



A qualitative investigation of Australian psychologists' perceptions about complementary and alternative medicine for use in clinical practice



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ARTICLE INFO

Article history:

Received 5 July 2017

Received in revised form

4 September 2017

Accepted 5 September 2017

Keywords:

Attitudes

Complementary and alternative medicine

Beliefs

Mental health

ABSTRACT

This study explored psychologists' knowledge of, attitude toward, and experience with complementary and alternative medicine (CAM) use for clinical purposes. Using a qualitative design, 18 Australian psychologists participated in a semi-structured interview. Psychologists had some understanding about CAM; yet, there was a mismatch between their perceived and actual knowledge. While psychologists were, in general, open toward using CAM with clients they were also sceptical. Attitudes did not overly influence psychologists' views about using CAM in practice, rather adhering to the scientist-practitioner model and embracing a client-centred approach affected their beliefs. Different views emerged as guiding psychologists' use of CAM; however, the codes of conduct played a major role in informing psychologists' use in clinical practice. Psychologists appear open to the idea to use some forms of CAM to enhance client care; yet, they experience unique difficulties such as ethical constraints that may prevent their actual use of CAM for clinical purposes.

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1. Introduction

The use of complementary and alternative medicine (CAM) has increased over the last two decades in places such as Europe and Australia [2,4,14,34]. While empirical evidence suggests the prevalence of CAM use is increasing [16] and that many use CAM for the treatment of health and mental disorders [4,26], little is known about how psychologists are dealing with this rising trend. Moreover, not only is the evidence behind CAM use for treating mental disorders equivocal [14], there is also a lack in standards and information among education and training institutions for safe CAM use in psychological practice [22]. Given the prevalence of CAM use for mental wellbeing, such as yoga, meditation, pilate, massage, acupuncture, homeopathy, hypnotherapy, chiropractic, and herbal medicine [11,13], psychologists need to be prepared to discuss such therapies with clients and adhere to their ethical responsibility to provide accurate information to clients about treatment options. This is important given recent claims that psychologists provide

such advice inadequately [32]. Even if psychologists have the appropriate training to implement a CAM technique on clients, the issues surrounding CAM make using such techniques complex both professionally and ethically. Accordingly, CAM use in psychological practice is a challenging issue, and it seems timely to explore psychologists' beliefs of CAM use for clinical purposes.

Previous research has focused on psychology students and registered psychologists' willingness to recommend or integrate CAM where it was shown that attitudes, beliefs of significant others, and risk factors influenced CAM behaviours [20,30–33]. Although current literature has provided some understanding of CAM and psychological treatment, there is a knowledge gap in understanding psychologists' use of CAM for clinical purposes. This knowledge will provide new insight into why psychologists think, feel, and act the way they do about CAM use, and potentially guide the development of best practice standards around CAM use and effective treatment outcomes. Regardless of how psychologists might choose to approach CAM, the increasing popularity of complementary and alternative approaches in mental health care around the world suggests that many individuals are combining or considering CAM strategies to treat their psychological symptoms, and are looking for knowledge and expertise regarding options for incorporating CAM techniques [35]. For this reason, a deeper

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understanding of CAM use for clinical purposes among psychologists is important to support best practice. The aim of the current study was to explore psychologists' knowledge about CAM, attitudes toward CAM, and experiences of using CAM in practice.

2. Method

2.1. Participants

A purposive sampling method [27] was used to recruit Australian psychologists who were either provisionally or fully registered. In Australia, undergraduate psychology programs are traditionally a three-year degree, with students competing for entry into an honours/four-year program of study. Students can then apply to the Australian Health Practitioner Regulation Authority (AHPRA) for registration as a provisional psychologist. To become a fully registered psychologist, students need to complete an additional two-year supervised work program, a combination of university coursework as a fifth year and one year supervised work program, or a Masters or Professional Doctoral program [21]. Students can then apply to AHPRA for registration as a general psychologist.

Individuals were recruited using existing social and professional networks, including contacting professional colleagues known to the research team, University psychology clinics, and psychological organisations (private and public). Participants were contacted via email or face-to-face, and the majority were unknown by the research team. Participants resided in metropolitan and rural areas of South East Queensland. The sample ($N = 18$; females, $n = 14$; males, $n = 4$) comprised of 11 fully registered psychologists and 7 provisionally registered psychologists. Psychologists ranged in age from 23 to 52 years, with an average age of 32 years. Seventeen participants identified as Caucasian and one as Asian. Fully registered psychologists were all currently practicing for a minimum of 1 year to a maximum of 20 years. Seventeen did their training in Australia while one gained their registration in Europe before obtaining full registration in Australia. The sample size was dependent on theoretical saturation. All participants volunteered and no gratuity was given in exchange for participation.

