UTS UNIVERSITY OF TECHNOLOGY SYDNEY

An Exploration of Complementary Medicine in Psychology Practice

by Carrie Thomson-Casey

Thesis submitted in fulfilment of the requirements for the degree of

Doctor of Philosophy

under the supervision of

Distinguished Professor Jon Adams and Associate Professor Deborah Debono

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Certificate of original authorship

I, Carrie Thomson-Casey, declare that this thesis, is submitted in fulfilment of the requirements for the award of Doctor of Philosophy, in the Faculty of Health, at the University of Technology Sydney.

This thesis is wholly my own work unless otherwise referenced or acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

This document has not been submitted for qualifications at any other academic institution.

This research is supported by the Australian Government Research Training Program.

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Date: 19th March 2024

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Format of this thesis

This thesis is structured in the format of *Thesis by Compilation*. The thesis is presented as a single, cohesive body of work comprising a combination of thesis chapters and published papers. In keeping with the format of Thesis by Compilation, content from papers resulting from this thesis which have been published or submitted for publication have been embedded within the relevant chapters of this thesis. A chapter preamble and relevant notes are included to indicate publication details. A copy of each published paper is included in the appendices in the format that they appear in their respective journal.

Published works by the author incorporated into the thesis.

Of the four drafted manuscripts contained in this thesis, all have been submitted for publication, and all four are published.

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3. Thomson-Casey, C., McIntyre, E., Rogers, K., & Adams, J. (2023). The relationship between psychology practice and complementary medicine in Australia: Psychologists' demographics and practice characteristics regarding type of engagement across a range of complementary medicine modalities. PloS one, 18(5), e0285050. https://doi.org/10.1371/journal.pone.0285050
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Statement of contributions contained in the thesis

As the author of this thesis and candidate for the award of Doctor of Philosophy, I have been the primary author of each of the published papers included within this thesis. For each included paper, I have been principally responsible for determining the research question, performing the analysis, drafting the full manuscript, overseeing the submission process, including responding to peer-review. Support in all these areas was provided by my supervisors. Please note the supervisory panel changed through the course of the thesis. During the analysis of papers in Chapters 5 and 6, guidance in the conduct and interpretation of analysis was also provided by Associate Professor Kris Rogers.

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Abbreviations

AAPI	Australian Association of Psychologists Incorporated
ACT	Acceptance and Commitment Therapy
ACNEM	Australasian College of Nutritional and Environmental Medicine
ACPA	Australian Clinical Psychology Association
AHPRA	Australian Health Practitioner Regulation Agency
AIMA	Australasian Integrative Medicine Association
AIPA	Australian Indigenous Psychologists Association
AoPE	Area of practice endorsement
APA	The America Psychological Association
APAC	Australian Psychology Accreditation Council
APACS	Australian Psychologists and Counsellors in Schools
APS	Australian Psychological Society
ASLM	Australasian Society of Lifestyle Medicine
BPS	British Psychological Society
CBT	Cognitive behavioural therapy
CAM	Complementary and alternative medicine

CHERRIES	Checklist for Reporting Results of Internet E-Surveys
CI	Confidence interval
CM	Complementary Medicine
CPA	Canadian Psychological Association
DBT	Dialectical Behaviour Therapy
EBP	Evidence-based practice
EBPP	Evidence-based practice in psychology
EFT	Emotional freedom techniques
EMDR	Eye Movement Desensitisation and Reprocessing
GP	General Practitioner
HODSPA	Heads of Departments and Schools of Psychology
ICD-11	International Classification of Diseases
IHC	Integrative health care
IM	Integrative medicine
IP	Internet Protocol - unique address that identifies a device on the internet or a local network
MBCT	Mindfulness-Based Cognitive Therapy

MHTP	Mental Health Treatment Plan
PHN	Primary Health Network
PsyBA	Psychology Board of Australia
RANZCP	Royal Australian New Zealand College of Psychiatrists
RCT	Randomised controlled trial.
READ	Ready materials, Extract data, Analyse data, Distil
SDM	Shared decision making
SPSS	Statistical Package for the Social Sciences
UTS	University of Technology Sydney
WHO	World Health Organisation

Abstract

Background: Many people with mental health problems utilise a range of complementary medicine (CM). Psychologists are likely to consult with clients who use CM, in some form, as part of their wider mental health treatment. This thesis examines the extent and ways in which psychology, as a health care discipline, and psychologists in clinical practice, engage with CM.

Methods: Documents relating to the governance or guidance of psychologists' clinical practice (e.g., ethical guidelines) from Australian professional associations and regulatory bodies, were analysed for reference to CM. Survey data was also collected and analysed from 202 Australian psychologists exploring aspects of CM engagement in their clinical practice. Finally, a thematic analysis was applied to interview data from 19 Australian psychologists to understand their perceptions and experiences of CM in their clinical practice.

Results: Despite the absence of any reference to CM in policy and guidelines for Australian psychologists, they are indeed engaging with CM in various ways including discussing CM with clients, recommending CM to clients, and referring to CM practitioners Psychologist engagement with CM in their clinical practice can be understood, in part, in terms of number of wider developments: as one means by which psychologists can attempt to be client-centred; as a response to client preferences; and as part of an exploration for a diversity of therapeutic approaches and tools which can to be utilised in clinical practice.

Conclusions: Substantial numbers of psychologists engage with CM as part of their clinical practice and perceive such engagement as positively relating to wider demands and trends facing their profession. The findings from this thesis suggest the

engagement with CM amongst psychologists in clinical practice is a significant issue that will require further consideration by the wider profession with regards policy, research, and education developments.

Chapter 1. INTRODUCTION

1.1 Preface

This thesis provides a critical assessment of psychology's (as a profession, its professional associations, regulatory bodies, academic bodies, and elite) relationship with complementary medicine (CM). The thesis centres on psychology (as a health care profession) and psychologists' (as practitioners in clinical practice) engagement with CM in Australia. Specifically, are psychologists in Australia engaged with CM? If psychologists are engaged with CM, how do they engage, and what are the justifications and challenges around any engagement they may have with CM? This chapter begins with an overview of the aims and scope of the thesis, including a statement of the research aim and objectives. The chapter then outlines historical and international contexts, offering insight into psychology (professional associations, regulatory bodies, and academia) in Australia broadly. This chapter also presents a summary of the frameworks that inform psychologists in clinical practice broadly and details the current landscape of psychologists in clinical practice in Australia. This chapter also provides a critical overview of psychology's identity and culture. The section on psychology is followed by an introduction to CM as a health care approach, CM in the context of mental health care, and the potential intersection between psychology and CM in the context of clinical practice of psychologists in Australia.

For the purposes of this research, psychology is defined as a professional and academic field that focuses on research, education, clinical practices, and policy for psychologists. As such, the use of the term psychology throughout this thesis also refers to psychology's academic and professional elite, those that hold power, influence, and have authority over the field in Australia. The psychology elite include the key members of regulatory bodies, academic bodies, and professional organisations that

influence and oversee how psychologists are educated, how they work in clinical practice, and their professional registration requirements. In many countries, including Australia, the title of "psychologist" is protected and can only be used by persons who have completed a specified sequence of tertiary training and subsequently attained formal registration as a psychologist. Thus, the term psychologist is used here to refer to a person who has attained formal registration as a psychologist.

1.2 Introduction

Psychologists in Australia work in a variety of settings, with most providing services to people experiencing mental health symptoms. There is high use of CM among people with mental health symptoms (Clossey et al., 2023; Olsson et al., 2021; Ong et al., 2021), including in Australia (Harnett et al., 2023; McIntyre et al., 2021; McIntyre et al., 2016; Reid et al., 2016). This high use of CM among people with mental health symptoms, suggests that those who are receiving the services of psychologists are also likely to be using CM in some form. However, little is known about how the field of psychology engages with CM, and how psychologists in clinical practice engage with their clients' use of CM. Although previous international and Australian research indicates some psychologists are interested in CM in some form, it is unclear if they are indeed engaging with CM in their clinical practice. The lack of clarity regarding psychology and psychologists' engagement with CM underscores the need for further exploration of the role and relevance of CM within the field of psychology in Australia.

1.3 Significance and scope of thesis

This is the first study to investigate how both psychology, and psychologists, engage with CM within the clinical practice of psychology in Australia. The current

thesis is unique, as it draws upon analysis of the formal policy and guideline environment that informs the clinical practice of psychologists in Australia, as well as grass-roots perspectives and experiences of psychologists who are in clinical practice. The current thesis makes a significant contribution to the fields of psychology, CM, and public health, by addressing knowledge gaps related to how psychology and psychologists in Australia engage with CM products, practices, and practitioners in the context of clinical practice. Subsequently, the current thesis may assist in the development of university curricula, development and/or modification of psychology clinical practice guidelines, development of CM relevant resources to assist safe and ethical clinical practice, and inform future CM and psychology research in Australia. On an international level, the outcome of this research may also provide psychology in Australia with initial guidance toward integrative practice, in accordance with the World Health Organisation (WHO) Traditional Medicine Strategy (World Health Organisation, 2013). The Traditional Medicine Strategy encourages member states to acknowledge the role of CM, particularly in the context of reducing the burden of mental health care on individuals and health care services, and to contribute to equity in health care access (World Health Organisation, 2013, 2023).

1.4 Research Aim & Objectives

The overarching aim of this thesis is to explore the contemporary relationship between psychology and CM in Australia. The below outlines the specific aims of the thesis.

1. To understand the historical and current landscape of the wider discipline of psychology that informs psychology's, and psychologist's, relationship with CM.

2. To understand in what ways, and to what extent, Australian psychology regulatory bodies and associations consider CM relevant to clinical practice. Specifically, how these regulatory bodies and professional association's formal policy, ethical and clinical practice guidelines, engage with CM.
3. To understand how much, and in what ways, Australian psychologists recommend CM products and/or practices, and/or initiate referrals to CM practitioners as part of their clinical practice.
4. To understand what types of CM products, CM practices, and CM practitioners are recommended and/or referred to by Australian psychologists as part of their clinical practice.
5. To understand whether Australian psychologists perceive their knowledge of CM as adequate in the context of their clinical practice.
6. To understand the relationship between Australian psychologists' perspectives about the efficacy, risks, and relevance of CM in psychology and their rates of recommending and referring to CM
7. To understand how Australian psychologists, who already, or wish to, engage with CM within their clinical practice, perceive the justifications for, and challenges to, their engagement with CM within their clinical practice and the broader discipline of psychology.
8. Finally, the research aims to offer insights that can contribute to discussions regarding the existing regulatory landscape and policy considerations concerning the future dynamics among psychology, psychologists in clinical practice, and their interaction with CM in Australia.

1.5 Thesis structure

This body of work has been developed as a thesis by compilation. This is a sequential mixed methods thesis consisting of three discrete but interrelated phases. Each of these three phases help to address the overarching aims and specific research questions, as outlined in the introductory chapter, to explore the contemporary relationship between psychology and psychologists, and CM in Australia. The thesis has resulted in four published journal papers (Chapters 2, 4, 5 and 6). As the research evolved across the thesis, the introduction and discussion subsections of those chapters overlap to some degree. The structure of this thesis is outlined below.

Chapter 1 provides an overview of the aims, scope, and structure of the thesis. Chapter 1 also presents an overview of the history of psychology as a discipline, as well as how psychology has emerged, and functions, as a health care discipline in Australia. Finally, an overview of CM and collaborative care is provided.

Chapter 2 reports on the historical and current landscape of psychology's relationship with CM by providing a critical integrative review of literature that discusses psychology, and psychologists', relationship with CM. The integrative review also incorporates previous quantitative and qualitative literature that discusses psychology/psychologists' relationship with CM internationally. This integrative review has been published by *Heliyon*.

Chapter 3 outlines the methodology employed throughout the thesis. There are three discrete but interrelated phases employing sequential mixed methods comprising a document analysis, survey data collection and quantitative analysis, and qualitative interviews and thematic analysis. Each phase of the thesis aims to address one or more specific research questions, to address the objectives outlined above.

Chapter 4 presents the findings from the document analysis which critically evaluates existing CM relevant guidelines available for psychologists and will be indicative of how psychology's professional associations and regulatory bodies consider CM relevant to psychology practice. The document analysis aims to address the research question: to what extent and in what ways does psychology's regulatory bodies and professional associations in Australia consider CM relevant to psychology practice? This document analysis has been published by *BMC Complementary Medicine and Therapies*.

Chapter 5 is the first of two quantitative results chapters. Chapter 5 presents survey data collected from psychologists in Australia who were asked to respond to questions relating to psychologist engagement with CM in clinical practice. The statistical analysis of the survey data revealed psychologists in Australia have considerable engagement with CM in their clinical practice. This statistical results paper has been published by *PLOS One*.

Chapter 6 is the second quantitative results chapter and provides additional results from the survey data collected from Australian psychologists. The second results chapter presents the statistical analysis of psychologist frequency of engaging with CM, self-rated knowledge of CM, and risk and relevance of CM were analysed. This statistical results paper has been published by *BMC Complementary Medicine and Therapies*.

Chapter 7 presents the first of two qualitative results chapters. The thematic analysis of semi-structured interview data, extracts of dialogue with psychologists in clinical practice, revealed two primary themes of justifications and challenges. Chapter

7 reports results of the reflexive thematic analysis to understand how psychologists in Australia present justifications for the inclusion of CM within psychology.

Chapter 8 presents the second qualitative results chapter. This chapter provides the results of the reflexive thematic analysis applied to interview data to understand how psychologists in Australia experience challenges related to the inclusion of CM within their clinical practice.

Chapter 9 provides discussion of the qualitative results presented in Chapters 7 and 8. This discussion chapter outlines key findings from the reflexive thematic analysis that are considered especially important and significant in the context of the aim and objectives of this thesis.

Chapter 10 provides an overall discussion of the main research findings of the thesis and considers their implications on a number of fronts and for a number of stakeholders. The chapter includes consideration of limitations of this research as well providing suggestions for future research to explore CM in the context of psychology and psychologists in clinical practice.

Chapter 11 provides a conclusion to this thesis, including a summary of the findings that address the study aim and objectives.

This is a sequential mixed methods thesis of three discrete but interrelated phases. Each of these phases help to address the overarching aim, to explore the contemporary relationship between psychology and CM in Australia.

1.6 Psychology

The etymology of the word *psychology* comes from the Greek roots of *psyche* meaning soul and *logos* meaning study or science (Benjamin Jr, 2023).

Psychology is a broad field encompassing research, education, and the direct application of psychological interventions to individuals and groups. The field of psychology provides insights into a broad spectrum of topics including sensation, perception, personality, cognition, learning, memory, intelligence, and psychopathology. The evolution of psychology has occurred across distinct periods and paradigms as well as theoretical orientations including; structuralism and functionalism, psychoanalysis and psychodynamic theory, behaviourism, humanistic and existential, neurosciences, and biological perspectives (Benjafield, 2019; Hyland, 2023). Psychology has evolved to encompass diverse topics and methodologies that explore the complexities of human experience and behaviour. Contemporary psychology offers rigorous methods to understand and improve human cognition, emotion, and behaviour in diverse settings, from hospital emergency departments to advertising campaigns.

1.6.1 Brief history of psychology

Psychologists from Western and European countries are taught that psychology first appeared in universities in Europe and America around 1879 (Benjamin Jr, 2023). Psychology arose to an independent discipline (separate from philosophy) which focussed on exploring, explaining, and assisting individuals whose illness had no evidence of physical origin or pathophysiology (Benjafield, 2019). These illnesses were described as nervous conditions (Hyland, 2023). However, even from its early days psychology has experienced division among its constituents (Richards & Stenner, 2022) as to how best conceptualise, assess, and treat these nervous conditions. The division

among constituents mostly related to some of the pioneers of psychology seeking to ensure psychology was considered a pure science at universities, while others felt psychology was an applied field that belonged in technical colleges (Hyland, 2023; Pickren & de França Sá, 2024). Psychology also experienced existential challenges around whether psychology operates as a hegemonic scientific discipline, or whether it adopts a more inclusive interdisciplinary approach, that embraces various modalities and serves diverse populations, including different cultures (Bhatia, 2019; Pickren & de França Sá, 2024). Some of these challenges and divisions will be discussed throughout the thesis.

These professional identity challenges and divisions in psychology appear to originate around the time psychology tertiary courses were being established at universities (Benjafield, 2019). Wilhelm Wundt, a German physiologist, and philosopher is credited with establishing the first experimental psychology laboratory in the late 1800s. Wundt sought to establish psychology as an applied science through the quantification of mental processes. Meanwhile Sigmund Freud, an Austrian neurologist, sought to establish psychological theories, rather than biological mechanisms, as a potential cause of mental illness, such as adverse childhood experiences leading to mental illness. Around that time, Freud's hypotheses were not considered quantifiable, and thus not scientific. Nonetheless, Freud, and his protégé Carl Jung, are perhaps the most prolific early authors of psychology text and the development of psychology tertiary courses, that included the process and techniques of talking therapies. Another pioneer of the time, Willam James, an American physician, was also a significant influence on early psychology, particularly at Harvard University. James lectured on the connection between mind and body as well as the role of spirituality in mental illness and psychological wellbeing. James pioneered aspects of applied psychology including

concepts that inform contemporary principles of education, learning, and motivation. Thus, by the early 1900s, psychology had formed two distinct branches: a "pure" science and an applied science.

Throughout the early twentieth century, psychology made significant progress as a distinct discipline, including the development of personality theories, psychological assessment tools, the differentiation and specialisation in child psychology, behavioural therapy approaches, and the role of cognition in mental illness. However, the divisions in psychology continued with tensions between Wundt ("pure" science) and James'(applied) methodological approaches to psychology (Benjamin Jr, 2023). These challenges to psychology appear to arise from whether one viewed psychology as oriented toward a singular specific approach to psychology (e.g., adherence to cognitive psychology a sole treatment psychotherapy for depression), or toward working on specific problems or disorders and tailoring diverse psychological approaches to address problems (e.g., pluralistic and interdisciplinary approaches toward treating depression) (Zagaria et al., 2020). Despite these tensions, both theoretical and applied approaches to psychology have significantly shaped its trajectory, paving the way for deeper explorations into the complexities of the field, particularly concerning psychology's methodologies and evolving paradigms.

1.6.2 Psychology's identity

The tensions within psychology, as described above, continue today (Benjafield, 2019; Gamsakhurdia, 2020; Richards & Stenner, 2022). There are some within, and external to, psychology that debate if psychology is a distinct unified profession or a collection of disciplines (Green, 2015). Further, some argue psychology should be monistic with a strong focus on scientific methods as the primary approach – a unified

framework based on high levels of empirical evidence – where diversity in approaches may be seen as potentially diluting the scientific rigor of psychology (Benjamin Jr, 2023; Silander & Tarescavage, 2023; Thomas, 2022; Walach, 2020). In contrast, plurality would be inclusive of diverse approaches, methodologies, theories, and perspectives. A pluralistic approach to psychology acknowledges that no single approach to psychology can fully capture the complexity of human experience and acknowledges that different approaches, and interdisciplinary collaboration, can offer valuable insights to understanding psychological phenomena (Leichsenring & Steinert, 2017; Lokugamage et al., 2021; Rodax & Benetka, 2021; Zagaria et al., 2020).

An illustration of some of the tensions in psychology can be found in America where there are two separate professional psychology groups, the American Psychological Association (APA) and the group, the Association for Psychological Science were formed with different agendas for psychology. It is reported the Association for Psychological Science subsequently formed to preserve the scientific autonomy of psychology (Cautin, 2009; Silander & Tarescavage, 2023). There is another example of tensions within psychology in Australia. A similar fractious situation emerged in Australia in 2006 following the elevation of clinical psychologists under the Australian government's Medicare Benefits Schedule (detailed in Section 1.7.5). Tensions, after the announcement of the Medicare Benefits Schedule's two-tiered rebates for psychologists (elevating clinical psychologists), resulted in two primary and distinct professional psychology groups in Australia, the established Australian Psychological Society (APS) and the recently formed Australian Association of Psychologist Inc (AAPi). It is reported the AAPi was established to "serve the needs of *all* psychologists" (Australian Association of Psychologist Inc, 2024), distinct from the APS which was viewed by some psychologists as focused heavily on the needs of

one group of psychologists, clinical psychologists (Australian Association of Psychologists Inc, 2024; Mathews, 2018). The literature suggests that psychology, akin to divisions in other health care professions, encounters divergence within the profession (Abimbola et al., 2021; Bradfield et al., 2023; Eichbaum et al., 2021; García & Ibáñez, 2022; Ibáñez et al., 2017; Sidhu et al., 2020).

There are also divisions within contemporary psychology between academic scholars and practitioners in clinical practice, regarding the application of psychological theories and methodologies (Fasce & Adrián-Ventura, 2020; Ligorio & Lyons, 2018; Ødemark & Engebretsen, 2022). These tensions have been described as "privileging narrow expertise over general intellectuality" (Pickren & Teo, 2020, p. 3), however this critique could apply to the elevation of clinical psychology in Australia (noted above). It appears divisions within psychology, such as academic schisms and disciplinary bifurcation, have been present since psychology's establishment as a discipline (Cautin, 2009; Green, 2015). These divisions within psychology are reiterated here as they reflect important elements of the landscape of psychology in Australia, and thus has the potential to impact psychology's relationship with CM, as discussed below.

1.6.3 Decolonising psychology

Psychology, its methodologies and practices, is not immune from dilemmas relating to power structures, biases and inequalities. Amidst the divisions within the profession, a history of Western-European dominance emerges, shaping the landscape of psychology's methodologies and clinical practice (De Vincenzo et al., 2024; Henrich et al., 2010). Unfortunately, the process of knowledge construction is often dependent on prevailing social and political contexts, potentially leading to the exclusion of other epistemologies (Goldney, 2018; Pickren & de França Sá, 2024). Epistemic exclusion in

psychology can be described as devaluing scholarship outside of dominant conventional psychology and excluding contributions to the production of relevant knowledge that is made by people from other fields, such Indigenous healing approaches to mental health care (Ciofalo et al., 2022; Settles et al., 2021). Epistemic exclusion is evident in the historical narrative of psychology which predominantly revolves around Western–European identities, as described above (Henrich et al., 2010). Critics argue that psychology maintains a Western hegemonic discourse, promoting a narrow understanding of psychological and social realities, while marginalising other epistemologies and their corresponding psychological realities (Grzanka & Cole, 2021; Henrich et al., 2010; Pickren & de França Sá, 2024; Reddy et al., 2021; Settles et al., 2021). It is important to note psychology broadly is undergoing reform to address its Western-European dominance. For example, the psychology profession in some jurisdictions (outside of Australia) has acknowledged historical ethnocultural and epistemic exclusion and has been aiming to enact reparation (Ciofalo et al., 2022; Pickren & de França Sá, 2024; Tummala-Narra, 2022). In the context of psychology in Australia, literature suggests there may be a need to shift towards decolonisation, in education and research, and create new understandings in the field of psychology (Clark & Hirvonen, 2022). Indeed, a narrow view of psychological realities has implications for the individuals served by psychology, potentially overlooking aspects of their lived experience, and overlooking the potential contributions from other health care fields that may contribute to mental health care.

In the context of this thesis, it is important to consider the potential for epistemic exclusion within psychology and the potential implications for psychologists in clinical practice. An example of an implication for psychologists in clinical practice may be a limited understanding of the relevance of ethnocultural approaches to mental health care

to some clients, such as some forms of CM that have ethnocultural relevance (e.g., Indigenous healing practices). From a scholarship perspective, inaction and neutrality may be viewed as complicit in the context of historical epistemic exclusion. Thus, it may be important for contemporary psychology, including clinical practice, education, and research methodologies, to become more inclusive. An example of psychology's effort toward reparative action is the American Psychological Association's (APA) Race and Ethnicity Guidelines (American Psychological Association, 2019) which acknowledges the historical neglect of non-Western healing methods, and emphasises the importance of understanding Indigenous resources for healing (Blignault et al., 2018; Blignault & Kaur, 2019). The APA's guidelines encourage psychologists to engage with their client's cultural beliefs and culturally orientated practices (Mattar & Frewen, 2020). It is important to remain mindful of the potential for epistemic exclusion, as well as the influence of power structures and bias, which may permeate every aspect of psychology. However, while the APA works towards reparation and encourages psychologist engagement with client's ethnocultural preferences, these guidelines do not directly apply to psychologists in clinical practice outside of the APA's jurisdiction in America. Nonetheless, awareness of the risk of epistemic exclusion and potential for bias in psychology broadly underpins the description of core principles in psychology, as discussed below.

1.6.4 Scientist-practitioner model in psychology

A core principle in the clinical practice of psychology is the scientist-practitioner model. The scientist-practitioner model recommends psychologists are trained in an "integrative approach to science and practice wherein each must continually inform the other" (Belar & Perry, 1992, p. 72). The scientist-practitioner model for psychology practice was first introduced in 1949, however it is reported the model arose out of

tensions between scientists/academics and practitioners in clinical practice (Castonguay et al., 2019; Moriana & Gálvez-Lara, 2020). These tensions relate to a disconnect between academic's research evidence for manualised psychotherapies and how grass-roots psychologists interpret and apply these psychotherapies in their clinical practice. Despite these tensions, the scientist-practitioner model continues to be the objective of professional training in psychology (Barrett et al., 2023; O'Gorman, 2001). The scientist-practitioner model suggests it is imperative to educate psychologists to develop a reciprocal relationship, where the psychologist applies scientifically informed methods to the psychological therapies they employ in their clinical practice, and vice-versa. Thus, psychologists are educated to be both consumers and producers of research (Australian Psychology Accreditation Council, 2023; Belar & Perry, 1992; Jones & Mehr, 2007; Paulik et al., 2020). The scientist-practitioner model is a cornerstone of psychology and informs the development of other key frameworks for clinical practice discussed below.

1.6.5 The biopsychosocial model

Another core tenet of clinical practice in psychology is based on Engel's biopsychosocial model. The biopsychosocial modal was proposed as an extension of the dominant biomedical model of disease where health practitioners are encouraged to consider the social, psychological and behavioural dimensions of illness (Engel, 1977, 1980). Interestingly, Engel proposed that a practitioner's use of deductive and reductive reasoning, in collaboration with a client in health care settings, is present across CM [folk medicine] and modern medicine as a means to achieve wellbeing (Engel, 1980). Engel proposes that practitioners should adopt a broader and more inclusive perspective (e.g., the biopsychosocial model) when addressing clinical problems, as opposed to the dualistic (separation of mind and body) and reductionistic (focus on symptoms rather

than whole person) approach of the biomedical model. In the realm of mental health and psychology, the biopsychosocial model suggests practitioners consider the client's health care needs in the context of psychological and social paradigms, such as the client's gender, education, workplace, home environment, and relevant health care policy (Bashmi et al., 2023; Pandey et al., 2024). There have been some criticisms from health care disciplines, such as psychology and medicine, that the biopsychosocial model needs to be even broader than first posited, and needs to be adapted to reflect social, cultural, economic and political issues, as well as shifts towards personalised/precision medicine (Bashmi et al., 2023; Gómez-Carrillo et al., 2023; Horwitz et al., 2021). The biopsychosocial model continues to be taught as a core tenet of health care in tertiary curricula for a number of medical and health disciplines, including psychology (Taukeni et al., 2023; Turner et al., 2023). The core principles of clinical practice in psychology encourage a whole person approach to mental health care.

1.6.6 Evidence-based practice in psychology (EBPP)

Evidence-based practice (EBP) is another core framework in psychology, particularly for psychologists in clinical practice. Originating from evidence-based medicine (EBM), EBP embodies a tripartite model that integrates the best available research evidence with clinical expertise and the client's characteristics and values (McKnight & Morgan, 2020; Sackett et al., 1996). Evidence-based practice (EBP) allows the principles of EBM to be translated into the clinical practice of other health care disciplines, including psychology (Alatawi et al., 2020; Paci et al., 2021; Portney, 2020). Evidence-based practice in psychology (EBPP), in contemporary psychology practice, refers to the integration of the best available research, clinical expertise of the psychologist, and client characteristics, culture, and preferences (Melchert et al., 2023;

Ward et al., 2022). There are some criticisms that EBM, and thus EBPP, is misinterpreted. For example, there is criticism that health care professions place too much importance on high level research evidence (such as randomised control trials and meta analyses) (Berg & Slaattelid, 2017; Harnett & Myers, 2018; McKnight & Morgan, 2020; Sackett et al., 1996). Further, there is concern that EBPP relies on the assumption that all psychologists uphold epistemic virtues and have sufficient knowledge to understand the merits of different kinds of health care approaches and healing modalities, including Indigenous and ethnocultural healing practices (Berg, 2020; Grzanka & Cole, 2021). Psychologists are required to incorporate the above core tenets into their clinical practice, thus using their education to develop clinical expertise and critical discernment, while considering their client's values, preferences, and characteristics (e.g., social, economic, political, and cultural circumstances), and to select best evaluable evidence/evidence-based psychological therapies based (discussed below) on best available research, and their clinical experience (Melchert et al., 2023; Sackett et al., 1996; Ward et al., 2022). Different types of psychotherapies, and the evidence for these psychotherapies, are discussed below.

