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Research paper

Beliefs, attitudes towards, and experiences of using complementary and alternative medicine: A qualitative study of clinical psychologists in Indonesia

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ABSTRACT

Introduction: Little is known about psychologists' beliefs, attitudes toward, and experiences of using complementary and alternative medicine (CAM). Exploring how psychologists' beliefs and attitudes toward CAM are developed may identify potential barriers toward integrating CAM in psychological education and services. Therefore, this study aims to explore clinical psychologists' beliefs, attitudes toward, and experiences of using CAM in Indonesia to reduce the understanding gap.

Methods: Total population sampling was used to recruit 43 clinical psychologists in public health centres. They were interviewed using a semi-structured interview schedule. Then, the recordings were transcribed and analysed using deductive thematic analysis.

Results: Six themes developed for beliefs and attitudes toward CAM and stretched along a continuum scale from negative to positive. Also, four themes arose for experiences of using CAM among the responses by participants: personal use, giving a recommendation, making a referral, and combining CAM into conventional psychotherapy. Participants often used CAM for themselves and family members but rarely integrated some CAM treatments into their clinical practice, especially when making a referral. Factors that affected beliefs, attitudes toward, and experiences of using CAM among participants were identified and discussed.

Conclusions: Based on the qualitative findings, it is recommended that education about CAM should be included into clinical psychology education curricula to increase the likelihood of psychologists discussing CAM openly and scientifically with their clients. In addition, the government and psychology associations should standardise the practice of CAM integration into psychological services in order to provide more holistic psychological services.

1. Introduction

Complementary and alternative medicine (CAM) has been used globally not only by people with a physical illness (i.e. chronic pain) but also for those with mental disorders, especially anxiety, depression, insomnia and fatigue [1–3]. People often use CAM before seeking psychological services or use CAM in parallel with psychotherapy. For example, it was found that more than half of psychotherapy clients in the USA had used CAM before or during their sessions [4]. However, they used it independently and mostly without the knowledge of their conventional health practitioners, including psychologists.

Clients did not disclose the use of CAM to their conventional health practitioners, especially to physicians, because of several reasons. Primarily, clients assumed that their health practitioners would discourage them from using CAM or discontinue the conventional therapies [5,6]. In addition, 60% of clients in cancer palliative care in Queensland, Australia, did not report their use of vitamins and herbal medicine because they were afraid of their physician's disapproval [7]. Similarly, more than 70% of breast cancer clients in Korea discontinued to discuss their CAM use, mainly exercise therapy and vitamins/minerals, because of negative responses from their physician toward CAM use [8]. In addition, this nondisclosure of CAM use among clients might endanger clients' lives [9]. For example, a CAM practitioner with insufficient training may misdiagnose a client's condition and provide an incorrect CAM treatment, which could worsen the medical condition of the client.

The distrust of clients in conventional health practitioners and their fear of disclosing CAM use are not without reason. These concerns exist in a reality uncovered by previous studies about beliefs and attitudes toward CAM among conventional health practitioners. For example, a

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review of studies in the USA and Canada on attitudes toward CAM concluded that physicians showed a more negative attitude towards CAM compared to nurses, public health professionals, dietitians, social workers, and pharmacists [10]. In addition, nurses' limited belief in CAM and negative attitude towards CAM in Israel predicted their reluctance to integrate CAM into their practice [11]. A study in Australia also found that nurses with a negative attitude towards CAM were less likely to refer clients to CAM practitioners [12]. However, a systematic review of the beliefs and attitudes toward CAM studies among medical students found that beliefs and attitudes toward CAM have been gradually shifting to be more positive due to more research and education on CAM becoming available [13]. For instance, the European Union (EU) established a particular Parliamentary Assembly entitled *A European Approach to Non-conventional Medicines* in order to promote research and education on CAM among EU members [14,15].

Despite the increase in CAM research and education, still little is known about psychologists' beliefs about, attitudes toward, and experiences of CAM because only a limited number of CAM studies with psychologists have been published [16]. These studies were mainly conducted in Australia [e.g. 17,18] and found that Australian psychologists' attitudes towards CAM were generally positive. However, they showed contradictory beliefs about which CAM treatments could be integrated into conventional psychotherapy. Additionally, some studies were conducted to investigate Australian psychology students' beliefs and attitudes toward CAM [19,20]. These studies reported that psychology students in Australia with positive beliefs and attitudes toward CAM were more likely to integrate CAM in their future practice as psychologists. Moreover, only one international comparative study was found [21]. This study reported that psychologists in New Zealand held a less positive attitude towards CAM and less willingness to recommend CAM compared to psychologists from Australia, the USA, and the UK despite relatively similar psychology qualifications from these four nations. It was assumed that a lack of Government support towards CAM integration into conventional health services might affect attitudes and willingness to recommend CAM among psychologists in New Zealand.

It is important to explore beliefs, attitudes toward, and experiences of using CAM among psychologists because the findings may potentially be used as a reference for modifying psychology education curricula and service regulation [1,19]. For example, based on findings among Australian psychology students, it was suggested that policy and educational initiatives to promote CAM integration into psychology practice should focus on developing students' confidence to offer clients more holistic services [19]. Also, investigating how beliefs and attitudes toward CAM are developed may identify potential barriers in integrating CAM into psychology education and practice [22,23]. By identifying these potential barriers, client-psychologist communication can be improved through, e.g. encouraging clients to disclose their use of CAM to psychologists and psychologists respecting their clients' treatment decisions. Moreover, a study among adults with anxiety who use herbal medicine in Australia found that the available information about herbal medicine could be complex and difficult for clients to understand [2]. Therefore, it is essential for psychologists as health professionals to educate clients with the most updated and accurate information, including about CAM treatments, particularly CAM limitations, interactions with other treatments, and potential benefits [4,18].

