs did not receive the study announcement. Those who participated in IHC but did not share the high satisfaction or outcomes had the same opportunity to enroll in the study but did not respond to the study announcements. Co-researchers reported knowledge of IHC clients who did not experience the same satisfaction with coaching. The researcher recommends that future studies design a mechanism to recruit participants who report a range of satisfaction with IHC as well as participants who report varied outcomes.

The qualitative approach involved the researcher as an instrument in the data collection and analytic process, thus creating the possibility that her assumptions and experience as an IHC coach may have influenced the findings (Patton, 2002). The researcher engaged in a reflexive process during the entire course of the study in an effort to identify her biases and assumptions. She also maintained ongoing mindfulness practice to support open-minded encounters with co-researchers and the data.

Implications for Health Education and Promotion

This study provided an initial exploration of IHC from clients' perspective. The qualitative investigation of client IHC experience held implications for how health coaches and health educators design and deliver programs to support clients living with chronic health conditions. IHC offers a promising approach for self-management and prevention for persons living with chronic disease. Co-researchers' experiences demonstrated that IHC empowered clients to realize well-being, an actuality that included improved health. The experience of the nine clients suggested that IHC reflects a new paradigm for health education and promotion that is holistic, patient-centered, guided by self-determined goals, engaging, and entails a relationship that facilitates change in contrast to a conventional medical model. Co-researchers embraced their experiences with mindfulness in IHC, underscoring the potential benefits for clients and practitioners. The study builds upon previous findings that IHC increased client engagement (Wolever et al., 2010) and underscored the importance that health educators and coaches understand the theoretical basis for engagement and practices associated with client engagement. The researcher found that the Self-Determination Theory (SDT) provided a theoretical approach helpful in understanding clients' experience in the IHC process.

Promising practice. The nine co-researchers living with a range of chronic diseases, often with multiple health conditions and risk factors, indicated that participation in IHC improved their health. The term health in this instance meant the health of the whole person encompassing multiple life domains. Co-researchers lost weight, increased physical fitness, gained energy, reduced stress, improved personal and professional relationships, and created nurturing physical environments. They shared that IHC helped them gain skills for self-management of conditions like arthritis and diabetes and reduce risk factors such as stress and

obesity. The study findings supported literature that IHC holds promise for chronic disease prevention and self-management (Edelman et al., 2006; Wolever et al., 2010). Health educators can consider IHC an important method for supporting clients not only in reaching their self-determined health goals, but also in changing their lifestyle and sense of well-being.

Well-being. Liburd and Sniezek (2007) called for a new paradigm for health promotion that shifts the horizon from a disease orientation to a focus on well-being and quality of life.

The nine co-researchers described their experience of well-being as the more important outcome of IHC. Perceived well-being encompassed co-researchers feeling happier, finding fulfillment, and experiencing a sense of freedom achieved from connecting health to their self-defined life purpose. Health behavior change became a vehicle for fulfilling their greater life dreams. They discovered that mindfulness, as an aspect of well-being, increased their self-awareness and self-acceptance. Co-researchers' experiences with IHC suggested that health education and coaching practices focusing on client well-being hold promise to support clients with chronic health conditions in leading happier lives. The most outstanding feature of co-researchers' experiences in IHC was not their weight loss or other health-related changes they made; it was their sense of well-being. This finding encourages health educators and coaches to discover "what matters most" to clients and apply that value or aspiration as a catalyst for the change process.

New paradigm. Co-researchers' experiences with IHC can serve as a guide for health educators who seek to implement the new paradigm for health promotion recommended by Liburd & Sniezek (2007). The new perspective for health education begins with support for clients' self-determination and a view of clients as intrinsically whole, resourceful, and capable of realizing well-being: in the words of one of the co-researchers, a view that "everyone has that flower inside them ready to blossom" (Grace). This central philosophical tenet of client

wholeness and capability distinguishes IHC from health education and promotion programs that assume a directive approach to fixing problems. Co-researchers emphasized that regardless of education, social standing, or life experience, most people need support with health behavior change. The nine IHC clients believed they needed more than the usual health education provided by their physicians or their employer to realize self-determined goals to improve their chronic illness and ultimately their health and well-being and thus sought IHC coaching.

Health education approaches to coaching for disease management and prevention have relied on a didactic style involving teaching and advising clients using pre-determined goals and action steps. The disease management orientation to health coaching has had mixed findings for individuals with lower motivation and engagement (Adelman & Greybill, 2005; Butterworth et al., 2006; Kravitz et al., 2009; Olsen & Nesbitt, 2010). Findings from this study encourage health educators and coaches to begin the shift to a new approach characterized by person-centered practice focused on self-determined goals that engage clients in a change process facilitated and supported by their coaches but not directed by them. The clients' agenda establishes the focus of the coaching interaction thus representing a reversal of the medical model and demonstrating a new approach for health education practitioners. Adoption of the IHC approach will require systemic changes to support the new paradigm for health education and promotion (Liburd & Sniezek, 2007).

Person-centered care, the integration of medical and behavioral health, and clients and providers working as partners reflect constructs found in IM applied with increasing frequency in primary care settings (Bell et al., 2002; Maizes et al., 2009; Snyderman & Dinan, 2010). Co-researchers' conceptualizations of IHC concurred with research literature that described the IM framework as a system that operated holistically (Bell et al., 2002). The practice of IHC

involves more than the addition of one or two constructs to traditional health management; it entails a philosophical and practice shift. A first step in the process to implement a new paradigm for health education and promotion would involve providing a foundation in IM principles to health educators early in their professional training.

Co-researchers' experience of the IM paradigm raised implications for the expansion of IHC practice. How do IHC practitioners translate the IM framework into practice settings outside an IM center? Study findings supported the need for further research to specify the role and application of IM principles in the practice model. Co-researchers' experience suggested that the IHC practice model holds promise for the worksite, a setting identified by six co-researchers as their source of IHC. Translation of the IHC model to community or worksite settings requires a program design that maintains fidelity to the IM paradigm. The client perspective in this study provided an exploratory framework for further investigation of core IM elements of the practice.

Mindfulness. Co-researchers' experiences in this study pointed to the potential benefits of the application of mindfulness in health promotion settings. Mindfulness practices hold the potential to increase client engagement in the process of health behavior change and enhance personal well-being (Brown et al., 2007; Deci & Ryan, 2008; Greeson, 2009; Kabat-Zinn, 2005). Study findings encourage health educators and coaches to regard mindfulness as a tool for improving clients' health and sense of well-being.

Co-researchers' descriptions suggested that the field of health coaching could benefit by advancement of training in the application of mindfulness. The ability to facilitate and support mindfulness in a setting such as IHC arises from the practitioner's authenticity and personal experience with mindfulness including their training in mindfulness. Their comments supported

recommendations that practitioners who facilitated mindfulness practices obtain specific training and commit to the ongoing personal practice of mindfulness (Brantley, 2009; Kabat-Zinn, 2003).

Health educators and coaches can look to programs such as Duke Integrative Medicine's Mindfulness Training for Professionals to help them learn and apply mindfulness in their work with clients (Brantley, 2009).

Study findings suggested that health educators and coaches could collaborate within a program that supports the practice of mindfulness. Distance learning mindfulness programs are available and can provide training and support for clients who do not have access to an IM center. Health educators and coaches can facilitate clients' engagement in centering practices other than mindfulness that meet their personal preferences. Tai Chi or contemplative prayer, for example, can be used to support self-awareness, self-regulation, and attending to the mind/body relationship.

Study findings indicated that knowledge and skills associated with mindfulness enhances the client-practitioner relationship. Mindfulness can provide a means of developing skills such as presence, attunement, and non-judgment that are important to clients in relationship-based practices such as health coaching or health education and promotion (Lawson, 2009; Spence, Cavanagh, & Grant, 2008; Wolever et al., 2011). Mindfulness practice can support health coaches and health educators by assisting them to cultivate the capacity for "being with" that Moustakas (1986) found essential to relationships that facilitated change.

The facilitative relationship. IHC coaches established a supportive partnership that can serve as a model for health education and promotion practice. Co-researchers described a facilitative relationship that empowered them in the change process. The nine IHC clients observed that the nature of the supportive partnership shaped their IHC experience, not the

length of individual sessions; their coaches' presence communicated care and knowledge of them as individuals, even with brief coaching sessions.

The IHC relationship dynamic differed from the health coaching dynamic that is typically applied in a medical model. The traditional medical model has established the provider as the active, didactic voice and the client as a recipient of information and advice. Co-researcher description of IHC called attention to the role of the practitioner as an instrument in this relationship-based process. Their experience suggests that health coaches and health educators benefit from training and skills to create supportive relationships that empower and engage clients. Mindfulness practice can be of value to health education practitioners in creating facilitative relationships with clients.

Engagement. These study findings contributed to a description of factors involved in client engagement in IHC. Co-researchers' experiences suggested that persons living with chronic disease benefit from approaches such as IHC that help clients identify intrinsic motivation for change, promote self-determination, and increase engagement in the process of change (Hibbard et al., 2004; Ryan et al., 2008; Wolever et al., 2011). Health educators and coaches need skills to assess client readiness for change and to increase motivation and readiness (Hibbard et al., 2004; Ryan et al., 2008; Wolever et al., 2011). Co-researchers found difficulty with making time for the coaching process and time to implement strategies for change, a barrier that the flexibility of phone coaching and the incremental, small step approach to goal-achievement helped address but did not resolve. Coaches and health educators can help clients manage and identify time to focus on their health and well-being.

The study findings suggested that mindfulness practice holds promise for increasing client engagement in health education and promotion programs. Study findings point to the need

for health educators and health coaches to have knowledge of the mechanisms of client engagement. Professional development and continuing education can provide training and skills for practitioners to enhance client engagement. The findings pointed to the need for further investigation of IHC structures that increased engagement (Wolever et al., 2010).

Training. Co-researchers observed that IHC coaches' legitimacy in terms of credentials, references, and affiliation with a trusted institution enhanced trust in the relationship consistent with findings from the organizational case study (Wolever et al., 2011). They described that IHC coaches demonstrated mastery of coaching practice and such "good coaching" contributed to their process of change. Study findings were consistent with conclusions from previous studies regarding the need for health coach training that supports proficiency in the motivational coaching process (Wolever et al., 2010, 2011).

In addition, study findings suggested that IHC coaches required training in the foundations of the IM paradigm and its application in health coaching. The study underscored that the practice of IHC involved a philosophical shift that required a different theoretical approach and skill set. IHC coaches need training and personal experience with mindfulness, evidence-based health promotion guidelines, and CAM practices accessible in an IM system of care. The study findings support the development of professional training programs specific to the IHC approach.

Recommendations for Future Studies

Study respondents and the nine co-researchers who participated in this study reported high satisfaction with their IHC experience. Study findings represented the lived experience of IHC clients who experienced high engagement, transformative change, improved health, and a sense of personal well-being. The nine co-researchers described consistent elements of their

experience as IHC clients. Investigation of disconfirming cases and the experiences of clients who report a range of satisfaction with IHC is a crucial next step for research that adds to the knowledge of client experience in IHC. Qualitative approaches such as focus groups or case studies that examine the experience of IHC clients who report a range of satisfaction would add to knowledge of IHC. Recommended studies would recruit clients with varied experiences and satisfaction including those who withdrew from coaching, those who reported a neutral experience and clients who reported less than satisfactory experience.

Engagement emerged as the structural essence of co-researcher experience in IHC. Wolever et al. (2010) found patient activation increased significantly for IHC participants and called for further research to identify factors associated with patient engagement. Co-researchers described that mindfulness and the IM framework, in addition to known factors of knowledge, skills, confidence, and the supportive relationship, contributed to their experience of engagement in IHC (Deci & Ryan, 2008; Hibbard et al., 2004). The SDT provides a theoretical framework to investigate client mindfulness and engagement in IHC. The descriptive research approach can apply a cross-sectional design to investigate the correlation between client mindfulness and engagement in IHC. Further investigation of the role of the integrative medicine framework in IHC would contribute to the knowledge of the IM role in client engagement and in IHC. Experimental research that compares client engagement in IHC to motivational interviewing–based health coaching is a possible next step.

The study findings provided an exploratory description of client experience with mindfulness in IHC. Co-researchers' descriptions suggested that mindfulness contributed to the coaching relationship, client engagement, and the IHC coaching process. The study findings suggested the need for research to add to the understanding of the role of mindfulness in the IHC

process model. Future research that investigates the relationship between the level of coach training and experience with mindfulness and client experience with mindfulness would help inform the application of mindfulness in IHC and health education programs.

Conclusion

This investigation of the IHC experience from the perspective of clients living with chronic health conditions engaged the researcher in a collaborative process of discovery with the nine co-researchers who participated in the study. The qualitative design employed in this study entailed a creative synergy of three discovery-oriented processes: phenomenology, photo-elicitation, and mindfulness. The researcher observed that the three processes worked effectively together to strengthen the research investigation by facilitating a study process in which the researcher and co-researchers adopted an open and curious stance to explore the IHC experience. Photo-elicitation activated co-researchers in the study process and provided a second source of data that added to internal validity of engagement in transformative change as the essence of the IHC client experience. In response to the research question, “What is the lived experience of clients in IHC?” the three processes fostered co-researchers’ sharing of rich description and images related to their IHC experience and the researcher’s discovery of significant themes and essences.

The study contributed to the knowledge base of IHC by describing significant elements of the lived experience of nine clients who sought IHC to address a chronic health condition and realized improved health and well-being in the process. The structures and conceptualization of IHC described by co-researchers supported previous findings that IM principles differentiated the practice from other approaches to health coaching and resulted in increased client activation and engagement (Edelman et al., 2006; Wolever et al., 2010; Wolever et al., 2011). The study

contributed to the understanding of what mattered most to the nine clients who encountered the coaches' calm voice and supportive presence that empowered them to apply insights and values to attaining self-defined goals and discover "a new me."

Findings from this study suggest that IHC clients experienced something different from previous health promotion interventions targeting their chronic health conditions. They experienced a supportive partnership focused on the whole person and their self-determined goals and values. IHC clients experienced mindfulness and the qualities of presence, kindness, non-judgment, acceptance, curiosity, and self-awareness associated with mindfulness practice. They experienced empowerment and activation fueled by the entire IHC process that kept them engaged and moving forward in incremental steps that built success. IHC clients experienced insights and new perspectives that helped them persist and overcome the difficulties of the change process. The study found that when individuals, such as the nine co-researchers, engaged in a coaching process informed by IM principles and practices they opened themselves to transformative change characterized by improved health and a heightened sense of personal well-being.

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APPENDIX A: UMCIRB # 10-0617 CONTINUING REVIEW 9/22/11



EAST CAROLINA UNIVERSITY

University & Medical Center Institutional Review Board Office
1L-09 Brody Medical Sciences Building • 600 Moye Boulevard • Greenville, NC 27834
Office 252-744-2914 • Fax 252-744-2284 • www.ecu.edu/irb

TO: Karen Lohr Goble, Student, Dept. of Health Education & Promotion, ECU
FROM: UMCIRB *KLG*
DATE: October 13, 2011
RE: Expedited Continuing Review of a Research Study
TITLE: "Integrative Health Coaching: A Phenomenology of Clients' Discoveries"

UMCIRB #10-0617

The above referenced research study was initially reviewed and approved by expedited review on 11.7.10. This research study has undergone a subsequent continuing review using expedited review on 10.7.11. This research study is eligible for expedited review because it is on collection of data from voice, video, digital, or image recordings made for research purposes. It is also a research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies. (NOTE: Some research in this category may be exempt from the HHS regulations for the protection of human subjects. 45 CFR 46.101(b)(2) and (b)(3). This listing refers only to research that is not exempt.)

The Chairperson (or designee) deemed this **unfunded** study **no more than minimal risk** requiring a continuing review in **12 months**. Changes to this approved research may not be initiated without UMCIRB review except when necessary to eliminate an apparent immediate hazard to the participant. All unanticipated problems involving risks to participants and others must be promptly reported to the UMCIRB. The investigator must submit a continuing review/closure application to the UMCIRB prior to the date of study expiration. The investigator must adhere to all reporting requirements for this study.

The above referenced research study has been given approval for the period of **10.7.11 to 10.6.12**. The approval includes the following items:

- Continuing Review Form (date 9.22.11)
- Protocol Summary
- Informed Consent (dated 9.22.11)
- Informed Consent to Publish (dated 9.22.11)

The Chairperson (or designee) does not have a conflict of interest on this study.

The UMCIRB applies 45 CFR 46, Subparts A-D, to all research reviewed by the UMCIRB regardless of the funding source. 21 CFR 50 and 21 CFR 56 are applied to all research studies under the Food and Drug Administration regulation. The UMCIRB follows applicable International Conference on Harmonisation Good Clinical Practice guidelines.

APPENDIX B: UMCIRB # 10-0617 REVISION JULY 1, 2011

06/19/2011 18:37 8282588971

WOODBERRY

PAGE 01/12

UMCIRB #: 10-0617 GOBLE INTEGRATIVE HEALTH COACH STUDY

RECEIVED

UNIVERSITY AND MEDICAL CENTER INSTITUTIONAL REVIEW BOARD
REVISION FORM

JUN 21 2011

UMCIRB

UMCIRB #: 10-0617

Date this form was completed: June 20, 2011

Title of research: Original Title: Integrative Health Coaching: Participants' Experience in a Mindfulness-Based Health Dyad

Revised Title: Integrative Health Coaching: A Phenomenology of Clients' Discoveries

Principal Investigator: Karen L. Goble

Sponsor: Study is unfunded.

Fund number for IRB fee collection (applies to all for-profit, private industry or pharmaceutical company sponsored project revisions requiring review by the convened UMCIRB committee). If you are a non-ECU entity payment is required at the time of submission:

| Fund | Organization | Account | Program | Activity (optional) |
|------|--------------|---------|---------|---------------------|
| | | 73069 | | |

Version of the most currently approved protocol: 4-13-11

Version of the most currently approved consent document: 4-13-11

CHECK ALL INSTITUTIONS OR SITES WHERE THIS RESEARCH STUDY WILL BE CONDUCTED:

- East Carolina University
- Beaufort County Hospital
- Pitt County Memorial Hospital, Inc
- Carteret General Hospital
- Heritage Hospital
- Bolice-Willis Clinic
- Other

The following items are being submitted for review and approval:

x Additional material: version 2 or date June 24, 2011 - Letter to Health Coaching Clients (received)

Complete the following:

1. Level of IRB review required by sponsor: full expedited
2. Revision effects on risk analysis: increased no change decreased
3. Provide an explanation if there has been a greater than 60 day delay in the submission of this revision to the UMCIRB.
4. Does this revision add any procedures, tests or medications? yes no If yes, describe the additional information:
5. Have participants been locally enrolled in this research study? yes no
6. Will the revision require previously enrolled participants to sign a new consent document? yes no

Briefly describe and provide a rationale for this revision:

The researcher is requesting approval for the attached revision of the Study Announcement in order to make the announcement more visually accessible and friendly to recipients. The information contained in the announcement is essentially the same as the original version; however, the wording has been clarified and organized in a way that is more responsive to recipients. The researcher is requesting IRB approval to resend the revised Study Announcement as described in the original approved study protocol. One of the IHC coaches who forwarded the announcement to clients provided feedback to the Duke IM research director and this researcher that it is helpful to send documents such as announcements to clients several times. The researcher brought the recommendation to the thesis committee who approved the revision and sending the revised announcement.