1.6.7 Evidence for psychological therapies

Psychological therapies emerged in the early 1900s. Psychotherapy, psychodynamic therapy, and psychoanalysis are terms often used interchangeably; however, each term describes a different approach to psychological theory and applied therapy. Psychotherapy is a broad term that encompasses talk therapies (i.e., verbal communication and interaction) that when applied, in the context of clinical practice, aims to address mental health problems. Psychoanalysis is a form of psychotherapy that explores the interaction of conscious and unconscious elements of the mind, bringing the unconscious into the conscious for analysis, and utilising any insights to create new

understandings and change (Benjafield, 2019). Traditionally psychoanalysis may take years of regular face-to-face therapy sessions between the psychoanalyst and the client. Although psychoanalysis is under the umbrella term of psychodynamic therapy, the term "psychodynamic therapies" generally includes a variety of psychological theories and therapies which are employed for short periods/lesser number of client sessions, and with a focus on problem solving and treatment goals/outcomes. One does not have to be a psychologist to apply psychotherapy in any form, and thus a range of professions (e.g., counsellors) utilise counselling skills and psychotherapy approaches as therapeutic tools in their professional clinical practice.

Following on from the above, it is important that psychologists select approaches with the best available evidence, often referred to as an evidence-based therapy/psychotherapy. Modern evidence-based psychotherapies employed by psychologists include Cognitive Behaviour Therapy (CBT), Dialectical Behaviour Therapy (DBT), Acceptance and Commitment Therapy (ACT), Eye Movement Desensitisation and Reprocessing (EMDR), Schema Therapy, Narrative Therapy, and Mindfulness-Based Cognitive Therapy (MBCT). Each psychotherapy is grounded in its own theoretical underpinnings concerning the aetiology of problems (the causes or origin of the symptoms/disorder), as well as the mechanisms and targets of therapy aimed at effecting change through talking therapy. For example, CBT draws on theories that propose therapeutic improvement comes about through changes in the content and processes of cognition, emotion regulation and behaviour (Leder, 2017). Each psychotherapy approach employs unique tools and techniques that reflect its underlying theoretical framework. For example, a specific technique in CBT is Socratic questioning where the client is gently guided by the psychotherapist to challenge commonly held beliefs and thoughts that may be unhelpful in the context of the client's presenting

problem, as well as helping the psychotherapist to see the world through the client's experiences (Overholser & Beale, 2023). In CBT it is believed that change occurs when the client is able to identify, challenge and replace unhelpful thoughts (Huibers et al., 2021). Behavioural activation, another specific technique in CBT, is the deliberate practice of behaviours that are considered desirable (in terms of a pleasant or constructive experience with a pleasant or constructive outcome) and in the context of the person's presenting problem. For example, a psychologist may recommend a client organise and attend an activity designed to improve social connection, such as meeting a friend for lunch. In summary, contemporary evidence-based psychotherapies encompass a variety of approaches and tools that psychologists can draw upon in clinical practice.

In line with the scientist-practitioner model and evidence-based practice in psychology, psychologists should select an evidence-based psychotherapy that demonstrates efficacy for their client's presenting problem(s). CBT has retained the position as the dominant form of evidence-based psychotherapy (David et al., 2018; Leichsenring & Steinert, 2017) due to its reported efficacy for a range of mental health problems (Salkovskis et al., 2024). Some contend that the perceived superiority of CBT stems, not from its inherent efficacy, but rather from a higher volume of research supporting CBT (Blackwell & Heidenreich, 2021; Copsey et al., 2021; Cuijpers et al., 2023). Others argue that CBT's prevalence in research is due its manualisation making it suitable for use in randomised controlled trials (RCTs) (Blackwell & Heidenreich, 2021; Salkovskis et al., 2024). Nonetheless, CBT is frequently cited as the gold standard in evidence-based psychotherapy approaches in Western countries (David et al., 2018), including for use in psychology tertiary curricula and subsequent clinical practice.

Although CBT is widely accepted as an evidence-based psychotherapy for psychologists to use in clinical practice, there is also concern that CBT has become incorrectly perceived as universally effective (Blackwell & Heidenreich, 2021; Hayes & Hofmann, 2017; Meadows et al., 2015). The literature reports that CBT may not consistently demonstrate efficacy for all mental health symptoms or across diverse populations (Huey et al., 2023; Leichsenring & Steinert, 2017), thus clinicians need to develop cultural competency and use their clinical expertise to actively adapt CBT to suit their clients' needs (e.g., ethnocultural needs) in clinical practice (Ayub et al., 2019; Huey et al., 2023; Phiri et al., 2023). Debate regarding the dominance of CBT has also contributed to debate surrounding the historical culture of psychology, implying that psychology actively seeks to uphold its position within the scientific and medical framework (Fennig & Denov, 2019; Hyland, 2023; Reddy & Amer, 2023; Richards & Stenner, 2022). The overemphasis on CBT, for instance, as a universal psychotherapy carries the risk of excluding individuals whose needs are not met by CBT. Moreover, an overemphasis on CBT could potentially shape the education and research priorities in psychology to align with CBT principles, potentially neglecting other effective therapeutic modalities. Indeed there is debate in the literature that being overly focused on particular forms of evidence, and particular psychotherapies, such as CBT, could leave psychology closed off to new or other psychotherapies (De Vincenzo et al., 2024; Wampold & Bhati, 2004). These internal debates within psychology regarding the selection and rationale behind using empirically supported psychotherapies, and associated tools in clinical practice, may influence the identity of psychology as a discipline. Further, overemphasis on one psychotherapy, CBT, may influence or reduce, the range of evidence-based psychotherapies from which a psychologist in clinical practice selects treatments from. Nonetheless, CBT remains the dominant

psychotherapy taught to psychologists, including at Australian universities (Impala et al., 2023; Petrik et al., 2023). How psychology makes decisions about what are effective tools for psychologists in clinical practice is important in the context of the current thesis, as it will provide some insights into what the required merits of specific therapeutic approaches in order for them are to be considered effective in psychologists' clinical practice.

1.6.8 Common factors theory

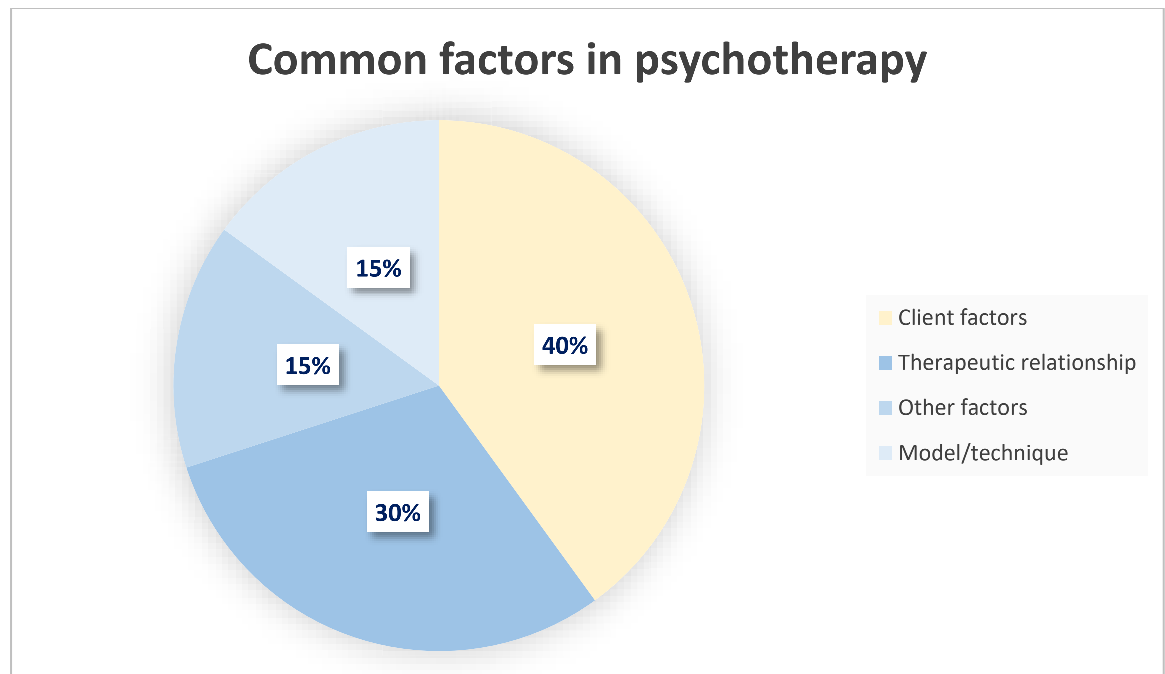
There are other elements or mechanisms that contribute to successful outcomes in psychotherapy, common to the delivery of all psychotherapy approaches in counselling settings, that are called c*ommon factors* (Wampold, 2015). Common factors include the quality of the relationship/alliance between psychotherapist (in this case the psychologist) and the client, mutual collaboration on goals and treatment approaches, the client's experiential validity of the psychotherapy approach and setting, and client expectations that therapy will be successful. The therapeutic relationship encompasses the feelings and attitudes between the psychotherapist and the client, along with their expression, its impacts are extensively researched (Norcross & Wampold, 2018; Wampold, 2015). When these interpersonal interactions include specific elements, the therapeutic relationship becomes a functional component of counselling and/or the psychotherapy relationship. Interestingly, despite the emergence of newer psychotherapies (e.g., Acceptance and Commitment Therapy) these common factors continue to be identified as key mechanisms for successful psychotherapeutic outcomes (Bayliss-Conway et al., 2021; Buchholz & Abramowitz, 2020; Cuijpers et al., 2019; Murphy et al., 2022; Salkovskis et al., 2024). It is important to note that there is also debate about the relevance and value of these common factors in psychotherapy, and if

and how these common factors act as mechanisms of change in psychotherapy (Tzur Bitan et al., 2022; Wampold & Imel, 2015).

Research on common factors suggests that there are consistent proportions of these elements (e.g., quality of the therapeutic relationship) across various psychotherapies when implemented in counselling settings, which are associated with successful outcomes in psychotherapy (Cuijpers et al., 2019; Wampold, 2015). There is dispute on how to organise the role of these proportions of common factors (Norcross & Lambert, 2018). For simplicity, Figure 1.1 is presented below to demonstrate the percentage each of these common factors that are reported to contribute to outcomes in psychotherapy. Approximately 40% is attributed to client related factors, such as their motivation, readiness for change, and social supports. Importantly, 30% is attributed to the quality of the therapeutic relationship, which includes rapport between the psychologist and their client, the psychologist's flexibility and ability to adapt, the psychologist's cultural responsivity and sensitivity, and clear and sustained professional boundaries. The quality of the therapeutic relationship is considered the most powerful of the common factors and has been described as a robust predictor of therapy outcomes (Buchholz & Abramowitz, 2020; Cooper et al., 2022; Murphy et al., 2022). A further 15% is attributed to other factors, such as hope, expectancy, and placebo factors. Finally, research consistently reports that approximately 15% of successful outcomes in psychotherapy can be attributed to the specific technique and/or model employed by the psychologist (e.g., CBT) (Wampold, 2015).

Figure 1.1

Contribution of common factors in psychotherapy



Note. Figure adapted from several resources (Fruggeri et al., 2023; Lambert, 1992)

Proponents of these common factors propose that regardless of the type of psychotherapy, the evidence for the psychotherapy, and the length of training required for mastery, *all* psychotherapies appear to be effective due to the presence of these common factors (Cuijpers et al., 2019; Norcross & Wampold, 2018; Salkovskis et al., 2024; Wampold, 2015). Further, any differences in effectiveness among the psychotherapies, including CBT, is small (Leichsenring et al., 2022; van Agteren et al., 2021). To be clear, common factors research attributes a small proportion of psychotherapy outcomes to the specific model/techniques (e.g., CBT) regardless of the

research evidence for the model/technique. In common factors research a larger proportion of success in psychotherapy is attributed to the quality of the therapeutic relationship, including empathy, flexibility, collaboration, and responding to client's preferences. The common factors theory is not without criticism, particularly from those who are proponents of specific psychotherapy techniques with high levels of evidence (e.g., CBT) (Fruggeri et al., 2023; Mulder et al., 2017). Nonetheless it is important to note that there is empirical evidence to support other factors, beyond specific psychotherapy technique (e.g., CBT), that contribute to outcomes in psychotherapy, such as the quality of the therapeutic relationship.

The above core frameworks and key principles (e.g., scientist-practitioner model) apply to psychology and the clinical practice of psychology broadly. However, each geographical jurisdiction will have a professional psychology advisory and/or professional member association (e.g., APA in America) to support how its constituent psychologists incorporate these key frameworks and principles, usually in the form of clinical practice guidelines (discussed below).

1.6.9 Clinical Practice Guidelines

Clinical practice guidelines (sometimes referred to as ethical guidelines/considerations) collate and synthesise large amounts of information on how to safely incorporate the best available evidence for approaches, for specific groups of people (e.g., children and young people), and for specific presenting problems (e.g., mood disorders). The types of treatment provided by psychologists often includes the direct application of psychological interventions, such as supportive counselling paired (e.g., therapeutic relationship) with specific evidence-based psychotherapies (e.g., CBT) and techniques (e.g., Socratic questioning), thus it is important psychologists have

resources to guide their incorporation of these approaches into their clinical practice (Correa et al., 2020; Medina et al., 2020; Pereira et al., 2022). Psychology professional organisations, like the American Psychological Association (APA) and Australian Psychological Society (APS), provide these resources for their member psychologists in the form of clinical practice guidelines. An example of a clinical practice guideline from the APS in Australia is the *Ethical guidelines for managing professional boundaries and multiple relationships* (Australian Psychological Society, 2016a). Clinical practice guidelines are not only a vital tool for translating evidence into practice, they also offer guidance on research methodologies and specific therapies to address challenges faced by diverse groups, including consideration of age, gender, sexuality, and ethnocultural background (Pereira et al., 2022). For example, another clinical practice guideline from the APS is the *Ethical guidelines for psychological practice with lesbian, gay and bisexual clients* (Australian Psychological Society, 2010). Some clinical practice guidelines have drawn criticism for failing to account for the diverse needs of populations, potentially limiting their clinical utility (Huey et al., 2023; Jorm et al., 2017). Moreover, the lack of clinical practice guidelines across a range of mental health problems has also been raised in the literature (Correa et al., 2020; Stapleton et al., 2015). Another contention is that clinical practice guidelines may be overly enforced and considered as rigid rules, rather than as clinical guidance for psychologists (Heatherington et al., 2012; Stiles & Fox, 2019). Clinical practice guidelines available to psychologists in Australia will be reviewed as part of this thesis (Chapter 4). Developing universally applicable guidelines for every presenting problem may not be possible, nonetheless clinically relevant clinical practice guidelines encourage psychologists toward evidence-based, inclusive, adaptive, and flexible practice.

Despite the historical and current contestations described above, key attributes of a *good psychologist* emerge – what is good psychology, and what it means to be a good psychologist. Based on the information above good, authentic, effective psychology practice would include utilising clinical expertise (e.g., scientist-practitioner training), discernment about a broad range of evidence-based approaches to mental health care, acknowledging client preferences, collaborating with other relevant health care approaches, and adaptive, flexible and innovation practice. Drawing on psychology's history, frameworks and clinical practice guidelines, effective psychology/psychologists leverage scientist-practitioner training to consider and select from a broad range of empirically supported interventions and apply these interventions to the client's presenting problem(s). Further, an effective psychologist would be client centred, fostering an effective and collaborative therapeutic relationship with the client, while considering and including the client's characteristics, values, preferences, social and ethnocultural background (Barrett et al., 2023; Gonsalvez, 2022; Vriesman et al., 2023). In contrast, one may consider that ineffective psychology/psychologists are not innovative, not responsive, not inclusive, and perhaps overly focused on a narrow set of prescribed rules, ideologies and therapy approaches. Given psychology's history, mandates, frameworks, and contestations above, there may be a number of interpretations of what is good, effective, and authentic psychology.

Having broadly defined psychology, and the key attributes of an effective psychologist, we now turn our attention to psychology in the Australian context. By reviewing the landscape of psychology in Australia, and the clinical practice of psychologists, we gain insight into how Australian psychology defines its role, and how psychology interacts with the wider health care landscape, including other health care approaches, such as CM.

1.7 Psychology in Australia

1.7.1 Key actors in psychology

To gain insight into the landscape of psychology in Australia it is important to review the key organisations and regulatory bodies that influence and inform psychologists in clinical practice in Australia. Psychology in Australia is governed by four key bodies: the Psychology Board of Australia (PsyBA), the Australian Psychological Society (APS), the Heads of Departments and Schools of Psychology Association (HODSPA), and the Australian Psychology Accreditation Council (APAC). These organisations have interconnected relationships, as evidenced by APAC's governance structure which includes three voting members: the APS, PsyBA, and HODSPA. These four organisations, their executive committees and boards, are the primary power structures that have influence on the education, registration, and clinical practice of psychologists in Australia. The APS, a psychology professional membership organisation, has largely been responsible for the development of resources, including clinical practice guidelines, for psychologists in Australia. Other psychology professional membership organisations have recently emerged in Australia, such as the Australian Clinical Psychology Association. However, these smaller emerging professional psychology organisations have not yet shown a similar level of influence within the psychology profession in Australia compared to the APS. The Australian Association of Psychologists Inc (AAPi), another psychology professional membership organisation, is gaining momentum and appears to have a strong advocacy presence, such as lobbying government on topics relevant to psychologists and their clients (Australian Association of Psychologists Inc, 2024). While the AAPi is gaining momentum, the key power structures in psychology in Australia are PsyBA, APS,

APAC, and HODSPA. At the time of writing this thesis the APS was proposing a rebranding to *Psychology Australia.*

To illustrate the timeline of influence the key power structures in psychology in Australia have, here is an example of an individual's pathway to become a registered psychologist in clinical practice in Australia. To become registered as a psychologist there is a period of formal tertiary education (psychology tertiary course content is informed and accredited by APAC (and thus approved by the PsyBA). APAC has a relationship with HODSPA as a link to discuss psychology university courses. APAC guidelines are also interpreted by academic personnel, such as psychology course developers and coordinators, as to what should be included in psychology courses. After completing tertiary training, the psychologist applies for registration with PsyBA. The PsyBA is one of 15 national boards overseeing the health workforce under the Australian Health Practitioner Regulation Agency (Ahpra) (Ahpra and the National Boards, 2023b). Following registration, the psychologist must participate in ongoing registration requirements around professional development activities, receive supervision, and adhere to ethics and clinical practice guidelines (guidelines to date are mostly provided by the APS – see Chapter 4). Of note, even if a psychologist is not a member of the APS, if they have had a complaint against them, the PsyBA (under Ahpra) may forward the complaint to a tribunal to formally review the complaint against existing APS clinical practice guidelines. For example, if there is a complaint against a psychologist in the Australian state of New South Wales (NSW) the PsyBA will forward the complaint to the Psychology Council of New South Wales. The complaint will be reviewed in the context of an expert psychologist's interpretation of the APS' Code of Ethics (Australian Psychological Society, 2007b) and the relevant clinical practice guidelines. The table below provides a summary of key actors in

psychology in Australia and their authority and/or role in psychology and potential influence on psychologists in clinical practice.

Table 1.1

Key Actors in Psychology in Australia

Name/acronym	Role
Australian Health Professionals Regulation Agency (AHPRA) www.ahpra.gov.au	Primary role is to protect the public by ensuring health practitioners are suitably trained, qualified and safe to practise. Made up of 15 national health practitioner boards including the Psychology Board of Australia. See Psychology Board of Australia
Psychology Board of Australia (PsyBA) www.psychologyboard.gov.au	PsyBA manages the registration process for psychologists. Psychologists pay for their registration each year. Sets regulatory standards, codes, guidelines, updates and other resources for practitioners, employers, students. Manages complaints made about individual psychologists. The PsyBA may refer complaints to independent state/territory based tribunals to hear the case and make recommendations about consequences for the individual psychologist.
Australian Psychology Accreditation Council (APAC) www.apac.au	Independent quality and standards organisation and the accrediting authority for the education and training of psychologists in Australia. Influence over what and how psychology content is included in psychology courses.

Heads of Departments and Schools of Psychology Association (HODSPA) www.hodspa.org.au	HODSPA describe themselves as leaders in Australian Higher Education, Research, and Training in psychology. Interpret APAC guidelines and decide what is included in psychology courses. Prepares submissions to relevant psychology associations.
Australian Psychological Society (APS) www.psychology.org.au	Professional membership organisation for psychologists. Approximately 27 000 members. Formed in 1966. Produced current Code of Ethics for psychologists. Producer of ethical guidelines, professional development and professional magazine/journals for members.
Australian Association of Psychologists Inc (AAPi) www.aapi.org.au	Professional membership organisation for psychologists. Approximately 9000 members. Formed in 2010 Not for profit organisation. Arose in response to advocating for removal of the Medicare two-tier rebate system under (explained below). Producer of professional development resources for members.

1.7.2 Pathways to registration as a psychologist

The following is a brief overview of the different pathways to general registration, and additional specialty training, for psychologists in Australia. These pathways are highlighted here, as engaging in specialty training in psychology can shape a psychologist's subsequent clinical practice (such as influencing theoretical orientation and psychotherapy techniques) (Liao et al., 2022; Lucock et al., 2006). These pathways entail different university curricula and periods of supervised practice requirements/periods, potentially influencing how psychologists acquire knowledge about CM (Ligorio & Lyons, 2018). Therefore, exploring these differences is important for understanding how they might affect a psychologist's engagement with CM in their subsequent clinical practice. There are two primary pathways to gain general registration as a psychologist, each of which require a six year sequence of education and training, they are called the "5 + 1 pathway", and the higher degree pathway (Psychology Board of Australia, 2023c; Society, 2024), each of which will be described below. Students must select an APAC accredited/PsyBA approved tertiary course (Psychology Board of Australia, 2023a).

The 5 + 1 pathway entails a four year sequence of study, followed by a fifth year of tertiary study (Master of Professional Psychology), which is then followed by a one year internship. The Master of Professional psychology includes a range of subjects on professional practice, psychological assessment and intervention, and a minimum of 300 hours of work integrated learning/placement. The one year internship must be supervised by a psychologist who has completed supervisor training (accredited by PsyBA) and then approved as a supervisor by the PsyBA (Psychology Board of Australia, 2023e, 2023g). The internship includes a range of activities, such as case

studies which are submitted to the PsyBA for marking/approval. During the period of supervised practice/internship the student must hold provisional registration and can use the title *provisional psychologist*. Finally the student must pass the National Psychology Exam (Psychology Board of Australia, 2015, 2023c). After the above steps are completed (five years of tertiary study, plus one year internship, exam) the individual can apply for general registration and use the title *psychologist* (Psychology Board of Australia, 2023c).

Some psychology students may choose a higher degree/six-year sequence of study, with the fifth and six years constituting a Master of Psychology degree (or PhD or Professional Doctorate) in one of the specialised area (Psychology Board of Australia, 2023d). Master of Psychology degrees in a specialty area include clinical neuropsychology, clinical psychology, community psychology, counselling psychology, educational and developmental psychology, forensic psychology, health psychology, organisational psychology, and sport and exercise psychology. The Master of Psychology in a speciality area includes advanced psychological assessment and intervention, and a minimum of 1000 hours of work integrated learning/placement. Students who complete a Master of Psychology in a speciality area do not need to sit the PsyBA National Psychology Exam nor complete the internship year. After completing the six year sequence of study the student can apply for general registration as a psychologist.

Psychologists with a Master of Psychology in an specialty area (e.g., Master of Clinical Psychology), can apply to be endorsed in the relevant AoPE by the PsyBA (Psychology Board of Australia, 2023f). The psychologist must complete two years of supervised practice under the supervision of an already AoPE endorsed supervisor to

gain the AoPE (referred to as PsyBA registrar program). Once these steps are completed the individual can have both general registration as a psychologist, and use the relevant AoPE title, such as *clinical psychologist*. Thus, the AoPE pathway results in the psychologist having both general registration as a psychologist plus endorsement in a specialised area of practice, such as clinical psychology. Even if a psychologist has completed a Master of Psychology in one of the AoPEs, they cannot use the title unless they have successfully applied for endorsement under and AoPE via the PsyBA.

There is an alternative pathway to attain an AoPE. A psychologist may apply to have their existing qualification, or other AoPE, to be considered as equivalent to another AoPE. For example, someone who has completed a Master of Counselling Psychology, has extensive experience and professional development in topics aligned with clinical psychology, and has completed a period of supervised practice under an approved clinical psychologist supervisor, they may apply for equivalence in the AoPE of clinical psychology. These equivalence applications are processed by the PsyBA and successful outcomes are dependent on “the Board’s opinion” if the individual’s qualifications are “substantially equivalent” (Psychology Board of Australia, 2019b, p. 1).

As described above, there are two main pathways to general registration as a psychologist. These pathways are presented here to illustrate how psychology in Australia differentiates between pathways; the 5 + 1 pathway and the higher degree pathway to general registration, as well as specialist endorsement, the AoPE.

1.7.3 Psychology workforce in Australia

After completing their registration, psychologists constitute a substantial segment of the mental health workforce. Table 1.2 and 1.3 below provides registrant data from the PsyBA (Psychology Board of Australia, 2023h). The registrant data reports there were 37 071 psychologists with general registration in Australia in September 2023. The distribution of AoPE within psychologists is also presented in Table 1.3 with the highest proportion being clinical psychologist (n = 11 850). The PsyBA Annual Report for 2023 noted 80.5% of psychologists are female and 19.5% are male (only binary data provided in the report), with 0.7% of psychologists identifying as an Aboriginal and/or Torres Strait Islander person (Psychology Board of Australia, 2023b). In 2022, the Department of Health, Health Workforce dataset, reported a total of 44 443 psychologists, including 7 375 provisional psychologists. Of the total psychologists, 20 399 worked full time, with two thirds of these psychologists working in the private sector, and the remaining third in the public sector. From the same 2022 dataset, it is reported 16 137 psychologists worked in a private practice, with approximately 50% (n = 7 781) of these psychologists in a solo private practice setting. The dataset also reported 29 272 psychologists described their primary work role as *clinician* (Department of Health and Aged Care, 2022), that is they provide client facing services in clinical practice. While psychologists can work in diverse settings, the focus of this thesis is psychologists in clinical practice providing psychological interventions and support to clients with mental health problems.

Table 1.2

Registration by Type and Principal Place of Practice

Registration	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP	**Total**
General	956	11,841	238	6,869	1,823	644	10,369	3,921	410	**37,071**
Provisional	165	2,470	50	1,310	345	145	2,245	807	14	**7,551**
Non-practising	52	574	5	295	104	35	417	161	200	**1,843**
Total	**1,173**	**14,885**	**293**	**8,474**	**2,272**	**824**	**13,031**	**4,889**	**624**	**46,465**

*No PPP registrant did not provide a principal place of practice

Table 1.3

Area of practice endorsements by state or territory

AoPE	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP	**Total**
Clinical neuropsychology	14	213	6	137	35	8	407	60	20	**900**
Clinical psychology	403	3,597	53	2,042	831	256	3,145	1,390	133	**11,850**
Community psychology	1	6	1	3			32	9		**52**
Counselling psychology	8	189		101	19	13	529	199	10	**1,068**
Educational and developmental psychology	8	160	1	188	33	20	435	67	7	**919**
Forensic psychology	14	244	10	74	34	9	216	55	4	**660**
Health psychology	5	64	1	71	41	11	141	4	2	**340**
Organisational psychology	16	224		108	59	2	202	67	7	**685**

Sport and exercise psychology	8	26		36	7	3	22	7		**109**
Total	**477**	**4,723**	**72**	**2,760**	**1,059**	**322**	**5,129**	**1,858**	**183**	**16,583**

*No PPP registrant did not provide a principal place of practice

1.7.4 Mental health services

Psychologists work in diverse settings within the mental health workforce. Many psychologists in clinical practice work within Australia's mental health care system including federally funded programs (e.g., Medicare Benefits Scheme and funding for mental health programs administered by primary health networks), state funded services (e.g., public hospitals and community mental health teams), and the private sector (e.g., group private practice) (Australian Institute of Health and Welfare, 2023).

In Australia, an estimated 43% of people aged 16–85 experience a mental health disorder during their lifetime (Australian Bureau of Statistics, 2023). In Australia, mental health and substance use disorders were estimated to be responsible for 12% of the total burden of disease (Australian Institute of Health and Welfare, 2022a). For the age group of 35 to 64 years, 45.7% had at least one consultation for their mental health, with 36.5% consulting a GP, 25.6% consulting a psychologist, and 12.1% consulting another health professional (Australian Bureau of Statistics, 2023). Psychologists provided 49% of mental health services under the Medicare Benefits Schedule which are subsidised mental health specific services (Australian Institute of Health and Welfare, 2022b). While psychologists in Australia work in a range of settings within the mental health system, almost half work in clinical practice providing services under the Medicare Benefits Schedule subsidy system (explained below).