1.1. CAM and psychology in Indonesia

Although studies have been undertaken to identify psychologists' beliefs, attitudes toward, and experiences of using CAM as described previously, similar studies among psychologists in Indonesia are still somewhat unexplored. Moreover, previous studies conducted in other nations might not be applicable in Indonesia because of the social and cultural differences between the nations [6,15]. Only one peer-reviewed publication was found regarding knowledge of, attitudes, and behaviours toward CAM among provisional psychologists (master of professional psychology students who are completing, or have completed, a professional internship but are not fully-registered) [24]. The study concluded that Indonesian provisional psychologists showed insufficient CAM knowledge but almost all used CAM for personal purposes; and they tended to accept CAM in clinical practice positively but were concerned about safety. Therefore, the current study aims to explore clinical psychologists' beliefs, attitudes toward, and experiences of using CAM in Indonesia to reduce the understanding gap.

In the CAM regulations issued by the Indonesian Health Ministry [25], CAM is categorised into six clusters: 1) mind and body interventions; 2) alternative systems of medical practice; 3) manual healing methods; 4) pharmacological and biological treatments; 5) diet and nutrition for the prevention and treatment of diseases; and 6) unclassified diagnostic and treatment methods. However, there is no further definition nor examples of CAM treatments for any of these six categories. Also, despite the fact that a definition[1] of CAM is provided in the regulation, no further explanation about the difference between "complementary medicine" and "alternative medicine" is available. In addition, a previous pilot study found that "complementary", "alternative", and "traditional" medicine were often used interchangeably in Indonesia [26].

There are three types of professional psychologists in Indonesia (clinical psychologists, educational psychologists, and organisational–industrial psychologists). However, only clinical psychologists are recognised as health professionals within the Indonesian law and the health system [27,28]. As explained previously, psychologists as health professionals, including in Indonesia, should be able to scientifically discuss CAM (e.g. its potential benefits and risks) with their clients [4,18]. However, this open discussion about CAM might not occur if psychologists are sceptical of CAM [18,19]. Moreover, the Indonesian Health Ministry found in their national survey that more than 75% of Indonesian people used CAM treatments, especially massage therapy, herbal medicine, and dietary-supplements [29]. Unfortunately, the number of clinical psychologists in Indonesia is very limited. In 2013, the Indonesian Health Ministry reported only 451 clinical psychologists were working in mental health services [30].

To become and practice as a clinical psychologist in Indonesia, an individual must complete a 4-year undergraduate degree in psychology and a 2.5-year master of professional (clinical) psychology program; hereinafter they must have an endorsement from the Indonesian Clinical Psychologist Association and a license from the Indonesian Health Professions Board [31,32]. These clinical psychologist educational stages and requirements are similar with the process in other Southeast Asian nations [33,34]. For example, in Singapore and Malaysia, an individual has to obtain an undergraduate and postgraduate degree in clinical psychology (including professional internship) to become a clinical psychologist. Also similar to other Southeast Asian nations, clinical psychology education in Indonesia adopts Euro-American psychology education that does not cover CAM in the curriculum [28,34]. Considering these similarities in educational background, findings from the current study can be used as a reference to understand psychologists' beliefs, attitudes toward, and experiences of using CAM in other Southeast Asian nations.

[1] Complementary and alternative medicine is non-conventional treatment aimed to improve public health status involving promotive, preventive, curative, and rehabilitative methods and it is obtained through a structured education with quality, safety, and high effectiveness that are based on biomedical science and have not been accepted in conventional medicine [25]. (translated from Indonesian). This theoretical definition shares some similarities with the definition from the WHO, "A broad set of health care practices that are not part of that country's own tradition or conventional medicine and are not fully integrated into the dominant health-care system. They are used interchangeably with traditional medicine in some countries. [15]"

2. Methods

2.1. Design

This relatively novel study uses a qualitative method because this approach allows the researcher to deeply explore and comprehensively understand complicated issues (e.g. beliefs, attitudes toward, and experiences of using CAM among psychologists) within their intrinsic dynamics and cultural contexts [35,36]. Also, a systematic review of previous quantitative studies concluded that it was hard to summarise the beliefs and attitudes of health professionals (e.g. physician and nurses) toward CAM through a questionnaire because of the breadth of CAM understanding between nations and cultures [10]. In other words, quantitative research could only partially explain beliefs and attitudes toward CAM or decision-making regarding CAM among health professionals, including psychologists [12,22]. Moreover, participants in quantitative studies had limited options for the CAM treatments that they used and could not elaborately explain their reasons for using them [12,37].

It should be noted that this study is part of a sequential-explanatory mixed-methods research that aimed to investigate Indonesian clinical psychologists' knowledge of, beliefs and attitudes toward, experience of, and educational needs regarding CAM. Quantitative data collection, using an online survey, was conducted first then followed by qualitative data collection. This current study particularly reported the clinical psychologists' beliefs, attitudes, and experiences of using CAM from the qualitative data collection. Findings about knowledge and educational needs regarding CAM were prepared to be reported separately.

2.2. Participants and procedures

Total population sampling was used to recruit clinical psychologists in all 43 public health centres (PHCs) from two districts in Yogyakarta Province, Indonesia. This purposive sampling method is effectively used where the number of participants to be included in the research is relatively small [38]. PHCs were chosen because they are the best way to integrate mental health services and outreach within small communities in Indonesia [31,39]. Moreover, a project of psychological services at PHCs in Indonesia was initially implemented in these two districts [40]. Participants were aged from 25 to 42 years with an average of 34 years, and the majority were from Java with a few from Sumatra and Borneo Island. They had been practising as psychologists for between 10 months and 18 years with an average of 6 years. The participants had been working as psychologists in PHCs for between 7 months and 10 years with an average of 4 years. There was only one male participant and thus, 'she' is used to discuss all interview responses in this study to maintain participants' anonymity.