Karen L. Goble
Principal Investigator Signature

KAREN L. GOBLE
Print

June 20, 2011
Date

Box for Office Use Only

UMCIRB Version 2/21/08

Page 1 of 2

UMCIRB #: 10-0617 GOBLE INTEGRATIVE HEALTH COACH STUDY

| | | |
|---|---|-----------------|
| The above revision has been reviewed by: | | |
| <input type="checkbox"/> Full committee review on _____ | <input checked="" type="checkbox"/> Expedited review on <u>7/1/2011</u> | |
| The following action has been taken: | | |
| <input checked="" type="checkbox"/> Approval for period of <u>7/1/2011</u> to <u>11.6.11</u> -KK | | |
| <input type="checkbox"/> Approval by expedited review according to category <u>45CFR 46.118</u> -KK | | |
| <input type="checkbox"/> See separate correspondence for further required action. | | |
| <u>Michelle Eble</u> | <u>Michelle Eble</u> | <u>7/1/2011</u> |
| Signature | Print | Date |

APPENDIX C: UMCIRB #10-0617 REVISION APRIL 13, 2011

UMCIRB #: 10-0617

Date this form was completed: April 1, 2011

Title of research: Original Title: Integrative Health Coaching: Participants' Experience in a Mindfulness-Based Health

Dyad

Revised Title: Integrative Health Coaching: A Phenomenology of Clients' Discoveries

Principal Investigator: Karen L. Goble

Sponsor: Study is unfunded

| Fund | Organization | Account | Program | Activity (optional) |
|------|--------------|---------|---------|---------------------|
| | | | | |

Fund number for IRB fee collection (applies to all for-profit, private industry or pharmaceutical company sponsored project revisions requiring review by the convened UMCIRB committee). If you are a non-ECU entity payment is required at the time of submission:

73059

Version of the most currently approved protocol: 12-23-10

Version of the most currently approved consent document: 12-23-10

CHECK ALL INSTITUTIONS OR SITES WHERE THIS RESEARCH STUDY WILL BE CONDUCTED:

East Carolina University

Beaufort County Hospital

Pitt County Memorial Hospital, Inc

Carteret General Hospital

Heritage Hospital

Boice-Willis Clinic

Other

The following items are being submitted for review and approval:

Protocol: version or

date April 1, 2011

Consent: version or date

April 1, 2011

Additional material: version or date April 1, 2011

Complete the following:

1. Level of IRB review required by sponsor: full expedited
2. Revision effects on risk analysis: increased no change decreased
3. Provide an explanation if there has been a greater than 60 day delay in the submission of this revision to the UMCIRB.
4. Does this revision add any procedures, tests or medications? yes no If yes, describe the additional information:
6. Have participants been locally enrolled in this research study? yes no
6. Will the revision require previously enrolled participants to sign a new consent document? yes no

Briefly describe and provide a rationale for this revision:

The researcher is requesting the following revisions recommended by the thesis committee. The title of the study will be changed to: Integrative health coaching: a phenomenology of clients' discoveries.

The Duke University IRB determined that UMCIRB approval was sufficient and Duke IRB approval unnecessary since the Duke IM health coaches and faculty will forward the study announcement to clients but not have further contact with study participants or have access to study data. Duke IM is therefore not a site for the study since no data will be collected or information regarding participants exchanged.

The second revision is design change that provides participants with the choice of having one longer interview that includes the photo-elicitation interview at the end or two interviews with the photo-elicitation interview during the second contact The change is reflected in the study announcement (Additional Materials) and

MCIRB Version 2121108

Page 1 of 2

UMCIRB 10-0617 GOBLE INTEGRATIVE HEALTH COACH

STUDY informed consent.

The third revision is a design revision that changes inclusion criteria by establishing that study participants will have engaged in IHC within the past 12 months. Study participants will be current or former clients of Duke IM health coaches who have received Integrative Health Coaching within the past 12 months. The thesis committee advised that the original inclusion criteria presented concerns regarding participant recall and in-depth description of experiences that occurred more than 12 months in the past. The change is reflected in the Study Announcement and the Informed Consent. The inclusion criteria will also be amended to state that participants will have a chronic health condition or a risk factor for a chronic health condition rather than "health condition."

The final revision is the addition of an elective consent allowing the researcher to publish the photographs participants take representing their WIC experience and use the photographs for educational purposes at conferences and trainings (Additional Materials). The consent will state that the researcher will only use photographs that contain non-identifying images. Photographs or images that participants submit for the photoelicitation component of the study that might be identifiable will be treated as confidential data even if participants sign the consent to publish.

Date _____

ε

P ncipal Investigator Signature

Box for Office Use Only

The above revision has been reviewed

II Full committee review on _____ iir Expedited review on _____

II

ie correspondent



APPENDIX D: INFORMED CONSENT TO PARTICIPATE IN RESEARCH 4/13/2011



Informed Consent to Participate in Research

Information to consider before taking part in research that has no more than minimal risk.

Title of Research Study: Integrative Health Coaching: A Phenomenology of Clients' Discoveries

Principal Investigator: Karen L. Goble
Institution/Department or Division: Department of Health Education and Promotion
Address: PO Box 19204, Asheville, NC 28801
Telephone #: 828-215-7418

Researchers at East Carolina University (ECU) study problems in society, health problems, environmental problems, behavior problems and the human condition. Our goal is to try to find ways to improve the lives of you and others. To do this, we need the help of volunteers who are willing to take part in research.

Why is this research being done?

The purpose of this research is to understand the experience and meaning Integrative Health Coaching (IHC) has for people with health concerns (a chronic health condition or risk factor for a chronic health condition). The decision to take part in this research is yours to make. By doing this research, we hope to learn about the meaning and lived experience of IHC from the perspective of adult clients with health concerns who participated in IHC for at least six sessions over three months.

Why am I being invited to take part in this research?

You are being invited to take part in this research because in the past year you participated in at least six sessions of Integrative Health Coaching over three months related to a health concern and are an adult resident of the United States. If you volunteer to take part in this research, you will be one of about ten people to do so.

Are there reasons I should not take part in this research?

I understand I should not volunteer for this research study if I have not participated in at least six sessions of Integrative Health Coaching over at least a three month time within the past year, or if I did not have a health concern that I explored in coaching, or if I am not an adult resident of the United States.

What other choices do I have if I do not take part in this research?

You can choose not to participate. You can share your Integrative Health Coaching experience with the organization that trained or certified your coach.

UMCIRB Number: 10-0617

Consent Version #003 4/1/11 or Date: _____
UMCIRB Version 2010.05.01

UMCIRB
APPROVED
FROM 4.13.11
TO 11.6.11

Participant's Initials

Title of Study: Integrative Health Coaching: Participants' Experience in a Mindfulness-Based Health Dyad

Where is the research going to take place and how long will it last?

The research procedure consists of one or two interviews conducted over the telephone. The researcher will set appointment times at your convenience for the interview/s and call you. You will also be asked to take a photograph representing your IHC experience and to send the photo to the researcher. You will be invited to comment upon the researcher's draft analysis. The total amount of time you will be asked to volunteer for this study is between one and a half to two hours in the next five months; projected time includes: 1) fifteen minutes to review the informed consent and photograph consent, 2) one hour in the initial interview, 3) twenty to thirty minutes for the photo interview, and 4) the amount of time you elect to comment upon the analysis. The interviews can be combined into one extended interview or multiple interviews to accommodate your preferences and needs.

What will I be asked to do?

You are being asked to do the following: You will be asked to take part in one or two telephone interviews and describe your experience with Integrative Health Coaching. Your identity will be confidential. You will choose or be given a pseudonym for the study. You will not give the name of your Integrative Health Coach or other information that would give a clue about your identity. Any personal information that could let others know who you are will be deleted and not used in the study. The researcher will call you at a time convenient to you. At the beginning of the telephone call the researcher will request that the call be digitally recorded in order to accurately transcribe your interview. Once the interview is transcribed the recording will be deleted. Participating in a recorded interview is essential to this research since accurate description of the experiences you share is the content of the research. Participation in the interview is voluntary and you can stop at any time.

You will be asked to take a photograph of an image that represents your experience with Integrative Health Coaching and share the photograph with the researcher. The researcher will ask you to tell about the photograph in the second telephone interview or for the second half of one extended interview. The researcher will ask if you give consent to publish your photograph in educational articles, presentations, or trainings if the photograph does not have images that would identify you or others. Consent to publish the photograph is voluntary and elective and does not affect participation in the study.

You will lead the interview process and talk about what you discovered with Integrative Health Coaching. The researcher will ask a few questions such as those listed below. The researcher might ask a follow up question to help make sure she understands your meaning. You can decide to skip any question or choose not to answer a follow-up question.

- How did you find out about Integrative Health Coaching?
- What is most important for me to know about Integrative Health Coaching?
- What does your photograph say about Integrative Health Coaching?

What possible harms or discomforts might I experience if I take part in the research?

It has been determined that the risks associated with this research are no more than what you would experience in everyday life.

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APPROVED
FROM 4.13.11
TO 11.6.11

Participant's Initials

Title of Study: Integrative Health Coaching: Participants' Experience in a Mindfulness-Based Health Dyad

What are the possible benefits I may experience from taking part in this research?

We do not know if you will get any benefits by taking part in this research study. This research might help us learn more about Integrative Health Coaching and the experience of adults with a health concern who receive Integrative Health Coaching. There may be no personal benefit from your participation but the information gained by doing this research may help others in the future.

Will I be paid for taking part in this research?

We will not be able to pay you for the time you volunteer while being in this study.

What will it cost me to take part in this research?

There will be no cost associated with your participation in this study.

Who will know that I took part in this research and learn personal information about me?

To do this research, ECU and the people and organizations listed below may know that you took part in this research and may see information about you that is normally kept private. With your permission, these people may use your private information to do this research:

- The researcher.
- Any agency of the federal, state, or local government that regulates human research. This includes the Department of Health and Human Services (DHHS), the North Carolina Department of Health, and the Office for Human Research Protections.
- The University & Medical Center Institutional Review Board (UMCIRB) and its staff, who have responsibility for overseeing your welfare during this research, and other ECU staff who oversee this research.
- Additionally, the following people and/or organizations may be given access to your personal health information and they are: no additional persons or organizations will have access.

How will you keep the information you collect about me secure? How long will you keep it?

The digital telephone recording using your pseudonym and a study number will be kept in a password protected file on the researcher's private computer until the interview is transcribed. Once the interview is transcribed the digital telephone recording will be deleted. The transcribed interview using your pseudonym and study number will be stripped of personal identifying information and details. The transcribed interview will be kept in a locked file cabinet in the researcher's personal office for three years. This consent and your contact information will be kept in a separate file and stored in the locked file cabinet. The consent and your contact information will be destroyed at the end of the three-year period.

What if I decide I do not want to continue in this research?

If you decide you no longer want to be in this research after it has already started, you may stop at any time. You will not be penalized or criticized for stopping. You will not lose any benefits that you normally receive.

Who should I contact if I have questions?

The people conducting this study will be available to answer any questions concerning this research, now or in the future. You may contact the Principal Investigator, Karen Goble, at 828-215-7418 weekdays between 8:00 am and 7:00 pm or weekends between 12pm and 5pm.

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Consent Version # 003 4/1/11 or Date: _____
UMCIRB Version 2010.05.01

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FROM 4.13.11
TO 11.6.11

Participant's Initials _____

Title of Study: Integrative Health Coaching: Participants' Experience in a Mindfulness-Based Health Dyad

If you have questions about your rights as someone taking part in research, you may call the UMCIRB Office at phone number 252-744-2914 (days, 8:00 am-5:00 pm). If you would like to report a complaint or concern about this research study, you may call the Director of UMCIRB Office, at 252-744-1971.

I have decided I want to take part in this research. What should I do now?

The person obtaining informed consent will ask you to read the following and if you agree, you should sign this form:

- I have read (or had read to me) all of the above information.
- I have had an opportunity to ask questions about things in this research I did not understand and have received satisfactory answers.
- I know that I can stop taking part in this study at any time.
- By signing this informed consent form, I am not giving up any of my rights.
- I have been given a copy of this consent document, and it is mine to keep.

| | | |
|-----------------------------------|------------------|-------------|
| Participant's Name (PRINT) | Signature | Date |
|-----------------------------------|------------------|-------------|

Person Obtaining Informed Consent: I have conducted the initial informed consent process. I have orally reviewed the contents of the consent document with the person who has signed above, and answered all of the person's questions about the research.

| | | |
|---|------------------|-------------|
| Person Obtaining Consent (PRINT) | Signature | Date |
|---|------------------|-------------|

UMCIRB Number: 10-0617 _____

Consent Version # 003 4/1/11 or Date: _____
UMCIRB Version 2010.05.01

UMCIRB
APPROVED
FROM 4.13.11
TO 11.6.11

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Participant's Initials

APPENDIX E: INTERVIEW GUIDE 4/13/2011

Integrative Health Coaching: A Phenomenology of Clients' Discoveries

Interview Guide

Study Purpose: The purpose of this study is to describe the meaning and lived experiences of IHC from the perspective of adult clients with chronic health conditions who have participated in IHC for at least six sessions over three months.

Interview Date:

Time of Interview: Start - End -

Interviewer:

Interviewee (Pseudonym and study number):

Review study purpose and informed consent.

Questions:

- Neutral initial question: How did you find out about Integrative Health Coaching?
- How would you describe Integrative Health Coaching to a friend?
 - ✓ What makes it _____ ?
 - ✓ What is coaching?
 - ✓ What happened?
- Please walk me through an Integrative Health Coaching session.
 - ✓ Describe your role.
 - ✓ What is the typical structure of a coaching session?
 - ✓ What does an Integrative Health Coach do?

- ✓ What makes it integrative?
- Please describe your understanding of mindfulness.
 - ✓ What role does mindfulness play with Integrative Health Coaching?
 - ✓ What would mindfulness look like in a coaching session?
 - ✓ What makes it _____?
- What is one word, phrase, or idea that represents what Integrative Health Coaching means to you?
 - ✓ [Pause, go deeper, discover dimensions]
 - ✓ Is there an image?
- What is a drawback or challenge you want to share about your Integrative Health Coaching experience?
 - ✓ What makes it _____?
 - ✓ What was that like?
- What is most important for me to know about Integrative Health Coaching?
 - ✓ What does a new participant need to know?
 - ✓ What do doctors need to know?
- What question could I have asked about Integrative Health Coaching but did not?
 - ✓ Did I leave anything out?

Please tell me about your experience with this interview.

- ✓ What contributed to _____ ?
- ✓ What would you suggest for future interviews?
- ✓ Do you have any questions for me?

Review next steps in study process.

Photo-elicitation Interview

Study Purpose: The purpose of this study is to describe the meaning and lived experiences of IHC from the perspective of adult clients with chronic health conditions who have participated in IHC for at least six sessions over three months.

Interview Date:

Time of Interview: Start -

End -

Interviewer:

Interviewee (Pseudonym and study number):

Review study purpose and informed consent.

- What would you title your photograph?
- What does your image say about Integrative Health Coaching
- What makes it _____?
- How is your Integrative Health Coaching experience reflected in the photograph?
- What is the one thing about Integrative Health Coaching you want to communicate through your image?

Follow-up question/s from first interview:

Please tell me how this interview process was for you.

What could have been different or helpful?

Do you have questions for me?

Review next steps in study process, member checking.

APPENDIX F: RESEARCH STUDY ANNOUNCEMENT 4/13/11

Research Study Announcement
Integrative Health Coaching: A Phenomenology of Clients' Discoveries
May 3, 2011

Have you participated in Integrative Health Coaching within the past 12 months?

This is an **invitation** to participate in a research study of your experiences in Integrative Health Coaching (IHC). The qualitative research study is an opportunity to contribute to the understanding of IHC from a client's perspective. Participation in the study is **voluntary** and you can stop at any time in the process.

The study is interested in what you want to share about Integrative Health Coaching.

Participants can choose to engage in one or two telephone interviews. The first phone interview will have open-ended questions exploring what the IHC experience was like for you, what it meant, and how the process and structure affected your experience. The second phone interview, or second part of an extended single interview, will involve you taking a photograph that represents your experience with integrative health coaching and sharing the photo and meaning with the researcher.

Your **privacy and confidentiality** will be respected and protected through a process of **informed consent and anonymity** with the use of a pseudonym. Information that is personal or identifying will be deleted to prevent your identity or your coach's identity from being revealed. The study is supervised by ECU faculty and approved by the University and Medical Center Institutional Review Board.

If you are an adult and resident of the United States and have a chronic health condition or risk factor for a chronic health condition and engaged in a minimum of six sessions of IHC over a minimum of three months within the past 12 months then you are eligible to participate in the study.

Please contact the researcher, Karen L. Goble, at 828-215-7418 by telephone or email klg.goble@gmail.com if you are interested in participating. The researcher is a graduate student in Health Education and Health Promotion at East Carolina University. The researcher is also a graduate of the IHC training program at Duke Integrative Medicine.

Thank you for consideration of this endeavor to understand IHC **through the eyes and experiences of clients.**

With kind regards,

Karen L. Goble
828-215-7418
klg.goble@gmail.com

The purpose of the study is to discover how clients experience IHC.

Your experience is what counts. You will be asked to participate in one or two telephone interviews.

As part of the study, you will be asked to take a photo that represents what IHC is like for you and talk about it with Karen, who is conducting the study.

Karen L. Goble
(828) 215-7418
Email:
klg.goble@gmail.com

Please contact the researcher by August 12, 2011 if you are interested in participating.

This research is a Master's thesis study conducted by Karen L. Goble, East Carolina University, Health Education and Promotion. The researcher is also an

Seeking Integrative Health Coaching Clients

July 11, 2011

Integrative Health Coaching: A Phenomenology of Clients' Discoveries

Dear Integrative Health Coaching Clients,

This is an **invitation** to volunteer in a research study of how clients experience Integrative Health Coaching (IHC). **The study is interested in your views and expertise about Integrative Health Coaching.**

Your **privacy and confidentiality** will be respected and protected. Information that is personal or identifying will be deleted to prevent your identity or your coach's identity from being revealed.

If you are an adult and resident of the United States and have a risk factor such as overweight, stress, or hypertension for a chronic health condition or have a chronic health condition and engaged in a minimum of six sessions of IHC over a minimum of three months within the past 12 months then you are eligible to participate in the study.

Thank you for consideration of this endeavor **to understand IHC through the eyes and experiences of clients.**

With kind regards,

Karen L. Goble
(828) 215-7418
klg.goble@gmail.com

APPENDIX H: PERMISSION TO PUBLISH STUDY PARTICIPANT'S ART WORK

UMCIRB# 10-0617

Karen L. Goble, Researcher
East Carolina University
Thesis Study

Integrative Health Coaching: A Phenomenology of Clients' Discoveries

PERMISSION TO PUBLISH STUDY PARTICIPANT'S ART WORK OR PHOTOGRAPHS

Dear Study Participant,

I am seeking your permission to publish photographs or art work or image that you provide for the study as representations of your Integrative Health Coaching experience. Photographs or art work might be included in the electronic thesis publication, publication, in professional or scholarly journals, and in presentations at professional conferences and trainings.

Photography or work cannot be used without your consent. You have the right to understand the purpose of the photography and how it will be used. You have the right to refuse to provide a photograph or work. Your refusal will not affect your participation in the study. Photographs that contain identifying images of persons or places will not be published or used in presentations and will be returned or disposed of securely based upon your preference. In order to protect anonymity, photographs or art work will not be identified with or attributed to the individual who produced it. If published, third parties would be able to view your photograph and/or work.

If you sign this consent it means that you agree to the following:

1. Karen L. Goble, East Carolina University, is able to publish photographs/work you provide for the research study in the ways mentioned above.
2. Your photograph/work will be published or presented anonymously and you will not be identified with the photograph or art work.
3. Your photograph/work may be reproduced either in colour or in black and white.
4. Your photograph/work will not be used for any purpose other than for publication of study findings, conference presentations, or trainings.
5. Any photographs will be kept for no longer than is necessary for the above mentioned purposes and will be stored and disposed of securely.
6. You can withdraw this consent to use the photographs for education or scientific publication by notifying the researcher in writing.

I agree to the publication of my photographs/work as outlined above. I will notify the researcher, Karen L. Goble, if I decide to withdraw this consent.

YES _____ NO _____

Participant Signature: _____

Print Name: _____ Date: _____

Witness: _____ Date: _____

UMCIRB
APPROVED
FROM 4.13.11
TO 11.2.11

APPENDIX I: CITI CERTIFICATION

CITI Collaborative Institutional Training Initiative

**Human Research Curriculum Completion Report
Printed on 8/27/2010**

Learner: Karen Goble (username: KarenGoble)

Institution: East Carolina University

Contact Department: Health Education

Information Phone: 828 215 7418

Email: Goblek09@ecu.edu

Group 2.Social / Behavioral Research Investigators and Key Personnel:

Stage 1. Basic Course Passed on 08/27/10 (Ref # 4797252)

| Required Modules | Date Completed | |
|--|-----------------------|------------|
| Introduction | 08/25/10 | no quiz |
| History and Ethical Principles - SBR | 08/26/10 | 4/4 (100%) |
| Defining Research with Human Subjects - SBR | 08/26/10 | 5/5 (100%) |
| The Regulations and The Social and Behavioral Sciences - SBR | 08/27/10 | 5/5 (100%) |
| Assessing Risk in Social and Behavioral Sciences - SBR | 08/27/10 | 5/5 (100%) |
| Informed Consent - SBR | 08/27/10 | 5/5 (100%) |
| Privacy and Confidentiality - SBR | 08/27/10 | 2/3 (67%) |
| Research with Prisoners - SBR | 08/27/10 | 4/4 (100%) |
| Research with Children - SBR | 08/27/10 | 4/4 (100%) |
| Research in Public Elementary and Secondary Schools - SBR | 08/27/10 | 4/4 (100%) |
| International Research - SBR | 08/27/10 | 3/3 (100%) |
| Internet Research - SBR | 08/27/10 | 4/4 (100%) |
| Workers as Research Subjects-A Vulnerable Population | 08/27/10 | 4/4 (100%) |

For this Completion Report to be valid, the learner listed above must be affiliated with a CITI participating institution. Falsified information and unauthorized use of the CITI course site is unethical, and may be considered scientific misconduct by your institution.