In Australia, the mental health care system is predominantly driven by the individual seeking support for their mental health symptoms. For example, the individual will organise their own appointment with their preferred health care professional. In Australia a General Practitioner (GP) is often the first health care

professional the individual has contact with (Australian Institute of Health and Welfare, 2023). Depending on the severity of the individual's mental health symptoms, the GP will make recommendations as described by the relevant clinical guidelines (e.g., Malhi et al., 2021), such as prescribe relevant medication, and or refer to a mental health professional, such as a psychiatrist or psychologist. If the person is acutely unwell, they may be referred to a community mental health team, who are trained to be responsive to acute mental health care needs (Australian Institute of Health and Welfare, 2023). If the GP refers the client to a psychologist, they are likely to be referred under the Australian federal government's Medicare Benefits Schedule subsidy system called the Better Access initiative, which aims to improve access to mental health professionals through the subsidisation of specific mental health services (discussed below) (Department of Health and Aged Care, 2024).

1.7.4 Medicare and psychology

In 2006 the Australian government announced subsidised psychology services under the Better Access initiative. GPs are the gatekeepers of the client's access to these subsidised psychology services. The client attends their GP who then assesses if the client is eligible for a Mental Health Treatment Plan (MHTP) (e.g., they are diagnosed with a mental health disorder) and then prepares the MHTP (Australian Institute of Health and Welfare, 2023) which includes the diagnosis and recommendations, such as attend a psychologist for cognitive behavioural therapy (CBT). The completion of a MHTP by a GP, along with the corresponding billing code submitted to Medicare, allows the client to access a Medicare rebate for up to ten sessions per calendar year with a psychologist. The GP sends a copy of the MHTP with a referral letter to the psychologist. The psychologist needs to be registered with Medicare and have a unique

Medicare provider number for each location they work from. The client can then claim Medicare rebates after paying for the sessions provided by a psychologist. For example, the client pays $200.00 to the psychologist after a session, and then the client can claim for and receive a rebate to be paid back into their bank account, paid by the government. The current rebate for a session with a psychologist who has general registration is $93.95 per 50-minute session. Medicare *bulk billing* means that the psychologist is paid the rebate (e.g., $93.95 per 50-minute session) for the session, and the client does not pay anything for the session. It is important to note that in Australia a client does not need a MHTP to access services from a psychologist. The MHTP only enables Medicare rebates or bulk billing. For example, some Australian psychologists choose not to provide sessions under the Medicare rebates (discussed below), likewise some clients choose to see a psychologist without a MHTP.

Table 1.4

Examples of psychologist billing practices and therapy types in a private practice setting

Plan	Type of client	Fees paid to psychologist	Rebate paid	Approved psychotherapy types
Without a Mental Health Treatment Plan (not Medicare)	Private/Fee paying	$200.00 from client	$0.00	Not prescribed
With a Mental Health Treatment Plan (under Medicare)	Private/Fee paying	$200.00 from client	Rebate from Medicare/government to client $137.05 if provided by clinical psychologist $93.95 if provided by all other psychologists	Psycho-education CBT/Cognitive interventions Relaxation strategies Skills training (e.g., problem solving skills) Interpersonal therapy Narrative therapy (for Aboriginal and Torres Strait Islander people) Eye Movement Desensitisation and Reprocessing (EMDR)
With a Mental Health Treatment Plan (under Medicare)	Private/Bulk billed	$0.00 from client Fees paid by Medicare/government $137.05 clinical psychologist $93.95 all other psychologists	Rebate from Medicare/government to client $0.00	

1.7.5 Debate about the Medicare rebate

While the Medicare Better Access psychology items (described above) aimed to facilitate greater consumer access to psychology services, the introduction of the system resulted in serious divisions in psychology in Australia (King, 2013). The reason for the divisions was the Medicare Better Access initiative created a two-tiered system. The two-tiered system refers to the situation whereby services provided by psychologists with an AoPE as a clinical psychologist attract a higher rebate than those provided services with general registration, including psychologists with any other AoPE (e.g., counselling psychologist). To clarify, a psychologist with twenty-five years' experience and an AoPE in counselling psychology is only able to use the general registration tier under Medicare, despite having an AoPE. In contrast a psychologist with an AoPE in clinical psychology and one year experience could use items in the higher monetary value, clinical psychology tier. From a consumer perspective, clients of psychologists with general registration or other AoPE can access a rebate of $93.95 per 50-minute session, while psychologists with an AoPE in clinical psychology attract a client rebate of $137.50 per 50-minute session. From a business perspective, a psychologist with AoPE in clinical psychology seeing five clients per day can bulk bill to the value of $687.50, while all other psychologists (general registration and other AoPE) seeing five clients per day can bulk bill to the value of $469.75. The Medicare two-tier rebate system created significant changes to the profession of psychology in Australia, including inequities among psychologists in clinical practice.

The Medicare two-tier rebate system resulted in significant disruption to the cohesion of psychology in Australia (King, 2013; Mathews, 2018). For example, some psychologists withdrew their membership from the APS. Those psychologists who

broke away from the APS cited reasons, such as a perception the APS was only focused on the needs of clinical psychologists, which the APS denied (Littlefield, 2011). The Medicare two-tiered rebate system has drawn criticism, with some arguing that it has led to perceptions of elitism, hierarchy, and exclusivity within the psychology profession in Australia (Davis-McCabe et al., 2019; King, 2013; Stone & Di Mattia, 2023). Critics suggest the peak psychology professional body, the APS, was overly focussed on the role of clinical psychologists, and that the APS were complicit in creating a false belief that non-clinical psychologists are sub-standard (Australian Association of Psychologists Inc, 2022; Davis-McCabe et al., 2019; Littlefield, 2011; Littlefield & Giese, 2008). Subsequently, new professional psychology groups formed as an alternative to the APS, such as the AAPi. While the Medicare psychology items facilitate the public's greater access to psychology services, the introduction of the two-tiered system resulted in serious divisions in psychology, and among psychologists, in Australia.

There are other sources of division among psychology and psychologists in Australia. Another source of tension relates to the PsyBA excluding some psychologists from endorsement under the equivalence pathway (completing another Master of Psychology/AoPE and then seeking endorsement as a clinical psychologist). Subsequently some of those psychologists, who felt their exclusion from an AoPE in clinical psychology was unfair, sought professional/legal advice and put their case forward to be re-assessed (Australian Association of Psychologists Inc, 2024). A recent landmark legal case, against the PsyBA's assessment of an individual psychologist's application for AoPE equivalence, resulted in the Victorian Civil and Administrative Tribunal finding that the PsyBA had relied "upon a narrow application of the

registration and endorsement criteria" and a "narrow interpretation of the National Law, contrary to relevant authority" ("*Dr Kolta v Psychology Board of Australia*," 2023). The tribunal awarded that the PsyBA should endorse the applicant psychologist with the requested AoPE in clinical psychology based on the applicant psychologist's equivalent standing (completion of an AoPE in counselling psychology, significant amount of relevant professional development activities, supervised practice). The Victorian Civil and Administrative Tribunal also awarded that the PsyBA pay the applicant psychologist's related legal costs. This tribunal outcome is interesting in that it may be indicative of how psychology in Australia (professional associations and regulatory bodies) demonstrates flexibility, or lack of flexibility in this case, having a "narrow interpretation" of its own policy and guidelines.

In addition to the above tensions, there are other criticisms of the Medicare Better Access initiative. One of these criticisms relates to the psychological therapy types that can be employed by psychologists when working under the Medicare Better Access initiative (Jorm, 2011; Jorm, 2018; Moulding et al., 2020). When providing services under Medicare, psychologists are restricted to certain psychological therapy approaches called *specific focussed psychological strategies*. The specific focussed psychological strategies included psychoeducation, CBT, relaxation strategies, skills training (e.g., anger management, skills training, stress management), and interpersonal therapy. In 2020 Eye Movement Desensitisation and Reprocessing (EMDR) was also added to the approved psychotherapies list. There is debate that the these approved psychological therapies are not appropriate for all clients, particularly in the context of diverse ethnocultural backgrounds (King, 2013). While practicing under Medicare, psychologists are expected to adhere to the approved listed of psychological therapies.

Deviating from these approved psychological therapies could potentially lead to adverse outcomes for the psychologist if they undergo an audit by Medicare (Mathews, 2018; Stiles & Fox, 2019) and are unable to demonstrate they adhere to the approved psychological therapies.

While the above contentions surrounding Medicare may seem trivial, it highlights that there is oversight over psychologist's clinical practice, such as interpretation of rules/guidelines and divisions around types and tiering of psychologists in Australia. The above contentions surrounding Medicare have also brought to light the ongoing tensions within the psychology profession in Australia. Regardless of who made the decisions about the Medicare two-tiered rebate system, (i.e., the federal Minister for Health and Aged Care at the time) it appears some psychologists in clinical practice blame the APS for the fractures within the psychology profession in Australia (Davis-McCabe et al., 2019; King, 2013; Littlefield, 2011; Meteyard & O'Hara, 2015). These fractures, particularly around the Medicare two-tiered rebate system, are an important element of the current landscape of psychology in Australia, and have been widely discussed by psychologists in professional magazines, newsletters, and government submissions (Australian Government Productivity Commission, 2024; Australian Psychological Society, 2019; King, 2013; Mathews, 2018; Riazati, 2023). The AAPi has been an advocate for alternatives to the Medicare two-tiered rebate system for psychologists, by suggesting a single rebate for all psychologists (Australian Association of Psychologists Inc, 2022, 2024). The APS acknowledges the above tensions and says it understands the "sensitivities associated with issues of status, valuing of psychological work and reimbursement for this" however the APS is concerned debate about the Medicare two-tiered rebate system will de-rail the unity of

the profession and "gives the appearance of self-interest" (Littlefield, 2011). Indeed, there are perhaps bigger issues at hand for psychology, as there is debate as to whether the Better Access initiative is having any discernible impact on the psychological wellbeing of Australians (Jorm, 2011; Jorm, 2018; Murray, 2019).

Perhaps the above debates in psychology in Australia, including the Medicare two tiered rebate system, are lingering vestiges of tensions from psychology's past (McGregor et al., 2019; O'Gorman, 2001). Of interest to the current thesis is how these debates and fractures might, in part, inform psychology's relationship with CM. In the next section, a review of CM and potential intersection with psychology is provided.

1.8 Complementary medicine (CM)

This section provides a broad overview of CM products, practices, and practitioners, including an overview of CM efficacy and CM use for mental health problems.

1.8.1 Definition of CM

The definition of CM can be problematic in research given that the term encompasses a very broad range of modalities, products, and services (Bassman & Uellendahl, 2003; Ng et al., 2022). The WHO uses the term complementary and alternative medicine (CAM), defined as "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" (World Health Organisation, 2013). Interestingly, the National Centre for Complementary and Integrative Health categorises complementary health approaches by their primary therapeutic input across nutritional, psychological, physical, and combinations of these approaches (National Center for

Complementary and Integrative Health, 2021). CM includes a large range of treatments not considered part of mainstream health care, such as biological medicines (e.g., herbal, vitamin, mineral and nutritional supplements) and mind-body therapies (e.g., yoga, mindfulness) (Ng et al., 2022; Zhang et al., 2019). CM treatments are often prescribed within CM systems, such as Western herbal medicine, chiropractic, osteopathy, naturopathy, traditional Chinese medicine, and homeopathy. For the purpose of this study, CM refers to a diverse collection of health care treatments and professions that are not traditionally associated with the conventional medical profession or curriculum (Harnett et al., 2019). Further, reference to CM in this research would be referring to CM approaches in complement to conventional psychology treatments and would not be an alternative to the work of psychologists.

1.8.2 CM practitioners

CM practitioners are health care providers who vary considerably in their approaches, required training, registration and regulation (Dunn et al., 2021; Gray et al., 2019). CM practitioners generally take a holistic view of their client's health care needs, which includes consideration of lifestyle factors, sleep, nutrition, and stress management. There is variability in the treatments used by CM practitioners and their traditional, cultural and spiritual origins. However, in a broader sense some CM approaches align with the biopsychosocial model used by psychologists through the use of client centred, symptom reduction, and holistic approaches (Barimah & Akotia, 2015; Gone, 2016; Graham et al., 2023; Steel, 2022). Similarly, some CM practitioners (e.g., naturopaths) are taught evidence-based client-centred approaches to health care as part of their training (Blignault et al., 2018; Foley & Steel, 2017; Foley et al., 2020). As an example, recent research utilised the lens of complexity science to investigate

naturopathic case management revealing considerable overlap with other health care approaches that are client-centred and oriented toward a whole person approach (Graham et al., 2022, 2023). While CM practitioners are not typically considered part of conventional medicine in Australia, some CM practitioners such as chiropractors, osteopaths, and traditional Chinese medicine practitioners are regulated by the Australian Health Practitioner Regulation Agency (Ahpra), akin to psychologists (Park & Canaway, 2019).

1.8.3 Demand for CM

The use of CM varies across age, gender, culture, geographical region, socioeconomic and education status, as well as health status (de Jonge et al., 2018; De Souza et al., 2022; Nguyen & Lavretsky, 2020; Zisman et al., 2020). Prevalence rates for CM use range from 10% to 89% of the general population (Green et al., 2017). The high variability for prevalence of CM use depends on factors such as local traditional medicine use and a region's cultural and spiritual practices (Crowe-Salazar, 2007). For example, CM, as part of health care, may have greater significance for some ethnocultural groups who use traditional medicines (e.g., Chinese, Indian, Aboriginal and Torres Strait Islander people)(Gone, 2016; Seet et al., 2020). Differences in CM use have also been found across sociodemographic factors and types of health complaints (Cant et al., 2011; McIntyre et al., 2019; Upchurch & Johnson, 2019). For example, many consumers use CM specifically for their mental health, with prevalence rates ranging between 0.7 to 86% (de Jonge et al., 2018; McIntyre et al., 2019; Sibbritt et al., 2021; Solomon & Adams, 2015). Consumer demand for CM is driven by several factors, such as self-directed choice of health care and preference for a whole person and natural approach (Liem & Newcombe, 2019b; Welz, Emberger-Klein, & Menrad,

2019). Consumers also report dissatisfaction with conventional medical treatment including high costs, side-effects, and ineffective treatments (Hernandez-Reif et al., 2019; Lewis et al., 2019). There is high demand for CM among mental health service consumers.

Of interest to the current thesis is the high use of CM among people with mental health symptoms globally (Clossey et al., 2023; Olsson et al., 2021; Ong et al., 2021), including Australians (Harnett et al., 2023; McIntyre et al., 2021; McIntyre et al., 2016; Reid et al., 2016). Given this high demand, psychologists in clinical practice are likely to encounter clients using CM in some form.

1.8.4 Controversies in CM

Despite client demand for CM, health practitioners must be critical and discerning when evaluating the merits of CM in the context of evidence-based practice. Some CM lack research to support their efficacy and/or the research related to some CM lacks scientific rigour (Gouws & Hamman, 2020; Meyer et al., 2013; Ng & Parakh, 2021; Tangkiatkumjai et al., 2020). There is also some resistance to the inclusion of CM in tertiary education and clinical practice guidelines, with critics concerned CMs inclusion "promotes usage" of "ineffective and potentially dangerous practices" (Braillon et al., 2019, p. e284). Indeed, some literature positions CM as a threat to the scientific development and/or scientific standing of health care professions, and that integrating CM into clinical practice means a clinician has rejected scientific research and evidence-based practice (Fasce, 2017; Li et al., 2018). There are legitimate concerns regarding the safety of some CM, particularly in the context of contraindications with other prescribed medications (Berman et al., 2020). It is important that clinicians are

familiar with CM and/or have tools to assist their clinical discernment around the evidence for CM, and as such utilising clinical practice guidelines that can assist health professionals to evaluate the best available evidence for some CM for specific health problems should be a priority for relevant professional and regulatory bodies.

1.8.5 Evidence for CM

Some CM approaches have demonstrated efficacy as an adjunct, preventative and/or as a treatment for specific mental health symptoms. For example, the herbal medicine *Hypericum perforatum* (St John's wort) has been found beneficial for depression symptoms (Forsdike & Pirotta, 2019; Sarris et al., 2022; Zhao et al., 2022). A Mediterranean diet has also demonstrated efficacy in treating depression symptoms (Bayes et al., 2019; Bayes et al., 2022; O'Neil et al., 2022; Opie et al., 2017). Nutraceuticals N-acetylcysteine and S-adenosyl-methionine (SAMe) have shown benefit as an adjunct treatment for schizophrenia (Yolland et al., 2019) and depression (Sarris et al., 2020; Sarris et al., 2022), respectively. Mind-body therapies, such as yoga, have demonstrated efficacy for treating stress and anxiety (T. Chang et al., 2022; Khunti et al., 2022). There is also much research interest in the role of the gut microbiome and the use of probiotics, called *psychobiotics,* for mental health and wellbeing (Morkl et al., 2021; Mörkl et al., 2020; Ribera et al., 2024; Teasdale et al., 2020). Although research and efficacy studies in CM are increasing, the lack of efficacy for CM overall, may limit the extent to which new empirical data regarding CM is incorporated into clinical practice (Mwaka et al., 2018; Willis & Rayner, 2013). Although some CM approaches show promise as part of preventative and adjunctive treatments in mental health care health, it is acknowledged there is much more research needed to critically appraise the efficacy of specific CM (Burnett-Zeigler et al., 2016; Morkl et al., 2021;

Nguyen & Lavretsky, 2020). Despite the need for more efficacy research, CM remains popular among clients with mental health problems (Clossey et al., 2023; Harnett et al., 2023) and some evidence-based CM are appearing in clinical practice guidelines in Australia (e.g., Malhi et al., 2021), which will be discussed below.

Given the evidence base for some CM, they have become increasingly incorporated into clinical practice guidelines for mental health care. For example, the latest version of the International Classification of Diseases (ICD-11) introduces a chapter for traditional medicine, encompassing mental and emotional disorders within the framework of traditional medicine (Reddy & Fan, 2021; World Health Organisation, 2018). Another example is the World Federation of Societies of Biological Psychiatry (WFSBP) and Canadian Network for Mood and Anxiety Treatments (CANMAT) Taskforce providing a summary of evidence for nutraceuticals and phytoceuticals for the treatment of psychiatric disorders. In Australia some CMs (e.g., St John's wort, SAMe, omega 3 fatty acids, zinc, folate, and healthy diet) are contained in the Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders (Malhi et al., 2021). Another area receiving scholarly interest in the context of mental health care are the psychedelics, such as psilocybin (Carhart-Harris et al., 2021; Davis et al., 2021; Murphy et al., 2022; Nichols, 2020). The inclusion of CM in clinical practice guidelines may also signify an acknowledgment of diverse health care paradigms (Reddy & Fan, 2021) and a readiness to consider descriptive and linguistic differences in addressing health issues (Wardle, 2019). Given the evolving evidence for a range of CM, and high client demand for CM, there is opportunity for interprofessional collaboration, such as conventional health care partnering with some CM approaches, to improve mental health outcomes.

1.9 CM and Collaborative health care

Interprofessional collaboration benefits health professionals through care coordination and contributes to positive client outcomes (Carron et al., 2021; Kacel et al., 2019; Petersen et al., 2019). Unfortunately, research has identified clients are reluctant to disclose their use of CM to non-CM practitioners out of fear of negative appraisal from their conventional health care professional (Foley et al., 2019; Lee et al., 2020; McIntyre et al., 2020; Salamonsen & Ahlzen, 2018; Teasdale et al., 2020). This fear of disclosing CM use to health practitioners is concerning in the context of WHOs recommendation that member states integrate CM into health care (World Health Organisation, 2013). The goal of the WHO Traditional Medicine Strategy is to encourage member states to develop policy, research, and education on CM as part of including CM in health care settings and to improve access to equitable health care (Ghanbari et al., 2020; Zhang et al., 2019). While there are some barriers to collaborative health care that includes CM, there is opportunity for interprofessional collaboration that includes CM practitioners (Steel, Rapport, et al., 2018; Wardle, 2019).

Australian health care policy and legislation also encourages interprofessional collaboration. The Australian Mental Health Framework states the importance of mental health services developing collaborative team environments when caring for people with mental health problems (Australian Health Ministers' Advisory Council, 2013b). Moreover, the report from the Productivity Commission's Enquiry into Mental Health states "the greater and more complex the needs, the larger and more diverse the team of providers" and that "the Australian Government should evaluate best practices for partnerships between traditional healers and mainstream mental health services"

(Australian Government Productivity Commission, 2019, p. 26). Interprofessional collaboration is also mandated, by psychology in Australia, as a core competency for psychologists (Australian Psychology Accreditation Council, 2019). There may be opportunities for psychology to engage with CM practitioners as part of interprofessional collaboration.

1.10 Summary

Psychology has experienced challenges, particularly in the context of a range of inequities among psychologists. Despite these challenges psychologists are key providers of mental health services in Australia. People with mental health problems have high rates of CM use, therefore it is likely that psychologists have clients who have a preference for CM approaches as part of their mental health care. Given psychology mandates psychologists respond to client preferences, and participate in interprofessional collaboration, there may be opportunities for psychology to engage with CM.

This thesis is a sequential mixed methods study of three interrelated phases. Each of these phases intends to address the overarching aim, to explore the contemporary relationship between psychology and CM in Australia.

Chapter 2. CRITICAL INTEGRATIVE REVIEW

2.1 Preface

The previous chapter provided an overview of the broader literature related to psychology, and complementary medicine, as health care approaches. This chapter aims to specifically illuminate the current landscape of how psychology, and psychologists, have engaged with CM in the context of clinical practice. Reviewing how previous research has discussed the relationship between psychology and CM directly informs the development of subsequent phases of the thesis (e.g., survey question development). This chapter presents a critical integrative review that aimed to broadly address the research question: To what extent and in what ways does the field of psychology consider CM relevant and/or appropriate to psychology practice and the treatment of mental health problems? Specifically, to identify granular concepts in empirical literature that discuss topics relevant to psychology's engagement, or lack of engagement, with CM. This chapter includes the accepted manuscript published in *Heliyon* in October 2023. While this was the first paper written for the thesis, it underwent progressive evolution over time and as such the paper has incorporated recent and relevant publications, including other research outputs from the thesis, until it found a scholarly platform for publication. This review is registered with PROSPERO 2020 CRD42020142972.

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2.2 Introduction

Globally, psychologists are likely to encounter clients who are using at least one form of complementary medicine (CM), including over the counter vitamin and mineral supplements, herbal medicines, traditional medicines, yoga, aromatherapy, meditation and massage (Clarke et al., 2015; de Jonge et al., 2018; Green et al., 2017; Steel, McIntyre, et al., 2018; Uysal et al., 2019). For the purpose of this review, CM (also referred to as complementary and alternative medicine [CAM]) includes a broad range of health care products, services and practices, that are “not part of a country’s own traditions or conventional medicine and are not fully integrated into the dominant health care system” (Harnett et al., 2019, p. 1). Products, services, and practices included within definitions of CM vary, as they are dependent on how CM is culturally, socially, and politically positioned (Adams, Broom, et al., 2019; Park, 2013; Solomon & Adams, 2015). In addition, some CM practices such as meditation and mindfulness are now more widely accepted by psychologists and integrated into their practice, yet they have not traditionally been considered a component of psychology (Haller et al., 2019; Lorenc et al., 2018; Moir et al., 2019).

CM use for mental health is substantial. Reported utilisation of CM amongst those with mental health problems (e.g., participants self-reporting a mental health diagnosis in last 12 months) ranges from 0.7 to 89% (de Jonge et al., 2018; Hansen & Kristoffersen, 2016; McIntyre et al., 2016; Pilkington, 2018; Solomon & Adams, 2015). Although there is large variation in these prevalence rates (due to CM definitions and inclusion criteria adopted and the population studied in each study), a preference for CM amongst people living with mental health problems is consistent across regions, such as Ireland, Netherlands, Saudi Arabia and the US (Fox et al., 2010; Jong et al.,

2019; Rajab et al., 2019; Wang et al., 2018). A study at various Saudi Arabian hospitals found 82.2% of inpatients with mental health problems reported using at least one type of CM within the last 12 months to treat their mental health problems (Rajab et al., 2019). Similarly, a study led by Jong found 75% of patients attending mental health care centres were using some form of CM (Jong et al., 2019). Research has found that CM use also varies across different mental health problems, with chronic pain, anxiety and depression symptoms found to be significant predictors of specific types of CM use (Fox et al., 2010; McIntyre et al., 2017; Wahlstrom et al., 2008). Given that CM use (including CM products, practices and practitioner visits) is high among people with mental health problems, psychologists are likely to consult with clients using some form of CM for the treatment of their mental health problems and/or comorbid physical health issues (Hughes, 2008; McIntyre et al., 2017; Sobieski & Grata-Borkowska, 2019; Wemrell et al., 2020). Indeed, one Swedish study found 67% of participants, who were patients accessing psychiatric services and psychologists, reported use of CM in some form to treat their symptoms such as anxiety, sleep disturbances and depression (Wemrell et al., 2020). CM treatments used by people experiencing mental health problems may be recommended by a CM practitioner, other health professional or through self-selection and self-management (de Jonge et al., 2018; Roberts et al., 2020; Seet et al., 2020).

There are barriers and risks associated with CM use in health care settings (Wardle & Adams, 2014). One example is the risk associated with concurrent use of some CM and psychopharmacological treatments (Bhikha & Glynn, 2019) – some herbal medicines used for mental health problems, such as *Hypericum perforatum* (St John's wort), can potentiate the effects of selective serotonin reuptake inhibitors

creating greater risk of serotonin syndrome (Bhikha & Glynn, 2019; McIntyre et al., 2017; Sobieski & Grata-Borkowska, 2019). Also, the substantial rates of CM non-disclosure to health care providers by patients exacerbates many of the clinical risks around CM use, including negative impact on clinical outcomes, patient safety, and the therapeutic relationship (Lee et al., 2020; McIntyre et al., 2020; Salamonsen & Ahlzen, 2018; Teasdale et al., 2020). There are also risks associated with interpreting CM research, including varying definitions of CM, participant bias toward CM, researcher bias toward CM, undisclosed conflict of interest, and selection bias in systematic reviews (Ernst, 2010; Veziari et al., 2022). Moreover, some research has identified adverse outcomes associated with CM practices previously considered benign, such as meditation (Farias et al., 2020) and yoga (Firebaugh & Eggleston, 2017).

There are specific CM interventions that show promise for mental health problems. For example, research has demonstrated the efficacy of yoga to address stress symptoms (Tong et al., 2020), early psychosis (Lin et al., 2015), anxiety (Butterfield et al., 2017), and depression (Nyer et al., 2019), and eating disorders (Foroughi et al., 2019). There is also strong evidence for the herb St John’s wort in treating mild to moderate depression (Forsdike & Pirotta, 2019; Sarris, 2018). Evidence also supports the adjunctive use of nutraceuticals such as N-acetyl cysteine with antidepressants for depression (Sarris et al., 2016) and with standard treatments for schizophrenia (Yolland et al., 2019). A pharmacoepidemiologic study also found folic acid to be beneficial in terms of lowering rates of suicide attempts (Gibbons et al., 2022). Nutritional interventions (e.g., Mediterranean diet, vitamin and mineral supplements) have also gained empirical support for the prevention and treatment of depression (Bayes et al., 2022; Jacka, 2017; Jacka et al., 2017; Khanna et al., 2019; Kutschera et al., 2021;

Rucklidge & Kaplan, 2013; Strasser et al., 2016). So much so, that the field of nutritional psychiatry is an emerging paradigm that is a core consideration for mental health prevention and treatment (Bastiaanssen et al., 2020; Bayes et al., 2023; Dinan & Cryan, 2020; Firth, Teasdale, et al., 2019; Sarris, 2019; Teasdale et al., 2020). This emerging evidence base suggests some CM treatments may have a role in helping to address mental health problems.

In response to consumer demand and increased evidence for some CM, the integration of CM into primary health care and health disciplines has increased (Ng et al., 2022; Roth et al., 2019; Zhang et al., 2019). This increase in CM integration is also likely influenced by the World Health Organisation (WHO) Traditional Medicine Strategy, which states that given CM has the “potential to improve individual health, its proper integration into national health systems will enable consumers to have a wider choice when they wish to use such services” (World Health Organisation, 2013, p. 37). A range of integrative relationships with CM within primary health care and health disciplines has emerged (including the direct integrative application of CM approaches by a conventional health care professional, conversations about CM between a client and their conventional health care professional, and the introduction of concepts of mind-body connection and related ideas into conventional clinical practice) (Lavretsky & Datta, 2022). CM integration has occurred in mental health settings internationally (Jacobsen et al., 2015; Jong et al., 2019; Salamonsen & Ahlzen, 2018). It must be noted that integrative psychology is here taken to refer to psychology that includes CM. Psychiatry and general medicine now include some CM in their practices, education, journals and clinical practice guidelines to treat mental health problems (Berk & Jacka, 2019; Berman et al., 2020; Malhi et al., 2021; Pirotta et al., 2010). Despite other health

and mental health professions incorporating CM (Malhi et al., 2021; McClafferty et al., 2017; Sarris et al., 2015; Schofield et al., 2010; Smith et al., 2018), there appears to be little consideration of CM within psychology. It is unclear how psychology (as a discipline) and psychologists (as practitioners) are engaging with CM.