In January 2016 the Indonesian Clinical Psychologist Association (IPK) was contacted as the gatekeeper in this research. A month later permission to conduct the research was given by the Chair of IPK. Following that, the Secretary of IPK sent an official email to their members informing them about the research and encouraging them to be involved as participants. In October 2016, after quantitative data collection was near completion, the 43 clinical psychologists were contacted by the author through posted mail to their institution. In this introduction letter, the author explained the qualitative study and asked whether the clinical psychologists were willing to be interviewed. Also, they were informed that they could choose to not participate without any consequences by contacting the author through email. No one sent an opt-out email. Finally, all interviews were conducted by the author between November 2016 and January 2017. Before having a face-to-face interview, participants were given a chance to ask questions related to the research and asked to sign the consent form. All participants voluntarily agreed to be interviewed and audio-recorded at their suggested time and place. Each interview lasted for between 30 and 100 min, with an average of 55 min, at the participants' convenience; most interviews were held at the PHCs where participants worked.

2.3. Data collection and ethics

The interview schedule for this qualitative research had been piloted and the results of this interview schedule development had been reported elsewhere [49]. Beliefs and attitudes toward CAM integration were explored by asking participants about the challenge of CAM integration into psychological services and education (e.g. "What is your attitude toward CAM integration into psychological services?" and "What are the challenges for integrating CAM into psychological services and education?). The participant's experience, both in their personal life and professional practice, in using CAM was also explored in the interview (e.g. "Do you have any personal experience in using CAM?" and "What is your experience with CAM in your clinical practice?). Participants were also asked about the reasons if they did not use CAM in their personal life or professional practice. Because of the explorative aim of this qualitative study, participants were not given the definition of CAM nor examples of CAM treatment. However, if participants stated that they did not know what CAM meant, the CAM definition from the Indonesian Health Ministry [25] (in the Introduction section) was given to them. This study had been reviewed and granted ethics approval by the Ethics Committee of the School of Psychology at the University of Queensland.

2.4. Data analysis

Data analysis started by transcribing the interview recordings. A research assistant (RA) assisted with the transcribing process. The first five audio recordings were initially transcribed by the author and given to the RA as examples of the standard for all transcripts. Then, the first five transcripts completed by the RA were evaluated for the standard assigned by the author before transcribing the 11th interview recording. Feedback was provided to the RA mostly in relation to incorrect medical terms and un-anonymised participant's or other people's names. The author then reviewed the transcriptions of all audio recordings for accuracy by comparing the texts with the audio recording. This process also gave the author the chance to develop familiarity with the data.

Interview transcripts were analysed using thematic analysis due to its flexibility to both report and examine explicit and latent contents [41]. However, despite the fact that thematic analysis has been frequently used in the field of health, this approach is still misunderstood or is "… not identified as any particular method at all." [41,42]. Compared with other more-known qualitative analysis approaches (e.g. grounded theory and hermeneutic phenomenology), thematic analysis does not require a complex interpretative process [42].

Deductive thematic analysis specifically was used because this current study is focused, delved into some aspect of the data (i.e. participants' beliefs and attitudes toward CAM integration into psychological services), and tended to be supported by findings from previous research [41,43]. Moreover, thematic analysis using a deductive approach might be used to complement and extend preceding quantitative studies [42]. The steps of thematic analysis followed guidelines from previous studies [43,44] and are presented in Table 1.

2.5. Trustworthiness

Numerous actions were taken to establish the trustworthiness of this qualitative study. Primarily, deductive thematic analysis was selected because the author recognised the influence of previous studies in developing this current research. By acknowledging this fact, the potential bias could be reduced as explained that researchers cannot completely free themselves from a theoretical framework [41]. Credibility was addressed by validating and verifying what the interviewer (the author) had understood by confirming it with the participant during the

Table 1
Steps of data analysis.

Step	Description
Initial coding	Each interview-transcript was read carefully and given an initial code (e.g. "A" for "attitudes toward CAM" and "X" for "experience of CAM"). This step was conducted manually using word and colour on a word processor. After all transcripts were initially coded, they were moved to two new documents (beliefs and attitudes toward CAM; experiences of using CAM).
Searching for themes	The coded data/transcripts were re-organised based on each code's proximity to generate potential sub-themes and themes. A thematic map was also created to help visualisation. A senior lecturer in Indonesian language and culture who understands and speaks Indonesian fluently reviewed the documents, sub-themes, and themes to enhance the trustworthiness of analysis.
Analysis	The re-organised data was analysed considering the consistency of code, sub-themes, and themes. At this step, the author also made notes and interpretations, drawing relevant quotes from the interviews when needed. Quote translation from Indonesian to English was made in the final report writing to avoid misinterpretation.

interview process [36]. In addition, all of the interviews were conducted by the same interviewer; transcribing process assisted by the same RA who assisted in the pilot interviews; and all of the transcripts were double-checked by comparing them with the audio recordings. These practices also increased the accuracy of data interpretation. To enhance the analysis and interpretation conformability [36,42], the author consulted with a senior lecturer of Indonesian language and culture who is also an expert in qualitative methodology. Codes, sub-themes, and themes were discussed and there was agreement between the author and senior lecturer. Lastly, transferability [35] was improved by providing adequate detail of the context of CAM and psychology services in Indonesia as well as participants' demography in order to assess whether the findings are applicable to other settings and populations.

3. Results

A deductive thematic analysis of 43 participants' interview results is presented separately into two parts: beliefs and attitudes toward CAM, and experiences of using CAM. Participant's number and transcript line are used in brackets to represent extracts and quotes. For example, (27–92) represents a quote from Participant 27 on line 92 of the transcript.

3.1. Beliefs and attitudes toward CAM

The beliefs and attitudes toward CAM expressed by participants were in regard to CAM integration into psychology services and clients' experiences in using CAM. Six themes developed for beliefs and attitudes toward CAM and stretched along a continuum scale from negative to positive. A visual map is presented in Fig. 1.