Paul Braunschweiger Ph.D.
Professor, University of Miami
Director Office of Research Education
CITI Course Coordinator

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APPENDIX J: FINDINGS

In this qualitative study informed by phenomenology the researcher sought to describe the essence or the “What is this?” of co-researchers’ lived experience as integrative health coaching (IHC) clients. The co-researchers selected for this study had sought to address a personal health concern by means of IHC and had engaged in a minimum of six IHC sessions within the year prior to study participation. The researcher applied the descriptive phenomenological approach originated by Husserl and set forth by Moustakas (1994). She apprised IHC clients about the study by means of two study announcements e-mailed 8 weeks apart to eight formative Duke IM health coaches. The Duke IM health coaches subsequently e-mailed the announcement to their clients who then voluntarily contacted the researcher.

Ten purposefully sampled respondents met study inclusion criteria and agreed, voluntarily, to participate in the study. The researcher enrolled the ten study participants between May 2011 and August 2011. Nine individuals completed data collection; one individual withdrew from the study due to an emergent health issue. The researcher will hereafter refer to participants in this study as “co-researchers” in order to acknowledge their role as collaborators.

The researcher collected data by means of two audio-recorded qualitative interviews with each of nine co-researchers. In the first in-depth interview she explored the co-researchers’ IHC experience. The researcher facilitated co-researchers’ exploration of their IHC experience from multiple horizons. In addition to responding to open-ended questions about their IHC experiences, they identified and discussed one word and one mental image that characterized their IHC experience and engaged in a photo-elicitation process. Table 2 presents co-researchers’ one word and mental image that they identified to reflect their IHC experience.

Co-researchers had the option to engage in the second interview immediately following the first or schedule a separate photo-elicitation interview. Five of the nine co-researchers elected to complete the two interviews in one session due to personal time considerations. The second interview involved a photo-elicitation process using a visual image that co-researchers had selected as representative of their IHC experience. During the second interview, they described their photograph and shared its meaning related to the perspective it provided on IHC. All co-researchers stated that the photo-elicitation component of the study contributed to their interest in study participation.

Co-researchers described their desire to present the “right” visual image representing their experience. Ericka had her IHC image in mind when she responded to the study announcement. Claudette sought assistance from others to create her image and created multiple versions of the image until she was satisfied. Ida and Grace described a lengthy process of reflection and exploring alternatives before deciding on their respective images. Ida found the photo-elicitation “such a different way to think about this [IHC] that I’m curious about what other people decided and what they chose.” Danny shared,

I had to think a lot about the photo and how that reflected my experience and it was such a strong image that I thought it was very satisfactory for that purpose, so I feel very good about it actually.

In accordance with Moustakas’ (1994) approach, the researcher engaged in a phenomenological reduction process that entailed horizontalizing the data to ensure that she viewed all data as having equal value. The researcher identified and coded invariant horizons that represented non-overlapping statements describing elements of the co-researchers’ experience. She maintained a codebook (Appendix Q) and memo for each invariant horizon.

Consistent with the analytical process described by Moustakas (1994), the researcher engaged in the next step in phenomenological reduction by clustering and identifying themes. She then developed individual textural and structural statements. Her textural descriptions addressed the content or “what” of co-researchers’ lived experience with IHC. Structural descriptions, on the other hand, addressed the dynamics of the co-researchers’ experience, specifically, how the IHC process operated for them. The final steps of phenomenological reduction involved developing the findings. The researcher utilized a thematic framework to present the composite textural statement and the composite structural statement. The synthesis described the essence of co-researchers’ lived experience as IHC clients.

The researcher considered the photo-elicitation images and interviews as a unique horizon or perspective within the body of data. She applied the phenomenological reduction process to the photo-elicitation images, titles, and interviews both as an individual data set and as a part of the whole body of data. A subsection of each textural theme described the photo-elicitation findings that illustrated the theme. Table J1 presents the photo-elicitation titles with corresponding statements that signified the co-researcher’s IHC experience.

Table J1
Photo-Elicitation Image Titles and Corresponding Statements

| Co-Researcher | Photograph or Image Title | One Word That Represents IHC | Mental Image That Represents IHC |
|----------------------|--|-------------------------------------|--|
| Ana | The New Me | Support System | Helping hands holding my hands |
| Bill | Before and After | Commitment | The new Bill |
| Claudette | My Health Coach: The Wind Beneath My Wings | Support and Success | I was at my own front door, leading my own regular life, feeling vital and healthy and centered and calm |

| | | | |
|---------------|-----------------|-------------------|--|
| Ericka | Metamorphosis | Empowerment | Making the right choices for me...I have my life back and I'm so much happier and that's empowerment |
| Grace | A Blooming Life | Freedom | The sun rising, illumination |
| Ida | The Tea Room | Comfort | A yellow kitchen, a happy, pretty future place... health coaching is making food for me |
| Kate | Refined | Peace and harmony | I feel light. I feel clean. I feel different |
| Mindy | Mini-me | Lifesaver | My grandchildren ...they're my motivation |
| Danny | Empowerment | Transformative | Strength and power to make my decisions |

The co-researchers' verbatim descriptions of their lived experience as IHC clients provided the foundation for presenting study findings. The researcher brought the individual co-researchers into the presentation of findings by using their voices in the form of quotations that she identified using pseudonyms. The researcher quoted co-researchers' statements in the text to support the analysis and discussion of findings. She included contextual information such as pauses or laughter in brackets to clarify the way in which co-researchers communicated information (Bailey, 2008). The researcher used ellipses (...) to identify the exclusion of data provided by co-researchers. Three ellipses (...) identified the exclusion of one or more words within a quoted sentence. Four ellipses (...) indicated excluded segments of one or more words

within a longer passage composed of two or more sentences. The researcher used brackets [] within quotations to include clarifying terms or references; for example, “she [coach].” Co-researcher and researcher verbalizations such as “hmm,” “ah,” and “you know” were omitted from the quotations to support fluency of the description where it did not detract from the meaning of the data (Bailey, 2008).

Co-researchers

The study co-researchers included nine clients who sought IHC to address a health condition or health risk and who engaged in a minimum of six IHC sessions within the past year. Co-researchers volunteered for the study by responding to a study announcement emailed to IHC clients by their coaches. Six co-researchers engaged in IHC through a worksite program developed by Duke Integrative Medicine (Duke IM) to prevent overweight and obesity (Wolever, personal communication, October 18, 2011). Three co-researchers received individual IHC through a membership at Duke IM. Duke IM membership entailed the development of a personalized health plan with a team of Duke IM faculty as well as personal IHC. The minimum co-researcher IHC participation was ten individual and twenty group sessions in ten weeks and the maximum was approximately 100 sessions over the course of three years. Three co-researchers had worked with their IHC coach for more than two years.

Co-researchers resided in locations across the continental U. S. The seven women and two men ranged in age; five co-researches identified as being in the to 50 to 69 year age range, three in the 35 to 49 year age range, one as 18 to 34 years of age, and one as over 70 years of age. Co-researchers described differing educational backgrounds from completing high school, some college, and currently pursuing a B.A., to holding professional or advanced degrees

including one participant who held four advanced degrees. Their varied professions included accounting, education, medicine, nursing, management and supervision, and customer service.

The nine co-researchers described a range of health concerns that prompted their IHC participation. Most co-researchers noted experiencing more than one health risk or condition. Six co-researchers described overweight or obesity, two described high cholesterol, three described stress, one described arthritis, one described diabetes, one described cancer, one described menopause, and one described an autoimmune condition. Co-researchers brought varied concerns to coaching including nutrition, eating behaviors, exercise, stress management, work-related challenges, personal relationships, physical environment, creativity, communication, prospective health, and education.

Overview

The researcher employed Moustakas' (1994) phenomenological approach to explore and document the lived experience of nine IHC clients by engaging in a progression of perspectives or horizons based on their direct descriptions transcribed from in-depth and photo-elicitation interviews. Consistent with Moustakas' method (1994), the perspectives presented in these findings include: a) the composite textural description; b) the composite structural description; and, c) the synthesis that provides an exploratory conceptualization of the nine clients' IHC experience. The researcher found an inherent logic in undertaking the successive steps of Moustakas' phenomenological process and recognized each step is necessary to reach the final synthesis that expressed the essence of co-researchers' lived experience. These findings present the final analytical outcome of that process.

Composite Textural Description

The researcher developed a composite textural description to explore four themes that expressed what co-researchers' experienced in IHC. The composite description relied on co-researcher's words and images to portray each of the four themes: a) the unique integrative approach to realizing self-defined goals; b) the supportive relationship with the skilled health coach; c) mindfulness as a foundation for change; and, d) the transformative change to a "new me" and experience of health and well-being. Through the exploration of the textural themes in the phenomenological reduction process, the researcher identified transformative change as the essence of what co-researchers' experienced in IHC. The researcher identified two overarching structures: the integrative medicine framework and the IHC coaching model. The integrative medicine framework encompassed the whole person approach, person-centered care, mindfulness, and the facilitative relationship.

Theme 1: Transformative change to a "new me." "The other weight loss's [programs] say do this and you'll lose weight. Not change yourself and you'll have control over that...It's [IHC] changed me. It's changed me to looking at things differently and looking at myself differently," noted co-researcher Danny. Co-researchers found that IHC entailed intrapersonal change that resulted in changes across life domains. Their experience of change extended beyond health and lifestyle to finding a new way of being in the world. They described their personal changes as transformative in that changes resulted in what Ana called, "The new me."

Consistent with what they shared during the in-depth interviews, each of the nine photo-elicitation images selected by the co-researchers illustrated an aspect of transformative change. Some images focused on the transformative change such as the three self-portraits while others included the theme as one element of the IHC experience. The textural description of this theme

presented co-researchers' description of what their experience of change entailed: transformative change, "metamorphosis" in Grace's image.

Multiple domains of change. Co-researchers' observed making holistic health-related change among multiple life domains as a result of engaging in IHC. Ericka's comment illustrated,

I was wanting to make some changes to improve my health and...it includes nutrition, mindfulness, diet, exercise, all that but it's more. It's taking it to a deeper level, going deeper into your health. It's like a full circle of your health.

The co-researchers' experiences of whole-person change reflected the IM approach that health and well-being encompass multiple life domains including self, nutrition, exercise, movement, rest, mind, relationships, personal and professional growth, physical environment, and spirituality. "Health is such a small part of it [IHC] in a way," Ida noted. "We talk about a wide variety of health issues if you look at health in an overarching way rather than just physical health."

Self at the center of change. Co-researchers discovered that IHC applied a mindfulness-based approach to change that increased self-awareness. Self-awareness entailed reflexivity and attention to internal states without self-judgment about them. Grace stated, "I feel a hundred percent better after I have a health coaching session because...I'm getting stuff that gets in the way of being me." Self-awareness led to empowerment and confidence for change that co-researchers considered significant qualities of the IHC approach. Ana shared, "It's really about becoming aware of who you are...what triggers you may have in life, what barriers you may have...how can you go about making changes...It's a whole new way of thinking."

Co-researchers described having to overcome beliefs that limit caring for self, a view noted by three of the female participants, particularly since, as Ericka remarked, “we [women] don’t like to do things for ourselves; we’re taught that’s selfish. They described letting go of self-judgment as a precursor to self-awareness and self-care. Claudette noted, “it was so radical for me to hear that you’re supposed to start with yourself in giving loving-kindness to yourself first ‘cause that’s just the opposite, I tend to beat myself up...” Ida shared that she was a baker who found reward in cooking for others. She discovered that, “health coaching is making food for me...I’ve always been interested in making other people happy and comfortable...I look at health coaching as a guilty pleasure.” Despite any sense of discomfort related to enacting self-care, co-researchers recognized that IHC placed self-awareness and self-care at the center of the change process.

Kate explored the importance of awareness of the mind/body relationship to her health by commenting, “Your body is controlled by your mind so, if your mind is cluttered, then I would think something would be going wrong in your body.” Grace acknowledged that, “if you don’t have a healthy mind, you don’t have a healthy body.” Co-researchers described changing habits of mind that contributed to unhealthy behavior patterns such as self-judgment, negative self-talk, beliefs and mental constructs, all or nothing thoughts, and the need to control. Co-researchers noted the ability to recognize and work with thoughts and emotions as an important aspect of “clearing the mind” for change.

Self-awareness involved finding a new lens to approach a life challenge and identify strategies for change. Ericka found that, “it gives you different vantage points. You can see and be aware of your thoughts and look at things from different angles and that helps you to stop and look and make choices.” Ida described her “kitchen” perspective as, “maybe if I think of

working on myself as baking a cake, it gives me a whole new way to look at things.” Ericka identified her “gardening perspective” as a means to clarify her personal vision and values and apply those in the process of defining and realizing goals.

Co-researchers identified and titled a visual image that represented their IHC experience and described the image and title in a photo-elicitation interview. Danny titled his black and white photograph (Supplemental Material, Figure S1) that captured an eagle perched on a tree limb surveying its surroundings “Empowerment.” He summarized the role of self-awareness in his photo-elicitation interview, “the goal has to be that we stay like that eagle, self-aware, so that we can achieve our goals.” Danny explained that by cultivating self-awareness, “[IHC] lets you stand on your own two feet... You’re in control of what you do and can make it a positive experience.” The self-awareness Danny experienced through mindfulness practices “helps you to know what’s going on inside you ... If you don’t know what’s going on inside you, you’ll be a poor judge of what actions you are taking to change the world around you and your self.” He observed that IHC and mindfulness practices increased his ability to make healthy decisions. Co-researchers described how insight through self-awareness supported action toward self-defined goals.

Nutrition and eating habits. Co-researchers’ experiences as IHC clients involved changing health behaviors. Eight co-researchers described changing their nutrition by making different choices about what food they consumed. Co-researchers also described changing their eating habits and behavior. Bill commented,

I’ve changed my eating habits. I don’t eat red meat like I used to. I don’t drink sodas like I used to, and I just drink a lot of water. I eat a lot of the foods that I always didn’t like in the past.

Claudette “already had wonderful cookbooks” and with the support of IHC was able to enjoy the “success” of trying one new recipe a week. Grace described increasing the number of meals she ate at home and setting goals to limit times she would “go out to eat.”

Seven co-researchers described participation in mindful-eating practices during group coaching sessions or through a mindful-eating program at the integrative medicine center. For these co-researchers, mindful-eating entailed paying attention to physical sensations, thoughts, and feelings associated with each moment of the meal and each bite taken. The practice of mindful-eating involved a significant change in how co-researchers experienced eating and their awareness of internal states associated with eating.

Co-researchers described increased awareness of their “inner body” (Ana) or internal state and increased ability to identify hunger, thirst, fullness, tiredness, boredom, or other conditions that might lead to eating. Kate spoke about mindful-eating in the following way:

[We learned the skill of] listening to our body where we can tell, if we’re in tune with our body, we can tell if we’re actually really hungry or if our body’s actually just digesting food or if we’re thirsty. Sometimes we might just need some water but if we’re not reading our bodies or being mindful of our bodies we can mistake it for being hungry.

Mindful-eating practices also helped participants experience the particular foods they consumed. As Ericka shared, “I had never tasted just one raisin, cause when you eat raisins you usually gulp down a bunch of them, and we chewed that raisin...and experienced every single bit of that raisin, and you know what, I liked it.”

The coaching helped co-researchers challenge old beliefs about eating such as, “You have to eat all your food” (Ericka), and changed how they consumed the food they ate. Mindy described her experience with mindful eating:

The thing is when I'm aware of what's going on, I don't pig out. I don't go for the extra big plate. I don't go for seconds. I eat til' I actually feel like I'm getting full and then I stop...I don't stress and overeat.

Movement, exercise, and rest. The self-awareness cultivated through IHC and mindfulness practices supported co-researchers with finding the balance of movement, exercise, and rest that supported their individual health and lifestyle. Co-researchers shared that IHC helped them set new priorities and make different decisions regarding physical activity by linking their self-defined goals to personal values that increased their motivation and ultimately resulted in the integration of the new behavior. Bill observed,

It's just like those exercises and the older I get the more I don't want to do them, but I have to make myself do them. And you know I'm just about getting into the rhythm where I don't have to make myself do them, I do them automatically.

Danny shared, "last night, there was a question whether I went to do an activity or have dinner and I saw that I'm really not hungry now, so I'll go do the activity." IHC helped co-researchers change how they valued and prioritized exercise. As Ana contended,

That was a big change...I'm now exercising on a regular basis...This past weekend I went camping and never, ever in my life have I gone somewhere and it was upsetting to me that I couldn't exercise...That's a first for me.

Kate noted, "I'm finding being creative trying to get some exercise in, even if it might be just stretching at home. Or walking up stairs." Ida described balancing "trying to live in a more healthy style" with the challenge that she "absolutely despises any kind of exercise and doesn't have time for it and all of those things that everybody always talks about." The change that Ida

shared entailed trying to implement, “a new type of exercise or a new schedule or a new way to do that.”

Relationships. Co-researchers described working on and making changes in their personal relationships issuing from their IHC experience, particularly by employing such self-care strategies as relinquishing control, remaining present in the moment, and saying no. Ericka commented that by letting go of control and taking care of her, she was able to be present with her family members and found that “even my husband and children and friends notice that I’m much happier.” Ana shifted her relationships from being a “pleaser” to “delegating things, or its okay in saying no.” Ida experienced a significant shift in the relationship with her brother while working together to renovate a room and make it a special place for her. Claudette and Ida shared that IHC provided support while they worked through difficulties involving personal relationships.

Co-researchers observed that health behavior changes through coaching could benefit personal relationships. Mindy considered how modeling healthy nutrition could extend to a client’s family: “If they have kids, this will help them with food and help them choose healthier choices.” Bill found time to walk with his wife every evening. He described an annual family gathering that typically involved eating in restaurants and “fixing big meals.” This year, however, Bill told his wife, “You know I can’t eat the things I ate last year,” and planned to model change and encourage his brother to address his own health concerns. Claudette and Bill noted the importance of their spouses’ support for dietary changes they were able to make.

Co-researchers described important relationships as motivation for change. Mindy shared a photograph of her grandchild as the image that represented her IHC experience, “I want to be around for them, ‘cause they’re my motivation.” Bill also found spending “good quality

time with my grandchildren” an important motivator for change. Grace shared that the desire to help other people recovering from cancer motivated her personal and professional growth.

Physical environment. Co-researchers described changing their physical environment and using their physical environment to facilitate internal change. Ericka practiced making changes in how she managed her home such as laundry or washing windows in order to make internal changes. She commented,

I used to have to control everything...how the windows are washed...the laundry, everything...Instead of just being so caught up in all these things and having to control, now I have my life back and I am so much happier and that’s empowerment.

Grace also worked with the external environment to practice making internal change, “I tend to be a control person and one of my home-works was when somebody else loads my dishwasher for me not to re-arrange it. I had that for a very long time.”

Ida contributed a photograph of her “tea room” (Supplemental Material, Figure S2) beautifully decorated with her collection of tea cups and memorabilia that represented the success she experienced with IHC in “taking space back.” She transformed a room and expressed her creativity and resourcefulness to create a place where she experienced, in her words, “comfort and hope and really a contentment.” The “tea room” represented Ida’s experience of empowerment and increased capability to initiate change that she developed through IHC. Creating the “tea room” led Ida to make changes in other areas of her life.

It does encourage me to continue that reclaiming...It makes me think, oh yeah, I did this, I can do this other, I need to do this other, and, you know how if you ever move one piece of furniture you have to move everything in your house? Or if you clean out one cabinet

then you have to rearrange everything else because nothing else fits anymore...once I got that done there was a lot of feeling about, oh, let's move on and do something else.

Personal and professional development. Co-researchers described changes in professional and personal development that resulted from their IHC experience. The most important quality of Grace's IHC experience acknowledged "the potential in me" for self-actualization. As she contends, "everybody has that flower inside of them and ...with assistance, with the health coaching you can actually become what you were meant to become."