How psychology engages with CM may be an important consideration for psychologists in clinical practice. For example, should a client disclose CM use it would be important for a psychologist to effectively gather and assess information about the client's CM use to understand any potential herb-drug interactions with relevant prescribed medications. Client safety may be at risk if a psychologist is unable to elicit information and/or discuss and understand the implications of their clients' CM use. This is relevant as psychologists in many regions are required to have sound knowledge of psychopharmacology (Goldberg & Wagner, 2019; Tomba et al., 2019). Navigating client CM use may also require cultural sensitivity as some cultures utilise CM more than others (Liem, 2020; Richmond & Jackson, 2018; Welz et al., 2019). Importantly, broader research shows conventional health professionals who are informed in CM are likely to be effective in identifying and communicating with clients regarding any potential risks that may be associated with CM use, thereby helping maintain client safety (Barnett & Shale, 2012; Hamilton & Marietti, 2017; Park, 2013; Wang et al., 2018; Wemrell et al., 2020; Wiesener et al., 2018). There also appears to be other benefits for clients when their conventional health professional is informed about CM, including broader treatment choices, facilitating a preventative and whole person approach to mental health care, and improving client mental health outcomes (Blignault & Kaur, 2019; Zhang et al., 2019). Specific benefits to psychology may include: additional therapeutic potential of an integrative approach, strengthened therapeutic

alliance through understanding a client's CM use, promotion of client autonomy and choice, research opportunities, addressing national mental health care goals, improving public health and mental health outcomes, and alignment with other advances in mental health care and WHO policy (Doolan & Carne, 2020; Gone, 2016; Herman et al., 2018; Mwaka et al., 2018; Park, 2013; World Health Organisation, 2013).

Given the high prevalence of CM use among mental health care consumers, the increasing evidence base for CM, and the engagement of other health professions with CM, a greater understanding of how the discipline of psychology and psychologists engage with CM is required. In direct response to these circumstances, this article reports the results of the first integrative review examining the contemporary and potential relationship between psychology and CM.

2.3 Methods

An integrative review was undertaken to gain insight into the current landscape, across qualitative and quantitative studies, of psychology's engagement with CM. A review protocol was registered with the International Prospective Register of Systematic Reviews (PROSPERO; Registration Number 142972) and reported using the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (Moher et al., 2009). The integrative review was also conducted in accordance with the Joanna Briggs Institute (JBI) Manual for Evidence methodology for mixed methods systematic reviews (MMSR) (Lizarondo et al., 2020).

2.3.1 Selection criteria

This review aimed to examine psychology's relationship with CM, using empirical data (e.g., psychologists surveyed about attitudes toward CM) relevant to this broad aim. Literature reporting new empirical data reporting on one or more aspects of the relationship between psychology (incorporating clinical practice, professional associations, and academia) and CM, and how that relationship may relate to or inform psychologists' engagement with CM in their clinical practice was identified. Commentaries, editorials and letters to the editor were excluded from the review in addition, due to the non-efficacy focus of this review, any literature reporting randomised control trials, efficacy of CM, or efficacy of CM integrated with psychology, was also not included.

2.3.2 Search strategy

A systematic process was used to identify articles reporting new empirical data relating to the relationship between the field of psychology (as described by psychologists) and CM, to understand if there is engagement between the two fields. A database search was conducted by the first author (CT) in May 2023. Search criteria were applied to the following databases for articles published from 1989 to 2023: MEDLINE, CINAHL, PsycINFO, Allied and Complementary Medicine Database, and EMBASE. The searches began with truncated Psychology (Psycholog*) and Complementary Therapies (MeSH term) including traditional medicine, complementary medicine, alternative medicine, and integrative medicine (see search terms in Appendix B). Additional search terms such as natural, holistic and functional medicine and therapies, were included to capture a range of specific modalities and treatments included within CM (see Appendix C). Specific modalities such as yoga or

aromatherapy, were not included as search terms due to the extensive number of individual CMs that would have to be included to cover all possible products, services and practices. After the databases were searched, references were imported into Endnote 20 referencing software (Clarivate Analytics, 2022). Duplicates were removed and reference lists of included articles checked for additional relevant studies. Articles were then uploaded into Covidence for screening. Only articles published in peer-reviewed journals were included on the premise that these publications had been screened and had met reporting standards.

2.3.3 Inclusion and Exclusion

Titles and abstracts were screened (CT) according to the inclusion and exclusion criteria (see Appendix C). As an MMSR, included studies were quantitative, qualitative, and mixed methods studies relating to psychologist engagement with CM. Conference abstracts, case reports, case series, editorials, and letters were excluded. Included articles reported psychologists' perspectives regarding CM, issues related to psychologists adopting CM in some form into practice (e.g., clinical decision making, referral process, ethics, risks, ethical guidelines, practice and policy guidelines, education) and psychologists' experiences of working with clients combining CM and psychology. All full texts were then screened (CT) according to the eligibility criteria. To increase robustness of the findings, the other two authors (EM, JA) were randomly allocated 50% of the articles each to review to determine eligibility. Articles were excluded if they did not explicitly discuss the discipline or practice of psychology as a distinct profession or psychologists as individual professionals and CM. For example, an article may have discussed CM engagement of a broad range of health professionals, however the data for psychologists was unable to be identified or extracted separately

(Baxter & Lovell, 2021). One article described the current guideline and policy environment of CM in Australia (Thomson-Casey et al., 2022) however the article was excluded as the data provided did not relate to the relationship between the field of CM and psychology, as described by psychologists. Articles were also excluded if they were reporting the efficacy of a CM service or product to treat mental health or were clinical trials of CM treatments for mental health problems (including comparison trials with psychological treatment or psychotherapy).

2.3.4 Quality assessment

Following systematic selection of included articles, a quality appraisal was completed for each article in Covidence systematic review software (www.covidence.org). The quality of each study was assessed using the mixed methods appraisal tool (Hong & Pluye, 2019). Articles were also assessed using two additional items created by the authors aimed to assess risk of bias; were the papers critical and/or balanced in regard to psychology's engagement with CM, and whether the article acknowledged and/or addressed risk of bias. For these two questions a Yes/Yes score represented acceptable/low risk of bias and No/No represented an unacceptable risk of bias toward/against psychology's engagement toward CM. Studies were excluded where three or less of the five MMAT items were attained and/or No/No for bias (e.g., Bassman & Uellendahl, 2003). Any disagreement on the quality of an article was discussed with all authors (CT, EM, JA) to reach agreement on subsequent inclusion/exclusion. Of the 30 articles that underwent appraisal, three were excluded as low quality. The results of the quality assessment are presented in Appendix D.

As recommended by Braun and Clarke (Braun & Clarke, 2006, 2022, 2023; Clarke & Braun, 2018) the authors of this paper discussed potential bias in selecting and appraising articles for inclusion, and measures to avoid, or limit, any undue influence on the research process and outcomes. This included each author providing a justification for their decision to include or exclude each article. At the time of review both EM and JA were academics at the Australian Research Consortium in Complementary and Integrative Medicine. CT was a registered and endorsed clinical psychologist with an interest in evidence-based CM as part of integrative mental health care. CT was also a Convener of an interest group "Psychology and Integrative Mental Health". JA was also Convenor of the Special Interest Group (SIG) "Complementary Medicine – Evidence, Research & Policy" at the Public Health Association Australia and EM is a member of this SIG. Both CT and EM held professional membership of the Naturopaths and Herbalists Association of Australia. EM previously practiced as a CM practitioner. All authors have used CM in some form for their health and wellbeing.

2.3.5 Data extraction and synthesis

Following systematic selection of articles and quality appraisal, an inductive thematic analysis and synthesis were undertaken to elicit common elements and themes across the method, results, discussion, and conclusion sections of included articles (Braun & Clarke, 2022). Quantitative data (results) were qualitised (author textual descriptions and summations of data) (Lizarondo et al., 2020; Stern et al., 2020) and synthesised along with qualitative data. Each article was organised into a spreadsheet to capture information. Analysis initially focused on open coding to identify themes, and a subsequent review of articles used codes that were both expected (e.g., concern about efficacy of CM) and relevant to the research question (e.g., descriptions of relationship

with CM). Once broad themes were identified, and categorised, each article was re-read to see how often it had a “hit” with each of the codes. Supporting text (both qualitised and qualitative) was also collected to support theme categorisation. The iterative process continued with re-reading the articles to refine and confirm codes and categories. This synthesis allowed the development of descriptive themes that provide an overall summary of findings (Braun & Clarke, 2022). Themes and sub themes were reviewed by EM and JA. Following this, triangulation of each author’s (CT, EM, JA) interpretation of the themes was conducted, and the final themes were determined by consensus. Articles that were excluded due to low quality were checked to ensure sensitivity of identified themes.

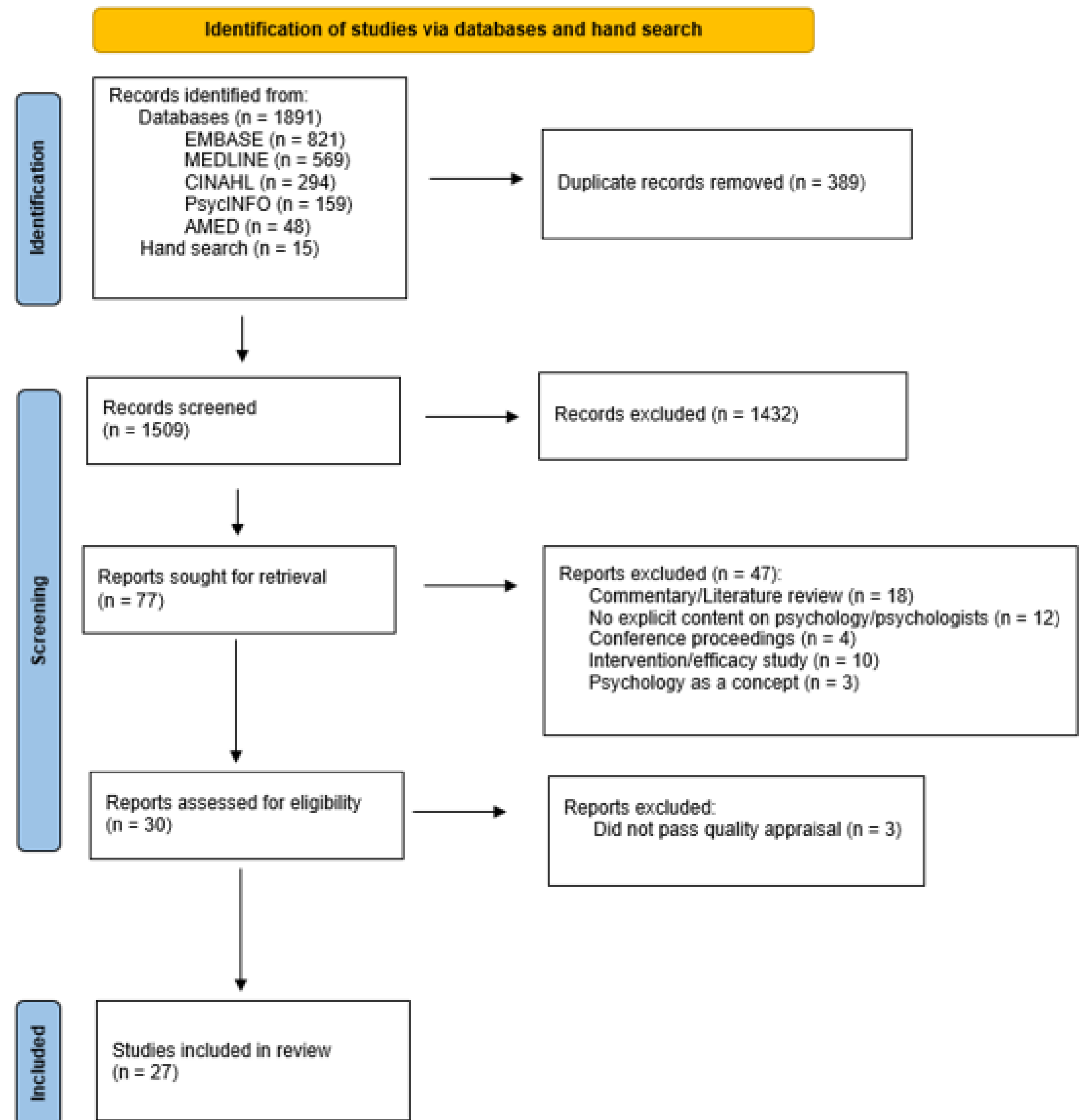
2.4 Results

2.4.1 Search Results

The initial literature search returned 1883 articles with 389 duplicates deleted. An additional 15 articles were identified from hand searches. After reviewing 1509 titles and abstracts a further 1432 articles were deemed ineligible using the eligibility criteria. Following a full-text review of the eligible articles, 77 met the criteria, with 47 excluded. The remaining 30 articles were subjected to an in-depth review and appraisal with a further three articles excluded. The PRISMA flow diagram outlining the article selection process is shown in Figure 2.1.

Figure 2.1

Flow diagram of data extraction and synthesis



2.4.2 Author and geographical characteristics

Of the 27 included articles 15 were written by the same two first authors with 10 and five publications each. The countries of origin for the papers, based on the geographic location of the participants (or origin of highest proportion of participants if multi-national paper), were predominantly from Australia (n = 12) and Indonesia

(n=10), and the remaining articles were one each from Austria, Brazil, Canada, Germany, and Hungary. The articles were quantitative analysis (n = 15), qualitative (n = 9), and mixed methods (n = 2) approaches. Most studies had a higher proportion of female participants - except one (Crowe-Salazar, 2007) – which reflects the gender profile of the profession in Western regions (Australian Psychological Society, 2021b; Lin et al., 2018). A third of the of the studies (n = 9) included student participants. Studies that included the attitudes of participants who were students and/or academics in psychology tertiary programs (i.e., non-clinical roles), will be referred to as psychologists throughout this paper. A summary of included manuscripts is provided in Table 2.1.

Table 2.1

Descriptive qualities of included manuscripts (in chronological order)

Study	Author (Year) Location	Method/Design	Population	Type of CM	Relevant findings/summary
1	Crowe-Salazar (2007) Canada	Qualitative/ Interviews	N = 3 Indigenous Elder, a psychiatrist, and a psychologist	Traditional healing practices in mental health	Importance of traditional values and traditional medicines in treating mental health in Indigenous communities.
2	Ditte et al (2011) Germany	Quantitative/ Survey	N = 388 333 medical and 55 psychology students	CM broadly in context of psychology practice	Differential acceptance levels of CM among medical and psychology students, with both groups described as reluctant to integrate.
3	Wilson & White (2011) Australia	Qualitative/ Interviews	N = 12 practising psychologists and psychology students	CM broadly in context of psychology practice	Theory of planned behaviour to examine intention to integrate CM. Limited guidelines propose risk and barriers to CM.
4	Wilson et al (2011) Australia	Quantitative/ Survey	N = 122 clinical psychologists	CM broadly in context of psychology practice	Psychologists are interested in CM, but aware that integration challenges and risks.

Study	Author (Year) Location	Method/Design	Population	Type of CM	Relevant findings/summary
5	McKenzie et al (2012) Australia	Mixed methods/ Survey with qualitative and quantitative responses	N = 212 91 1st year medical students, 49 2nd year medical students, 31 psychology students	Mindfulness in the context of mental health	Psychology students more knowledgeable and more likely to integrative mindfulness into their practice because they believe in a bidirectional relationship between mind and body.
6	Wilson et al (2012a) Australia	Quantitative/ Survey	N = 106 psychology students	CM broadly in context of psychology practice	Psychologists are willing to integrate CM Barriers include lack of knowledge, lack of scientific evidence, and absence guidelines are perceived barriers.
7	Wilson et al (2012b) Australia	Quantitative/ Survey	N = 106 psychology students	CM broadly in context of psychology practice	Psychology students are interested in CM in their future practice. Barriers include disapproval from peers or regulatory body.
8	Wilson et al (2013) Australia	Quantitative/ Survey	N = 122 clinical psychologists	CM broadly in context of psychology practice	Psychologists more comfortable providing CM recommendations and referring to CM practitioners.
9	Stapleton et al	Quantitative/ Survey	N = 193 psychologists	CM broadly in context of psychology practice	Psychologists engage in CM training and integrating CM into their practice.

Study	Author (Year) Location	Method/Design	Population	Type of CM	Relevant findings/summary
	(2015) Australia				
10	Fay et al (2016) Hungary	Quantitative/ Survey	N= 418 psychology students	Expressive therapies (e.g., creative, art, drama, music, writing)	Psychologists interested and open toward CM and further education in CM.
11	Hamilton & Marietti (2017) Australia	Qualitative/ Interview	N = 18 11 registered and 7 provisionally registered psychologists	CM broadly in context of psychology practice	Psychologists interested in CM.
12	Liem & Newcombe (2017) Indonesia	Quantitative/ Survey	N = 44 Provisional Master of clinical psychology students	CM broadly in context of psychology practice	Psychologists have low CM knowledge and want to learn more. Psychologists are recommending, referring, and applying CM.

Study	Author (Year) Location	Method/Design	Population	Type of CM	Relevant findings/summary
13	Liem & Rahmawati (2017) Indonesia	Qualitative/ Interview	N = 22 Psychologists and psychology lecturers	CM broadly in context of psychology practice	Variability among psychologist’s understanding of CM terms and practices.
14	Ligorio & Lyons (2017) Australia	Quantitative/ Survey	N = 240 professional and academic psychologists.	CM broadly in context of psychology practice	Professional psychologists held more positive attitudes toward CM than academic psychologists.
15	Liem (2018) Indonesia	Mixed methods/ Interview and survey	Phase 1 N = 274 Phase 2 N = 9 Psychologists and psychology students	CM broadly in context of psychology practice	More than half of the psychologists had recommended, referred and/or applied CM.
16	Liem (2019a) Indonesia	Quantitative/ Survey	N = 247 psychologists	CM broadly in context of psychology practice	Lack of guidelines contributes to uncertainty around CM. Psychologists believed CM education to be relevant and important.

Study	Author (Year) Location	Method/Design	Population	Type of CM	Relevant findings/summary
17	Liem (2019b) Indonesia	Qualitative/ Interview	N = 43 Clinical psychologists in public health	CM broadly in context of psychology practice	Mixed beliefs and attitudes among psychologists toward CM. Psychologists had recommended, referred and/or applied CM.
18	Liem (2019c) Indonesia	Qualitative/ Open ended survey questions	N = 127 Clinical psychologists	CM broadly in context of psychology practice	Psychologists are interested and willing to engage with CM research and education.
19	Liem (2019d) Indonesia	Qualitative/ Interview	N = 43 Clinical psychologists in public health	CM broadly in context of psychology practice	Variability among psychologist's understanding of CM terms and practices. Psychologists believed CM education to be relevant and important.
20	Liem & Newcombe (2019a) Indonesia	Quantitative/ Survey	N = 318 Clinical psychologists	CM broadly in context of psychology practice	Psychologists had positive attitudes toward building CM knowledge.

Study	Author (Year) Location	Method/Design	Population	Type of CM	Relevant findings/summary
21	Liem & Newcombe (2019b) Indonesia	Quantitative/ Survey	N = 274 Clinical psychologists	CM broadly in context of psychology practice	Psychologists had positive attitudes toward CM. Psychologists are interested in combining CM with their clinical practice.
22	Medieros et al (2019) Brazil	Quantitative/ Survey	512 students from 9 university health courses including 59 students of psychology	CM broadly in context of health modalities	CM knowledge was significantly associated with psychology; however psychology students had the lowest knowledge. Psychology only health course where CM was absent from course content.
23	Kassis and Papps (2020) Australia	Qualitative/ Interview	N = 6 psychologists who also have CM training	CM broadly in context of psychology practice	Psychologists are interested in integrating CM into their practice. Barriers include lack of guidelines on CM integration.
24	Liem (2020) Indonesia	Qualitative/ Interview	N = 43 Clinical psychologists		Psychologists are integrating CM into different practice settings. Importance of CM as part of cultural sensitivity.

Study	Author (Year) Location	Method/Design	Population	Type of CM	Relevant findings/summary
25	Morkl et al (2021) Austria	Quantitative/ Survey	N = 1056, 354 psychiatrists, 511 psychologists, 44 psychotherapists, and 147 MHPs in-training	Nutritional psychiatry	Approximately 65% of psychologists recommended dietary approaches or dietary supplements. 66.3% of psychologists also reported having no training in nutrition.
26	Nayda et al (2021) Australia	Quantitative/ Survey	N = 60 psychologists working with children	Nutrition	98% of psychologists believe diet is relevant mental health but scored lower on nutrition competence and nutrition communication and counselling.
27	Thomson-Casey et al (2023) Australia	Quantitative/ Survey	N = 202 psychologists	CM broadly in context of psychology practice	Psychologists recommend CM products and practices and/or refer clients to CM practitioners

2.4.3. Extent to which psychologists are engaging with CM

Prevalence rates varied across the reviewed literature for psychologists interested in integrating CM in some form into their clinical practice, dependent on the specific research aims and methodologies employed. Studies reported 70-85% of psychologists were willing to integrate CM and had positive attitudes toward CM (Fay et al., 2016; Wilson et al., 2012b). Morkl et al., (2021) reported 92.9% of Austrian psychologists in their study were interested in learning more about CM for mental health. Similarly, 39.3% of Indonesian psychologists in Liem's study (2019b) wanted to study CM treatments relevant to mental health. Nayda et al., (2021) reported 98% of Australian psychologists in their study perceive CM approaches, such as nutritional psychiatry, as relevant to psychologists. Stapleton and colleagues (2015) reported 64% of participant psychologists had trained in some form of CM. Prevalence rates for psychologists already integrating CM into their practice, also varied across the reviewed literature. Liem & Newcombe (Liem & Newcombe, 2019b) reported the highest rate of psychologists recommending (83%) and referring (52%) to CM among Indonesian psychologists. Similar rates of recommending CM were found among Australian (69%) and Austrian (64.5%) psychologists (Ligorio & Lyons, 2018; Morkl et al., 2021). Psychologists were also reported to be directly applying CM themselves as part of their own clinical practice with their clients in Austria (65.6%) and Indonesia (65.7%) (Liem, 2019b; Liem & Newcombe, 2019b; Morkl et al., 2021). Qualitative studies from Australia also reported participant psychologists were interested in, and already engaging with, a range of CM approaches with their clients including herbal medicine,

massage, meditation, naturopathy, nutrition, and yoga (Hamilton & Marietti, 2017; Kassis & Papps, 2020; McKenzie et al., 2012; Wilson & White, 2011).

2.4.4 Synthesis of themes

All papers report a potential, or existing, relationship between psychologists and CM as described through psychologists' different types of engagement or planned engagement (in the case of psychology students), with some form of CM in their clinical practice. Engagement was identified from the analyses as the unifying concept that relates to the different types of engagement psychologists have with CM in the context of clinical practice. Three themes were identified from the central unifying concept of engagement; how psychologists are engaging with CM, why psychologists engage with CM, and why psychologists do not engage, or limit engagement, with CM. An overall synopsis of themes and subthemes from included papers is outlined in Table 2.2.

Table 2.2

Integrated categorisation of identified themes, subthemes and supportive text

Theme	Subtheme	Example quote from participant psychologists	Frequency (%)
How psychologists engage with CM	Apply	"I think that psychologists that are armed with a second specialty can provide a unique service to their clients" (Kassis & Papps, 2020, p.5)	15 (55.5%)
	Recommend	"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." (Liem 2019b, p.6)	16 (59.2%)
	Refer	". . . you would know the quality of the person you are referring to." (Wilson & White, 2011, p.237)	15 (55.5%)
	Discuss	"I don't tell clients what to do, so if they are expressing an interest in something I will discuss it with them but I would not talk them out of it …" (Hamilton & Marietti, 2017, p.107)	11 (40.7%)
Why are psychologists engaging with CM	Provide a holistic/integrative approach	"Psychology was just that one part … and often that is not enough. I think you need to look at people more holistically and have various strategies to help them deal with the mental health issue or whatever it is that they are dealing with." (Kassis & Papps, 2020, p.5)	14 (51.8%)
	Cultural relevance	"Some areas seem to make more sense to involve traditional healing and other areas will require more thought and attention." (Crowe-Salazar, 2007, p.90)	7 (25.9%)

Theme	Subtheme	Example quote from participant psychologists	Frequency (%)
	Client centred/preference	"… guidelines of working in clinical work, quite clearly on one hand [are the] experiences of evidence-based practice, the other is to understand the client and the context of their lives." (Crowe-Salazar, 2007, p. 91)	5 (18.5%)
Why are psychologists engaging with CM	Lack of education/training	"I feel like psychologists don't get enough direction about it [CAM], it would be useful, definitely if there was a workshop about it and how it could be integrated in practice, I will be signing up for it" (Hamilton & Marietti, 2017, p.108)	14 (51.8%)
	Lack of guidelines	"Well, a lot of psychologists themselves would be quite keen but are working within strict guidelines." (Wilson & White, 2011, p.238)	13 (48.1%)
	Far of negative appraisal by peers	"I think if I used CAM in the clinic I don't think that people would have liked it … if I had done yoga with someone I think that my supervisor would have looked at my video and asked me 'what are you doing" (Hamilton & Marietti, 2017, p.108)	9 (33.3%)
	Uncertainty about efficacy of CM	"Certainly there is a message from the science that CAM is lacking evidence, but a lot of people are drawn into it" (Hamilton & Marietti, 2017, p.107)	29.6%)

2.4.5 How psychologists are engaging with CM

All papers report some psychologists as engaging, or open to engaging with CM in some form or another. In the context of this review, engagement refers to a psychologist in some way explicitly including or introducing CM as part of client assessment and/or treatment planning/application. Such engagement can be categorised via four subthemes—*discuss*, *recommend, refer*, and *apply*—that reflect the CM engagement types reported in the different papers, with some papers reporting more than one type.

The *discuss* sub-theme refers to findings directly reporting the extent to which psychologists currently (and in some cases would in the future) communicate about CM with their clients. The *recommend* sub-theme refers to findings directly reporting the extent to which psychologists are already recommending, or are interested in recommending, CM in some form to their clients. The *refer* sub-theme relates to findings and/or descriptions of psychologists referring, or expressing interest in referring, their clients to suitable, qualified CM practitioners (e.g., traditional Chinese medicine practitioner). Finally, the sub-theme *apply* refers to reported findings or descriptions within the literature identifying direct integrative practice (Adams & Tovey, 2000). Direct integrative practice included interest in, or the provision of, CM treatments and services delivered directly by psychologists to their clients (e.g., using a secondary qualification as a nutritionist to prescribe evidence-based dietary interventions for depression).

Eleven articles suggested psychologists should at least be open to and/or be able to discuss CM use with their clients. Several of the articles report that psychologists have an ethical responsibility to be informed about all known treatment paths, including CM, and failure to pass this knowledge on to clients may be considered substandard care and a patient safety risk (e.g., Hamilton & Marietti, 2017; Wilson et al., 2011). Sixteen articles reported psychologists as recommending CM to their clients (e.g., Liem, 2019d; Stapleton et al., 2015; Wilson et al., 2012a; Wilson & White, 2011; Wilson et al., 2013). Fifteen articles discussed psychologists referring to CM practitioners (e.g., Liem, 2019a, 2019c; Liem, 2020; Liem & Newcombe, 2017; Wilson et al., 2012b) and a similar number of articles (n = 15) reported psychologists as already applying CM as part of their own clinical practice offered to clients (e.g., Kassis & Papps, 2020; Liem, 2019a; Liem, 2020; Liem & Newcombe, 2017; Stapleton et al., 2015; Wilson et al., 2012a). These findings have been organised into a frame of reference to describe the four types of engagement (i.e., discuss, recommend, refer, and apply) a psychologist might have with CM in clinical practice (Appendix E).

2.4.6 Why are psychologists engaging with CM?

Participant psychologists from the included studies identified several reasons for their engagement with CM as part of their clinical practice. Their motivations for engaging with CM predominantly related to a holistic approach toward client care (n = 14) and acknowledging cultural relevance of CM (n = 7). Client centred care/client preference (n = 5) was also highlighted as an important reason for engaging with CM. For example, an author summary in a qualitative study states "… psychologists will prioritise and value the therapeutic alliance over and above psychological interventions, including CAM" (Hamilton & Marietti, 2017, p. 109).