3.1.1. Negative beliefs and attitudes

The first of the six themes found amongst the responses by participants was negative beliefs and attitudes. This negativity related to participants' beliefs about *social conditions* in Indonesian society. In particular, CAM treatments or CAM practitioners were described as being against participants' personal values. For example, mystical rituals carried out by spiritual healers were perceived as conflicting with the religious teachings/values held by participants. Participants also disliked some CAM treatments which they believed to be "*working outside a client's consciousness*", for example, hypnotherapy: "… it's called a therapy only if client consciously participates in it." (27–92). Participants also held negative beliefs of psychologists who performed CAM treatments because they *cross professional boundaries*, "If the psychologist learns acupressure, she will abandon the psychological [intervention]. Definitely. I think it is unwise if the psychologist is doing another profession." (10–140).

Some participants had *negative personal experiences* with CAM use and this led them to perceive CAM undesirably. *The negative experiences suffered by clients* when they visited CAM practitioners were also raised by participants. Stories from *participants' family members* also directed negative beliefs and attitudes toward CAM. For example, "My uncle was diagnosed with cancer. After tracing the herbal medicine that he drunk, in fact, was worsening his condition." (39–52). These negative beliefs and attitudes were not addressed to CAM use in general but rather at *irrational/ineffective treatments*, for example, bathing in the creek. As a result, the irrational/ineffective treatment was *worsening a client's condition,* especially for those with a severe mental disorder. Participants explained that clients were usually locked up by their family at home if CAM interventions were ineffective and were only brought to a PHC or hospital after it was already too late. Participants regretted the delay in bringing the client to conventional health services because this made treating the client more challenging. Participants also regretted that clients used CAM treatments that *conflicted with religious teachings* if the client and participant shared the same religion.

There were several *questionable issues* regarding CAM amongst the participants' responses. Participants were *questioning CAM's effectiveness* and believed that CAM treatments only showed a placebo effect. Participants also doubted the theoretical and scientific foundations of CAM. Participants distrusted the *credibility of CAM practitioners* and their training process because of the *unstandardised procedure* in their practice. For example, Participant 39 illustrated that one herbal medicine practitioner might treat a client differently from another practitioner although the treatment (herbal medicine) was similar. Therefore, participants who negatively perceived CAM tended to discourage their clients from visiting CAM practitioners. Lastly, *misleading advertising* (i.e. grandiloquent advertisements) made participants sceptical about CAM, "… like the brochure distributed at traffic intersection that claim it [CAM] can cure all kinds of diseases instantly." (13–116).

3.1.2. Powerlessness

Participants felt powerless when meeting a client or a client's family who trusted CAM practitioners more than conventional health practitioners like them. Also, participants believed that CAM was *part of clients' culture and hereditary customs* as Indonesian people. Therefore, participants believed that competing with CAM practitioners would be useless, "… the Elder [CAM practitioner] there has been trusted for a long time. People come to him for all health issues… [I] cannot compete with them [CAM practitioners]." (25–62). Also, participants believed that they *could not prohibit* a client from seeing CAM practitioners because it might be offensive to the client, eventually making them not trust the participants anymore. Participants were also aware that their profession is still unfamiliar for some people in Indonesia so that they need to be careful when educating their clients about mental health. For example, participants did not ask their clients to stop seeing CAM practitioners but rather encouraged them to think critically about CAM's effectiveness compared to conventional medicine and psychotherapy in order to raise their clients' awareness of these issues.

3.1.3. Ambivalence

The most common cause of ambivalence was described in participants' responses as an *internal conflict* between the role of health professional and their personal religious beliefs. For example, Participant 8