Ericka described her image of personal growth in IHC,

I am alive like the garden and the sun is shining. I don't have to be in control and most of all, I take care of me, have time for me and what I want. Before I thought that was being selfish. I didn't even know what I wanted and I wasn't growing.

Spirituality. Three co-researchers touched on how IHC experiences were consistent with their spirituality; however, co-researchers did not describe significant changes in the spiritual domain during the in-depth interviews. Two co-researchers identified spiritual qualities in their photographs and images related to whole person change. Kate described her image as reflecting her state of "peace, love, and happiness" resulting from being "refined" by her IHC experience. Claudette described her image of soaring wings reflecting "trust and a power greater than myself...trusting a higher power and then at the same time it, there is trusting myself." Claudette provided additional insight and description regarding change in her spiritual domain in comments she shared during the member checking process: "IHC coupled with Mindfulness has been the wind under my wings in keeping focus on my self-care & in making behavioral & spiritual changes which have led to body/mind/spiritual healing." Claudette clarified that changes in her spiritual domain related to her health and well-being. Bill placed his IHC

experience within the context of his spiritual life describing how “God sends things your way.” Spirituality as a health domain was not a significant theme for co-researchers’ when describing their IHC experience.

Co-researchers did not equate mindfulness with spirituality. They consistently described mindfulness as a state of awareness and attention that involved non-judgment and letting-go. Bill did equate the loving-kindness practice with his actions as a Christian.

Readiness for change. Co-researchers claimed that “everyone” would benefit from IHC, but when the researcher followed up with a probe to clarify if indeed they considered the experience applicable for all persons, they noted that IHC participants needed to be ready and willing to make changes. According to Ericka,

You need to be committed, you need to want to change or accept that there will be changes. Ah, you have to want it. I didn't know when I went into it what it would be like, but I did want to make changes, I was sure of that.

Five co-researchers stated that participation in the IHC process required their commitment of time and effort. Ana associated commitment with “being engaged” and recommended that IHC participants “take this opportunity to become engaged [in change].” Co-researchers discussed commitment as a reflection of readiness for the change process in IHC. Danny shared that, “it [IHC] does require commitment.” Bill found himself ready to commit to making changes when he received the results of his metabolic testing.

I mean if you want to continue at the pace that you're going you're not going to live very long. And I had to tell myself, you know, something had to change. And I had to tell myself, Bill, if you're going to get this weight off it's not going to be easy.... I just committed to doing whatever it took to lose the weight.

The experience of health. Seven co-researchers described improved physical and emotional health as an aspect of change resulting from their IHC experience. Bill stated, “you can probably tell with my smile” the sense of health his photo-elicitation self-portrait depicted. He had lost 26 pounds and increased his physical fitness and stamina. He declared, “I feel great and I look great (laughing).” Claudette shared her sense of success and empowerment as she avoided the need to take medication by mastering one new recipe at a time. Grace noted that IHC helped her address health goals even while involved in the treatment process for a cancer recurrence. Coaching supported Grace with achieving nutritional and exercise goals and, more importantly, with staying on track with realizing her dreams. Kate lost weight, stopped feeling tired, and described being “energized.” Mindy changed her diet, increased exercise, and improved her sleep resulting in weight loss and improvement in her glycemic control that allowed her to discontinue her diabetes medication, “I can be free and that’s how I felt when I went through it.”

The experience of well-being. Co-researchers described the experience of well-being resulting from their IHC experience. Whole person change led to the experience of growth and self-actualization; co-researchers’ well-being encompassed more than just physical well-being. Co-researchers described feeling happier and experiencing less stress. Well-being involved reclaiming personal space and creating comfort. Increased self-esteem and self-acceptance, learning to say no, and realizing that one can trust oneself characterized co-researchers’ well-being. Co-researchers described a sense of thriving in multiple life domains including self-care, personal relationships, and work. Kate shared a central characteristic of well-being as, “she’s loving herself.”

Ana shared that her photo-elicitation image of herself as the “new me” portrayed that “it’s a happier me with myself.” Claudette found learning to “give ourselves acknowledgement and credit...is something that fills you up in a good way.” Claudette’s image depicts her ability to trust in herself and “soar.” Ericka noted that, “I’m really a happier person...I smile more and am more relaxed.” Ida spoke about her sense of success in realizing her creative potential and new ability for self-acknowledgement, “It’s a very positive feeling...It turned out really well and that’s great.”

Grace described how mindfulness in IHC enriched her quality of life by helping her be present for each moment. The experiences of increased self-awareness, “becoming aware of who you are,” and “taking time for myself...prioritizing and taking care of me,” contributed to Ana’s sense of well-being. She said, “I learned how to take care of myself.” Claudette shared, “I’m mindful of how I’m treating myself.” Mindy described her experience of well-being in IHC in one word, “Freedom.” Mindy’s experience of well-being arose from mindfulness that helped her with “accepting me, who I am.” Kate noted, “it [IHC] kinda just boost[ed] my confidence and self-esteem and that kinda shined through,” resulting in a promotion at work. Ericka portrayed herself as “alive like the garden.” Danny found that IHC “really opened us up to things around us” so that he and his coaching group had more choice “to be able to manage their lives.”

Grace illustrated the theme of well-being through her image “A Blooming Life.” She shared a photograph of soft, fragrant roses that portrayed the beauty she experiences each day (Supplemental Material, Figure S3). She described her journey to discover “what I wanted to do with the rest of my life.” She shared how her lack of clarity and difficulty with making decisions

“was pretty much just stagnating.” IHC allowed Grace to “hone in on what I wanted to do and I did it.” Grace shared,

During the coaching I was able to really figure out, what she [coach] did was open my heart and my mind to be able to figure out what I wanted to do...for the rest of my life, cause I’m not the type of person to consider a real, sit back in a rocking chair retirement.

She returned to school and studied culinary arts in order to “open a yoga studio with an organic café...to teach people how to cook well for themselves.” She shared that “blossoming” felt like “getting up in the morning and just being ready to go, even though I was just diagnosed with breast cancer again...I don’t dwell on it at all because there’s so many other exciting things I’m doing right now.” IHC supported Grace to “understand myself so that I can blossom.”

The experience of transformative change. Co-researchers used change-evoking words and images to portray their experience of IHC. They characterized their change as “transformative.” When referring to IHC, Ericka said, “It’s a transition. It’s a rebirth, new opportunities.” She described, “Coaches had acknowledgement and understanding of our transformation process and so the caterpillars turned into butterflies.” Danny used the word “transformative” to capture his IHC experience in one word. Co-researchers’ experience of change extended beyond a specific health behavior or realization of a specific goal. Change involved a higher order change in self-awareness and in quality of life.

The qualities of transformative change and sense of well-being emerged from all the photo-elicitation interviews. Kate observed, “I say ‘Refined’ for the image [title] because it’s almost like, hmm, how can I put this? It’s almost like I was sculpted or I was just transformed through the experience, so I want to say that it refined me.” Eight of the nine image titles portrayed change as the primary element of the co-researcher’s IHC experience. Ericka’s title,

“Metamorphosis” represented her experience that IHC engaged the whole person in a transformative process. Claudette’s title emphasized her relationship with her coach as the primary experience and suggested change as a secondary theme: “My health coach: the wind beneath my wings.” The wind, representing the support of the coach entailed a change that transformed her wings from flapping to soaring.

Theme 1 summary. Change reflected the predominant texture or content of the co-researchers’ IHC descriptions. The multiple perspectives revealed during the study included a photo-elicitation image and title, a one-word characterization of IHC, and a mental image of IHC perspectives all of which highlighted co-researchers’ experience of change. Co-researchers described change that reached beyond their original health condition and reason they sought IHC. All nine co-researchers experienced significant change in multiple life domains and in self-awareness that gave rise to their larger sense of “transformation.”

Co-researchers described multidimensional changes consistent with the IM approach including increased self-awareness, lifestyle change such as changes in eating behaviors, changes in personal relationships and environment, professional growth, and personal changes such as being happier and realizing their potential. They found that IHC built “self-reliance” (Danny) for making the changes they identified as consistent with their values and priorities. Three co-researchers observed that IHC was consistent with their spirituality; however, none specifically described changes in their spiritual life domain.

Theme 2: The supportive relationship with a skilled coach. The co-researchers perceived that their relationship with their coach played a significant role in their IHC experience. They described the role of the coach as partner, guide, cheerleader, and educator who engaged and empowered the client. The co-researchers found skill with coaching

techniques, knowledge of mindfulness and IM, credentials, and the resource of an integrative health network prerequisites for IHC coaches. They identified supportive presence as the distinguishing characteristic of the relationship. Support entailed feeling personal, friendly, safe, accountable, and comfortable. The coaches' quality of presence contributed to co-researchers' experience of them as authentic with mindfulness practice. Co-researchers described specific qualities that characterized their coaches' mindfulness such as "one-hundred percent listening," non-judgment, loving-kindness, curiosity, and calm voice. Their description suggested that the coaches' mindfulness contributed to how the co-researchers experienced the relationship.

Role of the coach. Co-researchers described that their integrative health coaches engaged and empowered them in the change process. They agreed that "empowerment" was a primary role of the coach who acted as partner, guide, cheerleader, and educator with expectations of self-responsibility on the part of clients. Danny described the role of the coach as facilitative of "self-reliance." He observed, "although I was interacting with my health coach...I was alone in this and I would have to change myself to do what was necessary for myself."

Partner. Co-researchers described their experience of the coaching relationship as a supportive partnership. "It's [relationship] like holding hands," Ana shared, "The coach...cared about me. But I had to do it...she didn't tell me what to do. She was a partner, but I had to come prepared and have ideas." The co-researchers described the experience of a joint endeavor in which they experienced the coach as present and invested but not directive. They noted the significance of the sense that their coach had a "stake" (Ana) in the partnership and observed that the partnership role entailed teamwork and their active engagement. Bill compared it to a baseball team, "she was like the team coach...and I was the player. I was the one that had to

produce the results.” Co-researchers valued their coaches’ support and availability in the partnering relationship. Mindy, for example, found it important that her coach was, “there for me, she’s there for backup, she’s there for support...I know I can call her at any time...I know she’s there.”

Guide. Co-researchers described their coach as a personal guide who kept track of their journey and recognized progress. In Ida’s words, “There is the focus on how far I’ve come, how much change I’ve made, and I don’t always see it or remember it and it’s nice to have someone point that out to me.” The coach in the role of the guide supported the co-researcher’s efforts but did not direct or undertake the work. Ericka noted how the coach empowered her while guiding her, “It’s a guide, they don’t lead, they guide. It’s a different mindset, and they give you perspectives, but they don’t lead you.” The IHC coaches in the role of guide held the big picture for co-researchers. Grace spoke about the significance of her coach’s guidance that directed her attention to what mattered most.

One of the reasons I went back to school is ‘cause I wanted to enjoy it. The first time around I didn’t really enjoy it...And, at one point last semester I had signed up for three classes and I was so, trying to figure out how to juggle these into my life and all she said to me, she goes, ‘Are you enjoying this right now? (laughing). And it was like a light bulb went on and I was ‘oh yeah, I totally forgot about that.’ So for the first time in my life I dropped two of the classes...I was just going to enjoy it.

Cheerleader. Mindy compared her coach’s encouragement to the role of a cheerleader, saying, “So she was just encouraging me and she was cheering for me, kind of like my cheerleader.” Bill found the encouragement motivating in that “she just kept saying things like

that to motivate me... We kinda lifted each other up.” Co-researchers viewed the role of cheerleader as a conventional coaching role that demonstrated support and increased motivation.

Health educator. Health coaches served as health educators in both group and individual settings. Co-researchers described that the coaches promoted their autonomy and built on their strengths in the health education process by inviting them to draw on their knowledge and experience first. In the group context, coaches utilized a mindfulness-based health education curriculum and facilitated skill-building activities such as doing group stretches or practices involving awareness of breath. Bill noted that the coaches “really know what they’re talking about” and described the health education role of the group coach as,

[the coach in a process of health education] bringing up these things that we'd never heard of before...If you do eat out choose healthy and lower calorie options, it's just stuff like that, it got people to thinking, ‘oh if I eat a salad maybe I could put the dressing on the side and just take a little bit of the dressing out at a time instead of pouring dressing over the whole salad.’

Danny described learning practical and useful techniques that contributed to his skills such as, “scripts to use to yourself when you are faced with difficult situations, modifications in your purchasing, your cooking, your exercise, all sorts of ways to make your lifestyle more healthy.” Co-researchers emphasized that the health education role of the coaches concurred with a client-directed process and focused on clients’ individual needs and priorities. The health education role contributed to co-researchers’ empowerment and engagement by providing them with tools, skills, and information to achieve their identified goals.

Pre-requisite skills. Co-researchers observed that integrative health coaches demonstrated a high level of skill in their coaching practice. They cited skill and knowledge,

particularly in the areas of mindfulness and integrative medicine, evidence of training received from a reputable program, and being part of an integrative health network as pre-requisites for coaches. Grace expressed the importance of credentials in the following comment:

I pretty much trust Duke so I didn't have to do any background checks or anything on my health coach. I would imagine that if you go with a health coach, you should definitely check their certifications and where they studied.

Grace stressed that “you need to have training...as much training as possible” to be an integrative health coach. Bill summarized, “to finish up...you’ve got to have good coaching.”

Co-researchers identified a range of skills the coaches demonstrated that supported their IHC process, including acknowledgment, reflection, listening, asking open-ended questions, exploring values, validation, offering challenges, and maintaining the focus on the client’s agenda and process. Grace offered, “It's really nice to be able to have somebody listen to you 100 percent because you know, (laughing) even my husband doesn't do that all the time.” Claudette shared her experience of coaches using reflections as, “hearing the heart of what I've said reflected back to me...Also, having reflected back to me who she sees that I am, my strengths and my heart.”

Coaches guided co-researchers in clarifying their values and personal vision for their future. Claudette illustrated, “I saw myself opening my front door... and it was so profound because I was at my own front door leading my own regular life feeling vital and healthy and centered and calm.” Mindy shared that her coach helped her be clear about her vision for her future that entailed “being around” for her grandchildren. She described that the personal vision increased her self-acceptance and gave her “a way of actually working on it [her goal] without feeling stress about it.”

Ida found the incremental goal-setting process instrumental, “in a way that may be the greatest strength is helping me make the plans smaller and do things in smaller increments and not feel like I have to do everything immediately that teeny weeny steps are okay.” Claudette explained that the steps involved identifying what is doable, “It's not just breaking things into manageable parts. I think another thing is... where do you start, what's the first part, what's the first manageable part.” Co-researchers valued the coaches’ skillfulness with facilitating the goal setting process.

The co-researchers described that coaches supported them in a self-determined process of goal setting. The coaches’ facilitated the process that empowered co-researchers in goal setting and promoted their sense of responsibility for outcomes. Mindy found goal setting motivating,

I actually set the goals for myself, it was after the first meeting, then we talked about goals, I set it for myself cause I knew what I wanted...and when I reached that goal after class, I was really, really excited.

Danny found that his coach’s skills empowered him with setting goals, “I know that she was doing this in a way that I was the person who was forming the opinions and the goals and the methods to get to the goals, not the coach.”

Coaches helped co-researchers identify and overcome obstacles to achieving their goals. Co-researchers described how they came to understand “the root of the cause” (Ana) of unhealthy behavior or barriers and identified their own strategies to work around the obstacles. Coaches offered challenges to habitual thoughts or patterns of behavior that co-researchers identified as obstacles to change. Ida described how her coach’s challenges supported her change process.

It's sort of like having a new friend who challenges you very gently, but challenges you about things you've always thought or considered a certain way...about that moment where suddenly something you've always done because you did it that way for thirty years, you suddenly think, oh, here's this other person and they're telling me it doesn't really have to be that way.

The accountability the coach provided contributed to co-researchers' success in the change process. Ida shared, "I don't get away with much. I know that sounds sort of weird probably but she helps me keep on tasks that would be easier to sort of let go of." Ana described accountability as an element of the ongoing contact with her coach and found it crucial, "I could have so easily just said oh forget it, I'm just gonna, you know, go back to my old habits. But I didn't, because of having that coaching, that accountability." Grace clarified that accountability did not entail reproach or judgment.

She'll probably say, 'Well, what do you think got in the way of you doing that? Maybe you didn't really want to do it and if that's the case, then that's fine.' I mean she's ok with it. Because it's really my homework, it's really not hers. She's not there to say, 'Well you have to go to detention today because you didn't do your homework.'

The relationship, heartfelt support. Eight co-researchers emphasized the significance of their relationship with the coach. The experience of heartfelt support characterized the relationship. Co-researchers described building a relationship founded on trust and a sense of safety. Five of the nine participants experienced the relationship as similar to a friend's care but different because coaches do not bring their personal agenda to the relationship. Danny shared a different perspective. He acknowledge a facilitative relationship with the coach, however his emphasis in the "interaction" was on his "self-reliance."

Building relationship. Co-researchers collaborated with coaches to build the foundation for the IHC process. Coaches and co-researchers created agreements regarding confidentiality and anonymity, scheduling and process, and communication that established safety and trust. Bill described the individual and group agreements as, “everything was confidential, and they told us be on time and listen with kindness and respond promptly and quickly and that’s what we done.” Ida described the initial IHC sessions as “introductory, biographical.” She and other co-researchers noted that the initial sessions involved the coach getting to know them and that process contributed to rapport, safety, and trust. Grace described a sense of discomfort talking with a stranger in the beginning of the coaching relationship until “a rhythm kicks in and you start to feel really comfortable and develop a really good relationship with your health coach.”

Caring. Ida described the sense of comfort that she experienced from “the idea that there’s someone out there who really is working with me to make my life better.” Ana’s experience of support, “felt like someone cared, not that people don’t care in my life, but someone really had a stake in me.” Co-researchers experienced the support in the context of relationship as opposed to a more task-oriented form of assistance. As Claudette shared, “I feel deeply listened to and deeply encouraged, acknowledged, understood.” The supportive relationship with the coach engaged the co-researchers and empowered action. Coaches’ support sustained motivation since, as Ericka pointed out, “Support is what makes it possible to make changes.” Mindy noted that the coach was “there for support.” Bill experienced “a lot of support” through “teamwork” with the group coaching. He illustrated, “I kept telling them how much weight I lost and they kept saying GO!”

Personal. Co-researchers described a personal quality in the relationship with their coach that reflected the coaches’ focus on the client and restraint from bringing their ego-self into the

relationship. Grace described that her coach as knowing everything about her but she knew almost nothing about her coach. Kate “really felt like I bonded with my coach... although we just spoke on the phone and I have never seen her...It felt like I knew her, just a sense of trust.” Ana remarked, “I thought it was pretty incredible she could know who I am just from, from my 25 minute sessions.”

Safety and trust. Safety and trust formed the foundation of the coaching relationship. Co-researchers described safety in the confidentiality agreement and design of the coaching process including the telephone context. The client-centered approach employed by coaches contributed to clients’ sense of safety. Co-researchers described their coaches’ quality of presence, even in a telephone context, that contributed to a sense of safety and suggested that perceived safety gave rise to trust. Co-researchers expressed safety and trust in their ability to be authentic and open with their coach. Ida found that “the phone makes that easier.” Ana contributed, “I felt very safe that I could share anything” in the individual sessions but would not have shared as much “personal information in a group setting.” She explored the qualities that conferred safety and trust.

I guess right away I had that trust with my coach, you know, the friendliness. I just didn't feel threatened whatsoever and she conveyed that things would be held confidential and blah, blah, blah [laugh]...but it's just, I guess, it's how she came across on the phone and to me that's pretty amazing that I felt I could open up and feel comfortable without even seeing a face.

Co-researchers described the skillfulness of coaches in maintaining safety and trust. Ericka described how her coach was “just there for me,” the client-centered relationship contributed to

her sense of safety. Grace observed that safety and trust increased over time and resulted from the client-centered approach.

I think that what makes it safe is that, one, she is totally not connected to any other part of my life and I had no reason to even consider the fact that she might have an ulterior motive ... There's a whole trust between the two of us that, it doesn't happen right away but within a few sessions it does, so I mean that's what makes it safe for me. I don't have a whole lot of people in my life that are 100% impartial... My health coach, the only reason she has to be there is to listen to me impartially, so that makes it safe.