2.4.7 Why are psychologist not engaging or limiting their engagement with CM?

Another theme from the analyses of the literature related to why psychologists might be reluctant to engage with CM. Lack of education and training to develop knowledge of CM, in the context of psychology practice, was identified (n = 15) as a major barrier to engagement. Several articles (n = 4) report outcomes where psychologists recommend that all psychologists should have some training in CM (e.g., Hamilton & Marietti, 2017; Kassis & Papps, 2020; Liem, 2019c); other included empirical articles (n = 3) suggest psychology is lagging behind medical and other health professional education programs in terms of the inclusion of relevant CM in their training programs (e.g., Ditte et al., 2011; Hamilton & Marietti, 2017).

Another reported major barrier to psychologists' engagement with CM is a lack of relevant policy and/or guidelines available (n = 13) from psychology's professional and regulatory agencies to specifically inform the engagement of psychologists with CM in their clinical practice (e.g., Hamilton & Marietti, 2017; Kassis & Papps, 2020; Stapleton et al., 2015). Psychologists in the included studies identified risks associated with CM engagement. Fear of negative appraisal by their peers (n = 9) was the most common concern reported by psychologists for why they were limiting, or reluctant to engage with CM, as well as uncertainty about the efficacy of CM (n = 8). Three articles reported psychologists as: concerned that engaging with CM would put the profession's standing at risk; sceptical about the quality of some CM practitioners; and concerned with epistemological issues and perceived clashes between psychology and CM (Hamilton & Marietti, 2017; Liem, 2020).

2.5 Discussion

This review identified more than half of the participant psychologists in the reviewed articles, in several jurisdictions around the world, as engaging with CM in their clinical practice. This result is consistent with wider health professional engagement with CM internationally (Phutrakool & Pongpirul, 2022). Not only are psychologists interested in CM for mental health, but they are also already engaging with CM in some form as part of their clinical practice, including psychologists directly applying CM approaches as part of their client's treatment. Wider research shows psychologists and psychiatrists, seek to identify novel, accessible and alternative mental health treatments for their clients, including CM as an adjunctive health care approach (Allen et al., 2016; Blignault et al., 2018; Herman et al., 2018; Sarkar et al., 2018). This substantial level of psychologist engagement with CM has significant implications for policy and guidelines, and the conventional scope of practice for psychologists. For example, what level of education in CM would constitute competency for a psychologist to engage with CM as part of treatment planning with clients. This finding also provides a solid platform for future research to explore psychology's engagement with CM in more detail, focusing upon such areas as: the features of CM skills psychologists are acquiring and the processes and channels through which these skills are being acquired; how to inform guidelines for the integration of CM into clinical practice; and the ways in which psychologists manage risks and patient safety when engaging with CM, as part of their clients' treatments.

Our review also identifies four distinct ways in which psychologists engage with CM in some form (e.g., CM products, practices and/or practitioners) in their clinical practice (see Appendix E). The types of engagement identified are discussion,

recommendation, referral, and the direct application of CM in clinical practice. Importantly, these types of CM engagement also link to specific, and in most cases different, considerations regarding education, professional registration, ethics and insurance. These types also appear to align in general terms with a range of integrative models as identified with reference to other health professionals and settings (Adams, 2013; Tovey & Adams, 2003) and have wider implications for the politics of health professional identity and territory (especially with reference to conventional and CM providers) (Adams, 2013). Differentiating these types of CM engagement within psychology also helps the discipline and profession of psychology to develop bespoke education and guideline material well suited to the particulars of CM integration occurring at the grass-roots of psychology clinical practice.

The findings of our review suggest the reasons why some psychologists are integrating CM, in some form, into their clinical practice is to respond to consumer preference for holistic approaches, and to acknowledge the cultural relevance of some forms of CM for some clients. These client-centred reasons for psychologists engaging with CM is consistent with other research examining broader health practitioner (e.g., nurses, medical specialists, physicians) engagement with CM (Hall et al., 2017; Phutrakool & Pongpirul, 2022; Tekin et al., 2021). Further, the finding that psychologists want to engage with CM, and participate in relevant education in CM, as reported in the reviewed literature, is also consistent with broader research investigating the engagement with CM amongst other health professionals (e.g., psychiatrists) (Bahall & Legall, 2017; Mwaka et al., 2019; Shorofi & Arbon, 2017). Our review found psychologists, in line with other health professionals, acknowledge the importance of engaging with their client's CM use and collaborating with other relevant health care

providers regarding CM, especially as a means of enhancing the therapeutic relationship in the context of client preference and cultural relevance (Abdollahi et al., 2020; Anheyer et al., 2018; Barimah & Akotia, 2015; Berman et al., 2020; Huber et al., 2019; Ziodeen & Misra, 2018).

None of the reviewed empirical articles report psychologists explicitly objecting to, or rejecting, psychologist engagement with CM. However, some of the articles included in this review note that there are reasons why psychologists do not engage, or limit their engagement, with CM. For example, participant psychologists reported the two main reasons why they may not engage with CM is: limited CM relevant education; and limited CM relevant guidelines from associations, policy makers and educators within psychology. This lack of CM relevant education and guidelines appears to occur despite consumer demand for CM (Jong et al., 2019; McIntyre et al., 2017; Seeman et al., 2018; Thomson-Casey et al., 2022), psychologists' interest in CM (Fay et al., 2016; Hamilton & Marietti, 2017; Liem & Newcombe, 2017; Ligorio & Lyons, 2018; Wilson & White, 2007; Wilson et al., 2013) and the small but growing evidence to support some CM as effective treatment for specific mental health problems or as adjuncts to psychological treatments (Foroughi et al., 2019; Stub et al., 2020; Thirthalli et al., 2016). The lack of engagement with CM by psychology in the context of education and practice guidelines does not appear to be empirically supported within the literature reviewed. However, this may be due to a number of possible factors including psychology (as a discipline) underestimating the interest in CM amongst the grass-roots of the profession or an indifference to CM on behalf of dominant sections within the profession and discipline.

Psychologists in the included empirical studies, expressed confusion around what they perceive to be the wider disciplinary view of psychology regarding what is acceptable engagement with CM, especially with regards to psychologists in clinical practice. This confusion is described as a barrier to psychologist engagement with CM and may be due to conflicting views about CM presented in both CM and psychology journals. For example, some commentaries in the wider literature encourage psychologist engagement with CM (Barnett & Shale, 2012; Gone, 2016; Siegel & Turato, 2016) and empirical studies discuss the benefits of combining psychological therapies with CM (Kutschera et al., 2021; Tan et al., 2010; Thirthalli et al., 2016). However, other commentaries describe psychologists' use of CM as "treacherous", a "gamble" and "potentially deadly" (Friedman, 1999). Given the plethora of diversity of reactions and viewpoints to CM engagement it is important that the discipline and profession of psychology clarify a position with regard to relevant practice policy and research.

In addition to the lack of CM-relevant education and guidelines, and confusion around what is acceptable engagement with CM, psychologists in the included studies also reported fear of negative appraisal from their psychologist peers as a barrier to their potential engagement with CM in clinical practice. This fear of negative appraisal may also be driven by negative commentaries described above. For example, Fasce and Adrián-Ventura describe psychologists' engagement with CM, and other psychotherapies including trauma-focused approaches, as an illustration of psychologists' "resistance to evidence-based practice" and engaging in "potentially harmful practice" (2020, p. 4). This fear of negative appraisal for engaging with CM in clinical practice has also been identified across other health professions, such as nursing

and medicine (Hall et al., 2017; Singh & Kamath, 2021). There is no shortage of published commentaries that are critical of CM in the broader literature outside of psychology (Li et al., 2018; Marcus, 2020; Shahvisi, 2019). Yet, we found no empirical data at the grass-roots explicitly supporting the exclusion of CM from psychology/ clinical practice. Meanwhile, our review suggests possible risk of client harm due to the prolonged disconnection between psychology and CM. Psychologists are already engaging with consumer demand for CM, as illustrated in their grass-roots practice and behaviours which still lack support or guidance in relevant policy and education.

Our findings suggest the grass-roots practice engagement psychologists have with CM is not reflected in the actions and perspectives of the rest of the wider psychology discipline and profession. The findings of our review are mirrored in wider research reporting other health professionals, including doctors and psychiatrists, as having insufficient professional association education and resources on CM, potentially increasing client risk (Davison et al., 2017; Gray et al., 2019; Ring et al., 2020; Roberts et al., 2020; Veziari et al., 2022; Veziari et al., 2017). Both the studies included in our review and the wider literature report health professionals across different geographical jurisdictions (e.g., Indonesia, Austria) as well as different ethnocultural client groups (e.g., American Indian, Aboriginal and Torres Strait Islander Peoples) as raising concern about the lack of education and guidelines for mental health professionals on relevant CM (Barimah & Akotia, 2015; Crowe-Salazar, 2007; Gone, 2016; Jones et al., 2022; Liem, 2019d; Liem, 2020; Medeiros et al., 2019; Morkl et al., 2021). All articles in this review recommend that psychologists be able to *at least* discuss CM with their clients. CM-informed psychologists are in a unique position to provide psychoeducation around CM use to their clients and provide adequate informed consent, answer

questions about efficacy, risks, benefits, and interactions and play an important role in helping coordinate clients' interdisciplinary care.

2.5.1 Strengths and limitations

Our novel, in-depth analysis of existing literature is not without limitations. It is inherent in the research question that there may be a response bias in the empirical studies reported in the review. However, the critical appraisal tool aimed to reduce the impact of bias on the outcomes of this study. A further limitation of this review is only English language articles were included.

2.5.2 Recommendations for future research

Further research is required to examine a range of pertinent issues regarding CM relevant to psychology practice and the wider discipline of psychology. As some psychologists in clinical practice are interested in, and already integrating CM, it is important to further explore and understand a range of pertinent areas of enquiry including: the prevalence of CM integration in the clinical practice of psychologists; the perspectives of psychologists on how CM benefits their clients; and the decision-making of psychologists around, and justification for, including CM in their clinical practice. Further research should also aim to map the interface between psychologists' engagement with CM in their practice and the wider development of CM-psychology relevant policy, education, and research.

2.6 Conclusion

The findings from this review suggest that CM already has a role in the clinical practice of a substantial number of psychologists. More pressing is the issue that some psychologists already engaging with their clients' CM use, or incorporating CM into

their treatment planning, in some form, are doing so without guidance from the wider psychology profession or discipline. Psychology as a discipline is yet to take a clear position on what role CM may have for psychologists in clinical practice, and if relevant, to provide guidelines on CM for psychologists. Without guidance from the wider psychology profession there remains risk to client safety, the therapeutic relationship, and effective collaborative care. In line with WHO policy and other mental health professions, it is important for psychology to further explore and define the role of CM in the field's professional project and to help develop relevant guidance for clinicians on this growing area of health care seeking and provision.

2.7 Chapter summary

Of note, the review paper outlined a conceptual framework that describes and delineates the modes of engagement psychologists have with their clients in clinical practice regarding CM. These modes of engagement include discuss, recommend, refer, and direct application of CM. The integrative review indicated that some psychologists may consider CM as relevant to their clinical practice, despite challenges to that engagement, such as limited CM relevant resources. The critical integrative review also informed the development of the subsequent three interrelated phases of this sequential mixed methods thesis which aimed to explore the contemporary relationship between psychology and CM in Australia.

Chapter 3. METHODOLOGY

3.1 Preface

The previous chapters provide an overview of psychology as a health care discipline and profession. The integrative review (Chapter 2), sets the scene by reviewing historical interactions between psychology and CM as health care disciplines, including psychologist interest in engaging with CM within their clinical practice. The integrative review also suggests for a lack of CM relevant resources may present as a barrier to psychologist interest in CM. For example, psychologists in the reviewed papers describe limited CM relevant guidelines for psychologists, including within the Australian clinical practice context. Further research is needed to extend our current understanding of psychologist interest in CM and to explore the status of psychology and psychologist engagement with CM. The below chapter provides an orientation to the methods utilised in this thesis that are aimed to address the research questions (outlined below), with the overarching research aim of understanding the contemporary relationship between psychology and CM in Australia.

3.2 The researcher's position

As a clinical psychologist in Australia, my professional goal is to improve mental health outcomes for my clients, within the scope of the evidence-based practice framework as ascribed by Australian psychology professional and regulatory bodies. I have noticed over time that some clients are interested in non-pharmacological approaches to their mental health care, such as CM, to complement their psychotherapy. In my twenty-five years of clinical practice experience, I have also seen opportunities to direct interested clients toward some forms of CM, such as nutritional interventions, that have evidence as supportive for mental health and wellbeing (Jacka et al., 2017;

Khanna et al., 2019; Rucklidge & Kaplan, 2013; Strasser et al., 2016). I was drawn to learn more about evidence-based CM approaches (herbs, supplements and nutrition) as a potential adjunct to conventional psychotherapy and counselling approaches. For example, nutritional and dietary interventions for teenage clients where the preference was to avoid medication, or medication was not necessary, or not tolerated. I was also curious about herbal interventions, such as *Melissa officinalis* (Lemon Balm) used for its anxiolytic and sedative effects (Emami, Naseri, Alijaniha, & Heidari, 2019; Ozsavci, Ozakpinar, Cetin, & Aricioglu, 2019; Soltanpour, Alijaniha, Naseri, Kazemnejad, & Heidari, 2019). Subsequently, I attained formal qualifications in both naturopathy and nutrition. I also obtained CM professional association membership and separate professional insurance as a CM practitioner.

However, despite my intentions to integrate my formal qualifications in CM with my psychology qualifications, I became aware that there were barriers to integrating any other professional qualification (CM or not) into my clinical practice (e.g., lack of clarity on permissibility and practical methods of integration). This thesis came about as the current psychology guidelines explicitly prohibit Australian psychologists from combining two professional qualifications/disciplines into their clinical practice. I risk breaching clinical practice guidelines if I provide support to a client from both roles (e.g., psychology and naturopathy), even with informed consent and even if the consultations from each discipline/profession occur in separate sessions. This prohibition of dual qualifications (working from both roles with the same client, even in separate sessions) (Australian Psychological Society, 2016a, 2017) is unique to the governance of Australian psychologists. Other Western countries allow dual qualifications, by way of managing multiple relationships, if there is adequate informed

consent, avoidance of exploitation, and that psychologists maintain competence in any specialty area for which they declare competence (American Psychological Association, 2017; British Psychological Association, 2017; Canadian Psychological Association, 2017).

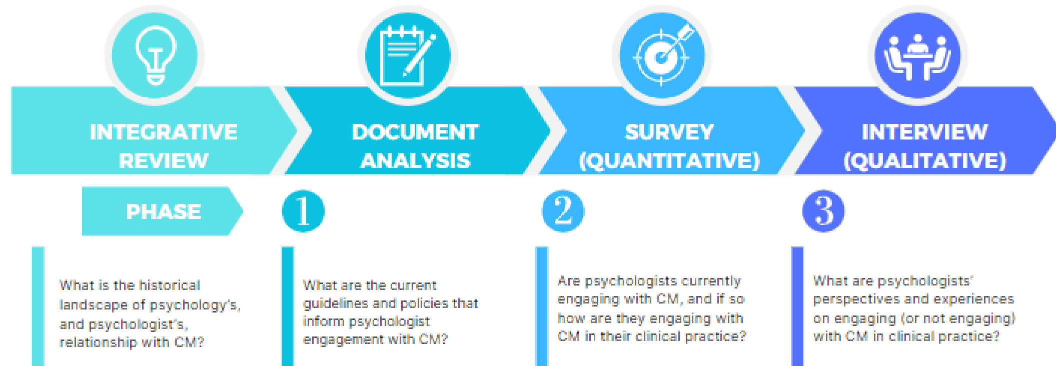
My PhD thesis came about due to my curiosity about whether psychologist engagement with CM warranted further attention in the context of consumer demand for CM, fellow psychologist interest in CM, and to understand more about the potential integration of CM to improve mental health outcomes for clients in my psychology practice. This thesis is presented as helping further contribute and advance the critical empirical examination of the engagement of psychology with CM.

3.3 Worldview and philosophical approach

The nature of the research questions (p. 93) requires a mixed methods research approach, and thus a theoretical lens that allows the flexibility to select methods that are suited to addressing the research question(s) at hand. Thus, the theoretical paradigm selected for this research is pragmatism. Pragmatism allows the selection of the best methods to analyse and provide answers to the problems described in the research questions (Creswell & Creswell, 2018). Pragmatism assumes that the collection of data using various methods provides a more comprehensive understanding of the research problem(s). This thesis used an explanatory sequential mixed-methods design. The below figure provides a visual representation of the sequencing of the phases of the thesis, the research questions, and the method utilised for each phase.

Figure 3.1

Visual representation of the three phases of sequential mixed methods thesis



The mixed-methods design utilised in this thesis is based on the nature of the research questions, which require both qualitative and quantitative methods, and is justified to satisfactorily explore grass-roots perspectives and experiences of psychologists in Australia. A mixed-method design also allows the research to identify connections across different types of data resulting in a more comprehensive explanation of the relationship between psychology and CM (Creswell & Clark, 2017).

As outlined above, the research has been undertaken via three interrelated but distinct phases of fieldwork:

1. Phase One: An exploration and analysis of relevant documents from Australian psychology professional and regulatory bodies to review how CM is considered within psychology, and thus how this may influence psychologist engagement with CM.
2. Phase Two: Quantitative – Design, collection, and statistical analysis of survey data from Australian psychologists to determine broader perceptions of the role

of CM within psychology, and if and how psychologists are currently engaging with CM in clinical practice.

3. Phase Three: Qualitative – Interviews and qualitative reflexive thematic analysis of the perceptions and experiences of Australian psychologists regarding the potential role of CM in clinical practice.

3.4 Research Questions

To address the aim, the thesis will answer five research questions:

1. To what extent and in what ways does the field of psychology, psychologists, their regulatory bodies, and associations consider CM relevant and/or appropriate to (their) clinical practice and the treatment of mental health problems?

   This question is addressed via Phase One (documents analysis) and Phase Three (interviews) analysis and discussion. The document analysis will include a critical evaluation of current formal policy and guidelines for psychologists (from Australian psychology professional associations and regulatory bodies) with regards to the relationship between psychology and CM. The qualitative interviews will directly ask psychologists about their perspectives and experiences relating to the relevance of CM to clinical practice.

2. In what ways, and to what extent, are psychologists in Australia engaging with CM in their clinical practice (e.g., recommending CM products and practice and/or referring to CM practitioners)?

These questions will be addressed via Phase Two (survey) that explores psychologists' rates of recommending and referring to types of CM within their clinical practice.

3. How do Australian psychologists describe their knowledge and the efficacy, risk, and relevance of CM to the practice of psychology in Australia?

   These questions will also be addressed via Phase Two (survey) that explores psychologist perceptions of their knowledge, and the risks and relevance of, CM within their clinical practice.

4. What clinical and other challenges face psychologists who may (wish to) utilise CM within their clinical practice? And how do psychologists explain and justify their relationship and engagement with CM in (their) clinical practice?

   These questions are addressed via Phase Three (interviews) where Australian psychologists explain their perspective and experiences of engaging (or not engaging) with CM in their clinical practice.

5. What important issues will require consideration with regards to navigating the future relationship between CM and psychology?

   This question will be addressed via Chapter 10 which presents the discussion and integration of the results of the three phases of the current thesis.

3.5 Research Methods

The below sections describe in further detail the phase designs, data collection and analysis techniques used within this thesis. Subsequent chapters will also provide additional details where relevant, and in the context of stand-alone publications.

3.6 Phase One - Document Analysis

The document analysis aimed to address the first research question: to what extent and in what ways does psychology's regulatory bodies and associations in Australia consider CM relevant to psychologists' clinical practice. Specifically, how do psychology's regulatory bodies, professional associations, and clinical practice guidelines engage with CM? The document analysis (Phase One) provided context for the regulatory environment in which the participants (Australian psychologists) operate, and adds depth to the research through triangulation with survey data (Phase Two) and interviews (Phase Three) (Creswell & Creswell, 2018). Further, the document analysis aimed to clarify issues, raised from the integrative review, relating to psychologists' complaint about the lack of CM relevant clinical practice guidelines for psychologists in clinical practice.

3.6.1 *Phase One Study design*

A systematic content analysis of current guidelines and regulatory codes, which have influence over psychologist's clinical practice, from three of the four major psychology regulatory and professional bodies, including the Australian Psychological Society (APS), Ahpra, the Psychology Board of Australia (PsyBA), and the Australian Psychology Accreditation Council (APAC) was conducted. Note, the fourth body,

Heads of Departments and Schools of Psychology Association (HODSPA), does not produce clinical practice guidelines and regulatory codes for psychologists in clinical practice.

1. Documents were searched using "find" functions to identify the reference terms; "complementary medicine", "CM", complementary and alternative medicine", "CAM", "integrative medicine", "traditional medicine" and "complementary therapies".
2. An iterative reading process was then used to identify pertinent references to CM within the documents that *explicitly* discuss CM in the context of psychology practice, ethics, standards, and education.
3. An iterative reading process was then used to identify pertinent references to CM within documents that *implicitly* discuss CM in the context of psychology practice, ethics, standards, and education.

3.6.2 *Phase One Data analysis*

The READ (Ready materials, Extract data, Analyse data, Distil) approach was applied as a systematic procedure (Dalglish et al., 2020) to analyse documents from Australian and international psychology professional and regulatory bodies. Documents were analysed using content analysis to identify themes that refer to and/or influence psychology/psychologist engagement with CM in clinical practice. Relevant data and themes were extracted and coded for analysis. Further, the possible absence of CM in the documents was also considered of relevance. Once the search and iterative reading process was complete, data and codes identified, checked and rechecked, the codes and

concepts were presented by CT to fellow researchers for triangulation and agreement on themes (Bowen, 2009).

3.7 Phase Two – Quantitative Survey

This second phase of the thesis aimed to address the research question: In what ways, and to what extent, are psychologists in Australia engaging with CM in their clinical practice (e.g., recommending CM products and practice and/or referring to CM practitioners)? In addition, how do Australian psychologists describe their knowledge and the efficacy, risk, and relevance of CM to the practice of psychology in Australia? A quantitative survey aimed to gauge opinion, relevance, and acceptability of CM within psychology.

3.7.1 Phase Two Study design

The integrative review informed the construction of an online survey with both closed and open questions. The 79 item survey was administered exclusively to Australian psychologists who have general registration (student and provisional psychologists were excluded) and work in a clinical practice setting at the time of survey.

3.7.2 Phase Two Survey development

Survey items covered psychologist's relationship with CM across the following domains: demographics, training and qualifications, practice characteristics, types of CM they may engage with, perspectives on ethical and practice guidelines for CM, risks, efficacy, and knowledge of CM. A copy of the survey is provided in Appendix H. This study employed an online survey administered exclusively to Australian

psychologists who held general registration at the time of survey between February and April of 2021. Email invitations to participate in the study were sent to psychologists whose contact details were collected from their publicly available websites. The recruitment emails contained information about the study, consent forms, and a link to complete the survey online. All participants were sent a reminder email four weeks following the initial invitation email. An advertisement inviting psychologists to participate in the research was also placed on two psychology professional association websites (Australian Association of Psychologists Incorporated and the Australian Psychological Society) and on relevant social media sites including Twitter, LinkedIn, and Facebook. Participants accessed the survey via an anonymous link (embedded in the email, website advert or in social media post), which initially directed the psychologist to the participant information and consent form followed by the link to the survey using Qualtrics software, Version 2021 (Qualtrics, 2022). The information page at the beginning of the survey included project details such as ethical approval, data protection, and voluntary participation. The information page also served as the participant consent form. Participants indicated their written consent after reading the information and consent page and clicking on the button confirming their agreement to proceed with the survey. Participants who completed the online survey were invited to supply their email address to enter a prize draw to win a gift voucher to the value of $250. Ethical approval was attained from the University of Technology Sydney Human Research Ethics Committee [ETH20-5138].

3.7.2 Phase Two Population sample

The initial survey was distributed to 1,479 Australian psychologists working in clinical practice at the time of recruitment. All psychologists (psychologists with

general registration, and those psychologists with general registration plus an area of practice endorsement (AoPE) were eligible to participate in the study. However, only responses from those psychologists working in an Australian clinical practice setting (e.g., inpatient hospital, private practice) and directly with clients were included. A priori power analysis estimates 400 participants were required. Two hundred and thirty-one psychologists completed the survey. After checking, 202 complete surveys were utilised in the second (quantitative) phase. Further details regarding the population are provided in Chapters 5 and 6.

3.7.3 Phase Two Recruitment

Convenience sampling was used to recruit psychologists via a listing in the "Research" section of the Australian Psychological Society's e-newsletter *APS Matters* which was distributed to member psychologists. As the researcher is a member of the APS there was capacity to advertise the research activity to attract a convenience sample. Direct emails were sent to psychologists who publicly listed their email address. Social media was also used to advertise and recruit to the study.

3.7.4 Phase Two Data analysis

Data was analysed using IBM SPSS statistics software (Version 27) predictive analytics software, and the significance level set at 0.05. Descriptive statistics including means, percentages, and frequencies were calculated for each variable. Multivariate tests were used to analyse data. Results from the Phase Two surveys were used to inform Phase Three interview questions.

3.8 Phase Three – Qualitative Interviews

The aim of this phase of the research was to explore perspectives and experiences of psychologists who may (wish to) engage with CM within their clinical practice. Specifically, what are the challenges for psychologists who wish to engage with CM as part of their clinical practice with clients, and how do they address these challenges. Further, how do psychologists explain and justify their support (or lack of support) for engaging with CM in (their) clinical practice?

3.8.1 Phase Three Study design

Following voluntary completion of an online survey (described above) that collected information regarding how many types of CM products, CM practices, and CM practitioners are recommended and/or referred by psychologists as part of their clinical practice (Chapters 5 and 6), psychologists could nominate themselves as potential participants in the next phase (Phase Three, qualitative phase). Those psychologists who self-nominated to participate in interviews were emailed an invitation to select a time to participate in a semi-structured interview. Data from the interviews was thematically analysed to develop themes that aim to explain psychologist engagement with CM.

The semi-structured interviews included a framework of questions aimed at eliciting rich and meaningful responses from psychologists relating to the research questions. Open questioning loosely directed by a semi-structured guide was used in the interviews to illicit the ways in which psychologists engage with CM in their clinical practice, how they educate themselves in CM, their perspectives on CM treatments for use by psychologists in clinical practice, their understanding of their clients' use of CM,

and their perspectives and experiences of opportunities and challenges relating to CM integration. The questions used in the interviews are described below in Section 3.8.5 Interview schedule.

3.8.2 Phase Three Recruitment

Convenience and snowball sampling was undertaken to identify and recruit psychologists. Participants in surveys (Phase Two) were invited to participate through an additional link in the survey. Those psychologists who nominated to participate in interviews received further information and invitation to select a time to participate in a qualitative interview with researchers (CT & JA) at a time convenient to the psychologists. Participants were advised the interview would be approximately 60 minutes in length. Participants selected an interview time via Picktime (appointment scheduling software) (Picktime Inc, 2021) and then received a Zoom invitation (video meeting platform) (Zoom Video Communications, 2024) via email.

The initial survey was distributed to 1,479 Australian psychologists working in clinical practice at the time of recruitment. It was also important to the third (qualitative) phase to include both psychologists who did and did not have additional qualifications in any CM approach. Including psychologists across the spectrum of types of engagement (discuss, recommend, refer, apply) and those with no engagement, ensured the breadth of perspectives and experiences in relation to the research question. From the 202 participants that were included in the survey data analysis, 125 indicated an interest in participating in the third (qualitative) phase. Twenty-two psychologists in clinical practice confirmed their interest via reply email, with two psychologists not responding further. Twenty psychologists scheduled an interview time, with one

psychologist not arriving to the scheduled interview. Thus, 19 psychologists proceeded to participate in interviews. The psychologists who completed the interview process were provided with a $100 gift e-voucher by email.

3.8.3 Phase Three Demographic survey

Prior to the scheduled interview, demographic data including the psychologist's year of birth, gender identity, and the predominant state/territory in which they practice were collected via brief survey. Psychologists were also asked to provide practice characteristics, such as an AoPE if they had one, their work setting (solo or group setting), and their years in practice as a psychologist. A copy of the consent form and copy and brief demographic survey are provided in Appendix P.

3.8.4 Phase Three Participant characteristics

The study sample ($N = 19$) comprised 16 women (84.2%) and 3 men (15.7%). The age range of participants was 33 to 72 years ($M = 54$, $SD = 14$). There were no participants from South Australia or Western Australia. The highest representation was from Queensland ($n = 8$), followed by New South Wales ($n = 5$), Victoria ($n = 3$) and the lowest from Australian Capital Territory ($n = 1$), Northern Territory ($n = 1$) and Tasmania ($n = 1$). Most psychologists identified with the AoPE of clinical psychologist ($n = 8$) or as a psychologist with general registration ($n = 7$). Participants also identified as health psychologists ($n = 2$), counselling psychologist ($n = 1$), and education and developmental psychologist ($n = 1$). Solo practice was the most common work setting reported among participants ($n = 13$), followed by group practice ($n = 5$) and one person in "other" setting. The other setting was clarified as private practice consultancy via government funded program, where clients were individuals in a residential care setting.