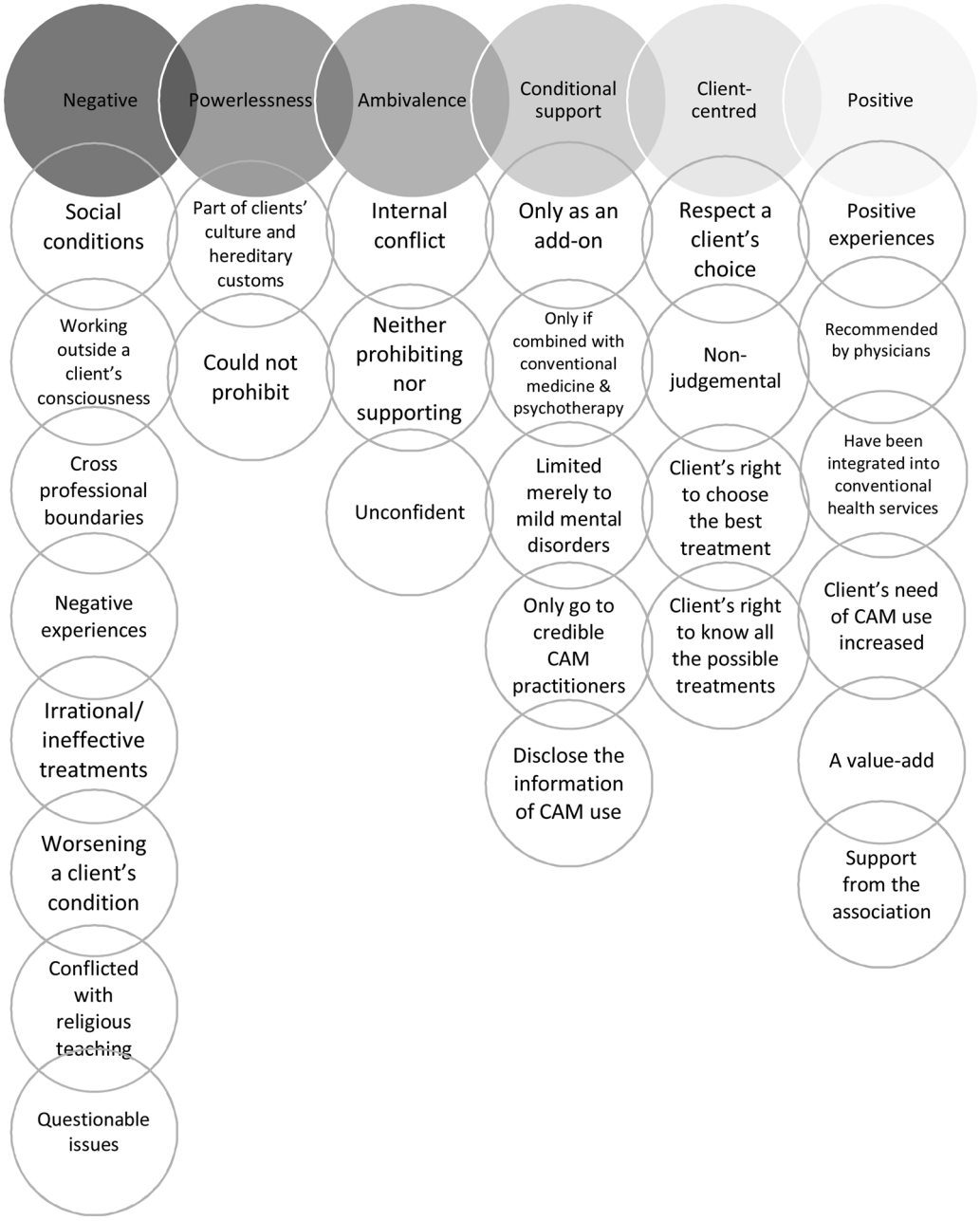

Fig. 1. Beliefs and attitudes toward CAM.

admitted that as a religious person she believed that religious leaders for spiritual-religious therapy (SRT) were needed for an individual's inner peace, particularly if that person had undergone a supernatural experience. However, as a health professional, she could not explain these experiences nor could she recommend a client to a particular religious leader because she believed that such things are not scientifically based and breach the code of conduct of psychology. Some participants expressed ambivalence by *neither prohibiting nor supporting* CAM use. Participants did not persuade their clients to stop their CAM use but rather educated them about mental health and disorders from a biomedicine perspective and what psychological interventions they provided. A few participants showed positive beliefs and attitudes toward CAM integration into psychological services but were also *unconfident* about their understanding and competency of CAM.

3.1.4. Conditional support

In some responses, participants showed their support for CAM use or integration but with some conditions. For example, CAM might be used by the client but *only as an add-on* to conventional medicine and psychotherapy. In line with this, some participants displayed their support for CAM use but *only if combined with conventional medicine and psychotherapy*. However, the combination should be *limited merely to mild mental disorders* because participants believed that CAM would not be effective in treating severe mental disorders. In addition, participants would support clients to use CAM if they *only go to credible CAM practitioners*. Also, participants would support CAM use but the clients need to *disclose the information* about what CAM they used or where they met their CAM practitioner so that participants can help to assess the potential risks and benefits.

3.1.5. Client-centred

Some participants believed that, as health professionals, they should *respect a client's choice* and *be non-judgemental*. Even if they had explained about mental health from a biomedical perspective, in the end,

if a client or their family still chose to go to a CAM practitioner, participants must respect the effort by clients and their families to seek treatment rather than just locking up a client at home. Participants believed that it is the *client's right to choose the best treatment for them*, including CAM as an option. Therefore, participants also mentioned that clients have the *right to know all the possible treatments available*, including CAM treatments, and their safety and effectiveness. For example, "For new clients [parents of a child with autism] I usually inform them of some alternative treatments like acupuncture and acupressure. … But it is not recommending. Just sharing what I know and other clients' testimonies." (21–74).

3.1.6. Positive beliefs and attitudes

Participants with *positive experiences* tended to show positive beliefs and attitudes toward CAM. The positive effect of CAM use experienced in various forms was expressed by a range of participants. Some participants expressed a shifting attitude from negative to positive toward CAM because the CAM treatment was *recommended by physicians* when participants consulted with them. Participants also found that some CAM treatments (e.g. herbal medicine and acupuncture) *have been integrated into conventional health services*. Additionally, participants felt that physicians who combined CAM into their practice were more sympathetic when communicating with them than when they were treated by conventional physicians. Participants also believed that a *client's need of CAM use highly increased* and would be *a value-add* if participants have competency in delivering CAM in their psychology services, "In the future, it seems it will be in demand [psychologists with CAM skills]. Even, this skill [CAM] may help a psychologist in treating clients." (3–72). Further, speeches by the executive members of a psychology association in some formal events were also perceived as *support from the association* towards CAM integration.

3.2. Experiences of using CAM

Four themes arose for experiences of using CAM among the responses by participants: personal use, giving a recommendation, making a referral, and combining CAM into conventional psychotherapy. The last three themes of CAM experiences overlapped considerably in participants' professional practice. A visual map of CAM experiences is presented in Fig. 2.

Additionally, the majority of participants had been asked about CAM by their clients, particularly clients with chronic diseases (e.g. diabetes and hypertension). The most frequent questions were about how various CAM treatments worked and the effectiveness and safety of CAM. In addition, based on their sessions in PHCs, participants observed that clients from high socio-economic status (SES) backgrounds and who lived in the city tended to ask more about CAM compared with clients from low SES backgrounds and who lived in rural areas. Moreover, quite a lot of clients had unreasonable expectations that CAM, particularly hypnotherapy, would instantly cure them in one session. In fact, numerous participants were also requested to do hypnotherapy by their clients.