Friend. Safety, trust, and the personal quality manifested in the co-researchers' experience of the coach as friend. Grace described, "It's like having a totally non-judgmental best friend (laughing). I mean she listens to me totally, I mean she gives me 100 percent of her attention." Kate experienced intimacy and safety with her coach as, "almost like talking to a friend. And then even, some things you might not share with your friends...I would share it with her." Ida captured the essence of the quality of friendship as,

Really the sense that I have this outside person who knows a lot about me, who listens and who is interactive and encouraging...it's like having a friend who's, well, I was going to say a friend who's not a friend.

The "friend" quality reflected the significance of co-researchers' experience with the coaches open, attuned, and non-judgmental presence.

Quality of presence. "My health coach is grounded in mindfulness. I can feel it and see it," noted Claudette. "They listen, it's a lot about listening," shared Ericka, "never judgment in the voice, [and] kindness, the sense of kindness." The kindness, non-judgment, and presence co-researchers valued in their coaches pointed to the coaches' authenticity with mindfulness

practice. Kate spoke of the importance of the coach modeling and practicing mindfulness in the sessions. Other co-researchers described attitudes and qualities of mindfulness that included openness and the ability of coaches to let go of expectations or an expert perspective and be with them in the coaching process. Eight co-researchers described their coach leading mindfulness practices during group and individual sessions; they noted that leading mindfulness practices necessitated that the coach have knowledge and experience with mindfulness practice. The ninth co-researcher, Ida, recognized that the coach's mindfulness "showed up" in the substance of the relationship such as the coach's open and curious questions rather than in facilitating mindfulness practices.

Ida experienced "validation" in her coach's non-judgmental approach. Claudette described the importance of her coach's non-judgment, "so whether I'm continuously succeeding or whether I'm going backwards and then having to find my way forward again there's always just unconditional love and support and approval and kindness." Mindy discussed how the coach's acceptance supported her continued participation in coaching when she faced work obstacles. Ida stated, "I don't ever have the sense of failing at it...I never sense any frustration on her part."

Four co-researchers discussed the qualities of mindfulness expressed in the coaches' voice. Grace noted that a "very calm" and nonreactive voice is a "prerequisite" for integrative health coaches, "you need to develop some type of phone bedside manner." Ana shared, "They have that voice that is very soothing, very easy to listen to, very calming I guess is the word." Bill remarked, "You could almost fall asleep listening to her talk." "They have a certain voice, I don't know if they take voice lessons, a very calm voice...soothing and friendly," according to

Ericka, “there’s something about her voice, she has a voice that just leads you through, that’s a big piece, and her voice is calm and it just creates this good feeling.”

Images of my health coach. Three photo-elicitation images illustrated the significance of the relationship with the coach. All the photo-elicitation interviews, with one exception (Kate), described coach support. It is possible that the extended interview framework in which the photo interview immediately followed the in-depth interview influenced the exception since Kate extensively described the importance of the relationship with the coach immediately prior to the photo-elicitation section. Mindy stated her photo-elicitation image communicated, “That I’m not alone. That I have somebody with me.” Ericka’s garden collage image portrayed the support of the coaches.

Claudette portrayed the relationship with her coach as the primary theme in her photo-elicitation image. She discussed the importance of creating a satisfactory image of the relationship with the researcher prior to the photo-elicitation interview. The meaning and care in illustrating the coaching relationship mirrored the significance of the relationship. Claudette did not have what she termed the “right” image completed prior to the interview but she had several draft images. Claudette visualized the image she sought in detail and shared the visualization during her interview.

Claudette titled her image, “My health coach: the wind beneath my wings,” and shared that the phrase, “my health coach,” signified the personal quality of the relationship (Supplemental Material, Figure S4). She placed a heart in the center of her image depicting the relationship in which, “I feel that their guidance and support is heartfelt and there’s a heart-to-heart connection between us.” Claudette shared the significance of the loving-kindness, presence, acceptance, openness, non-judgment, and awareness she experienced with her coach.

The attitudes of mindfulness her coach demonstrated played a central role in Claudette's IHC experience and in her image.

In-depth interview images of the relationship. Four co-researchers depicted coach support in their one word characterizations or mental images that they provided during the in-depth interview. Ana stated that her one word describing her IHC experience was "support system" and described her mental image as "helping hands holding my hands cause that's how I think of it, it [coach's support] was guiding me through a process." Claudette saw "support and success." Grace's mental image of "the sun rising" was a metaphor for the significance of "my health coach's help." Ida's word, "comfort," characterized the significance of "the idea that there's someone out there who really is working with me to make my life better." Mindy's "lifesaver" represented the "help" she experienced from her coach.

In summary co-researchers described the relationship with their coach as a significant component of their IHC experience. They indicated the coach wore multiple hats such as guide, cheerleader, and friend. They identified skills, resources, and credentials prerequisite for IHC coaches. The coaches guided mindfulness practices during individual and group sessions. The co-researchers described mindful qualities demonstrated by the coaches that contributed to the relationship such as non-judgment, acceptance, and a calm, non-reactive presence. Co-researchers found that the supportive relationship with the coach was a significant contributor to their change process.

Theme 3: Mindfulness as a foundation for change. "Mindfulness is the basic piece" of Ericka's IHC experience. Co-researchers engaged in mindfulness practices during individual and group sessions and described experience with MBSR classes at Duke IM and their workplace. The worksite groups received direct instruction in mindful eating and mindfulness

practices such as the body scan, awareness of breath, and loving-kindness. Co-researchers noted benefits from their experience with mindfulness including increased self-awareness, relaxation, and a “clear mind” (Kate) to help make choices. Co-researchers found that mindfulness increased their ability to focus and sustain attention. They experienced gratitude and the quieting of self-criticism. Three co-researchers described difficulty with the mindfulness practices, but all engaged in some form of MBSR or centering practice to relax and reduce stress. Co-researchers described the role of mindfulness in IHC, specific mindfulness practices, and the significance of mindfulness practices for self-regulation and stress reduction.

A basis in mindfulness. Co-researchers viewed mindfulness as a central element of IHC. They described mindfulness as a goal or at least an essential ingredient of their IHC experience. Five co-researchers described mindfulness as the goal. Danny stated, “The goals were for you to achieve mindfulness and everything would flow from that and that was the goal. The goal really was mindfulness.” Kate shared, “My coach was a support system to help me be mindful.” Ericka and Grace described how the insight and self-awareness cultivated through mindfulness practices supported letting go of control and being present for choices and actions. Ericka noted, “Mostly I let go of control, that’s the big difference...it’s like letting go and getting my life back.” Mindy had prior experience with MBSR and sought IHC because of the mindfulness component. Mindy described her IHC success with her doctor, “I told her how I was using relaxation to stop all the stress eating, how now I do the breathing techniques, and pay attention to how I’m eating, like not eating a full plate, now when I’m stressed I do a relaxation technique.”

Four co-researchers described the qualities of insight and awareness, steadiness or equanimity for change, non-judgment, acceptance, and loving-kindness as important and

necessary elements of the IHC process. Bill stated that mindfulness “played a small part” with his success “but like I say all this came together for me, like the twenty breaths, the mindful eating, the body scans, and the yoga – it was all just part of it. You know it takes it all I think.” Ana described the role of mindfulness in IHC, “I think the two are intertwined... The mindfulness showed me how to take a moment for myself and really be aware of how my body is feeling.” Claudette focused on the significance of loving-kindness practice and cultivating non-judgment and compassion for self that supports change and growth and once internalized naturally radiates to others. Ida found mindfulness practices difficult and did not do the practices in coaching sessions. She observed the role of mindfulness in IHC as part of the process of developing insight and self-awareness that supported her process of change.

Mindfulness practices. The primary mindfulness practices identified by co-researchers included breath awareness, awareness of body, noting thoughts, loving-kindness, and mindful eating. Co-researchers described experience with the array of mindfulness practices found in the MBSR program as well as practices developed to support mindful eating. Eight co-researchers noted that coaching sessions began with a brief mindfulness practice. “The coach would encourage me to do, start with a meditation, which I find very pleasurable...it clears your mind for what you are going to do next,” shared Danny. Ida, on the other hand, preferred not to work with mindfulness practices in coaching sessions.

Three co-researchers found mindfulness practices challenging even though they were helpful. The experience of encountering difficulty with mindfulness practices did not lessen the significance of mindfulness for the IHC process. Mindy, Claudette, and Ida shared the importance of not judging yourself because a certain practice is difficult. They emphasized that comfort with such practices is individualized.

Breath awareness. Eight co-researchers described the practice of breath awareness. Bill, for example, described his experience with heightening his awareness of breathing:

We had the five minute awareness of the breathing and of course also the twenty [minute], she'd count up to like ten and back down to zero, you know on the breathing. It was the twenty breathes, I think is what she called it...I just appreciate breathing more than I had in the past. I mean just taking the time to breathe in and feel what that breath is like.

Breath awareness supported present moment attention, clearing the mind, and relaxation. Grace shared the significance of attention in the present by stating that, "paying attention is so important because that moment's not going to happen again." Co-researchers described that breath awareness played a significant role in mindful eating.

"I can use certain breathing techniques to relax and get my mind set on not eating all the food I want," Mindy shared. Awareness of breath helped co-researchers bring their attention to the full sensory experience of eating and of their body. They learned to distinguish between hunger, thirst, and emotional states like boredom. They learned to notice and rate the sensations of hunger and fullness. Awareness of breath created a pause to make a choice about, "what and why: what's going on with you and identify the why of your choices and your actions", according to Ericka.

Awareness of body. An awareness of the physical body involved co-researchers in body scan practice. According to Ana, the practice involved, "taking that moment to really feel each of your body parts." Co-researchers described how the body scan supported mindful eating and stress reduction. Ericka shared, "we rated our hunger and noticed in our body." Mindy related her experience with the body scan, "you went from the tip of your head down to your toes,

different sections of the body, relaxed.” Co-researchers described practicing yoga. Yoga links awareness of breath and body. Kate told of a memorable experience with yoga:

We were doing like a yoga stretch...and I turned around and my whole row at my job was behind me doing stretching (laughing)...I used that example because it was something positive and everyone wanted to join. Normally when you're being mindful, you're not negative.

Loving-kindness. Co-researchers found letting go of self-judgment and working with loving-kindness helped them overcome self-defeating beliefs and limitations. Bill described loving-kindness as the “nicest part [of IHC].” Kate identified loving-kindness and “forgiving yourself” as a “big piece in the program. A lot of times we are so hard, at least I'm my worst critic.” Co-researchers described that the practice of loving-kindness applied in IHC helped them increase self-acceptance. They noted that self-acceptance contributed to goal attainment by helping them to reduce stress and overcome habitual thought patterns associated with caring for themselves.

Noting thoughts. Co-researchers described the mindfulness practice of noticing thoughts without trying to change or judge them. The mindfulness practice involved being a friendly observer while witnessing one's thoughts. Kate described, “my mind might wander somewhere and it might not be a good place, it might be negative thoughts, and just being mindful of that fact that your mind has wandered off to another place and get your attention back.” Claudette's practice of witnessing, rather than judging her thoughts was helpful to her in coping with her symptoms of Attention Deficit Disorder (ADD):

Mindfulness for me is watching my thoughts, getting quiet...I have ADD so my, it's quite a field day where my thoughts go and how many of them there are and so...the

main thing that I've learned is to bring compassion and loving-kindness to my thoughts because it's very easy for me to kick myself.

Mindful eating. Mindful eating is both the experience of being present and attentive while eating and an approach to the relationship with food that builds upon mindfulness practices. Kate described mindful eating as, “stop, breathe, and bite...instead of inhaling your food taking that time to stop, take a deep breath, and bite slowly. And you never realized how full you can get and not even have to finish your food.” Ana identified mindful eating as “my new learned practices of eating.” Eating became an opportunity to practice mindfulness. Ericka described bringing attention to each bite, each moment of eating. Co-researchers described that mindful eating involved paying attention on purpose to the physical sensations of smell, taste, texture experienced with the food. It also involved witnessing the “inner body” and thoughts that arise while eating. Kate described her mindful eating experience while using the body scan practice to help her differentiate sensations of hunger and thirst,

Another thing is listening to our body where we can tell, if we're in tune with our body, we can tell if we're actually really hungry or if our body's actually just digesting food, or if we're thirsty. Sometimes we might just need some water but if we're not reading our bodies or being mindful of our bodies we can mistake it for being hungry.

Mindful eating empowered co-researchers to pause, become aware, and chose their next bite or chose to stop eating. The six work-site IHC participants shared that mindful eating contributed to their weight loss, but all noted that practicing mindfulness had a greater impact than just weight loss and the experience of mindful eating.

Self-regulation and stress reduction. Co-researchers emphasized the significance of learning mindfulness practices for stress reduction, relaxation, and self-regulation. Bill

commented, “I think it helps a lot because it gets you relaxed and it gets you to appreciate breathing.” Ana found stress reduction important,

One of the great exercises is sitting there and trying to relax your whole body, which for me is very, very difficult. So it was teaching me ways to do that....decompress, to get rid of that anxiety, or get rid of whatever else...going on in your life.

Ida shared that she has difficulty with formal mindfulness practices but discovered a relaxation practice while participating in an MBSR group. She described the relaxation and centering practice that she found helpful,

When you’re at the beach and you’re out in the waves, and they lift you up, and then you go back down the other side...when I kind of connect to that, I could really feel the relaxation that comes...you breathe in as you’re going up and you let your breath out as you’re going down...and I can just think about that and find that I relax. So when I have an unpleasant meeting planned at work or I’m having trouble falling asleep or something like that I’ll have this image of going up and going down.

Ida identified the benefit of mindfulness as “getting out of my head and into my body...I’ve sort of spent most of my life thinking and not as much doing.” The experience of relaxation and stress reduction gained through mindfulness and centering practices introduced through IHC supported change for all co-researchers.

Images of mindfulness. Co-researchers portrayed the significance of mindfulness in their photo-elicitation images and interviews. Seven co-researchers described aspects of their experience with mindfulness in the photo-elicitation interview. Six images depicted mindfulness. Ana’s photograph of the “new me” expressed “a whole new way of awareness” that she developed through mindfulness practices and the support of her coach. Danny’s eagle

represented the self-awareness, “looking inward to doing outward,” that is cultivated with mindfulness. The heart in the center of Claudette’s image portrayed the loving-kindness component of mindfulness that was the basis for the relationship with her coach. Ericka’s collage portrayed mindfulness as a practice that nurtures autonomy and personal growth. Mindy’s photograph of her granddaughter spoke to the “freedom” she experienced through self-acceptance that was strengthened with the support of mindfulness practice in IHC.

Kate’s image titled “refined” illustrated the role of mindfulness in her IHC experience (Supplemental Material, Figure S5). Kate stated IHC transformed or “sculpted” her and contributed to her new sense of well-being, “I’m aware and I’m mindful.” The clip art image depicted the essence of Kate’s IHC experience.

I picked a lady that’s meditating and I chose that image because that’s where it starts. That’s where you get in tune with yourself, through the meditation, through the mindful breathing, and it’s like, if you look at the image, it’s almost like that person, or that image is reflecting peace in the moment of meditation. So that’s what I felt like through the experience of [IHC] and chose that image.

The words characterizing IHC that Kate shared during her in-depth interview, “Peace and harmony,” suggested the importance of her experience with mindfulness and were consistent with her photo-elicitation image. Ericka described mindfulness in coaching:

That's the foundation. That's so important. Mindfulness is opening to your thoughts, it's listening to your body, it's slowing down. Mindfulness is being aware of right here and right now and letting go of distractions, just watching and observing.

In summary co-researchers found that mindfulness practices formed a cornerstone in the “foundation” of their change process. Mindfulness increased self-awareness, a quality co-

researchers attributed to their ability to change habitual patterns. Co-researchers observed that increased self-awareness cultivated through mindfulness practices in IHC contributed to their experience of well-being, “peace and harmony” (Kate). Mindfulness practices promoted co-researchers’ ability to increase relaxation, reduce stress, and experience self-regulation related to goal attainment. Mindfulness in IHC promoted co-researchers’ ability to be present with thoughts, emotions, and physical sensations. It gave co-researchers’ insight into their habitual patterns and empowered their choices and actions

Theme 4: Unique integrative approach to realizing self-defined goals.

Co-researchers experienced IHC as a “different approach to making my-self healthier” (Danny). Ana shared that she “never had anything like this [IHC].” Bill termed IHC “innovative” coaching. Co-researchers’ described the “integrative” framework that distinguished IHC from other health-related experiences such as the health education they received at their primary care medical practices. They explored what constituted the experience of “integrative” and stated that integrative included the holistic and multidimensional approach, their experience of collaboration and teamwork, mindfulness, IM resources, and the client-centered and empowering process that engaged and motivated them as individuals.

Holistic approach. Co-researchers described the significance of the whole person approach in distinguishing IHC as integrative. Ana explored her understanding of integrative by commenting,

This integrated program, health program, taught me it’s just not about the physical weight, it’s about changing other things in your life. So, to me that's what integrated meant for me, is looking at other things in my life that may be contributing to my health, whether it be physical or mental.

Ericka understood integrative as holistic, “one definition is that it's a well-rounded approach, more well-rounded, full-circle like I said, my physical, emotional, relationships, all of me.”

The first theme of transformative change explored the multiple life domains in which co-researchers experienced change. The co-researchers described the integrative approach as unique in that it concerned the whole person and not “just symptoms” (Ana). Ana shared that the whole person approach differed from care she received from her doctors, “they don’t teach this, they treat your physical symptoms, that’s it. But they don’t get to the root of the cause.” Danny noted that IHC meant, “integrating the knowledge and tools of healthy lifestyle into the participants’ lives.” Grace offered, “Just the mere fact that, you know, there's a recognition that the mind and body are associated is integrative to me.”

Teamwork. Bill identified “teamwork” as a quality of the integrative approach. “I'd just about compare it to a baseball team myself....You gotta have teamwork, that's the main thing.” Teamwork entailed collaboration, coordination, and communication among all the “players” in the IHC process. Co-researchers identified the experience of their health care providers, coaches, and groups working together as a significant element of the integrative approach. Grace found communication to be central to integration: “I think that that's the integrative, I mean that's the part of integrative medicine that’s so great is that everyone speaks to each other.” Ida stated, “the integrative part to me is the sense that I don’t talk to her in isolation.” Co-researchers identified their integrative team members who included conventional health care providers and complementary medicine providers and noted the significance of communication and coordination among all providers. The coach played a significant role in facilitating communication.

Individualized. Ida shared that IHC could be different for each person since the individual client's needs drove the process, "I think the idea that it is flexible to provide the person with what's important for them right at that time would be what I would want someone to know." Co-researchers described their role as active participants in the design and process of their coaching sessions. The quality of integrative meant that they determined the focus, goals, action steps, and pace. Danny shared, "it's integrated, one because it's, the participant actually participates... we kind of develop where we're going with this and ... you work on something you want to work on not what the program wants you to work on." Co-researchers found the individualized approach empowering and motivating. The active role promoted autonomy and engagement and resulted in co-researcher ownership and responsibility for the change process. Danny concluded that integrative entails "different ways of getting you to participate as well as possible."

Had she said, 'Well, go do this' then, I might have done it once. But would I have done it the second time because it wasn't a part of me? Making it part of me allowed me to see how it was important to me and to do it again and again.

Access to resources. Co-researchers found that coaches contributed important health promotion resources. Materials, an IM network, books and websites as well as the coaches' personal experience and expertise comprised what the co-researchers viewed as valuable resources. They emphasized that their IHC coaches empowered them in the process of identifying resources and drawing from their knowledge and strengths prior to providing information. The approach of asking the client what they know and how they might approach finding resources contributed to co-researchers' experience of autonomy and competence in the change process.

The worksite IHC participants received weekly materials in the group coaching sessions from a health education curriculum that addressed a wide range of health behaviors including nutrition, exercise, mindfulness, stress reduction, and mindful eating. They described how the group contributed to the education process and to building a knowledge base of strategies and resources for change. Co-researchers shared that they benefited from the expertise of the group. Ericka viewed the resources as “tools, they give you tools,” such as mindful-eating. Co-researchers valued the health education resources available through their coaches and the IM center. Ana shared, “the amount of knowledge, that was conveyed, and the amount of materials, and the different techniques ...I printed the stuff out and I will go back to it because it’s something I look at, that I can have for the rest of my life.”

Claudette noted that the coach must either be housed in an IM program or, if working independently, participate in an IM referral network that had “a wide variety of integrative resource people and places.” Co-researchers observed that IM coaches demonstrated knowledge of IM and the role of complementary and alternative practices such as yoga, nutrition, acupuncture, and mindfulness in the process of realizing health and well-being. They shared that in addition to understanding IM and the principles and practices, health coaches needed authentic personal experience with optimizing their own well-being in an IM process.