2.2. Measures

A brief demographic survey collected general background information of the participants while a semi-structured interview guide was used to explore the research aims. The interview protocol comprised open-ended questions that were based on the research questions, extant literature, and experience of the researchers; however, the questions were flexible to allow a variety of perceptions and experiences to emerge. The semi-structured interview guide was piloted with two participants and feedback was used to revise questions to improve participant understanding. The interview guide consisted of three main discussion sections. The first section explored psychologists' knowledge about CAM (e.g., "What do you currently know about CAM?") including knowledge about any potential risks, benefits, and scientific implications. After this discussion, copies of the various CAM classifications and examples of the various CAM techniques were provided. These classifications were based on the four CAM categories outlined by the National Centre for Complementary and Integrative Health [24]: 1) "Mind-Body" CAM, which includes meditation, yoga, relaxation techniques, healing touch, and hypnosis; 2) "Body-Based" CAM, which consists of acupuncture, massage therapy, movement therapies, and chiropractic; 3) "Biological" CAM, which involves vitamins and minerals taken to maintain health; and, 4) "Other Biological" CAM, which constitutes herbal therapies, homeopathy, naturopathy, and traditional Chinese

herbal therapies. The second section examined participants' attitudes toward the different CAM categories for use in clinical practice (e.g., "What is your attitude towards CAM for psychological purpose?"). The third section investigated psychologists' experience with CAM in clinical practice (e.g., "What is your experience with CAM in your psychological practice?").

2.3. Design and procedure

A qualitative research design using interview methods and adopting an inductive thematic analysis approach [8] was employed to understand psychologists' views and experiences of CAM use for clinical purposes. The University Human Research Ethics Committee granted ethical clearance for this study. Participants were approached via email or face-to-face and given an information sheet explaining the study. Interviews took place at a location convenient to the participant. Participants signed a consent form and completed a brief demographic survey before beginning the interview. The interviewer briefly explained the purpose of the interview and reminded participants of their rights detailed on the information sheet.

Author VM conducted all interviews, which averaged 1-h in length. The interview was guided by semi-structured open-ended questions, allowing the interviewer to be flexible to probe for clarification and elaborate on responses. This process was guided by several criteria of good practice in qualitative research [29], including worthiness of the topic, sincerity (the interviewer practicing being self-reflective), as well as the research having rich rigour, credibility, and relational ethics. Upon completion, the interviewer summarized the discussion to ensure the qualitative validation of collected information [8] and invited each participant to modify or elaborate on this summary. Furthermore, a reflexive journal was kept by the interviewer to record key ideas expressed throughout the interviews and to note comparisons and contrasts between the interviews; this journal was used to assist with the data analysis and as a guide to indicate a point at which theoretical saturation had been reached [7,8]. Interviews were audio-recorded and author VM transcribed all data verbatim (removing any identifying data and assigning pseudonyms). At the time of the interviews, author VM was a provisionally registered psychologist and author KH was a senior lecturer with research interests in health psychology. Both authors have used some form of CAM for their health and wellbeing including mindfulness and nutrient supplements (VM) and yoga, pilate, massage, and chiropractic (KH). As recommended by Ref. [17]; authors' discussed their biases and expectations with each other prior to, and throughout, the research process to ensure that these did not unduly influence the data collection and analysis process.

2.4. Analytic strategy

Inductive thematic analysis of the data followed the six phases described by Refs. [7,8]. The first step consisted of repeated reading of the data to gain familiarity of the content. From this step, initial codes were generated. This process led to the third step where codes with related ideas were grouped together to be refined into themes. Next, themes were grouped according to the three main interview topics and a thematic map was generated for each participant. The fourth step consisted of defining and naming themes while using quotes to capture the essence of each theme with reference to raw data. At this stage, both authors reviewed the data and discussed, refined, and came to consensus on emerging codes and themes. The fifth step focused on producing the outcome results where themes were developed to an in-depth level. The definition of each theme was written and re-written for each

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