3.2.1. Personal use

Most of the participants had used CAM *for themselves or family members*. The treatments they used varied but the most common were spiritual-religious therapy (SRT) and supplement-vitamins. Participants used CAM mainly for three reasons: *relaxing body and mind*, *maintaining physical fitness*, and *beauty purposes* (e.g. facial skin care and body slimming). Participants liked particular CAM treatments (i.e. yoga) because they are easy to do. Some participants were using CAM because their *parents, parents-in-law, or partner asked them* to use it, particularly herbal medicine, when participants were pregnant and during breastfeeding to avoid the side effects of conventional medicine. The majority of participants who used CAM had *positive experiences*, for example, CAM decreased physical and psychological tension. Some participants *discontinued using CAM*, predominantly yoga and acupuncture, because they did not have time to do it. On the other hand, some participants *had never used* particular CAM treatments (e.g. herbal medicine and massage therapy) because they disliked its aroma and felt uncomfortable when their body was touched by another person.

Participants with positive personal experiences of CAM also tended to use it in their professional practice. For example, Participant 23 practised meditation to manage her emotions and also taught clients the same treatments as part of relaxation techniques in conventional psychotherapy. However, personal use of CAM did not always interact with professional use in participants' psychology services, particularly for CAM treatments that were consumed directly (e.g. herbal medicine and supplement-vitamins). Furthermore, participants felt incompetent to answer the clients' questions about the working mechanisms of CAM although they had experienced positive effects of CAM treatments.

3.2.2. Recommendation

Some participants had previously recommended several CAM treatments to their clients, especially SRT, yoga, and meditation. The reasons why participants recommended CAM to their clients were because CAM included *less stigmatised* treatments and *clients can do them independently*. However, participants mentioned that a *client's background* affected their recommendation of particular CAM treatments. For example, yoga and meditation were recommended more often to clients with higher levels of education because they were more understanding and willing to try such treatments when compared with clients with a lower educational background. On the other hand, some participants *had never recommended* CAM to their clients. The main reason was because they had no knowledge of or experience with CAM treatments. In addition, some participants who personally used CAM were *not confident in recommending* these to clients because they believed that personal sharing was different from a clinical recommendation which needed a scientific evidence basis.

3.2.3. Referral

A few participants had previously referred their clients to *other health professionals* at PHCs regarding CAM questions or use. Most of the referred clients were pregnant women who asked about or used herbal medicine or supplement-vitamins. Participants referred them to a nutritionist, midwife, or physician because participants did not have sufficient knowledge about those treatments. In addition, some participants referred their clients who requested hypnotherapy or SRT to their *colleagues or senior psychologists* who practise these CAM treatments. However, even if participants doubted the CAM treatment's effectiveness or did not know their colleague's certification in these treatments, they still referred their clients to other psychologists to ensure that the CAM treatments given were in line with psychotherapy concepts. Participants *had never referred* clients to CAM practitioners because *the system did not allow* them to refer to practitioners outside conventional health services. In addition, participants who recommended CAM treatments did not make a referral because they *did not have a network* of credible CAM practitioners and were concerned about clients' safety, "Because I do not know [any CAM practitioners] so I do not recommend them [CAM treatments] to clients. … It [referral] is priceless." (28–136).

3.2.4. Combining CAM into psychotherapy

Participants had previously combined CAM into their psychotherapy practice, particularly SRT, music therapy, meditation, and acupressure. The primary reason participants combined CAM into their psychotherapy was because many PHC *clients usually only attended one meeting* with them, due to several factors (e.g. time and geographical limitations). *Clients also expected* that they would get some kind of applied treatment to practice at home and not simply talk with the participants during their therapy sessions. Therefore, participants combined CAM treatments with relaxation techniques which clients could

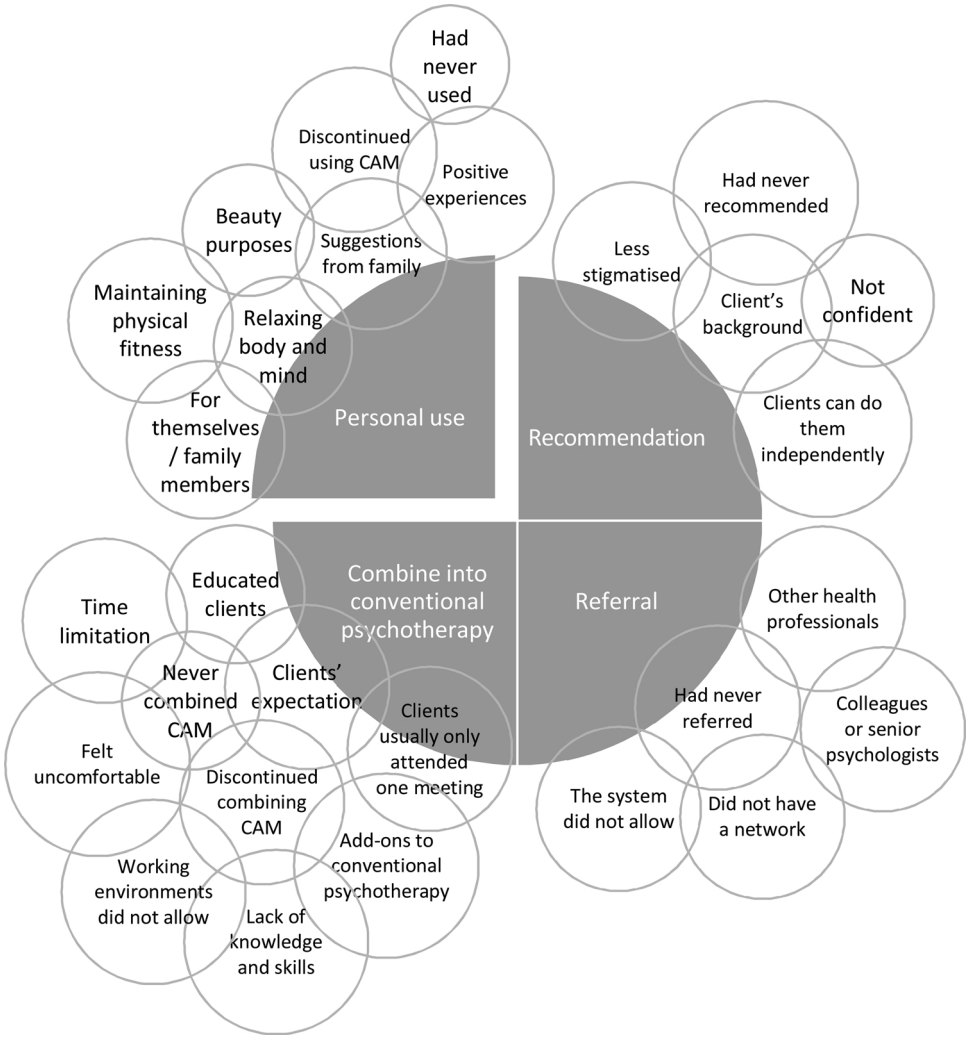

Fig. 2. Experiences of using CAM.