Photo-elicitation view of integrative approach. Co-researchers described the integrative medicine approach as different and significant for their experience of change. Ericka created a collage that illustrated the elements of integrative medicine applied in IHC (Supplemental Material, Figure S6). In the coaching process, she centered on her love of gardening since, “my coach challenged me to take my passion and apply it to myself.” Ericka shared how her passion

served her health in stating, “How do I take something I love like gardening and apply my love for that to my own life?”

Summary. The nine co-researchers experienced transformative change; they used change-evoking images and words to describe personal change characterized by self-acceptance, self-awareness, and self-realization. IHC engaged the whole person in connecting their personal vision and values to goals they defined in varied life domains. Co-researchers shared that they sought IHC to improve chronic health conditions and realized a sense of health and well-being.

All co-researchers described qualities of mindfulness evidenced in the IHC process. Some co-researchers viewed IHC as a coaching process to help them change their personal mindfulness that would then result in changes in health and well-being. Other co-researchers described mindfulness as one element in the broader change process. Mindfulness played a significant role in the coaching relationship and created a foundation of safety, self-awareness, and presence for change. Most but not all co-researchers practiced mindfulness during their IHC sessions or in an affiliated MBSR group. Each co-researcher described IHC as an individualized coaching process that empowered them in realizing self-defined goals. All co-researchers experienced a supportive relationship with their coach, although the nature of the support differed among them. Coaches demonstrated proficiency with health coaching competencies and knowledge of the IM framework.

Co-researchers described that the basis in IM distinguished IHC from their prior health care and health promotion experiences. Mindfulness and the holistic approach were key elements of the IM framework according to co-researchers. Collaborative relationships and the resources of an IM network contributed to the integrative approach. Co-researchers described that the integrative medicine framework entailed promoting autonomy and self-determination in

the IHC process. The composite textural description found that IHC involved an IM framework and health coaching process that promoted co-researchers' engagement in transformative change resulting in health and well-being. The composite structural description addressed how IHC supported co-researchers' engagement in transformative change.

Composite Structural Description

The composite structural description presented co-researchers' views of the workings of IHC. The structural description built upon themes identified in the textural description as well as themes arising from imaginative variation to depict how IHC led to transformative change. The composite structural description explored how the two essential structures, the IM framework that encompassed mindfulness and the health coaching process, opened pathways for change. The researcher synthesized the co-researchers' individual structural themes in this composite structural description. She identified that co-researcher activation and engagement reflected the central underlying process of IHC.

The composite structural description explored co-researcher experiences that pointed to how IHC operated in guiding whole person change. According to Moustakas, "there is not a single inroad to truth, but that countless possibilities emerge" in the case of this study, to understand the dynamics of co-researchers' experience (1994, p. 99). The researcher employed imaginative variation and identification of invariant structural themes to understand the underlying process of co-researchers' lived experience. The central dynamic appeared to be co-researchers' total involvement or engagement in the IHC process.

Co-researchers described how the central structures of the IM framework and health coaching practice contributed to their experience of active engagement in the change process. Insight from the application of mindfulness and coaches' discovery-oriented questions increased

self-awareness and opened the way for co-researchers to discover new horizons in relation to self. The mindfulness-based presence and skillfulness of the coach created a relationship with co-researchers that empowered and engaged them in the change process. The coaching process linked self-defined goals to personal values increasing motivation and engagement. Engagement in change involved a series of small steps that co-researchers described as a “building” (Ana) process. The whole person engagement in the IHC process resulted in co-researchers’ experience of internalizing and integrating change, getting it “in my bones” (Claudette).

The composite structural description explored the dynamics of co-researcher engagement in IHC. Co-researchers’ descriptions of their lived experience suggested that the entire IHC process contributed to sustained engagement that included making and integrating changes, an experience they found “transformative.” Three elements of engagement discussed in this section included the role of mindfulness that increased self-awareness, the empowering relationship, and the skillful health coaching practice.

Mindfulness increased self-awareness. Kate expressed that IHC was “life changing” because it helped her become “in tune more with myself.” She noted, “Sometimes you can be yourself all your life and not really know yourself. So I’m starting to get to know me.” Co-researchers described forming a new awareness and relationship to mind and body that contributed to their process of change. Ericka found that mindfulness increased attention to the “what and why” of her actions and choices. She observed that mindfulness “supports your commitment and helps you slow down. Slowing down's a big piece, just to watch what's going on and ask why.” Grace found self-awareness and presence cultivated through mindfulness necessary for her change process.

It's [mindfulness] being, living in the moment. Being there at that same time and not someplace else in your mind. Mind and body. I struggle with mindfulness all the time. Cancer, believe it or not, actually helped with that. You stop rushing about and doing things with only half your head attached. It makes you much more aware of enjoying each minute...paying attention is so important because that moment's not going to happen again.

Co-researchers noted that coaches applied mindfulness in the IHC process to help increase self-awareness and facilitate insight. Ida observed, "I think it shows up a lot in terms of the focus on ...how does an event make me feel? What reactions do I have to something?" Coaches worked with mindfulness to facilitate co-researchers' insight into feelings, reactions, and habitual patterns. Co-researchers observed that IHC changed patterns of relating to self. Claudette shared that mindfulness helped her pause and look at the connection between self-judgment and limiting beliefs and being stuck in a habitual way of viewing herself.

Co-researchers described that mindfulness in IHC increased their ability to manage internal states such as stress. They increased self-regulation skills through relaxation and stress-reduction practices that supported their presence and engagement in the change process. Mindy noted that mindfulness practice "helps me relax, 'cause I do eat when I'm stressed." Ida observed that her relaxation practice helped her pause and shift perspective

Kate discussed how mindfulness practices helped her shift from negative thoughts and emotions by stating, "Normally when you're being mindful, you're not negative, you're being healthy because you're being mindful with your eating, being mindful with exercising." Danny observed the significance of greater awareness of internal states, "to know what state you're in so you can know how to act from then on." He found that it applied not only to his relationship

with food, but also to his speech when upset, actions when tired, and “to know that you’re aware of your own body and wants, needs at the time you are making a decision.”

Mindfulness-based IHC empowered co-researchers to change how they experienced their mental and physical states. Co-researchers increased self-awareness and attended to internal states. The resulting insights helped co-researchers let go of habitual physical, mental, and emotional reactions and opened the possibility of choice and empowerment regarding their actions. Co-researchers shifted out of autopilot to be present for the experience of life.

Empowering relationship facilitated engagement. Co-researchers described how the supportive coaching relationship empowered and engaged them in making change. The textural description of “my health coach” presented characteristics co-researchers found in their coaching relationship. The structural description of the relationship pointed to how coaches empowered co-researchers. Claudette visualized that her health coach was “the wind beneath my wings” that she found “essential” to exercising her power in “soaring.” Bill described how his coach empowered him in the same way that a baseball team coach motivates the players; he had to “score the runs” but his coach played an integral role in facilitating his success.

The dynamics of how the relationship operated involved both the coaching practice and the coaches’ own mindful presence. Co-researchers described coaches using skills and techniques that the co-researchers found empowering and that facilitated change. Danny emphasized that his health coach empowered him to be “self-reliant,” “poised,” and ready to act, by increasing his mindfulness and maintaining his agenda as the focus of the coaching practice as well as acknowledging his successes. Ericka discussed the significance of her coach’s non-judging, friendly “partnership of support.” Her coach’s voice created the sense of calmness and support so that Ericka “felt like I could talk about very personal things.” She addressed the

empowering coaching practice, “The coach provided a structure to plan and prepare what I want to achieve so I’ll be successful and make me feel good and be successful. “ Claudette found her coaches’ mindful presence significant in that their “work with me comes from their hearts, I can feel it.”

Skillful coaching promoted engagement. The coaching practice created the structure for co-researchers to explore and discover the qualities of their inner landscape such as values, strengths, dreams that built their sense of autonomy and motivation for change. Grace noted, “when I sit down with my health coach it helps me to see the forest through the trees. It helps me to, to understand myself so that I can blossom.” Ericka described her feeling of empowerment resulted from discovering what she valued and wanted in her life. She said, “Strength, it gave me my life back...I’m in control of the choices and I slowed down a lot.” The coaches empowered and supported the co-researchers by asking “open-ended questions” but did not “give answers,” according to Ida. Co-researchers generated the content and explored new perspectives. Kate described how her coach’s questions supported insight and engaged her in discovery.

She’ll ask me questions, like probing questions, and sometimes if I wasn’t giving enough she’ll ask other questions so I can open up...It’s not that I didn’t really want to open up... I probably wasn’t looking at all that I could have said on a certain topic... To get more insights she’d probe me with more questions....She’ll say,... ‘What have you noticed? How do you feel about it?’

Coaches empowered co-researchers by engaging them in the practice of building incremental change through small, do-able steps. Ana found “each session was a, a set of building blocks.” Grace contended that her coach’s facilitation of incremental steps kept her on

track with walking and exercise. Bill cited the importance of making incremental changes in his eating behaviors through the coaching process, “each week we just picked that [dietary changes] up a little bit more. I didn’t take everything away from me all at one time.” The coach’s guidance in taking small steps played a “key” role in Claudette’s success with making dietary changes recommended by her physicians. She shared, “I still remember my coach at that time saying absolutely no more than one new recipe a week.” Claudette described her coach empowering her by facilitating incremental change.

She’ll have me think through what might make it easier to begin, how it might again be broken down into smaller, manageable parts, what support I might need to get started. And then we’ll review the list and she’ll often say, ‘Wow, that’s quite a long list (laughing) and so she helps me to be mindful of not being crazy and having too much on my list.

Engagement. Co-researchers described that they benefited from IHC to the extent that they engaged in the process. Engagement reflected total involvement and activation of the whole person in the process. Mindy contended that IHC necessitated that participants be “100 percent active.” All of the elements of IHC supported co-researcher engagement in the change process. Mindfulness, the coaching relationship and practices, and the multidimensional IM approach served to bring the whole person into the change process. Danny observed that IHC engaged co-researchers because it addressed life domains they chose as significant and for which they experienced intrinsic motivation to change. Claudette described internalizing the coaching as one would “good parenting.” Bill found that he integrated the changes so that they were a part of “the new Bill.” Ericka stated that readiness to change constituted a pre-requisite for IHC

participation. Grace advised that IHC entailed the initial willingness to make changes. Co-researchers described barriers to engagement with time being the primary obstacle.

Engagement entailed committed effort in making change. Ana described that IHC entailed “being engaged” that involved committing the time, being active, having an “open mind,” and learning about oneself. Bill observed, “I was the player. I was the one that had to produce the results...the bulk of it was on my back...I knew that if I didn’t do it I wasn’t gonna accomplish my goal.” Grace observed the dynamics of engagement in her sessions.

Because this [IHC] call is about you, and if you really think about it you have to direct everything, once you get over that initial, "Oh my god, what am I gonna talk about now," it's really easy. Now from the time she says, "Hey, how are you doing?" (laughing) everything just spills out so it's (pause). You direct the call.

Co-researchers found that IHC engagement supported the sustained effort required in the change process. Claudette shared, “it is hard to make lifestyle changes and that there is help available through integrative health coaching to manage.” Ida stated, “The only challenge I see is really my own challenge of not just talking about things but actually doing them. Um, you know looking at issues, at something and talking about it, and coming up with the plan, and actually following through on it. I guess if everybody could do that all the time we wouldn't need any health coaching, right.”

Grace described how mindfulness in IHC is time that “one hundred percent I spend on myself.” Co-researchers described the significance of building their internal capacity to maintain changes and translate their success to other areas in their lives. Bill noted, “it’s a part of my life now, it is. Even my wife says that.” Ericka emphasized how IHC empowered her to make ongoing decisions to sustain his health and wellness. Co-researchers who participated in group

coaching noted that the group dynamics enhanced the internalization of coaching skills.

Claudette offered an analogy for finding her inner coach.

I'm not going to have a coach for the rest of my life and I feel that my coaching has enabled me to have a way of thinking...I've been taught to fish, and I've been taught to break things into manageable parts, and I've been taught to consider support, and I've been taught to prioritize, and I've been taught to simplify.

Integrative health coaches conveyed skills to clients. Co-researchers observed that they adopted skills the coaches modeled. Claudette shared, "It's sort of like good parenting... you parent so that your child will have this, the skills, will have learned behaviors so that they can go out and do and live their own life." Claudette learned to acknowledge and give herself credit. Danny stated IHC meant, "integrating the knowledge and tools of healthy lifestyle into the participants' lives." Ana offered that her coaches "taught us how to become aware of our hunger, rating our hunger, going over the pillars of our health...recognizing our strengths, our weaknesses." Bill incorporated the coach's skill to build his intrinsic motivation, "you gotta feed off that and you gotta motivate yourself."

Co-researchers found that engaging in IHC presented challenges. Ericka described devoting time to the process as an issue:

A challenge is making the time...making the time to do the activities like the mindfulness meditation or do your take away for the week...To do the plans and...what you say you're going to do in between sessions and making that time is a challenge.

Five co-researchers described the effort necessary to make time for the sessions, the mindfulness practices, and for following through with their action plans. Mindy experienced conflict with

work demands but advised, “just be 100 percent active in it.” Bill observed that the time and follow-through was related to personal commitment,

I keep coming back to the commitment part. I just keep coming back, that you've got to be mindful about it, you've got to want to do it. And if you don't totally commit yourself to it, you won't do it.

Danny also found time a challenge but underscored that as he experienced success his engagement in IHC and motivation to make time for the sessions and practices increased.

Ida noted that the telephone setting used for the coaching sessions reduced her tendency to be a “pleaser” and supported her being more authentically engaged with the coach. Grace described instances when she did not “feel like talking” and rescheduled the session but felt “obligated” by the appointment with her coach. She stated that the feeling did not last once she made the effort to call. The worksite group setting presented an initial barrier for Kate; she experienced a lack of privacy in doing the activities and practices. Kate shared that the concern subsided as her engagement in IHC increased.

The structure of change. Co-researchers shared that IHC required total involvement and engagement in the change process. Engagement entailed sustained effort, motivation, and commitment that resulted in the integration of changes. Mindfulness established the foundation for engagement by increasing self-awareness and supporting self-regulation. Co-researchers described how the empowering relationship with the coaches supported engagement. The holistic IM approach engaged the whole person. Coaching practices such as facilitating co-researcher discovery of intrinsic motivation for change and building incremental change sustained co-researchers in their efforts. Change required ongoing support and skills to work

with difficulties and barriers. Engagement led to internalization and integration of both the IHC skills and the changes that co-researchers experienced as transformative.

Synthesis: Co-researchers' Lived Experience with IHC

The final synthesis presented an exploratory conceptualization of co-researchers' lived experience as clients who sought IHC to address a health risk or condition. The researcher considered meaningful elements from the textural and structural descriptions identified as significant by all co-researchers in developing the synthesis. Her synthesis addressed the question, "What was the lived experience of IHC for the nine co-researchers?" She found that co-researchers described their lived experience of IHC as whole person engagement, with coach support, in a mindfulness-based IM coaching process that led to transformative change characterized by health and well-being. The four pillars of co-researcher experience in IHC that formed the synthesis included the structures of the IM framework and the health coaching practice, the process of engagement in change, and the essential experience of transformative change.

Co-researchers used powerful change words to describe their IHC experience: transformed, sculpted, blooming, soaring, reclaimed, metamorphosis, lifesaver, and a new me. Co-researchers changed health behaviors but the larger experience of change was change that engaged the whole person or transformative change. Changes occurred in multiple life domains and resulted in a sense of health and well-being. Co-researchers entered IHC ready and open to change. The nine IHC clients described changes in multiple life domains such as weight loss, healthier nutrition, improved fitness, relaxation and stress reduction, feeling happier, greater self-awareness, benefits for relationships, a better physical environment, and professional growth.

IHC activated the whole person in the change process and that gave rise to the experience of whole person change or transformation.

The IM framework applied the practice of mindfulness in IHC. Mindfulness provided a cornerstone for change and engagement in IHC. Co-researchers found mindfulness practices increased self-awareness integral to the discovery-oriented IHC process. They described that self-awareness and attention to the present increased their ability to shift from habitual patterns of thought and behavior and engage in purposeful choices. Mindfulness contributed to safety and trust in the coach and in oneself that supported engagement. Loving-kindness and non-judgment calmed the inner critic, a common barrier to engagement in change. Co-researchers described mindfulness as embedded in the fabric of IHC with threads visible in their ability to recognize inner states such as hunger and boredom, the ability to slow down and make purposeful choices, and the new perspectives that shifted their horizon from habitual beliefs and views. The experience of mindfulness in IHC supported co-researchers' insights and access to new experiences.

The supportive relationship with the coach facilitated co-researchers' engagement in change and empowered their autonomy and intrinsic motivation in the coaching process. Coaches assumed multiple roles including partner, guide, health educator, and cheerleader. The co-researchers found their coaches' proficiency with health coaching competencies, credentials, and knowledge of IM pre-requisites for practicing IHC. Coaches collaborated in the integrative medicine team and worksite group processes. Qualities of attention, calmness, presence, deep listening, non-judgment, and acceptance characterized the coaches and attested to their authenticity with mindfulness practice.

The integrative approach seemed unique and different from prior health care and health promotion experiences because co-researchers directed the holistic and multidimensional change process; IHC was for and about them. Coaches empowered clients to clarify their life purpose, dreams, and values through self-discovery. Co-researchers determined the focus of coaching sessions and set incremental goals and specific, doable action steps that led to success. Autonomy and success increased motivation and engagement. Change required sustained effort and working with difficulties. Co-researchers internalized the tools and skills to maintain the change process.

The nine co-researchers who shared their lived experience as IHC clients engaged in a mindfulness-based process of transformational change. They directed the changes in health, relationships, self-awareness, and physical environment that resulted in a sense of a “new me.” Coaches empowered and supported their IHC clients; the clients made and sustained the effort. The researcher discovered that, for the nine co-researchers, IHC engaged the whole person in a mindfulness-based process of change that, with the coaches’ support, resulted in the experience of transformation. At first glance, the essence seems obvious; yet rarely in health promotion practice do programs fully engage clients in the process of realizing health and well-being. The skillful health coaching and the IM model engaged the IHC clients and activated mind, body, spirit, relationships, and the environment to achieve their goals. Co-researchers found the process transformational.

APPENDIX K: SAMPLING MATRIX

| Study ID | Date Respond | Pseudonym | Group: Small Bytes; DIM Member; Independent | Health Condition for IHC | Gender | Age Range 18-34 35-49 50-69 70+ | Profession |
|----------|--------------|-----------|---|--|--------|--|---------------------|
| 051101 | 5/18/11 | | Phone, Small Bytes | Overweight | F | | |
| 051102 | 5/23/11 | Ana | Phone, Small Bytes | Obesity | F | 35-49 | Customer Service |
| 051103 | 5/24/11 | | Phone, Small Bytes | Overweight | F | | |
| 051104 | 5/25/11 | | Phone, DIM membership | Stress | F | 50-69 | Management |
| 051105 | 5/27/11 | Bill | Phone, Small Bytes | Overweight, asthma | M | 50-69 | Customer Service |
| 051106 | 5/31/11 | Claudette | Phone; DIM membership | cholesterol; arthritis, autoimmune, CVD | F | 70+ | RN |
| 051107 | 6/1/11 | Ericka | Phone; Small Bytes | Overweight | F | 35-49 | Supervision |
| 051108 | 6/2/11 | Grace | Phone, DIM membership | Cancer | F | 50-69 | Allied Health |
| 051109 | 6/8/11 | Ida | Phone, DIM membership | Menopause | F | 50-69 | Education |
| 051110 | 6/14/11 | Kate | Small Bytes | Overweight | F | 18-34 | Supervisor |
| 051111 | 7/19/11 | Mindy | Phone, Small Bytes | Diabetes, Overweight | F | 36-49 | Manager |
| 051112 | 7/27/11 | Danny | Phone, Small Bytes | Overweight | M | 50-69 | M.D. |

| Study ID | Ethnicity | Education Highest Completed | Meets inclusion criteria (US resident, English speaking, 18+, health condition, within 1 year) | Other/ comments | Enrolled/ Date |
|----------------|---------------------|-----------------------------|--|--|----------------|
| 051101 | | | | Did not reply to request to schedule sampling interview once she learned length of interview during initial contact. | |
| 051102 Ana | White, non-Hispanic | BA | Y | Combined interview | 5/27/11 |
| 051103 | | | | Did not keep sampling interview appointment or reschedule once she learned of length during initial contact. | |
| 051104 | White, non-Hispanic | College | Y | Enrolled but then had to withdraw on 6/16/11 due to unforeseen illness | 6/2/11 |
| 051105 Bill | White, non-Hispanic | Some college | Y | Combined interview | 5/27/11 |

| Study ID | Ethnicity | Education Highest Completed | Meets inclusion criteria (US resident, English speaking, 18+, health condition, within 1 year) | Other/ comments | Enrolled/ Date |
|---------------------|---------------------|-----------------------------|--|--------------------|----------------|
| 051106 Claudette | White, non-Hispanic | College | Y | 2 interviews | 6/2/11 |
| 051107 Ericka | White, non-Hispanic | Some College | Y | Combined interview | 6/7/11 |
| 051108 Grace | White, non-Hispanic | College graduate | Y | 2 interviews | 6/6/11 |
| 051109 Ida | White, non-Hispanic | MA | Y | 2 interviews | 6/16/11 |
| 051110 Kate | African American | Current BA student | Y | Combined interview | 6/20/11 |
| 051111 Mindy | White, non-Hispanic | Some college | Y | Combined interview | 7/27/11 |
| 051112 Danny | White, non-Hispanic | M.D. | Y | 2 interviews | 7/27/11 |

APPENDIX L: TRANSCRIPTION GUIDE

The researcher utilized the following transcription key adapted from Bailey (2007). She transcribed the interviews verbatim using NVivo-9 software (QSR International, 2011). The researcher noted pauses longer than 2 seconds and provided comments in brackets [] to clarify study participants' words or events that occur during the interview such as interruptions or issues with phone reception.