The highest proportion of years of experience reported by participants was 21 to 30 years (*n* = 5), followed by 5 to 10 years (*n* = 4), 11 to 20 years (*n* = 4), and 31 plus years of clinical experience (*n* = 4). The remaining participants had less than 5 years experience (*n* = 2). While two participants reported having additional qualifications in education (e.g., Bachelor of Education), four participants hold additional qualifications in a CM related profession (e.g., Bachelor of Naturopathy). Demographic information relating to the psychologists, whose interview data underwent thematic analysis, are presented in Table 3.1 below.

Table 3.1

Demographics of interviewed psychologists

Demographic	N=19
Gender	
Female	16
Male	3
Age (years)	
18 to 35	1
36 to 50	5
51 to 65	6
65 plus	7
Current location	
Queensland	7
New South Wales	6
Victoria	3
Australian Capital Territory	1
Northern Territory	1
Tasmania	1
AoPE*	
Clinical	8
Health	2
Counselling	1
Education and Developmental	1
None (general registration)	7
Practice setting	
Solo private practice	13
Group practice	6
Years of practice	
Less than 10	6
11 to 20	4
21 to 30	5
31 plus	4
Additional qualifications	
Naturopathy	4
Education	3
Other	1
None	11

*AoPE Area of practice endorsement

3.8.5 Phase Three Interview schedule and design

The construction of interview items was informed by previous literature on psychologist engagement with CM to produce a framework of questions that best captured the ways psychologists might be engaging with CM, and how they explain their motivation and justification for engaging with CM, within their clinical practice. The interviews were based on an open-ended and semi-structured design. Using a framework of questions had the potential to produce answers that best address the research question(s). The framework of questions for the interview consisted of exploring the psychologists' perspectives regarding the following main topic areas: their engagement with CM within clinical practice; the relevance and position of CM within clinical practice; the relevance and position of CM within and in relation to psychology as a broader discipline in Australia; what drives and/or influences their engagement with CM; any benefits to the psychologist when they engage with CM; the perceived benefits when a psychologists engages with CM in their clinical practice; any challenges to psychologist engagement with CM; the risks associated with a psychologist engaging with CM; the response from their professional peers when they express interest in CM; how the psychologists envision CM within their psychology practice; how the psychologist may feel if engagement with CM in clinical practice was explicitly prohibited by psychology's professional and regulatory bodies; what makes a good psychologist. Participants were encouraged to explain their responses in depth.

In-depth interviews were initially conducted and digitally recorded via Zoom between October to December 2021 and again between October to December 2022. A supervisor (JA) attended some of the interviews to provide training in situ, to check analyses and interpretations progressively, as well as provide further insight into how

fieldwork is undertaken. The second round of interviews provided an opportunity to revisit issues raised in the first interview as well as to raise issues introduced by other participants in their interviews. At the beginning of each interview, participants were reminded of their capacity to withdraw at any time. To establish rapport with participants introductions and an explanation of the context of the research, and position of the interviews within the thesis, was provided. Participants were also reminded that the interviews would be recorded. Nineteen semi-structured interviews were conducted lasting approximately 45 to 180 min. In some instances, these interviews occurred over shorter sittings. One interview was stopped after 17 minutes due to technical issues and rescheduled to an alternative time. Variability in interview length also depended on participant psychologist's availability – but also on participant openness to explore their answers further when encouraged. For example, Marie expressed some frustration with the interview process "I think we're going over the same ground a bit here".

During the interview the primary researcher also took notes. These notes included contemporaneous notes relating to the content of the interview including key and pertinent points to return to for further clarification from the participant. Notes were also taken as part of a reflection following the interview, to capture the primary researcher's initial response relating to the interview, how the interview may relate or differ from other interviews already conducted, and how the interview data may relate to the research question(s) broadly. The primary researcher also kept a journal throughout the qualitative research process to track and record the research process, to monitor thoughts and feelings, and to reflect on any potential biases. These notes and journal entries were reviewed during the analysis phase and were salient to the final analysis.

3.8.6 Phase Three Data analysis

Recorded interviews were downloaded as audio files from Zoom and uploaded to an artificial intelligence transcription software (Otter, 2022). Care was taken during the interviews not to record or elicit identifying information. To preserve anonymity, participants were assigned a pseudonym. The assigned pseudonyms were derived from figures in French history inspired by the primary researcher's visit to France during the analysis phase.

The thematic analysis of the interview data adopted an experiential orientation to interpret and highlight meaning, and meaningfulness, as ascribed by the interviewed psychologists. Adopting an experiential orientation meant that the analysis acknowledged the socially constructed nature of the world of the individual psychologists in clinical practice in Australia. In addition, the prioritisation of the subjective states of the participant psychologists allowed an exploration of their own accounts of their attitudes and opinions in relation to CM within clinical practice. A framework analysis was also used to answer specific questions from the psychologists in clinical practice, as a setting, as a defined sample, and allowed flexibility to describe and interpret what is happening in psychology, as a field (Srivastava & Thomson, 2009). Interviews were transcribed and reviewed, organised, and coded for relevant ideas and concepts. Ideas and concepts were then organised into themes that inform and aim to answer the research question(s) through reflexive thematic analysis (Braun & Clarke, 2006, 2022, 2023).

Implementing the above approach meant that the analysis did not aim to make claims about the social construction of the research topic (which would more so

necessitate a critical perspective), but rather acknowledge the social constructions described by the psychologists. An experiential orientation was the most appropriate lens, as the aim of the study was to explore psychologists' meanings, perspective and experiences of CM in their clinical practice (Byrne, 2022). Reflexive thematic analysis of the data followed the six steps as described by Braun and Clarke (2006; 2012; 2019; 2021; 2022). The below section describes the steps taken to conduct the qualitative analysis in more detail.

Step one: Familiarisation.

The interview transcripts were checked for accuracy against the corresponding audio files and were corrected where necessary (CT). The audio files were listened to a second time while following the corrected transcript line by line. This step also allowed for more active listening and familiarisation with the interview data. Whole interview transcripts were then re-read without audio.

Step two: Initial coding.

An inductive approach was taken to produce initial coding. The primary researcher began re-reading whole interviews to assign descriptive and interpretive labels to the interview data. Initial coding aimed to reflect participant's meaning utilising both semantic and latent codes. This initial process was conducted in Microsoft word using tables and comments functions. During this process the second researcher (JA) also read clean transcripts and offered reflections as a non-psychologist in relation to interview data.

Once initial codes were developed the transcripts were uploaded to Delve (Twenty to Nine LLC, 2023), a Computer Assisted Qualitative Data Analysis

(CAQDAS) tool, to assist with organisation, collaboration, and analysis in a reflective, critical, and rigorous manner. Initial codes were also added into the tool. Transcripts were then re-read while progressively and systematically assigning initial codes and identifying additional codes. This process was repeated three times with codes subsequently organised into categories and subcodes. At times a deductive approach was utilised during the recursive and iterative process to check whether later codes were also reflective of participant meaning in earlier interview data from previous rounds of coding.

Step three: Generating themes.

It was important to the primary researcher, as guided by reflexive thematic analysis, that meaning and development of representative themes, was derived from the intersection of the primary researcher's contextual understanding of the topic and subsequent interpretation of the interview data. Coded data was analysed for underlying and unifying concepts of meaning to form themes and sub-themes.

Step four: Reviewing potential themes.

Two researchers (CT and JA) reviewed themes in relation to both the research question and the aggregate interview data. Theme relevance and utility was reviewed utilising guidelines with some potential themes discarded (e.g., clinical practice workarounds) (Braun & Clarke, 2016, 2022, 2023). Although consensus is not required as part of reflexive thematic analysis, the researchers (CT and JA) utilised discussion to ensure that any potential biases had not resulted in the overstatement or exclusion of themes. Further, this discussion aimed to ensure final themes and subthemes were indeed informed by the interview data, were representative of the meaning provided by

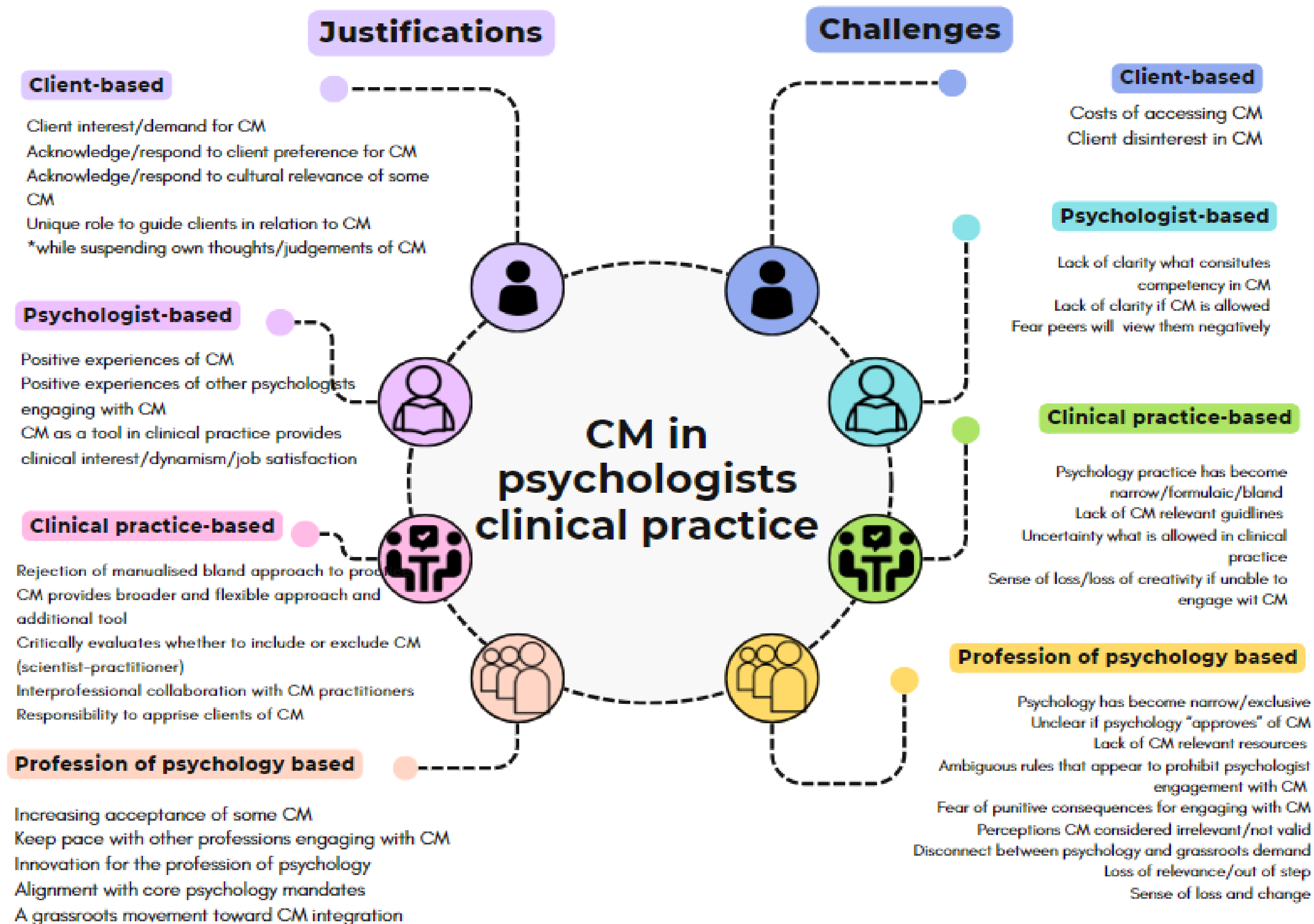
participant psychologists, and were fully realised themes. It was also important to the primary researcher to remain true to reflexive thematic analysis, with the primary researcher's subjectivity to the topic as a primary resource (Braun & Clarke, 2019).

Step five: Defining and naming themes.

Once the potential themes had been reviewed, and the primary researcher felt there was adequate depth of understanding to build a theory, a map of themes was developed (Figure 3.2 below). In accordance with pragmatism as the guiding theoretical framework, the criteria applied to the interview data and subsequent themes were determined through a pragmatic lens, and by a combination of the research objectives and patterns identified in the interview data (Ramanadhan et al., 2021). Transcripts were then re-read, aided by the thematic map, to ensure themes and subthemes provided both representation and interpretation of the data in relation to the research question and broader thesis. In the context of the reflexive thematic analysis approach that guided this research, data saturation was not considered useful or meaningful. Rather, that themes produced were representative of the breadth and diversity of psychologist perspectives and experiences and provided a coherent and compelling story in relation to Australian psychologist engagement with CM in clinical practice.

To support the methodological quality of this analysis the Reporting Standards for Qualitative Research (JARS-Qual) checklist items (Levitt et al., 2018) were used. Although the JARS-Qual for reporting qualitative research does not align with

Figure 3.2 *Thematic map of themes, subthemes, and broad codes*



reflexive thematic analysis guidelines in relation to saturation (Braun & Clarke, 2021; Shaw et al., 2019), nonetheless the checklist guided reporting, where relevant, across six domains: (1) research design overview, (2) study participants or data sources, (3) researcher characteristics, (4) participant recruitment, (5) data collection, and (6) analysis.

3.8.7 Phase Three Position of the primary researcher

From the start of this thesis project, I have been genuinely curious about psychologist's thoughts, feelings and behaviours relating to CM within their clinical practice. Additionally, I have pondered the potential impact of the thesis findings on psychology in Australia, including impacts on clinical practice via the development of CM relevant education, research, and policy.

I am mindful that the third phase interview data may uncover instances where psychologists deviate from clinical practice guidelines. I intend to handle any disclosures about their clinical practice behaviours with due regard. In Australia, psychologists are mandatory reporters of fellow psychologists whose practices significantly depart from professional standards, and places the public at substantial risk of harm (Ahpra and the National Boards, 2023a).

When conducting these interviews, I loosely adhered to the questions that had been developed to guide the interview and illicit response that aimed to address the research question(s). The interview discussions were typically guided by what I interpreted to be meaningful to the interviewee and at times we would explore adjacent topics. A key principle I adopted throughout this study was to reflect psychologists' own accounts of their attitudes, opinions and experiences as faithfully as was possible,

while also accounting for the reflexive influence of my own interpretations as the primary researcher.

3.8.8 Phase Three Research Researcher's reflexivity and positionality

At the time of the interviews, primary researcher CT was a psychologist with general registration, a Master of Psychology (Counselling), and an AoPE as a clinical psychologist. CT also worked part time in a solo private clinical practice. CT was the convenor for both the Australian Psychological Society (APS) interest group called Psychology and Integrative Mental Health, and the Australasian Integrative Medicine Association (AIMA) interest group Integrative Mental Health. CT also holds additional qualifications in, but does not practice, Naturopathy and Nutrition. Researcher JA was a Distinguished Professor at the Australian Research Consortium in Complementary and Integrative Medicine. Both researchers have used some form of CM for their health and wellbeing. Both researchers discussed their potential biases with each other throughout the planning, data collection, and analysis to ensure any potential bias and influences did not unduly impact the research.

3.9 Chapter summary

This chapter has overviewed the broad design of the thesis and detailed specific aspects of each of the distinct but interrelated phases of the thesis. The three phases include a document analysis, survey data collection and analysis, and finally interviews and subsequent thematic analysis. The methods utilised throughout the thesis intend to help address the research aim, what is the contemporary relationship between psychology and CM in Australia? In the next chapter the first phase of the thesis, the document analysis, is presented.

Chapter 4. PHASE ONE – DOCUMENT ANALYSIS RESULTS

4.1 Preface

The integrative review (see Chapter 2) revealed there may be a range of reasons why psychologists do not engage, or limit their engagement, with CM in their clinical practice. The two main reasons suggested by psychologists were limited CM relevant education, and limited CM relevant guidelines. This chapter aims to clarify the complaints made by psychologists in the integrative review, that there is inadequate guidance from psychology's professional associations and regulatory bodies on how psychologists might safely engage with CM. Critically evaluating existing CM relevant guidelines available for psychologists, and identifying any gaps in policy, will be indicative of how psychology's professional associations and regulatory bodies consider the role and relevance of CM to psychology and psychologists in clinical practice. This document analysis aimed to address the research question: to what extent and in what ways does psychology's regulatory bodies and professional associations in Australia consider CM relevant to psychology practice? This chapter includes the accepted manuscript which has been published in *BMC Complementary Medicine and Therapies* in June 2022.

Thomson-Casey, C., Adams, J., & McIntyre, E. (2022). Complementary medicine in psychology practice: an analysis of Australian psychology guidelines and a comparison with other psychology associations from English speaking countries. BMC Complementary Medicine and Therapies, 22(1), 171. https://doi.org/10.1186/s12906-022-03620-2

4.2 Introduction

Internationally psychologists are engaging with their client's complementary medicine (CM) use, in some form, with limited policy, clinical practice guidelines, or formal support from their professional associations or regulatory bodies (Hamilton & Marietti, 2017; Liem, 2019a). Studies suggest Australia's psychology professional associations also do not support psychologists who engage with CM (Hamilton & Marietti, 2017; Kassis & Papps, 2020; Stapleton et al., 2015; Wilson & White, 2011). The current article critically evaluates existing guidelines for psychologists with regards to the relationship between CM and psychology.

CM includes a broad range of health care products, services and practices (including traditional medicine practice), that are not part of conventional medicine and "are not fully integrated into the dominant health care system" (Harnett et al., 2019, p. 1). CM is often self-selected, including over the counter vitamin and mineral supplements, herbal medicines, traditional medicines, yoga, aromatherapy, meditation and massage (Clarke et al., 2015; de Jonge et al., 2018; Green et al., 2017; Steel, McIntyre, et al., 2018; Uysal et al., 2019). There is demand for CM in mental health settings with prevalence rates reaching 82% in some countries (Malhotra et al., 2020; McIntyre, 2016; Rajab et al., 2019; Wemrell et al., 2020). People with mental health problems in Australia also have high CM use and it is likely that psychologists will encounter clients who are using at least one form of CM (McIntyre et al., 2021).

Internationally the lack of CM-focused guidelines for psychologists has been noted. For example, Siegel and Turato (Siegel & Turato, 2016) reported that Brazil's professional association for psychologists has not adequately responded to their

National Policy for Integrative and Complementary Practices stating “no specific material on [applied psychology] and CAM [complementary and alternative medicine] has been produced so far” (6 p1529). Similarly, Barimah and Akotia (Barimah & Akotia, 2015) observed that “Despite this growth in consumer demands for complementary medicine or TRM [traditional medicine], the policy responses of African and other governments and health professions have been either absent or inadequate” (18 p 100). The discipline of psychology may not be adequately informing psychologists on how they might engage with their client’s preference for CM as part of mental health treatment (Kassis & Papps, 2020; Liem, 2020). In the context of informed consent, Liem’s research on psychologists in Indonesia and Australia (Liem, 2019a) reported that participants believed “clients have the right to know all the possible treatments available, including CAM [CM] treatments, and their safety and effectiveness” (p 6).

Research has demonstrated the efficacy of CM approaches, such as yoga, to address mental health symptoms such as stress, anxiety, and low mood (Butterfield et al., 2017; T. Chang et al., 2022; O'Dea et al., 2022). There is also strong evidence for ingestible CM, such as the herbal medicines St John’s wort and saffron in treating mild to moderate depression (Forsdike & Pirotta, 2019; Ghajar et al., 2017; Jackson et al., 2020; Sarris, 2018). Nutritional interventions (e.g., Mediterranean diet, probiotics) have also gained empirical support for the prevention and treatment of depression (Jacka, 2017; Khanna et al., 2019; Rucklidge & Kaplan, 2013; Strasser et al., 2016). There is evidence to suggest some CM treatments may have a role in helping to address mental health problems (Fernandes-Nascimento & Wang, 2022; Haller et al., 2019). However,

there are a number of identified risks associated with the use of some CMs, especially within the context of wider concurrent use alongside pharmacological treatments.

In some countries (e.g., America and England) specific CM approaches are accepted by psychologists and integrated into their practice, such as meditation and mindfulness; yet they were not previously considered a component of psychology (Haller et al., 2019; Lorenc et al., 2018; Moir et al., 2019). Some psychologists report engaging with CM based on holistic and client centred principles (Kassis & Papps, 2020; McKenzie et al., 2012; Wilson et al., 2012a), while others discuss client demand and acknowledge the cultural relevance of some CM (Barimah & Akotia, 2015; Crowe-Salazar, 2007; Liem, 2018; White, 2009). Psychologists are also seeking training in, and already using, some CM approaches in their practice (Hamilton & Marietti, 2017; Kassis & Papps, 2020; Liem, 2020; Stapleton et al., 2015). Prevalence rates for psychologists integrating CM into their practice vary dependent on research aims, methodologies, and what is included in definitions of CM. Up to 83% of psychologists have recommended some form of CM to their clients, 52% had made a referral to a CM practitioner, and 65% were directly applying CM as part of their practice (Liem, 2019a; Liem & Newcombe, 2019a; Ligorio & Lyons, 2018; Morkl et al., 2021). For example, a recent study reported more than 50% of Australian mental health practitioners (73.1% of participants were psychologists) recommend improved nutrition and dietary changes for depression, anxiety, and stress, at least weekly in their practice (Baxter & Lovell, 2021). Similarly, psychologists acknowledge the value of physical activity (e.g., yoga) as part of mental health care treatment and recommend physical activity, or refer to movement/exercise-based health professionals (Martland et al., 2021; McCurdy et al., 2020; Way et al., 2018). Despite consumer and psychologist interest in CM, there is

uncertainty among Australian psychologists how to safely integrate these approaches into their clinical practice (Liem, 2019b; Wilson & White, 2011).

Australian psychologists note the absence of CM relevant guidelines (Hamilton & Marietti, 2017; Wilson et al., 2011). The concern for lack of guidelines is reported by participant psychologists in relevant papers, and includes: 1) confusion around the ethical responsibility to advise clients appropriately about CM (Liem, 2019c; Wilson & White, 2011), 2) what is allowable in terms of integrating CM in clinical practice (Liem, 2020; Wilson et al., 2012a), 3) how the efficacy of CM can be explored by psychologists in safe and ethical ways (McKenzie et al., 2012; Stapleton et al., 2015), and 4) that psychologists in clinical practice are attempting to address consumer demand for CM without clear policy and guidelines (Kassis & Papps, 2020; Liem, 2019a, 2019b). Australian studies also cite lack of knowledge or education as a barrier to psychologist engagement with CM (Baxter & Lovell, 2021; Nayda et al., 2021). For example, Baxter and Lovell state "mainstream psychological practices to date have not included the use of dietary change or supplementation as part of their training"; however, psychologists in the study, report utilising CM (in this case nutrition) with their clients at least weekly and believe "the role of dietary change for positive mental health has further informed and justified mental health practitioners' prescription of dietary change" (Baxter & Lovell, 2021, p. 251). A lack of guidance on CM for psychologists has implications for broader client care, including risks to patient safety, disconnection from emerging research and evidence for mental health treatments that include CM, and psychologists' potential disconnect from certain clients and ethnocultural groups who may prefer CM treatment options. Further, the absence of CM

in guidelines for psychologists may subsequently exclude relevant CM from psychologist tertiary education curricula.

There are several psychology organisations responsible for the development and enforcement of regulations, code of ethics, and clinical practice guidelines for psychologists in Australia, including the Australian Health Professionals Regulation Agency (Ahpra), the Psychology Board of Australia (PsyBA), the Australian Psychology Accreditation Council (APAC) and the Australian Psychological Society (APS). The APS is the largest psychology professional association in Australia with 25,000 members (Australian Psychological Society, 2021a). There are smaller psychology professional associations, such as the Australian Association of Psychologists Incorporated (AAPI) and Australian Clinical Psychology Association (ACPA). Speciality psychology groups beyond the above organisations represent other diverse areas of psychology practice, such as the Australian Indigenous Psychologists Association (AIPA), the Australian Psychologists and Counsellors in Schools (APACS), and the Australian Music and Psychology Society (AMPS). There are also psychology speciality groups within the APS, such as the College of Health Psychologists, and the Psychology and Integrative Mental Health Interest Group. These organisations and groups have varying influence on how psychologists' practice in clinical settings. Psychologists are guided by their education and, once in clinical practice, they must adhere to Ahpra guidelines, the APS Code of Ethics, and APS ethical guidelines. The APS also provides "ethical considerations" documents that provide examples of interpretation of the ethical guidelines.

Currently there is no explicit policy and/or clinical practice guidelines for CM within psychologist clinical practice from Australian psychology professional

associations and regulatory bodies. The exception is the APS ethical guideline for hypnosis teaching and use (Australian Psychological Society, 2016b). Hypnosis is often included in definitions of CM (Grégoire et al., 2021). Given the concerns raised in the literature about the lack of guidelines, this paper aims to explore how Australian psychology associations and regulatory bodies inform psychologist engagement with CM. This paper presents the findings of a document analysis of existing guidelines, for references related to the integration of CM into psychologists' clinical practice. In addition, a brief comparison of the CM relevant clinical practice resources provided across Australian, American, British, and Canadian psychology associations is explored.

4.3 Method

The READ (Ready materials, Extract data, Analyse data, Distil) approach was applied as a systematic procedure (Dalglish et al., 2020) across two phases to analyse documents from Australian and international psychology professional and regulatory bodies. The document analysis aimed to address the research questions; Do Australian psychology associations and regulatory bodies consider CM relevant to psychology practice? How do Australian psychology associations compare to other English-speaking countries (The America Psychological Association (APA) and British Psychological Society (BPS)) psychology associations in terms of their engagement with CM topics? Psychology association and regulatory body policy and guidelines were considered credible sources of text that can be analysed using a deductive approach (Bowen, 2009). The first phase of the content analysis involved a superficial review of documents for direct mention of CM within psychology practice. Following the initial review, the decision was made to create a priori codes from the literature to assist data extraction. Key search terms/codes developed were "complementary

medicine", "complementary and alternative medicine", "complementary therapies", "integrative medicine", "integrative health", "integrative mental health", "traditional medicine", and "traditional healing". Widening the codes to include terms such as nutrition and naturopathy was considered and dismissed to keep the research focused on umbrella terms as representations of CM. Further, a search using an exhaustive list of terms to describe CM professions, products and practices is beyond the scope of the current study.

Phase 1 search was *within* documents produced by Australian psychology professional and regulatory associations around the governance (e.g., registration, auditing, accreditation, complaints, and compliance) or guidance of the activities of psychologists in clinical practice (e.g., code of ethics, ethical guidelines). The associations were contacted by email in June 2020 to request information regarding access to their policy and guideline documents. The associations were also asked if they have *policy/guidelines that they have developed (separate to the Australian Psychological Society guidelines) that are relevant to psychologists who might be engaging with CM in their practice.* One of the associations did not respond to an email request for documents (ACPA), and three replied (AIPA, AAPI, APS) by email advising that their association (psychologist members) adheres to the APS code of ethics and ethical guidelines, or advised that they are informed by psychology's regulatory bodies (Psychology Board of Australia and Ahpra). Access to APS policy and guideline documents were available through the first author's APS membership. The remaining documents were retrieved from the Psychology Board (www.psychologyboard.gov.au) and Ahpra (https://www.ahpra.gov.au/). APAC was

excluded from the guideline and policy search as they advise psychologist education standards and not clinical practice. A list of included documents is shown in Table 4.1.