do by themselves at home. However, some participants were unsure if they were already combining CAM or not because they were unfamiliar with the term.

In the integration process, participants also *educated clients* about general information on CAM and how it improves clients' mental health. However, participants emphasised that the CAM treatments were *just add-ons to conventional psychotherapy* and might not be effective if the core of the psychological issue was not solved. They encouraged clients, especially with moderate mental disorders, to come to the next meeting as planned. Participants mentioned that in *the limited-maximum* 50 min *of therapy sessions*, they could not rigidly apply conventional psychotherapy as they had learnt in training, "Applying solely the skills [conventional psychotherapy] that we learnt from university is limited by time, since the client only comes once." (23-12).

Some participants *discontinued combining CAM into their practice*, particularly acupressure. They stopped using acupressure because they *felt uncomfortable* when interacting with opposite-sex clients to teach them about the treatments. In addition, participants terminated use of CAM treatments after having discussions with academics and senior psychologists who question CAM's effectiveness and scientific evidence. On the other hand, some participants *never combined CAM into their psychotherapy* mainly because they *did not have sufficient knowledge and skills*. For some participants, their *working environments at PHCs did not allow* them to use CAM treatments, for example, there were no devices in their room to play music therapy on and the high noise levels outside the room prohibited the practice of meditation.

4. Discussion

The current study aimed to explore beliefs, attitudes toward, and experiences of using CAM among psychologists in Indonesia. Findings from this study may extend results from previous studies among psychologists in other nations [17,18,21] and health professionals in general [10–12]. By understanding psychologists' beliefs, attitudes toward, and experiences of CAM better, this potentially increases the likelihood of psychologists openly discussing CAM with their clients and respecting clients' decisions to use CAM [4,18,19].

4.1. Beliefs and attitudes toward CAM

In general, there were mixed beliefs and attitudes toward CAM amongst participants. These findings are comparable to other studies conducted among Australian psychology students and professionals [i.e. [16]] and numerous health professionals in the USA [e.g. [22] [37],] that also found varied beliefs and attitudes toward CAM. The primary issues highlighted by participants in this current study were the effectiveness and safety of CAM treatments. Participants' hesitation in using CAM treatments might be because they believed that CAM effectiveness was placebo effect only. These findings support previous studies among Australian psychologists [18] which also negatively perceived some CAM treatments because of their insufficient scientific evidence. On the other hand, participants also hold positive beliefs and attitudes toward CAM treatments provided by conventional health

services. Personal positive CAM experiences might establish participants' positive beliefs and attitudes toward CAM as discovered in a previous study among Australian nurses [12] and Israeli obstetricians [23].

Participants believed that the practice and training experiences among practitioners of similar CAM treatments were not standardised. This belief supports a review study of physicians' attitudes in Brazil, Korea, and the USA who also distrusted CAM practitioners' competency because of their vague training backgrounds [13]. Participants also experienced difficulty finding reliable CAM practitioners, so that they had little trust in CAM practitioners. This struggle in finding credible CAM practitioners was also identified among Polish physicians [45] and Australian psychologists [16], which made them sceptical about recommending CAM to clients or referring clients to CAM practitioners.

However, interestingly, participants believed that CAM is part of Indonesian culture and could not be detached from people's lives. This supports previous findings that "complementary", "alternative", and "traditional" medicine were used conversely among the Indonesian psychology community [26]. In addition, the World Health Organization (WHO) used these three terms concurrently because one CAM treatment in one culture can be recognised as a traditional medicine in another culture or nation [14,15]. As an illustration, this current study found that SRT was a complicated treatment for some participants because of internal conflicts between their religious beliefs and their role as mental health professionals. This result is unique when compared with previous studies among Australian psychologists [18,46] that did not discover cultural influences on psychologists' attitudes toward CAM.

Participants' also expressed their unfavourableness towards CAM integration into psychological services. This negative attitude might be caused by participants' lack of confidence in their understanding and competency regarding CAM. Furthermore, participants acknowledged that CAM was not part of their professional training. These findings are supported by previous studies, which concluded that clinical psychology education in Southeast Asian nations, including Indonesia, adopts Euro-American psychology education that does not cover CAM in the curriculum [28,34].

Participants showed client-centred approaches when working with clients who use CAM. Participants believed that the use of CAM is an effort that needs to be acknowledged non-judgementally but, at the same time, they also encouraged clients to try conventional medical approaches. This finding was similar with psychologists' attitudes in Australia who respected clients' choice to combine CAM with psychotherapy [18]. Another possible explanation for this client-centred approach displayed by participants might be due to the recent recognition of clinical psychologists as health professionals in 2014 by the Indonesian government [27]. Therefore, participants might worry about losing clients' trust if they prohibit CAM use. However, as health professionals, participants believed that it is necessary to inform clients about the safety and risks of CAM with the expectation that, in the end, clients themselves would choose conventional medicine and psychotherapy over CAM.