Transcription Key

| | |
|-----------------|--|
| (3) | Time of pause or silence longer than 2 seconds |
| Ahh, eh, mmm | Vocalizations |
| (?) | Word or statement that is unintelligible |
| <u>My</u> goal | Emphasis |
| (laughing) | Expression of emotion or audible client activity |
| [clarification] | Clarification or comments |
| [| Overlapping talk begins |
|] | Overlapping talk ends |
| Sto- | Cut-off word |
| ... | Omission of words within a sentence |
| | Omission of words that bridges two sentences |

APPENDIX M: RESEARCHER'S REFLEXIVE JOURNAL EXCERPT

9/1/11 4:00pm Photo-elicitation interview w 051108. She was late and at 1:05 pm I was able to practice mindfulness and tune into my inner voice and give a lot of spaciousness to situation and follow sense to stay on the line. She connected at 1:07. One part of my mind was chattering about how she is avoiding and maybe I should let go and another part was suggesting patience and just staying with what is. Glad I listened. I committed to keeping the interview to around 20 minutes and not continuing to ask questions due to wanting to respect her time needs. I was able to self-manage with that although she is very interesting and her description and insights pull me in. She is an inspiring and powerful person and it is easy to want to learn more. There were no new themes but great illustration and description. I had tremendous gratitude for her contribution (as I do for all participants). I am aware that I identify with this participant due to her experience with breast cancer and returning to school and achieving a certification in a CAM and managing family. She also volunteers and works. I was intrigued not only as researcher but as survivor when she described experience with recurrence and coaching. I am aware of identification and leaning toward this participant and will be attentive during coding and analysis as I was during interview to keep her experience in view. Interesting, while we shared similar external circumstances, her internal experience and meaning differ. That makes it easier to be present for her described experience.

9/2/11 1:00pm. Interesting during mindfulness practice prior to interview notice sense of uncertainty and anxiousness re: participant as MD; my own perceptions and mental map related to that role. I did LK practice and that was helpful. Also, breathing and attention to how the energy was in my body. Once in the interview I was completely comfortable. I think the MD thing related to my intensive medical experiences in last couple years. Also, my judgment/mental map regarding physician and mindfulness practice – that this participant might not be open to the question, not significant. Very interesting to continue to be aware of my attachment to experience of mindfulness in IHC. I keep my lens in the foreground. Practicing body scan and mindful walking really helps me with this awareness. I can sense leaning, striving, pulling back, holding on. Ironically, this was most articulate participant re: mindfulness and role of mindfulness which was the essence of his experience and what differentiates IHC by his own description. This participant stated that mindful awareness was the goal and essence of IHC and that mindfulness is the path to transformation by helping you find your way on the path.

9/4/11 9:00pm. Today I transcribed 051112 interview. I enjoyed this participant's descriptions again while transcribing. Today the themes of the participant directed process and transformation stood out. He articulated both elements of IHC clearly. I am even more interested in the significance of transformation and the influence of mindfulness in his process given his profession as a physician. My mental map would expect a description of a goal oriented process and the educational materials in the group. But it really was about how he discovered mindful awareness and how that changed him. Beautiful. I feel so privileged to be conducting these interviews and witnessing the participants' process of transformation and hearing how their lives have been enriched by the coaching. It is very powerful. I am engaged every time. I am aware in listening to the interview that I was more flexible with probing and asked more follow up questions. I feel that my health makes a big difference in the quality of probes and since it's been so up and down I'm glad I've had the interview guide so there is a basic consistency. I am still working with trying to keep within a time-frame that respects each participant's needs and wanting to ask more questions. I could have continued to ask questions of this participant and was aware of needing to prioritize because he had time constraints. The essence of this participant's experience was mindful awareness that brought about transformation. His description reflects what makes it integrative health coaching to me and what interests and attracts me to the practice so I'll have to bracket and be aware during analysis.

APPENDIX N: ANALYSIS AND INTERPRETATION MEMO EXCERPT

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| <p>6/2/11 11:00am Memo 010</p> | <p>Process for informed consent</p> | <p>I am applying a multi-step process for informed consent. I review the key elements of the informed consent during the sampling interview after sending the respondents the consents with a SASE. Respondents have the option to call or email if they have further questions regarding the consent. Respondents sign the consent and return in the SASE prior to the interview (or fax or email if preferred). The entire informed consent is then reviewed again immediately prior to the interview. I double check for consent to record immediately prior to activating the recording feature during the interview process.</p> |
| <p>6/7/11 6:00pm Memo 011</p> | <p>Use 2015 Hurricane names as pseudonyms</p> | <p>Decided to use 2015 Hurricane names for pseudonyms so I am not picking name for participant; apply in order. Systematic method to assign names appropriate and 2015 names far enough into future to not be distracting.</p> |
| <p>6/17/11 6:00pm Memo 012</p> | <p>Worksite participants - unique perspective?</p> | <p>I am still curious if worksite participants will have a unique view of IHC due to the design of their IHC experience. The first two worksite participants sent the same image/ photo. Will be interesting to attend to this group's responses during study.</p> |
| <p>6/17/11 8:30pm Memo 013</p> | <p>Is there a difference in quality of data for extended vs. multiple interviews?</p> | <p>Does having one extended interview limit the responses and perspectives of participants re: IHC? Participants with extended interviews have saturation within the interview and repeat the same ideas with nothing new added. I wonder if having a break and a second interview for the photo/image results in new information or perspectives? Will have to wait until I transcribe and analyze but will watch to see if there is an effect. I am also trying to be mindful of the potential and give a pause for me and the participant to consider responses between the in-depth and photo and after the photo when feasible. One participant 051105 was clear he had said everything he had to say and was ready to wrap up.</p> |
| <p>6/22/11 9:00am Memo 014</p> | <p>Saturation</p> | <p>It is still early in the data collection process but I am monitoring individual interviews for a sense of completeness and saturation. At this time I have a sense that recruiting 12 initial participants would strengthen the study in terms of saturation. It is within the scope of the proposal, but I initially proposed to start with ten participants. There are many common themes re: the IHC coaching experience among participants to date, but there are</p> |

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| | | also interesting individual or unique statements. I will monitor and begin to plan for 12 initial participants. |
| 6/23/11 4:00pm Memo 015 | Participants report interview like coaching session | Four of five participants have commented at the end of the interview that it reminded them of a coaching session and that they appreciated and enjoyed the experience because of that. I asked what reminded them of their coaching session and they replied starting with mindfulness practice, the questions, and that my voice sounds like a coaching voice. For individuals who had a positive IHC experience I do think the commonalities with in-depth interviewing can be a benefit to participation in the study. The study provides participants an opportunity to take a different and empowered perspective on their coaching experience and facilitates a process of inquiry. Open-ended questions, powerful questions that cause the participant to stop and think, reflecting, being present, acknowledging, probing, summarizing are all interviewing and coaching skills. The participants recognize the pattern and it feels similar. The process of discovery in interview and coaching is similar and beneficial. Through the interview they encounter the values and what matters most about coaching and about what they brought to coaching – health and life values. They have an opportunity to recognize and reflect on their successes and achievements. The interviews are really powerful for me as well as for participants. The interview guide is helpful in keeping me from slipping into coaching mode as it keeps me focused on IHC as the session content. I do find myself shifting into other-focused listening and full presence and I think the participants recognize those qualities as similar to coaching and they also create a sense of safety and trust. |
| 6/24/11 10:30am Memo 016 | Coach voice | The majority of the interview participants have commented on the coaches' voice as significant to their experience. "The voice." What is that? How interesting! Probing leads to description about qualities of calmness, creating ease and safety, kindness. Participants of different coaches, coached in different contexts all describe "the voice" as being important, often multiple times in the interview. My initial thought is that the voice reflects the personal mindfulness practice of the coaches but I remain open and very curious for the analysis. |

APPENDIX O: RESEARCH TIME AND ACTIVITY LOG EXCERPT

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| <p>10/31/2011 9:16 PM</p> | <p>Finished the composite textural description except the summary. Reflected on imaginative variation using Moustakas and using my experience of having a nurse health coach through my insurance company. Explore invariant horizons for structural theme - commitment. Eight of the nine co-researchers described commitment. Am looking through one eye, tired, will take a second look at 051108 in the morning when fresh. It is interesting how I thought everyone identified as a structural quality.</p> | | <p>A&I Memo 59 Imaginative variation table and structural themes</p> |
| <p>11/1/2011 9:17 PM</p> | <p>I wrote the summary composite textural description. I engaged in imaginative variation with Moustakas' Being with, being for, being in and my experience with two conventional health coaches provided by my insurance company. I reviewed the structural codes and nodes and notes and identified six structural themes: ready to change, establish foundation, engage, insight to action, make an effort, and finding your inner coach. I wrote the structural description for the first three structural themes. I contacted co-researchers (participants) and informed them that I will email draft findings by Friday 11/4/11 and asked if they would also like a hard copy mailed to them and inquired regarding their preference for commenting on the findings.</p> | | <p>A&I Memo 60 Structural Themes</p> |
| <p>11/2/2011 1:31 PM</p> | <p>Trust in the logic of the process, after writing the composite structural description, summarizing in my words and recognizing with the successive steps and shift in perspective that engagement is the structural essence. The "what" of IHC is change and the "how" is engagement. Funny how it seems pretty simple and obvious in one way and yet is significant and meaningful when fully considered in</p> | <p>Replies from 051105, 051106, 051107, 051110, and 05111. So interesting how I now am familiar with them by their pseudonyms and I have to work to connect with their actual names. I had forgotten many of their actual names.</p> | <p>A&I 61 Engagement as structural essence. A&I 62 Moustakas' Logic Model</p> |

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| | practice. | | |
| 11/3/2011 8:32 PM | Ten hours of working on revisions to initial draft; find that text is coherent until I "hit the wall" and then the organization and coherence break down and a whole section that I tried to force myself to finish has to be redone. Again and again (and again) I see the futility of trying to work past mind-lock, tiredness, but evidenced that I'm ignoring throughout the draft. Could not finish revision of structural themes and synthesis tonight. | Question - how much description and detail do I include? Findings so lengthy I cannot follow or read through. | |
| 11/4/2011 9:30 PM | Complete first revision, proofing; complete synthesis; outline themes and subthemes; email 2 page synthesis, outline of themes, and draft to co-researchers who requested receipt by email (07,08,09,10,11,12) with request that they prioritize feedback on synthesis and whether it "fits" their experience. Will mail to remaining 3 co-researchers on Monday. Requested feedback by November 22 - a little over the 14 day window. | | |
| 11/6/2011 7:30 pm | Review synthesis and draft; prepare 02, 05, and 06 drafts for mailing. | | |
| 11/7/2011 10:00 AM | Mail drafts to 02, 05, 06. Will contact pilot study co-researchers and send synthesis for feedback. Re-group, organize, and prepare to write Chapter five. Still reflecting on "discovery" and significance to me of structural theme of engagement supported by mindfulness and relationship with the coach. Still exploring what and how. | | A&I Memo 63 Synthesis A&I Memo 64 - send synthesis to pilot study participants |

APPENDIX P: CODEBOOK

Integrative Health Coaching: A Phenomenology of Clients' Discoveries

Thesis Codebook

September 18, 2011

Revised October 11, 2011: a) include examples; b) include all description of role of mindfulness in one code

| Code | Includes | Excludes |
|-------|---|---|
| IHCLL | <p>Description of the IHC Client – “The new me.”</p> <p>The code describes the IHC client. The code includes description of the whole person across all life domains: physical, emotional, mental, spiritual, relationship, environment; the experience of personal change; the new experience of self. The code includes the description of what is different; personal outcomes as client; what personal qualities that contributed to the IHC experience and their role as a client.</p> <p>Examples: “It makes you into a new person, you know, I mean, you so become aware of who you are and what your barriers may be in life. It's learning about yourself.” [051102]</p> <p>“You need to be committed, you need to want to change or accept that there will be changes. Ah, you have to want it. I didn't know when I</p> | <p>The code does not include the description of the coach, or the relationship with the coach.</p> <p>The code excludes description of personal mindfulness, self-awareness, personal mindfulness practice, or what mindfulness in IHC entails, it excludes the IHC process such as what happens during coaching, or the health and lifestyle change process.</p> <p>Example: “That you have to work with the whole person, um, it goes full circle.” [051107] Code this under: IHCPRO.</p> <p>“I actually set the goals for myself, it was after the first meeting, then we talked about goals, I set it for myself cause I knew what I wanted...” [051111] Code this under IHCPRO.</p> |

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| | <p>went into it what it would be like but I did want to make changes, ah, I was sure of that. That's why I signed up. You have to be open-minded and committed to making changes.” [051107]</p> | |
| <p>MNDFL</p> | <p>Description of the role of mindfulness – “foundation for change.” The code includes participant description of mindfulness in the IHC process including the role of self-awareness, awareness of inner body, awareness of physical and emotional states; attention; loving kindness and non-judgment; mindful eating; letting go; presence and present moment awareness. The code includes mindfulness practices used or developed in IHC, description of the experience and role of mindfulness in IHC. It includes the structural description of how the experience of mindfulness influenced their IHC experience. 10/11/11 Change to include textural and structural description of mindfulness in IHC process such as starting session with centering breath or working with loving kindness to calm inner critic.</p> <p>Examples: “I picked a lady that's meditating and I chose that image because that's where it starts. That's where you get in</p> | <p>The code does not describe qualities of the IHC client except those related to mindfulness and self-awareness; it does not describe attributes of mindfulness identified as qualities of the IHC coach; the code does not describe the IHC process or health and lifestyle change or client change except as specific to mindfulness.</p> <p>Examples: “it's [IHC] like having a totally non-judgmental best friend. I mean she listens to me totally. I mean she gives me 100 percent of her attention.” [051108] Code this in the IHCCOA.</p> <p>“I just feel great and I'm happy.” [051105] Code this under IHCCL.</p> |

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| | <p>tune with yourself, through the meditation, through the mindful breathing, and it's like if you look at the image, it's almost like that person, or that image is reflecting peace in the moment of meditation. So that's what I felt like through the experience of and chose that image.” [051110].</p> <p>“The funny thing is that, ah, weight goals were never discussed really. I mean people shared that they had lost weight in the program. But, you know, they didn't, the coaches didn't emphasize that that was the be all and the end all. The goals were for you to achieve mindfulness and everything would flow from that and that was the goal. The goal really was mindfulness.” (051112)</p> | |
| <p>IHCPRO</p> | <p>Description of process of IHC. This code includes participant description of IHC skills, tools, techniques, process such as acknowledgment, reflection, overcoming obstacles, and goal setting. It includes description of the coaching context, and the role and interactions of the client and coach in the IHC process. The code includes the descriptions of what makes it “integrative.” This structural dynamics of IHC are descriptions of how it works and how the participants experience the</p> | <p>The code does not include description of client or coach characteristics; it does not include description of the role or relationship with the coach; it does not include description of the role of mindfulness or client experience of mindfulness; or description of elements of health and lifestyle change.</p> <p>“I feel that their guidance and support is heartfelt and there’s a heart to heart connection.” [051108] Code this in IHCCOA.</p> |

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| | <p>coaching process.</p> <p>Examples: “she would really get you motivated and you know just tell you that you're doing real good and all, you know, a lot of times people will just say that you're doing good, and, just let it go at that. But [name] wouldn't do that, she just said, uh, Bill with what you say that you want to do and with your commitment to do it, she said, there ain't no way you can fail.” [051105]</p> <p>“The offering of skillful means to break things down to manageable parts, that's been very key.” [051106]</p> | <p>“Mindfulness is what makes it [IHC] work. It’s what helps you slow down. It’s what helps you observe and listen and ask why. Mindfulness is the basic piece.” [051107] Code this under Mindfulness.</p> <p>10/11/11 Change: The code originally included mindfulness practices and the dynamics of mindfulness in the coaching session but the researcher changed the code to exclude the dynamics of mindfulness and practices of mindfulness that are included in the code “MNDFL.”</p> <p>Example: “[The coach] taught us relaxation techniques, uh, it was the e-mindful, and mindful eating (laughing)... We had a meal during the session, um and we rated our hunger and noticed in our body,” [051107] Code this in MNDFL.</p> |
| <p>IHCCOA</p> | <p>Description of IHC Coach – “a friend who’s not a friend.” This code includes characteristics of the IHC coach as described by clients; what clients find important or significant about the coach including qualities of mindfulness; qualities clients find necessary to be an IHC coach including skills and resources; the role of the coach. Structural description includes how the</p> | <p>This code excludes characteristics of the client, description of IHC process; the dynamics of interactions with the coach in the coaching process; and elements of health and lifestyle change.</p> <p>Example: “And this is so much more interactive in terms of, um, the health coach's participation in pointing out what they are hearing, um, and making</p> |

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| | <p>characteristics of the coach contribute to the client’s IHC experience. Examples: “she just had that soothing voice and was able to guide me in the direction I needed to go. She was very crafted, very skilled.” [051102]</p> <p>“Well the coach has to be one, and I know this is because, I can't see this person, but they have to have a very calm voice, I mean, I think that's a, a prerequisite, that you have this coaching voice and I don't know how you get that but honestly. You don't want somebody to overreact, because when you're on the phone that's the only way you can relate to somebody and if they have some weird tone in their voice or something it's going to immediately turn you off so, actually you need to develop some type of phone bedside manner (laugh), something” [051108]</p> | <p>suggestions of ways things could be done or, um, so that's been really interesting to me” [051109] Code at IHCPRO.</p> <p>“The coaches were very facile at getting each of us to understand what our skills were and what our skills could be and using those skills to attack the problem of unhealthy lifestyles.” [051112] Code this at IHCPRO.</p> |
| <p>HLTHED</p> | <p>Description of Health and lifestyle change process – “what doctors need to know.” This code includes client description of health and lifestyle change including response to the question, “what do doctors need to know” when it describes factors participants identify as important for health and lifestyle change. The code will be reviewed throughout the process as there is some</p> | <p>This code excludes description of co-researchers’ specific health changes; mindfulness as a foundation for change; IHC as a change process; and the coach as a guide through the change process.</p> <p>Example: “So I think, well, it's such a personal thing tied to the person on the end of the phone, but it, it, I think it's the totality of the involvement</p> |