Table 4.1

Frequency of search terms within relevant documents published by the APS, PsyBA and AHPRA

Document type	Title	Organisation	Date	Frequency, n (%)
Code of ethics	APS Code of Ethics	APS	2007	0 (0.0)
Guideline	Guidelines: Mandatory notifications about registered health practitioners	AHPRA	2020	0 (0.0)
Guideline	Guidelines for advertising regulated health services	AHPRA	2020	0 (0.0)
Guideline	Guidelines for supervisors	PsyBA	2018	0 (0.0)
Guideline	Guidelines for supervisor training providers	PsyBA	2018	0 (0.0)
Guideline	Guidelines: Continuing professional development	PsyBA	2015	0 (0.0)
Guideline	Guidelines on area of practice endorsements	PsyBA	2019	0 (0.0)
Guideline	Guidelines for the 4+2 internship program	PsyBA	2017	0 (0.0)
Guideline	Guidelines for the National Psychology Exam	PsyBA	2019	0 (0.0)
Guideline	Guidelines for the 5+1 internship program	PsyBA	2013	0 (0.0)
Policy	Policy for provisional registration in combined 4th and 5th year programs of study	PsyBA	2019	0 (0.0)
Policy	Common Protocol - Informing notifiers about the reasons for National Board decisions	PsyBA	2018	0 (0.0)
Policy	Policy for recency of practice requirements	PsyBA	2016	0 (0.0)
Policy	Policy on working in addition to placements	PsyBA	2015	0 (0.0)
Policy	Policy for higher degree students applying for general registration	PsyBA	2016	0 (0.0)
Policy direction	Policy Direction 2019-01 - Paramountcy of public protection when administering the National Scheme	PsyBA	2020	0 (0.0)

Document type	Title	Organisation	Date	Frequency, n (%)
	Policy Direction 2019-02 - Requirements to consult with patient safety bodies and health care consumer bodies on every new and revised registration standard, code and guidelines			
Manual	National psychology exam candidate manual	PsyBA	2019	0 (0.0)
Ethical guideline	Ethical guidelines for Aboriginal and Torres Strait Islander Peoples	APS	2015	0 (0.0)
Ethical guideline	Guidelines for the use of therapeutic aversive procedures	APS	2020	0 (0.0)
Ethical guideline	Ethical guidelines on confidentiality	APS	2016	0 (0.0)
Ethical guideline	Ethical guidelines on providing psychological services in response to disasters	APS	2014	0 (0.0)
Ethical guideline	Ethical guidelines regarding financial dealings and fair trading	APS	2020	0 (0.0)
Ethical guideline	Ethical guidelines for psychological practice in forensic contexts	APS	2013	0 (0.0)
Ethical guideline	Ethical guidelines for working with clients when there is a risk of serious harm to others	APS	2013	0 (0.0)
Ethical guideline	Ethical guidelines on the teaching and use of hypnosis	APS	2016	0 (0.0)
Ethical guideline	Ethical guidelines for psychological practice with clients with an intellectual disability	APS	2016	0 (0.0)
Ethical guideline	Ethical guidelines for providing psychological services and products using the internet and telecommunications	APS	2011	0 (0.0)
Ethical guideline	Ethical guidelines for psychological practice with lesbian, gay and bisexual clients	APS	2010	0 (0.0)
Ethical guideline	Ethical guidelines for psychological practice with clients who disclose memories related to traumatic experiences	APS	2018	0 (0.0)
Ethical guideline	Ethical guidelines for psychological practice with men and boys	APS	2017	0 (0.0)
Ethical guideline	Ethical guidelines for psychological services involving multiple clients	APS	2014	0 (0.0)
Ethical guideline	Ethical guidelines for managing professional boundaries and multiple relationships	APS	2016	0 (0.0)

Document type	Title	Organisation	Date	Frequency, n (%)
Ethical guideline	Ethical guidelines for working with older adults	APS	2014	0 (0.0)
Ethical guideline	Ethical guidelines relating to procedures that involve psychologist-client physical contact	APS	2016	0 (0.0)
Ethical guideline	Ethical guidelines on providing pro bono or voluntary psychological services	APS	2014	0 (0.0)
Ethical guideline	Ethical guidelines for psychological assessment and the use of psychological tests	APS	2018	0 (0.0)
Ethical guideline	Ethical guidelines on record keeping	APS	2020	0 (0.0)
Ethical guideline	Ethical guidelines on reporting abuse and neglect, and criminal activity	APS	2020	0 (0.0)
Ethical guideline	Ethical guidelines for psychological practice in rural and remote settings	APS	2016	0 (0.0)
Ethical guideline	Ethical guidelines on working with sex and/or gender diverse clients	APS	2013	0 (0.0)
Ethical guideline	Ethical guidelines on the prohibition of sexual activity with clients	APS	2017	0 (0.0)
Ethical guideline	Ethical guidelines relating to clients at risk of suicide	APS	2014	0 (0.0)
Ethical guideline	Ethical guidelines for psychological practice with women and girls	APS	2012	0 (0.0)
Ethical guideline	Ethical guidelines on supervision	APS	2013	0 (0.0)
Ethical guideline	Ethical guidelines for working with and in the media	APS	2018	0 (0.0)
Ethical guideline	Ethical guidelines for working with young people	APS	2018	0 (0.0)
Ethical consideration	Ethical considerations when providing pro bono services	APS	2017*	0 (0.0)
Ethical consideration	Ethical considerations when providing second opinions	APS	2017*	0 (0.0)
Ethical consideration	Assessing risk of harm to others	APS	2018*	0 (0.0)
Ethical consideration	Client suicide: considerations for psychologists	APS	2017*	0 (0.0)
Ethical consideration	Contracts and ethical concerns	APS	2017*	0 (0.0)
Ethical consideration	Establishing and maintaining boundaries	APS	2017*	0 (0.0)
Ethical consideration	Ethical issues in rural practice	APS	2017*	0 (0.0)

Document type	Title	Organisation	Date	Frequency, n (%)
Ethical consideration	Making sound ethical decisions	APS	2017*	0 (0.0)
Ethical consideration	Managing clients at risk of suicide	APS	nd*	0 (0.0)
Ethical consideration	Managing multiple relationships	APS	2017*	0 (0.0)
Ethical consideration	Psychologist's clients' rights	APS	2017*	0 (0.0)
Ethical consideration	Record keeping - templates	APS	nd	0 (0.0)

*Originally published at an earlier date in InPsych magazine

Included documents were searched (December 2021) using the a priori codes developed from the literature (Ng et al., 2016). Search results were extracted and recorded in a spreadsheet with documents as rows and columns recording document details and occurrences of codes. Where a full or partial code (e.g., alternative) appeared in text the whole section was copied and pasted into the spreadsheet with the page number. This process allowed interrater checking for relevance and context for each occurrence. Where documents contained key search terms, the surrounding text was examined for contextual relevance to CM in psychology practice. The outcome measures were the number of relevant occurrences of the code within each document (Table 4.1).

Phase 2 of the document analysis was a search (December 2021) *across* Australian and comparable English speaking psychology association websites for potentially relevant documents that discuss psychologists in clinical practice engaging with CM. The American Psychological Association (APA), British Psychological Society (BPS), and Canadian Psychology association (CPA) were selected as comparative association websites (Winter, 2015), were in English and were also accessible without association membership. Relevant documents (web pages) were selected from the first page of results returned using search terms. The search terms were a priori codes developed from the literature (Ng et al., 2016) relating to frequency of CM terms and included “complementary medicine”, “complementary and alternative medicine”, and “complementary therapies”. Returned page headings and descriptions were copied and pasted into an excel spreadsheet and examined for relevance. Relevant occurrences and a sample of documents were recorded (Table 4.2).

Table 4.2

Search results across Australian and international psychology associations

Association/website	Occurrences n (%)	Sample document type/title/link	Description/context
Australian Psychological Society/psychology.org.au	2/10 (20)	Interest group: Psychology and integrative mental health https://groups.psychology.org.au/PsyCT/	This interest group is concerned with developing and nurturing professional links between psychologists and professional practitioners and researchers working in the field of Complementary and Alternative Medicine (CAM)
Australian Psychological Society/psychology.org.au		Professional development: Complementary medicine: What psychologists need to know https://psychology.org.au/event/21419?view=true	Workshop to cover aspects of complementary medicine within psychology, ethics, evidence, and resources, introduces psychologists to CM products and services broadly
American Psychology Association/ www.apa.org	6/10 (60)	Curriculum: APA Substance Use Disorders Curriculum: For Training Psychology Graduate Students to Assess and Treat Substance Use Disorders https://www.apa.org/ed/graduate/substance-use	Describes intervention approaches including *alternative methods and complementary medicine approaches (acupuncture, etc.)*
American Psychology Association/ www.apa.org		Guideline: APA Clinical practice guideline for the Treatment of depression across three age cohorts https://www.apa.org/depression-guideline/guideline.pdf	This guideline addresses the efficacy of psychological and complementary and alternative medicine treatments, the comparative effectiveness of psychotherapy in combination with pharmacotherapy as well as compared to pharmacotherapy and complementary and alternative treatments
American Psychology Association/ www.apa.org		Book: Complementary and Alternative Medicine for Psychologists: An Essential Resource https://www.apa.org/pubs/books/4317345	Provides psychologists with therapists with the information they need to provide advice on the safety and effectiveness of complementary and alternative medicine therapies and describes a broad array of approaches that may benefit clients.

Association/website	Occurrences n (%)	Sample document type/title/link	Description/context
American Psychology Association/ www.apa.org		Magazine article: More than psychotherapy http://www.apaservices.org/practice/good-practice/more-than-psychotherapy.pdf?_ga=2.106805830.413613913.1641097362-2012957043.1638914638	Magazine article has discussed psychologists integrating CM into their practice
American Psychology Association/ www.apa.org		Professional development: Alternative techniques https://www.apa.org/monitor/2013/04/ce-corner	"Today's psychologists are increasingly integrating complementary and alternative medicine techniques into their work with clients. Here's an overview of the most popular treatments, the research on their efficacy and the ethical concerns they raise." (APA, n.d.)
British Psychological Society/ https://www.bps.org.uk	6/10 (60)	Interest group: Division of Clinical Psychology Faculty of Holistic Psychology https://www.bps.org.uk/member-microsites/dcp-faculty-holistic-psychology	The Faculty also seeks to apply the accepted models and methodologies of clinical psychology to the psychological aspects of complementary therapies.
British Psychological Society/ https://www.bps.org.uk		Briefing paper: Alternatives to antipsychotic medication: Psychological approaches in managing psychological and behavioural distress in people with dementia bps.org.uk/sites/www.bps.org.uk/files/Member%20Networks/Divisions/DCP/Alternatives%20to%20Antipsychotic%20medication.pdf	A form of alternative and complementary medicine based on the use of very concentrated 'essential' oils from the flowers, leaves, bark, branches, rind or roots of plants with purported healing properties.
British Psychological Society/ https://www.bps.org.uk		Annual conference (Northern Ireland branch) presentation: "A study examining Complementary and alternative medicine (CAM) use and its relationship with Attitudes towards CAM, Holistic Health and Locus of Control of Behaviour, in Adults with Chronic Fatigue Syndrome (CFS)	Research on Complementary and Alternative Medicine (CAM) use in worldwide populations whilst becoming more frequent, remains linked to more readily recognised diagnoses, such as cancers, musculoskeletal disorders, or arthritis.

Association/website	Occurrences n (%)	Sample document type/title/link	Description/context
		and/or Myalgic Encephalomyelitis (ME) in Ireland." https://www.bps.org.uk/sites/www.bps.org.uk/files/Member%20Networks/Branches/Northern%20Ireland/2017%20UG%20Session%20Schedule%20 23%20March%202017.pdf	
British Psychological Society/ https://www.bps.org.uk		Presidential blog: Eight months of success in making psychology relevant to citizens and the real world https://www.bps.org.uk/blogs/presidential-blog/eight-months-success-making-psychology-relevant-citizens-and-real-world	Previous (2017) BPS President's blog. "Our position isn't of course, to reject or oppose diagnosis as an element of care, but to ensure that alternative and complementary approaches are given attention commensurate with their importance."
British Psychological Society/ https://www.bps.org.uk		Minutes: Minutes of the Meeting of the Covid 19 Coordinating Group (15/07/2020) https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Covid-19%20Coordinating%20Group%20Meeting%20 Minutes%20-%C2%A015%20July%202020.pdf	"The workstream have had discussions around creating guidance relating to providing alternative or complementary outdoor therapies e.g. animal therapy. "
Canadian Psychological Association/ https://cpa.ca/		https://cpa.ca/psychology-works-fact-sheet-pediatric-oncology/	It is important to also acknowledge that beyond the aforementioned treatments, a number of additional treatments and supports may also be provided or sought out by families. For example, complementary and alternative medicine approaches such as herbal remedies, diet and nutrition interventions, faith-healing, homeopathy, mind-body therapies, and massage therapy may be used.

This study has been reported as per the Standards for Reporting Qualitative Research (O'Brien et al., 2014). To improve the trustworthiness of the findings, the authors discussed their potential biases with each other prior to, and throughout, to ensure that these did not unduly influence the data collection and analysis process. Any disagreements were resolved through author discussion until consensus was reached. No ethical approval was required as all data (web-based documents) were retrieved from the public domain. All methods were performed in accordance with the relevant guidelines and regulations.

4.4 Results

For phase 1, 58 policy and guideline documents were included and searched—42 from the APS, 14 from the Psychology Board, and two from AHPRA—none had a direct reference to the CM search terms. Where key search terms were found in the text, they were checked for context with CM. Although several of the search terms were partially present in the text, they were not contextually relevant to CM and therefore not included as an occurrence. For example, the term "alternative" appeared several times; however, it was used in the context of "alternative provider" or "alternative services" and not in the context of complementary and alternative medicine. In the above example "alternative" refers to a different psychologist or a different psychology service. For phase 2 several sample documents (e.g., guidelines, book, professional development activity) were extracted from websites and a description of the occurrences are provided in Table 4.2. There were less occurrences on the APS (20%) website compared to the APA (60%) and BPS (60%) websites. A search of the Canadian Psychological Association (CPA) was also conducted using the search terms, however the search yielded only one result (10%). The search result did mention CM in the context of

psychologists working in paediatric oncology, and encouraged psychologists to be aware that some paediatric oncology clients may also use a variety of CM.

Of note, there was a reference to CM in an APS magazine article available online, which referred to naturopathy—a system of CM practice (Australian Psychological Society, 2017). The magazine article also appeared as a link to a professional resource described as an ethical consideration titled *Managing multiple relationships*. An extract from the question-and-answer style magazine article on managing multiple relationships follows:

> "I have qualifications in both psychology and naturopathy and believe my clients would benefit from receiving both services. Can I use both skill sets with my clients?
>
> Psychologists may be qualified as members of two or more professions. The APS Guidelines for managing professional boundaries and multiple relationships (2008) state that "psychologists can be qualified as members of two or more professions (for example, psychology and law). If a psychologist attempts to work in both roles with the same client there is a strong risk of role confusion for both client and psychologist. Consequently, such situations should be avoided." If psychologists choose to provide two distinct professional services, it is advisable that they run two distinct practices servicing different clientele and ideally from different locations."

Informal searches also located an Ahpra document *Guidelines for advertising a regulated health service* (Ahpra and the National Boards, 2020) which contained reference to Ahpra regulated CM professions including traditional Chinese medicine,

osteopathy and chiropractic, and referred to “herbal” and “acupuncture” in the context of those professions. Similarly, the document *Guidelines on area of practice endorsements* (Psychology Board of Australia, 2019a) contained reference to “nutrition” in the context of sport and exercise psychology. Similarly, the most recent Australian *Accreditation Standards for Psychology Programs* document (Australian Psychology Accreditation Council, 2019) was also reviewed for CM relevant content for general interest in the context of this article. Under the heading Master of Sport and Exercise Psychology the document states a competency as "Apply advanced psychological knowledge of ... nutrition and eating behaviour ... to their practice in sport and exercise”. To the author’s knowledge the current Master of Sport and Exercise Psychology program at an Australian university does not explicitly contain nutrition as a subject. As these documents were not captured using the search terms they are not included in the results tables, however their presence and relevance is discussed below.

4.5 Discussion

The document analysis presented here has established that there is no explicit policy or clinical practice guidelines from Australian regulatory bodies and psychology professional associations to inform psychologist engagement with CM within their clinical practice, despite the growing demand (Fernandes-Nascimento & Wang, 2022; Harnett et al., 2019; World Health Organisation, 2013) and evidence of efficacy for some forms of CM in mental health treatment (Malhi et al., 2021; Sarris et al., 2022; Yolland et al., 2019). This insight is important as it substantiates the concern outlined in previous publications regarding the lack of a clear position, specific directions, or guidelines from Australian psychology associations on their members’ engagement with CM (Hamilton & Marietti, 2017; Wilson & White, 2011).

Although these findings are consistent with international literature that discusses the absence, or inadequacy of, guidelines for psychologists on CM (Davison et al., 2017; Swan et al., 2015) it also highlights that psychology is not engaging with CM as much as other mental health professions such as psychiatry, that do provide guidance. For example, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) clinical practice guidelines for mood disorders recommend some evidence-based CM, such as St John's wort and nutrition interventions (Malhi et al., 2021). The National Preventive Health Strategy 2021–2030 (Department of Health and Aged Care, 2021) also includes nutrition and physical activity as important preventative measures for mental health. Consequently, the omission of CM from psychology's policy and guidance documents does not align with practices and guidelines of other mental health professions (Hoenders et al., 2011; Wemrell et al., 2020).

The finding that there is no direct reference to CM in Australian psychology ethical guidelines, is important because it highlights potential safety risks for all psychologists who have clients that use CM. The literature demonstrates that client's lack of disclosure of their CM use to their health care providers is a safety risk; for example, not disclosing self-prescribed ingestible CM that has potential contraindications with concurrent conventional medicine use (Foley et al., 2019; McIntyre et al., 2020). However, even if clients do disclose their CM use, their treating psychologist may lack the knowledge needed to respond appropriately. If psychologists are not informed by their professional associations about how to discuss CM as part of mental health treatment planning there are potential risks, such as being unaware of, and unable to advise clients with regards to possible CM treatment-drug interactions. The inability of psychologists to keep up with demand and/or client preference for CM may

partly be due to psychologists' lack of understanding and/or knowledge of CM (Baxter & Lovell, 2021; Mattar & Frewen, 2020). Further, the *National framework for recovery-oriented mental health services* (Australian Health Ministers' Advisory Council, 2013a) suggests health professionals should have capacity to discuss client's treatment preferences with the client's treating practitioners, including CM practitioners. It is important for psychology associations to inform psychologists of how to discuss CM with their clients to ensure client safety.

Psychologists are already referring, recommending, or directly applying CM as part of their client's treatment planning (Baxter & Lovell, 2021; Ligorio & Lyons, 2018; Stapleton et al., 2015). Subsequently, the development of guidelines may need to be a priority for Australian psychology associations. With no specific guidelines for CM in psychology and no direct reference to CM in psychology association's guidelines, psychologists are left to interpret vague guidelines for how they may safely engage with their client's CM use (Bassman & Uellendahl, 2003; Wilson & White, 2011). There are risks when psychologists are required to interpret indirect and limited clinical guidance for CM, such as breaches to scope of practice (unintentionally or intentionally), inadequate informed consent, and potential for complaints against the psychologist. The literature discusses psychologist's confusion around interpreting indirect references in policy and guidelines, as to what could be considered engagement with CM (Liem, 2019a; Swan et al., 2015). Further, there is a lack of clarity on what constitutes sufficient knowledge or competency in CM (Hamilton & Marietti, 2017; Stapleton et al., 2015). The ethical guidelines may be open to interpretation (Barnett & Shale, 2012; White, 2000) as to how that psychologist would incorporate a formal CM qualification (dual qualifications) into their practice. For example, if a psychologist holds

qualifications as both a CM practitioner (e.g., traditional Chinese medicine) and a psychologist, the current "ethical considerations"—on managing multiple relationships—could be considered prohibitive, particularly to those psychologists with advanced knowledge in CM via dual qualifications (discussed below). Psychologists need to interpret such things as contingent liability for referring to a CM practitioner, informed consent when including CM in treatment planning, and potentially managing multiple professional relationships in the context of dual qualifications. Without direct references or adequate guidelines specifically addressing CM in psychology, psychologists engaging with CM could be in breach of their scope of practice and risk complaint to Ahpra or punitive measures from the Psychology Board.

Further, the absence of CM in guidelines for psychologists reflects limitations in psychology's acknowledgement or engagement with the cultural relevance of CM for some people. For example, the therapeutic relationship may be at risk if a psychologist, unable to engage with their client's CM use, and/or minimises the cultural relevance of CM for some ethnocultural groups. CM may have greater significance for some ethnocultural groups who use traditional medicines (e.g., Chinese, Indian, Aboriginal and Torres Strait Islander people) seeking support from a psychologist (Gone, 2016; Liem & Rahmawati, 2017; Seet et al., 2020). In contrast, although the American Psychological Association's (APA) Race and Ethnicity Guidelines in Psychology (American Psychological Association, 2019), do not directly discuss CM, they aim to address health disparities and recommend psychologists engage with their client's cultural beliefs (Mattar & Frewen, 2020) and engaging with culturally-oriented practices and ideologies (e.g., traditional Chinese medicine) are invaluable for informing mental health practice (American Psychological Association, 2019). The

APA guidelines encourage psychologists to "actively educate themselves about diverse Indigenous/ethnocultural healing modalities" and suggest "training programs could incorporate Indigenous healing theories and practices throughout the curriculum" (79 p 25). The APA guidelines also acknowledge that psychology in the "United States and abroad reflect Western European methods and have neglected forms of healing from other ethnocultural perspectives"; further, that psychologists "operating from the dominant Western paradigm often view 'alternative' forms of healing, such as ritual healing practices, as inferior to the interventions consistent with the training they received" (79 p 24). Although these guidelines encourage psychologists to understand Indigenous and/or ethnocultural resources for healing, there is no direct reference to how these CM approaches could be integrated with psychology practice. The APS does have a document/guideline aimed at addressing the needs of Aboriginal and Torres Strait Islander people; however, this document has no reference to Indigenous traditional healing or Aboriginal and Torres Strait Islander traditional medicine/healing practitioners or practices.

Beyond the absence of CM policy and guidelines, Australian psychology professional associations are not engaging with CM to the same degree as international psychology associations. For example, the APA provide some education and guidance for psychologists interested in CM, and recommendations have been made by APA (Health Service Psychology Education Collaborative, 2013) accreditation agencies that psychologists be "familiar with common medical, dental, and other health treatments, as well as complementary and alternative treatments" (80 p16). The APA also encourages engagement with client preference for CM, particularly in the context of patient centred care (Mattar & Frewen, 2020) and "to understand and encourage

indigenous/ethnocultural sources of healing within professional practice" (79 p24). Table 4.2 provides examples of international psychology association's engagement with CM. The APA and BPS provide resources and professional development opportunities on their website related to CM. In addition, an APA magazine article discussed psychologists integrating CM into their practice including navigating referral to CM practitioners and legal aspects of informed consent when integrating CM into their clinical practice (Deangelis, 2019). It is interesting to note that the CPA had limited mention of CM on their website given the Canadian Network for Mood and Anxiety Treatments (CANMAT) Taskforce is inclusive of CM (Sarris et al., 2022). Similar to the APS, the CPA may not be influenced by medicine and psychiatry's inclusion of CM in clinical practice guidelines.

Further, the advice provided in the APS magazine article, regarding dual qualifications in naturopathy, supports the notion that psychology should distance itself from CM (Swan et al., 2015). The article does not provide references (other than the APS *Code of Ethics* and *Guidelines for managing professional boundaries and multiple relationships*) that might justify psychology's distance from CM, or dual health qualifications as unethical for psychologists. References that are provided in the related guideline contrast with the above advice. For example, the referenced APA code of ethics (American Psychological Association, 2017) states "multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical" (p. 1065). Australian psychology association's disconnection from CM is problematic given the literature and findings from the above-mentioned studies, the integration of some forms of CM into RANZCP guidelines, the APA and BPS resources

on CM, the APA flexibility on dual qualifications, and the APA statement on the cultural relevance of CM/traditional healing resources.

Australian psychology associations may consider that CM within psychology is only relevant to a small group of Australian psychologists and that guidelines for CM in psychology practice are not necessary. It is possible that the authors of Australian psychology association guidelines think differently about CM than psychologists in clinical practice (Ligorio & Lyons, 2018). It is also possible that Australian psychology associations are cautious regarding CM in psychology. There are sceptic groups, such as the "Friends of Science" that directly oppose CM in any form and question the legitimacy of CM products and services (Lewis, 2019). The concern of such groups appears to be the potential loss of purity of psychology and risks to evidenced-based practice across the sciences, and in some cases these groups also dismiss psychology as a pseudoscience (Fasce, 2017; Li et al., 2018). Further, these sceptic groups are concerned that including CM in tertiary education and guidelines for health professionals "promotes usage rather than a critical rejection of these ineffective and potentially dangerous practices" (Braillon et al., 2019). There are published commentaries that perceive CM to be a threat to the scientific development and/or scientific standing of psychology (Hughes, 2008; Swan et al., 2015). For example, Fasce and Adrian-Ventura (Fasce & Adrián-Ventura, 2020) state that a psychologist integrating CM into their practice has rejected scientific research and evidence-based practice. Psychologists have also been found to fear negative appraisal from their psychologist peers if they express interest in, or integrate, CM into their clinical practice (Liem, 2019a; Wilson et al., 2011).

The absence of CM relevant guidelines is not commensurate with consumer and psychologist demand for CM within psychology practice, emerging evidence for some CM for some mental health problems, and the cultural relevance of CM. Australian psychology professional associations may need to review and develop contemporary guidelines, that consider the inclusion of CM, and a shift toward an integrative approach. For example, in the context of multiple professional roles and dual qualifications the APA accommodates "Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical" (American Psychological Association, 2017, p. 6). In addition, in the context of ethnocultural competence, the APA recognises that implementing a new "guideline may require an epistemological and power shift in which psychologists acknowledge that local Indigenous/ethnocultural epistemologies and systems of healing are viable approaches through which to address the mental health and wellness of individuals and communities"(American Psychological Association, 2019, p. 25). It appears psychology as a discipline may need to consider CM, similar to psychiatry and medicine, in the context of psychologist and consumer demand. Further, Australian psychology professional associations may need to follow the lead of other international psychology professional associations in terms of their engagement with CM. It will be important for psychology associations to address the risks highlighted above and to develop resources and guidelines that assist psychologists to navigate CM with their clinical practice.

4.6 Strengths and limitations

Our novel, in-depth analysis of current Australian policy is not without limitations. It was not within the scope of this paper to search within policy and guideline documents using an exhaustive list of CM related professions and practices.

As such the results of the searches are limited by the specific CM search terms as described in the method. A further limitation of this analysis is only a selection of English-speaking psychology professional associations, and their websites were included.

4.7 Conclusion

CM approaches are used by consumers to address mental health symptoms and some psychologists are engaging with their clients CM use. However, the current paper highlights there is limited support, in the form of policy and guidelines from the discipline of psychology, for psychologists to engage with CM in their clinical practice. There are risks associated with a lack of CM relevant policy and guidelines for psychologists, including disconnection from certain clients and ethnocultural groups who may have a preference for some CM approaches. More research is needed to establish why Australian psychology professional associations have not addressed client preference for, and psychologist interest in, CM as part of mental health treatment. Further research may assist an understanding of how psychologists engage with CM and how psychology can support this engagement through the development of CM relevant policy, guidelines, and education.

4.8 Chapter summary

The findings from the document analysis confirm that Australian psychology professional and regulatory bodies have not engaged with CM, nor its relevance to clinical practice, thus far. The findings from the document analysis suggest psychology may not consider CM relevant to psychology/psychologists in Australia. If this is the case, psychology may be underestimating the relevance of CM to clients and to psychologists. Further, the omission or exclusion of CM from guidelines, education and policy is not in line with broader health care policy (World Health Organisation, 2013).

It will be important to explore to what extent, and in what ways, psychologists in Australia are engaging with CM in their clinical practice. The next chapter explores Australian psychologists' patterns of recommending and referring to CM in the context of their clinical practice.

Chapter 5. PHASE TWO – SURVEY RESULTS
Psychologists' characteristics regarding engagement with CM types

5.1 Preface

Previous literature reports high demand for CM among people with mental health problems (Fernandes-Nascimento & Wang, 2022; Malhotra et al., 2020; Wemrell et al., 2020) and that psychologists internationally have interest in CM in clinical practice (Ditte et al., 2011; Liem, 2019a; Medeiros et al., 2019; Stapleton et al., 2015). However, the previous chapter established that Australian psychology professional and regulatory bodies have not published guidelines that inform psychologists how they might safely engage with CM. In the context of this thesis, to explore psychology/psychologists' relationship with CM, it will be important to establish if, how much, and in what ways, psychologists are engaging with CM in their clinical practice.

This chapter presents the results of survey data collected from psychologists in Australia. The survey asked psychologists to respond to questions relating to psychologist engagement with CM in clinical practice. The statistical analysis of the survey data revealed psychologists in Australia have considerable engagement with CM in their clinical practice. This chapter includes the accepted manuscript which has been published in *PLOS ONE* in May 2023.

Thomson-Casey, C., McIntyre, E., Rogers, K., & Adams, J. (2023). The relationship between psychology practice and complementary medicine in Australia: Psychologists' demographics and practice characteristics regarding type of engagement across a range of complementary medicine modalities. PloS one, 18(5), e0285050. https://doi.org/10.1371/journal.pone.0285050

5.2 Introduction

Psychologists are likely to have clients who choose complementary medicine (CM), in some form, as part of their wider mental health treatment (Fernandes-Nascimento & Wang, 2022; Wemrell et al., 2020). CM refers to health care products, services and practices, that are "not part of a country's own traditions or conventional medicine and are not fully integrated into the dominant health care system" (Harnett et al., 2019, p. 1) and often includes a wide range of products, services and practitioner types that can vary with cultural and political context (Adams, Parker, et al., 2019; Ng et al., 2022; Park, 2013; Solomon & Adams, 2015).

CM use is high among the general population. For example, an Australian study of the general population found 63.1% of participants used some form of CM and 52.8% had consulted a CM practitioner (e.g., massage therapist, naturopath, osteopath) in the last 12 months (Steel, McIntyre, et al., 2018). Consumers choose CM for a range of reasons including: alignment with cultural and personal beliefs; an expectation of benefit; dissatisfaction with conventional approaches; to help address side effects caused by conventional medication use; to address symptoms related to severe or complex illness; and/or as a preference for a holistic approach to their care (Ashraf et al., 2021; Chatterjee, 2021; Tangkiatkumjai et al., 2020).