4.2. Experiences of using CAM

The current study extends the results of similar surveys among psychologists, occupational therapists, and nurses, in Australia, New Zealand, the UK, and the USA that found that the majority of participants were also personally using CAM [12,21,22]. However, an overworkload in PHCs was found in this current study as the reason for participants to stop practising CAM, an aspect which was not explored in the previous international surveys. This study also discovered that the personal use of CAM was intensely advised by family members when participants were pregnant and breastfeeding. This finding confirms a qualitative study among Indonesian women that found the extensive use of herbal medicine, particularly *jamu*, for fertility and reproductive issues [47].

Participants believed that the CAM effect they personally experienced might differ with what clients have experienced. Moreover, despite their positive attitudes towards CAM, participants had a lack of confidence in integrating CAM into their clinical practice. Moreover, participants did not feel confident in integrating CAM into their practice because they felt it was not their area of competence. These findings are inconsistent with international studies that found nurses and psychologists with a positive attitude and personal experience using CAM were most likely to use CAM in their professional practice [11,12,21].

Findings from this study confirm the national survey in Indonesia, which found that massage therapy, herbal medicine, and dietary-supplements were the most common CAM treatments used by Indonesian people [29]. The current study is also consistent with previous studies among Australian nurses and Turkish midwives, which discovered the use of supplement-vitamins, herbal medicine, and meditation for personal purposes and in clinical practice [12,48]. However, the finding of SRT as the most common CAM treatment personally used by interviewed participants might uniquely relate to cultural aspects that were not found among participants in the international surveys such as in Australia, New Zealand, the UK, and the USA [12,21,22]. This finding supports previous research that found spiritualism and religion are part of Indonesian people's cultures and beliefs [26]. Moreover, SRT was also extensively used as a CAM treatment by Israeli nurses and cancer patients in Saudi Arabia because the influence of religion in participants' culture [11,35].

Participants in the current study displayed more caution when making CAM referrals than recommending CAM to their clients. This result is consistent with previous research among psychologists in Australia and physicians in the USA and Canada [10,16,46] who showed discrepancies between referring clients to CAM practitioners and recommending CAM to clients. The current study also discovered that the limitations of the health services system and lack of network with credible CAM practitioners were the primary reasons for this gap. These findings supplement previous research that found psychologists in New Zealand showed less willingness in making CAM referral compared with psychologists in Australia, the UK, and the USA because regulation of CAM integration into conventional health services was less clear in New Zealand compared with the other three nations [21].

This study found that, despite having insufficient CAM knowledge, participants felt it is necessary to educate their clients about CAM, especially if clients had an unreasonable expectation of CAM effectiveness. Participants also often encountered clients who asked about CAM working mechanisms, especially clients with chronic diseases and in palliative care. This experience supports advice for psychologists to provide and educate clients about the most comprehensive treatments available, including CAM [1]. Therefore, this study might expand the finding of the urgency of CAM education inclusion in medical curricula [13], which is also needed in clinical psychology education.

The current study also found that participants paid attention to the disapproval of CAM use from their seniors, a finding which parallels the results of a study amongst Australian psychologists [18]. However, in Indonesia, no such interest group of CAM exists to contrast with the condition in Australia where the "Psychology and Complementary Therapies" interest group is recognised by the Australia Psychological Society [16]. Moreover, it is assumed that participants in this study might want to maintain the profession's image in front of other health professionals by not combining CAM into their practice because of its limited scientific evidence. This finding might extend studies on nurses who reported their belief that physicians would disapprove of their CAM recommendations to clients because of the lack of scientific evidence [12,36].

4.3. Limitations and recommendations

Forty-three participants working at PHCs were interviewed in this qualitative study and provided a comprehensive view of CAM beliefs, attitudes, and experiences. However, the limitations of the current study need to be considered. First, there was only one male psychologist interviewed and previous quantitative studies found that female health professionals showed a more positive attitude towards CAM and more often used it than males [12,21,23]. Therefore, the future study may explore beliefs and attitudes toward, and uses of CAM among males psychologists to supplement the current findings. Second, from the interviews it was revealed that the opinions of senior psychologists and executive members of psychology professional associations were important to integrating CAM into psychological practice. It might be useful to explore their attitudes in forthcoming research to be contrasted with those of junior psychologists and regular members, particularly regarding the ethics and regulation of CAM integration into psychological services. Finally, despite the similarity of psychological education with other Southeast Asian nations, findings from this qualitative study among Indonesian psychologists may not be completely able to be generalised in different social and cultural settings. Cross-cultural research on psychologists in other Southeast Asian nations should be conducted to understand more comprehensively about psychologists' beliefs, attitudes toward, and experiences of using CAM.

5. Conclusion

The deductive thematic analysis from 43 clinical psychologists in Indonesia found that participants had mixed beliefs and attitudes toward CAM. Participants often used CAM for themselves and family members but rarely integrated some CAM treatments into their clinical practice, especially when making a referral. Some factors that affected beliefs, attitudes toward, and experiences of CAM among participants were identified. First, this study uniquely discovered that cultural aspects affected participants' attitudes toward CAM because CAM was believed to be part of Indonesian culture, a finding not discovered in studies among psychologists from developed nations. Second, lack of CAM knowledge and skills, and networks with credible CAM practitioners inhibit CAM integration by participants even when clients requested it. Therefore, education about CAM (e.g. working mechanisms, and potential benefits and risks) should be included into clinical psychology education curricula to increase the likelihood of psychologists discussing CAM openly and scientifically with their clients.

Third, unclear regulations of CAM integration into psychological services and limitations in the health care system made participants hesitate to use CAM in their psychology services. Finally, professional use of CAM among participants was shaped by colleagues' attitudes towards CAM, including senior psychologists and other health professionals. Consequently, it is recommended that the government and psychology associations clearly standardise the practice of CAM integration into psychological services in order to provide more holistic psychological services.

Conflict of interests

The author declared no potential conflict of interest with respect to the research, authorship, and/or publication of this article.

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