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| | <p>overlap with mindfulness as a foundation for change and IHC as a change process. The code does not directly describe mindfulness and IHC but can describe how participants note the importance of mindfulness and IHC related to health and lifestyle change.</p> <p>Examples: “You know looking and seeing what your blood pressure is, you know your cholesterol, your triglyceride, and I, I took about four or five of those tests last year and they was five parts of the test and I failed three of them. And that scared me, that told me you know you're not doing something right. So you know I tried my best, if you pass three out of five, you got a reduction in your insurance rate. And I was right on the verge, and every time I would go and they even took blood each time that I went. I mean my arms was sore as can be when I got done there. I was going to do what it took to pass those tests. And when I kept seeing that my cholesterol was still high, my triglycerides was high, and my waist, I couldn't get my waist under forty and I told myself I had to do something and you know if nothing else it was costing me more on my insurance. “ [051105]</p> <p>“I'd gone to my own internist and gone to a cardiologist and I'd gone to a rheumatologist</p> | <p>because it's not really therapy, it's not seeing the doctor, it's not going to a meditation class, it's kind of all of those things (KG: mmm) and it in many ways ties those things together.” [051109] Code this at IHCPRO</p> |
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| | <p>and you know each one of them would say things like, you know, the Mediterranean diet would be a good idea and that was it. No guidance about how to do that or um or where or definitely no guidance as to where to go to learn how to do that.” [051106]</p> | |
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APPENDIX Q: INDIVIDUAL COMPOSITE STATEMENTS EXCERPT

| Participant | Key Themes | Individual Composite Statement |
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| 051102 Ana | Transformative Change, “new me”; Partnership w Coach; Self-Awareness through mindfulness; Building blocks, incremental IHC process; Sense of whole person well-being | <p>Ana’s IHC experience of "The new me" or transformative change was supported by the partnership with the coach, self-awareness through mindfulness practices, and the “building blocks” or incremental IHC process. Transformative change represents textural description of essence of participant's IHC experience. Participant photo is of herself (new me), smiling (well-being), in front of a tree (new lifestyle). Participant describes new way of being with, in, for self and new way of being in the world. New awareness. New priorities and behaviors. New way of relating to self, others, world; new sense of well-being.</p> <p>Structural elements described by participant are “being engaged” in the mindfulness based process of developing awareness of self, as well as the skillful guidance and supportive partnership with the coach through an incremental process of setting goals and having accountability.</p> |
| 051105 Bill | Transformative change; “The new Bill;” Teamwork with coach and being a “player,” autonomy and self- determination; IHC works as “whole;” | <p>The photo title “Before and After” reflects the description of transformative change as essence for this participant; teamwork with the coach is a “main thing” with motivation and acknowledgement key qualities of relationship and process. The educational materials and skills “had a big role.” The motivational, self-directed, and incremental IHC</p> |

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| | <p>educational materials and skills; motivational and incremental IHC process; commitment and engagement; sense of well-being; integration – new way of life.</p> | <p>process led to success. “The new Bill” experience of well-being, “looking and feeling great,” “happy and smiling.” The experience of new way of life entailed integration of changes.</p> <p>The structural elements are sustaining motivation (metabolic tests, quality of life for grandchildren, coach, group), teamwork with the coach to identify action steps; developing skills, and committed personal effort “bulk of it was on my back.” IHC kept individual and group participants active and engaged in the change process. The worksite program with individual and group coaching, mindfulness, health education – the “whole thing” was significant and all parts necessary. IHC necessary for health and lifestyle change “it has to start with the innovative health coaching.”</p> |
| <p>051106 Claudette</p> | <p>Relationship w/ coach; Incremental IHC process; Mindfulness and loving-kindness; teamwork and communication in IM context; transformative change – “internalize;” sense of well-being – “soaring;” commitment and engagement.</p> | <p>The image title “my health coach is the wind beneath my wings” and the heart and ear for listening describe the significance of the relationship with the coach. The incremental change process, “no more than one” recipe a week, describes the key element of the IHC experience. The personal mindfulness practice of the coach. “I can see it, feel it,” and the practice of loving kindness to self were essential elements as was the context of the teamwork at DIM. The participant described the significance of “internalizing”- being empowered and “taught to fish” through coaching. Transformative change reflected by realization of a sense of well-being – wings were “soaring, not flapping,” “flapping” had been lifelong way of being</p> |

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| | | <p>in the world until IHC transformed to purposeful, mindful soaring.</p> <p>The key structural dynamics of IHC described by this participant include the supportive (“wind”) relationship with the coach in which “she listens to me with acceptance, kindness, and love.” The IHC process that builds her “internal coach” or self-efficacy for change and the need to be fully committed and engaged in the process. The mindfulness of the coach and the participant’s mindfulness practice created the “heart at the center” of IHC and the coaching relationship.</p> |
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APPENDIX R: INVARIANT STATEMENTS EXCERPT

Co-researcher Invariant Statements: Integrative

Danny: "It's integrated, one because it's, the participant actually participates... here we kind of develop where we're going with this and particularly the weekly one on one coach lets you work on something you want to work on not what the program wants you to work on. So it's two different ways of getting you to participate as well as possible."

Danny: "Integrating the knowledge and tools of healthy lifestyle into the participants' lives. (pause 2) Maybe that's what they mean by integrative health coaching."

Ana: "This integrated, you know program, health program, taught me it's just not about the physical weight, you know, it's about changing other things in your life. So, to me that's what integrated meant for me, is looking at other things in my life that may be contributing to my health, whether it be physical or mental."

Claudette: "I'd gone to my own internist and gone to a cardiologist and I'd gone to a rheumatologist and you know each one of them would say things like, you know, the Mediterranean diet would be a good idea and that was it (KG: mm, hmm). No guidance about how to do that or um or where or definitely no guidance as to where to go to learn how to do that. They leave, the doctors need to do that, and so the beautiful thing about integrative medicine was that I had nutritionist, I could go to the classes to learn how to make smoothies, to learn the cereal brands, looking for how much protein that was included in the cold cereal for example, the sources for cooking everything, and then the sanity given to me by my coach to do one recipe at a time. I would have failed miserably if I did not have the coaching."

Claudette: "Well my coaches are both totally aware of all of the services and the values of the integrative approaches that were offered at Duke Integrative and um the names of the practitioners and you know what they had to offer, because they're aware of these integrative approaches and fortunately we're in this wonderful place where they're familiar with all the practitioners and they know how to support."

Bill: "I'd just about compare it to a baseball team myself...innovative coaching... you gotta have teamwork, that's the main thing."

Ericka: "One definition is that it's a well-rounded approach, more well-rounded, full-circle like I said, my physical, emotional, um relationships, all of me."

Grace: "Just the mere fact that, you know, there's a recognition that the mind and body are associated is integrative to me. And she also works with my doctor who also believes the same thing. I mean my doctor at Duke will actually prescribe yoga or acupuncture, you know, it's Duke Integrative Medicine, so of course it is but you know the alternative therapies are prescribed more so than anything else and she is part of that whole process. And she talks to my doctor, which, um, you know, before I started at Duke, I tried to make my own integrative network because I knew how important it was for everyone to speak to each other including my

yoga teacher and it's really difficult to get a medical doctor to um agree to that. They don't want to share information. (KG: mm) It's been a much more pleasant experience and just the fact that you know, sometimes, especially when I first found out I had cancer again, there was actually, my doctor at Duke, you know, I told her first and my health coach actually knew about it first, before I even spoke to her, which was a good thing because in the beginning it's really difficult to say those words (laugh) (KG: mm, hm) again (emphasis). I mean, I think that that's the integrative. I mean that's the part of integrative medicine that so great is that everyone speaks to each other.”

Ida: “Well in my particular case it's been um having someone who has been in touch with the doctors that I see at IM and also has talked to the people, um, that I took mindfulness courses from and a person, and she knows all of the different possibilities of activities at IM....That whole interconnectedness of it is really nice.”

Ida: “What makes it integrative to me is that it's a combination of, um, there's the real practical. I absolutely despise any kind of exercise and don't have time for it and all of those things that you know everybody always talks about and so we circle around to that periodically encouraging me to try a new type of exercise or a new schedule or a new way to do that, so there's the actual physical health issues. Um, there's the mental health issues, part of it. Um, dealing with any number of you know things between work and my living situation and um I've had a number of um, I, after my mother died and part of it was just it seemed like a good time to get control of my life and um so we, and I've had a number of family members of various closenesses die, and recently, and we've talked a lot about that and I think having that person's ear has helped in that. (KG: mm, hm). But the integrative part to me is the sense that I don't talk to her in isolation. We talk about a wide variety of health issues if you look at health in a overarching way rather than just physical health and we also include all of the other people that I see.”

Kate: “I believe it would make it integrative, um, (pause 2), because the way it, the way it starts, part of the coach setting, you know I have different, during the whole study we have different homework assignments that we have to do and we followed up with each other.”

Mindy: “Because we worked together (emphatic).”

APPENDIX S: MEMBER CHECKING RESPONSES

Bill 11/8/11 “Very good Karen. I will look at it more at home, but I did like the comment "Change is the texture and engagement is the essential structural theme." Bill provided further written comments by mail: “I read 75% of the report [draft Findings] and it was exactly what occurred & my comments.”

Danny 11/8/11 “you definitely hit the nail on the head. I could not construct a more apt description of my experience.”

Claudette 11/8/11 “This DOES fit, Karen.

IHC coupled with Mindfulness has been the wind under my wings in keeping focus on my self-care & in making behavioral & spiritual changes which have led to body/mind/spiritual healing. Nice work on your part!

Grace 11/8/11 “I will look at the document and if I have any feedback or changes send them asap.”

Ida – no response

Kate 11/9/11 “This is great I think you captured my thoughts in both my words and some of the words of others. As I read other’s experience I was nodded in agreement. I hope this really makes a difference and other’s will experience integrated health coaching. I know that it will change their life as it did mine.”

Erika 11/17/11” All of this is GREAT!!!! You captured it perfectly. Really enjoyed reading what others had to say about the experience and was able to relate to so many of the comments. I am doing well and reading this re-energized me. Work has been extremely busy and I have had to stop and remind myself of what I need to do often and be mindful! So glad I got to be a part of this experience and would do it again in a heart beat! I never wanted it to end in the first place. Ha-ha. I look forward to the copy!”

Mindy 11/21/2011 “I agree completely and am glad I got to do this because it changed my life. I read my comments and the others and was missing the program because it helped me so much. The experiences of the others sounded like mine and I had fun seeing their pictures.”

Ana 11/28/2011 “ I have read through the materials you sent. You did a very nice job capturing the experience. I want to thank you for sharing all of the information. I wish I were still in the program – as I have found it so beneficial!!!”

APPENDIX T: UMCIRB #10616 VERSION 11/8/10



EAST CAROLINA UNIVERSITY

University & Medical Center Institutional Review Board Office
1L-09 Brody Medical Sciences Building • 600 Moye Boulevard • Greenville, NC 27834
Office 252-744-2914 • Fax 252-744-2284 • www.ecu.edu/irb

TO: Karen Lohr Goble, Student, Dept. of Health Education & Promotion, ECU
FROM: UMCIRB *KL*
DATE: November 8, 2010
RE: Expedited Category Research Study
TITLE: "Integrative Health Coaching: Participants' Experience in a Mindfulness-Based Health Dyad"

UMCIRB #10-0617

This research study has undergone review and approval using expedited review on 11.7.10. This research study is eligible for review under an expedited category number 6 & 7. The Chairperson (or designee) deemed this **unfunded** study **no more than minimal risk** requiring a continuing review in **12 months**. Changes to this approved research may not be initiated without UMCIRB review except when necessary to eliminate an apparent immediate hazard to the participant. All unanticipated problems involving risks to participants and others must be promptly reported to the UMCIRB. The investigator must submit a continuing review/closure application to the UMCIRB prior to the date of study expiration. The investigator must adhere to all reporting requirements for this study.

The above referenced research study has been given approval for the period of **11.7.10 to 11.6.11**. The approval includes the following items:

- Internal Processing Form (dated 10.14.10)
- COI Disclosure Form (dated 10.25.10)
- Informed Consent (version date 11.7.10)
- Research Study Announcement
- Dear Integrative Health Coaches

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

The UMCIRB applies 45 CFR 46, Subparts A-D, to all research reviewed by the UMCIRB regardless of the funding source. 21 CFR 50 and 21 CFR 56 are applied to all research studies under the Food and Drug Administration regulation. The UMCIRB follows applicable International Conference on Harmonisation Good Clinical Practice guidelines.



Informed Consent to Participate in Research

Information to consider before taking part in research that has no more than minimal risk.

Title of Research Study: Integrative Health Coaching: Participants' Experience in a Mindfulness-Based Health Dyad

Principal Investigator: Karen Goble
Institution/Department or Division: Department of Health Education and Promotion
Address: PO Box 19204, Asheville, NC 28801
Telephone #: 828-215-7418

Researchers at East Carolina University (ECU) study problems in society, health problems, environmental problems, behavior problems and the human condition. Our goal is to try to find ways to improve the lives of you and others. To do this, we need the help of volunteers who are willing to take part in research.

Why is this research being done?

The purpose of this research is to understand the experience and meaning Integrative Health Coaching has for people with health concerns. The decision to take part in this research is yours to make. By doing this research, we hope to learn about the meaning and lived experience of adults with health concerns who participated in Integrative Health Coaching for at least six sessions over three months.

Why am I being invited to take part in this research?

You are being invited to take part in this research because you participated in at least six sessions of Integrative Health Coaching over three months related to a health concern and are an adult resident of the United States. If you volunteer to take part in this research, you will be one of about ten people to do so.

Are there reasons I should not take part in this research?

I understand I should not volunteer for this research study if I have not participated in at least six sessions of Integrative Health Coaching over at least a three month time, or if I did not have a health concern that I explored in coaching, or if I am not an adult resident of the United States.

What other choices do I have if I do not take part in this research?

You can choose not to participate. You can share your Integrative Health Coaching experience with the organization that trained or certified your coach.

UMCIRB Number: 10-0617

Consent Version # or Date: 11-7-10
UMCIRB Version 2010.05.01

UMCIRB
APPROVED
FROM 11-07-10
TO 11-06-11

Participant's Initials

Title of Study: Integrative Health Coaching: Participants' Experience in a Mindfulness-Based Health Dyad

Where is the research going to take place and how long will it last?

The research procedure consists of two interviews that will be conducted over the telephone. The researcher will set appointment times for the interviews at your convenience and call you. The total amount of time you will be asked to volunteer for this study is between one and one and a half hours on the initial call and thirty to forty five minutes on the second call in the next five months.

What will I be asked to do?

You are being asked to do the following: You will be asked to take part in two telephone interviews and describe your experience with Integrative Health Coaching. You will be asked to take a photograph of an image that represents your experience with Integrative Health Coaching and share the photograph with the researcher. The researcher will ask you to tell about the photograph in the second telephone interview. Your identity will be confidential. You will choose or be given a pseudonym for the study. You will not give the name of your Integrative Health Coach or other information that would give a clue about your identity. Any personal information that could let others know who you are will be deleted and not used in the study. The researcher will call you at a time convenient for you. At the beginning of the telephone call the researcher will request that the call be digitally recorded in order to accurately transcribe your interview. Once the interview is transcribed the recording will be deleted. Participating in a recorded interview is essential to this research since accurate description of the experiences you share is the content of the research. Participation in the interview is voluntary and you can stop at any time.

You will lead the interview process and talk about what you found with Integrative Health Coaching. The researcher will ask a few questions such as those listed below. The researcher might ask a follow up question to help make sure she understands your meaning. You can decide to skip any question or choose not to answer a follow-up question.

- How did you find out about Integrative Health Coaching?
- What is most important for me to know about Integrative Health Coaching?
- What does your photograph say about Integrative Health Coaching?

What possible harms or discomforts might I experience if I take part in the research?

It has been determined that the risks associated with this research are no more than what you would experience in everyday life.

What are the possible benefits I may experience from taking part in this research?

We do not know if you will get any benefits by taking part in this research study. This research might help us learn more about Integrative Health Coaching and the experience of adults with a health concern who receive Integrative Health Coaching. There may be no personal benefit from your participation but the information gained by doing this research may help others in the future.

Will I be paid for taking part in this research?

We will not be able to pay you for the time you volunteer while being in this study.

What will it cost me to take part in this research?

There will be no cost associated with your participation in the study.

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Participant's Initials

Title of Study: Integrative Health Coaching: Participants' Experience in a Mindfulness-Based Health Dyad

Who will know that I took part in this research and learn personal information about me?

To do this research, ECU and the people and organizations listed below may know that you took part in this research and may see information about you that is normally kept private. With your permission, these people may use your private information to do this research:

- The researcher.
- Any agency of the federal, state, or local government that regulates human research. This includes the Department of Health and Human Services (DHHS), the North Carolina Department of Health, and the Office for Human Research Protections.
- The University & Medical Center Institutional Review Board (UMCIRB) and its staff, who have responsibility for overseeing your welfare during this research, and other ECU staff who oversee this research.
- Additionally, the following people and/or organizations may be given access to your personal health information and they are: A bonded and certified medical transcriptionist for the purpose of transcribing the interview.

How will you keep the information you collect about me secure? How long will you keep it?

The digital telephone recording using your pseudonym and a study number will be kept in a password protected file on the researcher's private computer until the interview is transcribed. Once the interview is transcribed the digital telephone recording will be deleted. The transcribed interview using your pseudonym and study number will be stripped of personal identifying information and details. The transcribed interview will be kept in a locked file cabinet in the researcher's personal office for three years. This consent and your contact information will be kept in a separate file and stored in the locked file cabinet. The consent and your contact information will be destroyed at the end of the three-year period.

What if I decide I do not want to continue in this research?

If you decide you no longer want to be in this research after it has already started, you may stop at any time. You will not be penalized or criticized for stopping. You will not lose any benefits that you should normally receive.

Who should I contact if I have questions?

The people conducting this study will be available to answer any questions concerning this research, now or in the future. You may contact the Principal Investigator, Karen Goble, at 828-215-7418 weekdays between 8:00 am and 6:00 pm.

If you have questions about your rights as someone taking part in research, you may call the UMCIRB Office at phone number 252-744-2914 (days, 8:00 am-5:00 pm). If you would like to report a complaint or concern about this research study, you may call the Director of UMCIRB Office, at 252-744-1971.

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Participant's Initials

Title of Study: Integrative Health Coaching: Participants' Experience in a Mindfulness-Based Health Dyad

I have decided I want to take part in this research. What should I do now?

The person obtaining informed consent will ask you to read the following and if you agree, you should sign this form:

- I have read (or had read to me) all of the above information.
- I have had an opportunity to ask questions about things in this research I did not understand and have received satisfactory answers.
- I know that I can stop taking part in this study at any time.
- By signing this informed consent form, I am not giving up any of my rights.
- I have been given a copy of this consent document, and it is mine to keep.

| Participant's Name (PRINT) | Signature | Date |
|----------------------------|-----------|------|
|----------------------------|-----------|------|

Person Obtaining Informed Consent: I have conducted the initial informed consent process. I have orally reviewed the contents of the consent document with the person who has signed above, and answered all of the person's questions about the research.

| Person Obtaining Consent (PRINT) | Signature | Date |
|----------------------------------|-----------|------|
|----------------------------------|-----------|------|

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Participant's Initials

*****IMPORTANT INFORMATION*****

Continuing Review/Closure Obligation

As a investigator you are required to submit a continuing review/closure form to the UMCIRB office in order to have your study renewed or closed before the date of expiration as noted on your approval letter. This information is required to outline the research activities since it was last approved. You must submit this research form even if you there has been no activity, no participant s enrolled, or you do not wish to continue the activity any longer. The regulations do not permit any research activity outside of the IRB approval period. Additionally, the regulations do not permit the UMCIRB to provide a retrospective approval during a period of lapse. Research studies that are allowed to be expired will be reported to the Vice Chancellor for Research and Graduate Studies, along with relevant other administration within the institution. The continuing review/closure form is located on our website at www.ecu.edu/irb under forms and documents. The meeting dates and submission deadlines are also posted on our web site under meeting information. Please contact the UMCIRB office at 252-744-2914 if you have any questions regarding your role or requirements with continuing review.
<http://www.hhs.gov/ohrp/humansubjects/guidance/contrev0107.htm>

Required Approval for Any Changes to the IRB Approved Research

As a research investigator you are required to obtain IRB approval prior to making any changes in your research study. Changes may not be initiated without IRB review and approval, except when necessary to eliminate an immediate apparent hazard to the participant. In the case when changes must be immediately undertaken to prevent a hazard to the participant and there was no opportunity to obtain prior IRB approval, the IRB must be informed of the change as soon as possible via a protocol deviation form.
<http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.htm#46.103>

Reporting of Unanticipated Problems to Participants or Others

As a research investigator you are required to report unanticipated problems to participants or others involving your research as soon as possible. Serious adverse events as defined by the FDA regulations may be a subset of unanticipated problems. The reporting times as specified within the research protocol, applicable regulations and policies should be followed.
<http://www.hhs.gov/ohrp/policy/AdvEvntGuid.htm>