CM use is also high among people with mental health problems who have been found to utilise different types of CM practitioners, including naturopaths and massage therapists, as well as a range of CM products and practices (Avci & Sabanciogullari, 2021; Sibbritt et al., 2021; Solomon & Adams, 2015; Steel, McIntyre, et al., 2018). An Australian study of adults diagnosed with a mental health disorder reported 42.4%

consulted a CM practitioner, 56.9 % used a complementary medicine product, and 23 % used a complementary medicine practice in the previous three years (McIntyre et al., 2021). Similarly, another Australian study found 21.3% of participants, who were middle aged women with a diagnosis of depression, had consulted at least one CM practitioner in the last 12 months (Sibbritt et al., 2021).

There is emerging evidence for some CM approaches in addressing mental health symptoms, such as nutraceuticals (e.g., omega 3 fatty acids, probiotics, and zinc) (Sarris et al., 2022), nutrition (e.g., the Mediterranean diet) (Bayes et al., 2022), herbs (e.g., St John's wort, saffron)(Kuchta et al., 2018; Ng et al., 2017; Sarris, 2018; Sarris et al., 2022), and probiotics (Zhu et al., 2022) for depression. Manual therapies and movement approaches also demonstrate benefit for people experiencing stress, anxiety, and depression (Feng et al., 2022; Hall et al., 2020; McGregor et al., 2018; McMahon et al., 2017). Although these CM approaches show promise as part of preventative and adjunct treatments for mental health, it is acknowledged there is much more research needed to further critically appraise the efficacy of specific CM (Burnett-Zeigler et al., 2016; Morkl et al., 2021; Nguyen & Lavretsky, 2020).

There has been commentary, beyond and within psychology, that criticises the field for what has been seen as a monocultural Westernised approach to mental health care that diminishes the relevance of CM and traditional healing approaches associated with specific cultural and ethnic groups (Canham et al., 2021; Consoli & Myers, 2021). Meanwhile, others have highlighted the importance of psychologists embracing culturally sensitive practice, which may include acknowledgement of a clients' preference for CM use (Liem, 2020; Richmond & Jackson, 2018; Welz et al., 2019).

Consistent with the latest World Health Organisation Traditional Medicine Strategy (World Health Organisation, 2013), CM has been integrated into a number of health care settings (Roth et al., 2019; Zhang et al., 2019) including those providing mental health services (Jacobsen et al., 2015; Jong et al., 2019; Salamonsen & Ahlzen, 2018; Taylor et al., 2019; Wheeler et al., 2018). CM integration into health care settings may take a variety of forms facilitated through a range of practice circumstances and practitioner networks (Adams & Tovey, 2000) and CM integration in the context of psychology practice, and for purposes of this study, refers to a psychologist engaging with CM in some form in their clinical practice as part of a client's mental health treatment planning. Such integration can be via: *discussing* CM with a client in their care (e.g., asking questions about a client's CM use), *recommending* CM to a client in their care (e.g., suggesting a client attend a yoga class for relaxation), *referring* a client in their care to a CM practitioner (e.g., verbal or written referral to Western herbal medicine practitioner), the psychologist directly practising and *applying* CM to a client in their care (e.g., explicit dietary instructions to improve nutrition in the context of evidence-based nutritional psychiatry), and/or a combination of these options above.

Some CM approaches have been integrated into psychology practice (Haller et al., 2019; Lorenc et al., 2018; Moir et al., 2019). For example, mindfulness, emotional freedom techniques (EFT), and eye movement desensitisation and reprocessing (EMDR), all previously considered fringe or beyond the field of psychology, are now considered evidence-based psychology interventions (American Psychological Association, 2016; Australian Psychological Society, 2018). Similarly, nutritional psychiatry has emerged as a significant paradigm in mental health care (Adan et al., 2019; Morkl et al., 2021; Teasdale et al., 2020) and although not traditionally part of

psychologists' tertiary education (Nayda et al., 2021), psychologists are increasingly engaging with this approach (Baxter & Lovell, 2021). There is limited research describing the referral practices of psychologists to CM practitioners, which may be a reflection of limited guidelines for psychologists on how they might engage with CM in their practice (Thomson-Casey et al., 2022).

As novel approaches to mental health care emerge, psychologists have sought additional training in CM, are subsequently more inclined to engage with CM, and are discerning about recommending and referring to CM practitioners (Fay et al., 2016; Hamilton & Marietti, 2017; Kassis & Papps, 2020; Liem, 2020). An Indonesian study of clinical psychologists reported approximately 73% were recommending CM to their clients and 39% were referring to a CM practitioner (Liem & Newcombe, 2017). Reasons psychologists choose to engage with CM in their clinical practice include positive experiences with personal use of CM, receiving education in CM, and wanting to offer a holistic service to clients that includes CM (Kassis & Papps, 2020; Nayda et al., 2021; Wilson & White, 2011). However, some psychologists express concern about a broader lack of education and guidelines for the integration of CM within psychology (Fay et al., 2016; Kassis & Papps, 2020; Liem & Newcombe, 2019b; Medeiros et al., 2019; Morkl et al., 2021). Overall, the acceptance of CM within the discipline of psychology remains contested (Ditte et al., 2011; Fasce & Adrián-Ventura, 2020; Liem & Newcombe, 2019b; Swan et al., 2015)—a situation not dissimilar to that for medicine and other health disciplines (Ee et al., 2021; Pirotta et al., 2010).

Previous work suggesting psychologists in Australia are favourable toward CM (Ligorio & Lyons, 2018; Stapleton et al., 2015; Wilson et al., 2012b) has invariably included focus upon psychology students and interns, academic psychologists,

psychologists from other countries, and other mental health professionals. In contrast, the research reported here focusses exclusively on psychologists in clinical practice to examine how often, and in what ways, these grass-roots practitioners recommend a range of CM products and/or practices to their clients, and/or refer their clients to a range of CM practitioners.

5.3 Methods and materials

5.3.1 Aim

The aim of this research was to determine how much, and in what ways, Australian psychologists recommend CM products and/or practices, and/or initiate referrals to CM practitioners as part of their clinical practice and to explore if these behaviours have any association with the characteristics of the psychologist or their wider practice.

5.3.2 Study design

A survey was distributed online to Australian psychologists who were fully registered and working in a clinical practice setting at time of recruitment (between February and April of 2021). Email invitations to participate in the study were sent to psychologists whose contact details were collected from their publicly available websites. Recruitment emails contained information about the study, consent forms, and a link to complete the survey online. A reminder email was sent to psychologists four weeks after the initial invitation email. An advertisement inviting psychologists to participate in the research was also placed on two psychology professional association websites (Australian Association of Psychologists Incorporated and the Australian Psychological Society) and on relevant social media sites including Twitter, LinkedIn,

and Facebook. Participants accessed the survey via an anonymous link embedded in the website advert, or social media post, and were directed to the participant information and consent form via the link. The open survey was completed online via Qualtrics software, Version 2021 (Qualtrics, 2022). The information page at the beginning of the survey included project details such as ethical approval, data protection, and voluntary participation. The information page also served as the participant consent form. Participants indicated their written consent after reading the information and consent page and clicking on the button confirming their agreement to proceed with the survey. Upon completion of the survey participants were invited to supply their email address to enter a prize draw to win a $250 gift voucher. Ethical approval was attained from UTS Human Research Ethics Committee [ETH20-5138].

5.3.3 Sample

The survey was distributed to 1479 Australian psychologists working in clinical practice at the time of research. All psychologists in Australia (n = 34,872) are considered to hold general registration, which enables them to use the title of psychologist (Psychology Board of Australia, 2022). Some psychologists with additional tertiary training in psychology may also hold an area of practice endorsement (AoPE) enabling them to use a restricted title (e.g., clinical psychologist). These AoPE titles are clinical neuropsychologist, clinical psychologist, community psychologist, counselling psychologist, educational and developmental psychologist, forensic psychologist, health psychologist, organisational psychologist, and sport and exercise psychologist. A psychologist with an AoPE title has general registration plus an AoPE. To clarify, a psychologist with general registration, without an AoPE (i.e., psychologist), can work in clinical practice settings; however, working in clinical

practice does not mean a psychologist is necessarily a clinical psychologist. All psychologists (psychologists with general registration and those psychologists with general registration plus an AoPE) were eligible to participate in the study; however, only responses from those psychologists who work in a clinical practice setting (e.g., inpatient hospital, private practice) directly with clients were included in the data analysis for this study.

The initial screening question asked participants if they were a psychologist undertaking work as a psychologist. Participants who selected “No” were redirected out of the survey. Prior to conducting the analyses, raw survey data were screened for any missing or incomplete responses and duplicate IP addresses. While there were no duplicate IP addresses, during this process, nine cases were removed as the data (responses) were incomplete. After removal of the nine cases, 222 cases were included in the initial analyses which identified significant outliers. On review the outlier responses were mostly from cases who did not work in clinical practice settings. These cases were removed resulting in 201 participants in the final data set. The original sample size was planned to be 400, based on achieving a 0.10 confidence interval width on estimates of prevalence of binary questionnaire items. As noted above, we were able to recruit 231 participants, of which 201 passed the inclusion criteria and were used in this study. With this sample size we are able to estimate a confidence interval for the prevalence of a single binary item with a CI width of 0.14; or compare a continuous or binary variable between two equally sized groups with 0.8 power and an effect size of 0.39 (Cohen’s D).

5.3.4 Instrument

The construction of survey items was informed by previous literature on psychologist engagement with CM to produce survey items that best captured the ways psychologists might be engaging with CM, including the types of CM products and/or practices they had ever recommended and the types of CM practitioners they had ever referred to. The 79-item questionnaire aimed to examine the extent and ways in which psychologists consider CM relevant and/or appropriate to (their) psychology practice, their clients, and the treatment of mental health problems. Participants were also provided with a definition of CM similar to the one provided above and in line with the World Health Organisation Traditional Medicine Strategy (World Health Organisation, 2013). The survey collected participants' demographics and practice-related information, any relevant qualifications attained or professional memberships outside of psychology, participants' perspectives on their scope of practice in Australia in relation to any kind of adjunctive additional health qualifications, and finally participants' perspectives and behaviours regarding engagement with CM in clinical practice in Australia. Prior to recruitment, the survey was tested for face validity and functionality by three PhD students from psychology adjacent fields. Changes were made to provide clearer definitions and reduce repetitive questions. Based on feedback from the PhD students who tested the survey, the time required to complete the survey was approximately 15 minutes. Where relevant this paper adhered to the CHERRIES checklist for reporting results of internet e-surveys (Eysenbach, 2004, 2012).

5.3.5 Demographics

The survey collected data regarding each participant's year of birth, gender identity, and the predominant state in which they practise. Participants were also asked

to provide practice characteristics, such as AoPE, their work setting (solo or group setting), and years in practice as a psychologist.

5.3.6 Additional qualifications

The survey collected data on participants' tertiary qualifications in addition to their psychology qualification (i.e., business, criminal justice/criminology, dietetics, education, exercise physiology, law, medical, nursing/midwifery, physiotherapy) and CM related professional qualifications (naturopathy, nutrition, traditional Chinese medicine, Western herbal medicine, yoga instructor) as well as the options of "No" or "Other". If a psychologist selected "Other" they could then add text to describe their additional qualification(s). If the psychologist indicated they had additional qualification(s) they were asked further questions in relation to each additional qualification including highest level of education in that qualification, if they have separate insurance and/or professional membership for that qualification, and whether they integrate that additional qualification into their psychology practice and treatment planning with clients.

5.3.7 Psychologists' scope of practice

Psychologists were asked to indicate their level of personal agreement/disagreement with regards to statements describing psychologists using practices/treatments from an additional health-related qualification with their psychology clients (e.g., a psychologist treating a client from two separate qualifications, such as a psychologist and a dietitian). Questions on this topic explored attitudes toward psychologists who utilised an additional health-related qualification in the context of treatment planning; communication with clients, client outcomes, and

impacts on the scope of psychology practice and psychology as a discipline if a psychologist incorporated a second health related discipline into their practice.

5.3.8 Attitudes towards CM in the context of psychology practice

The last section of the survey invited psychologists to rate their personal agreement/disagreement with statements relating to psychologist engagement with CM products, practices, and practitioners. Likert scales were used to record participant attitudes toward CM (six response choices ranging from strongly agree to strongly disagree) and are reported as measured. Participants also reported the types of CM products and/or practices they recommend to clients, and the types of CM practitioners they have referred to at any time as part of their psychology practice.

5.3.9 Data Analysis

IBM SPSS Statistics Premium Edition Version 27 (Armonk, New York, IBM Corp) was used to analyse the data. Descriptive statistics were used to determine the percentages and frequencies. Chi-square analysis was used to assess associations between categorical demographic and practice characteristics and CM engagement related variables (*recommending* CM products and/or practices, and/or *referring* to CM practitioner types). A Firth's correction for logistic regression was employed due to small cell sizes and to address the possibility of separation of data (Firth, 1993). Descriptive tables reporting the percentage of psychologists who recommend CM products and practice, as well as those who refer to CM practitioners is provided in the appendix (Appendix K and L). A complete-case analysis was used to deal with item non-response.

Psychologists have general registration; however, some also hold an AoPE. There were an adequate number of participants to create groups for general psychologists and AoPE clinical psychologists, but the remaining individual AoPE categories (community psychology, counselling psychology, educational and developmental psychology, forensic psychology, health psychology) were small (cell size < 5). An additional category was created for these psychologists called *other AoPE*.

For analysis purposes, the types of CM products and/or practices were categorised into six groups as informed by previous literature (Ng et al., 2016; Ng et al., 2022; Wieland et al., 2011) and consistent with the definition of CM used in this study: mind/body approaches (hypnotherapy, meditation, yoga), movement approaches (exercise and movement-based activities, such as walking), ingestive therapies (herbal medicine, probiotics, vitamin and nutrition supplements), dietary changes, and manual approaches (acupuncture and massage). The sixth category, cultural and spiritual approaches, included participant's free text responses indicating recommending or referring to music, creative arts, prayer, and spirituality, and Aboriginal and Torres Strait Islander traditional healing.

The types of CM practitioners were categorised into six groups that were informed by previous literature (Ng et al., 2016; Wieland et al., 2011) and consistent with the definition of CM used in this study. For the purpose of this this study the six practitioner categories included: mind/body practitioners (i.e., hypnotherapists and yoga teachers), movement practitioners (i.e., exercise and movement trainers and/or coaches), practitioners who predominantly prescribe ingestibles (i.e., naturopaths, herbalists, and traditional Chinese practitioners), prescribes nutrition (i.e., nutritionists), and manual (i.e., acupuncturists, chiropractic, massage therapists). As the number of participants

referring to Aboriginal and Torres Strait Islander traditional healers was small, a new category of cultural and spiritual practitioners was created that incorporated participant free text responses which indicated they refer to music, creative arts, kinesiology, and energy practitioners.

5.4 Results

Of the completed surveys, 65% (n = 134) were completed via email invitation link and the remaining 35% (n = 68) accessed the survey via website or social media link as described above. The completion rate for opened surveys was 77%.

5.4.1 Participant characteristics

The study sample (n = 202) comprised 165 women (81.6%), 36 men (17.8%) and one person who identified as other (0.5%). The mean age of participants was 48 years ($M = 48$, $SD = 26$). All Australian states and territories were represented within the sample, with highest representation from New South Wales (n = 65) and Queensland (n = 64) and the lowest from Northern Territory (n = 1). Most psychologists identified as holding the AoPE of clinical psychologist (n = 79) or a psychologist with general registration (n = 76). Participants also came from other AoPE including counselling psychologist (n = 25), forensic psychologist (n = 8), health psychologist (n = 7), educational and developmental psychologist (n = 6), and one community psychologist. Solo practice was the most common work setting reported among participants (n = 137). The highest proportion of participants reported having 11 to 20 years of clinical experience (n = 72) and the lowest proportion (n = 31) reported having 31 plus years of clinical experience. Psychologists' characteristics are summarised in Table 5.1.

More than half of the participants (55.5%) had attained additional qualifications beyond their psychology qualification(s) in one or more of the following fields: education (n = 39), complementary medicine (n = 35), non-health related qualifications (n = 30), and health related qualifications (n = 18).

Psychologists estimates of what percent of their clients use CM ranged from 0% to 100%, with an average of 53% (M = 53.52, SD =19.42). Psychologists were also asked how frequently they question their clients about possible CM use, with 82.6% (n = 166) reporting 'most of the time', 12.9% (n = 26) 'sometimes', and 4.5% (n = 9) 'rarely or never'.

Table 5.1

Psychologist characteristics. Psychologist demographic and practice characteristics, number (n) and percent of Area of Practice Endorsement (%)

	All (n = 202)		**General psychologist (n = 76)**		**Clinical psychologist (n = 79)**		**Other AoPE psychologist (n= 47)**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Gender								
Female	165	81.7	62	81.6	68	86.1	35	74.5
Male	36	17.8	14	18.4	10	12.7	12	25.5

Other	1	0.5	0	0.0	1.0	1.3	0	0.0
Age (years)								
18 to 35	20	9.9	7	9.2	13	16.5	0	0.0
36 to 50	66	32.7	30	39.5	26	32.9	10	21.3
51 to 65	76	37.6	23	30.3	27	34.2	26	55.3
65 plus	40	19.8	16	21.1	13	16.5	1	23.4
State								
New South Wales	65	32.3	26	34.2	30	36.1	22	42.3
Victoria	31	15.4	9	11.8	14	17.9	8	17.0
Queensland	64	31.8	28	36.3	29	37.2	3	10.9
Other states	41	20.4	13	17.1	17	21.8	11	23.4
Practice Setting								
Solo private practice	137	67.8	51	67.1	51	64.6	35	74.5
Group practice	65	32.2	25	32.9	28	35.4	12	25.5

Years of practice								
Less than 10 years	51	25.2	19	25.0	23	29.1	9	19.1
11 to 20	72	35.6	27	35.5	31	39.2	14	29.8
21 to 30	48	23.8	19	27.7	16	20.3	13	27.7
31 plus	31	15.3	11	14.5	9	11.4	11	23.4
Additional qualification								
None	94	46.5	30	39.5	48	60.8	16	34.0
Education	39	19.3	16	21.1	12	15.2	11	23.4
Complementary Medicine	35	17.3	15	19.7	9	11.4	11	23.4
Non-health	30	14.9	12	15.8	8	10.1	10	21.3
Health	18	8.9	6	7.9	8	10.1	4	8.5

5.4.2 Psychologists recommending CM products and/or practices

Mind/body approaches were the most recommended type of CM products and/or practices (90.5%) and cultural/spiritual approaches the least recommended (7.5%). Table 5.2 reports the results of the analysis conducted between demographic and practice characteristics and recommending types of CM. Psychologists holding additional qualifications in education (OR = 0.28 [0.11; 0.75]) or complementary medicine (OR = 9.33 [1.22; 1196.31]) were more likely to recommend mind/body approaches to their clients.

5.4.3 Psychologists referring to CM practitioners

Psychologists also refer to CM practitioners, with referrals to practitioners who prescribe ingestible products (e.g., naturopaths) the most common (57.9%), and referrals to cultural/spiritual healers/practitioners (e.g., Aboriginal and Torres Strait Islander traditional healer) the least common (6.9%). The results of Firth-corrected logistic regression yielded some interesting results for psychologists referring to CM practitioner types (see Table 5.3). While psychologists with 31 plus years experience were more likely (OR = 3.14 [1.27, 8.16]) to refer to manual therapy practitioners (e.g., massage therapists), those who were 65 plus years old were less likely to refer to movement therapy practitioners (OR = 0.93 [0.31, 2.79]) (e.g., personal trainer) indicating rates of referral were similar, with no evidence for difference.

Psychologists in the group with an AoPE in clinical psychology were less likely than other participating psychologists to refer to mind/body (OR = 0.64 [0.85, 4.15]), movement (OR = 0.84 [1.49, 7.28]) and manual therapy (OR = 1.04 [1.14, 5.16]) practitioner types, indicating rates of referral were similar, with no evidence for

difference. Further, dual qualified psychologists, in education, were more likely to refer to movement and cultural/ spiritual practitioners. While those psychologists with dual qualifications, in non-health (e.g., law) were more likely to refer to mind/body practitioners.

Table 5.2.

Characteristics and recommending CM. Demographic and practice characteristics of psychologists and recommending CM products and/or practices, with odds ratios (OR) for recommending a specific product/practice, and a test (p, likelihood ratio test) of heterogeneity in probability of recommending a specific product/practice

	Mind/Body (n=202)		*p*	Movement (n=202)		*p*	Ingestibles (n=202)		*p*	Dietary changes (n=201)		*p*	Manual (n=202)		*p*	Cultural/Spiritual (n=201)		*p*
	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR
Gender			0.30			0.99			0.24			0.97			0.48			0.45
Female	0.34	0.03; 1.4		0.97	0.37; 2.25		0.56	0.26; 1.67		0.90	0.38; 1.98		1.55	0.74; 3.22		2.26	0.52; 21.14	
Male	ref																	
Other	0.13	0.003; 21.6		0.76	0.03; 115.93		1.72	1.08; 258.78		1.03	1.05; 156.49		2.16	0.11; 324.41		7.88	0.04; 256.46	
Age																		

	Mind/Body (n=202)		p	Movement (n=202)		p	Ingestibles (n=202)		p	Dietary changes (n=201)		p	Manual (n=202)		p	Cultural/Spiritual (n=201)		p
	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR
18 to 35	ref		0.84			0.63			0.69			0.20			0.17			0.79
36 to 50	1.51	0.25; 6.89		1.17	0.35; 3.51		1.65	0.61; 4.61		0.42	0.10; 1.35		0.61	0.20; 1.67		0.53	0.10; 3.25	
51 to 65	1.25	0.21; 5.19		1.83	0.54; 5.60		1.81	0.68; 4.97		0.72	0.17; 2.6		1.32	0.43; 3.71		0.79	0.19; 4.55	
65 plus	0.87	0.14; 4.04		1.17	0.33; 3.90		1.62	0.56; 4.83		0.36	0.08; 1.25		0.81	0.25; 2.47		0.48	0.6; 3.34	
State																		
NSW	ref																	

	Mind/Body (n=202)		p	Movement (n=202)		p	Ingestibles (n=202)		p	Dietary changes (n=201)		p	Manual (n=202)		p	Cultural/Spiritual (n=201)		p
	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR
VIC	0.44	0.11; 1.85	0.67	0.55	0.21; 1.49	0.64	.97	0.41; 2.27	0.80	0.94	0.37; 2.45	0.68	1.13	0.46; 2.83	0.78	1.17	.003; 1.62	0.18
QLD	0.56	0.15; 1.86		0.98	0.40; 2.36		1.16	0.58; 2.33		0.92	0.43; 1.98		0.97	0.47; 1.99		1.65	0.54; 5.45	
Other states	0.61	0.14; 2.49		0.92	0.35; 2.51		0.79	0.36; 1.71		1.56	0.63; 4.11		1.46	0.64; 3.49		0.69	0.12; 3.05	
Practice setting																		
Solo practice	ref																	

	Mind/Body (n=202)		*p*	Movement (n=202)		*p*	Ingestibles (n=202)		*p*	Dietary changes (n=201)		*p*	Manual (n=202)		*p*	Cultural/Spiritual (n=201)		*p*
	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR
Group practice	1.29	0.48; 3.93	0.62	0.77	0.38; 1.59	0.48	1.29	0.72; 2.53	0.38	0.74	0.39; 1.44	0.38	0.95	0.51; 1.78	0.87	0.36	0.7; 1.24	0.11
Years of practice																		
Less than 10	ref																	
11 to 20	0.63	0.14; 2.24		2.3	0.95; 5.74		2.60	1.26; 5.84		1.19	0.53; 2.64		1.68	0.80; 3.58		13.57	0.80; 3.58	
21 to 30	0.47	0.10; 1.77	0.74	1.12	0.46; 2.76	0.23	1.96	0.89; 4.39	0.07	1.42	0.58; 3.52	0.87	1.38	0.62; 3.51	0.54	13.02	1.41; 1728.48	0.06

	Mind/Body (n=202)		p	Movement (n=202)		p	Ingestibles (n=202)		p	Dietary changes (n=201)		p	Manual (n=202)		p	Cultural/Spiritual (n=201)		p
	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR
31 plus	0.59	0.11; 2.94		1.86	0.64; 6.03		2.01	0.82; 4.98		1.03	0.39; 2.78		1.67	0.66; 4.39		8.73	0.68; 1220.48	
AoPE			0.22			0.97			0.11			0.30			0.24			0.08
General	ref																	
Clinical	2.3	0.77; 8.39		0.97	0.44; 2.12		0.52	0.27; 0.98		0.65	0.32; 1.30		1.18	0.62; 2.81		0.29	0.07; 0.93	
Other	0.89	0.31; 2.74		0.90	0.37; 2.22		0.59	0.28; 1.23		1.15	0.49; 2.79		1.97	0.89; 4.54		0.34	0.06; 1.27	
Additional qualifications																		

	Mind/Body (n=202)		*p*	Movement (n=202)		*p*	Ingestibles (n=202)		*p*	Dietary changes (n=201)		*p*	Manual (n=202)		*p*	Cultural/Spiritual (n=201)		*p*
	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR
None	1.51	0.59; 4.09	0.38	1.00	0.51; 2.00	0.98	0.65	0.37; 1.13	0.13	0.92	0.50; 1.73	0.81	1.01	057; 1.82	0.96	0.57	0.18; 1.63	0.30
Education	0.28	0.11; 0.75	0.01	0.79	0.36; 1.88	0.58	0.73	0.36; 1.47	0.38	0.51	.24; 1.06	0.07	0.65	0.32; 1.34	0.24	2.33	0.72; 6.77	0.14
Complementary Medicine	9.33	1.22; 1196.31	0.02	1.22	0.51; 3.32	0.17	2.58	1	1.21; 5.84	1.51	0.66; 3.85	0.34	1.77	0.80; 4.30	0.16	1.94	0.55; 5.86	0.28
Non-health	0.83	0.26; 3.32	0.76	0.75	0.32; 2.04	0.59	1.03	0.48; 2.25	0.92	0.77	0.33; 1.85	0.54	1.16	0.51; 2.75	0.71	1.04	0.19; 3.67	0.96
Health	0.43	0.13; 1.79	0.22	1.16	0.38; 4.63	0.80	1.43	0.55; 3.93	0.46	0.83	0.30; 2.58	0.73	1.25	0.46; 3.84	0.66	1.92	.035; 7.13	0.40

Table 5.3.

Characteristics and referring to CM. Demographic and practice characteristics of psychologists and their referring to types of CM practitioners with odds ratios (OR) for referring to a CM practitioner for a specific product/practice, and a test (p, likelihood ratio test) of heterogeneity in probability of referring to CM practitioner according to each of the characteristics.

	Mind/Body (n=202)		*p*	Movement (n=202)		*p*	Prescribes ingestibles (n=202)		*p*	Prescribes nutrition (n=201)		*p*	Manual (n=202)		*p*	Cultural/ Spiritual (n=201)		*p*
	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR
Gender																		
Female	0.76	0.35; 1.77	0.81	1.19	0.58; 2.46	0.66	1.01	0.48; 2.08	0.63	0.91	0.44; 1.88	0.81	0.55	0.24; 1.14	0.22	2.10	0.48; 19.72	0.48
Male	ref																	
Other	0.84	0.005; 17.13		0.37	0.002; 7.44		0.24	0.001; 4.82		-	-		0.21	.001; 4.31		7.88	0.04; 256.4 6	
Age																		

	Mind/Body (n=202)		*p*	Movement (n=202)		*p*	Prescribes ingestibles (n=202)		*p*	Prescribes nutrition (n=201)		*p*	Manual (n=202)		*p*	Cultural/ Spiritual (n=201)		*p*
	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR
18 to 35	ref																	
36 to 50	2.69	0.57; 25.97	021	1.30	0.48; 3.62	0.04	1.63	0.61; 4.47	0.60	1.17	0.43; 3.20	0.88	3.06	1.03; 10.79	0.02	0.53	0.10; 3.25	0.86
51 to 65	5.7	1.32; 53.57		2.50	0.94; 6.92		1.94	0.73; 5.27		1.30	0.49; 3.52		5.02	1.72; 17.53		0.68	0.15; 3.95	
65 plus	6.61	1.41; 64.19		0.93	0.31; 2.79		1.72	0.59; 5.10		1.48	0.51; 4.39		3.85	1.21; 14.33		0.49	0.07; 3.42	
State																		
NSW	ref																	
VIC	1.92	0.75; 4.85	0.38	0.44	0.18; 1.06	0.19	1.37	0.57; 3.35	.89	1.4	0.62; 3.51	.64	0.85	0.36; 2.01	0.84	0.22	0.35; 2.00	0.18

	Mind/Body (n=202)		*p*	Movement (n=202)		*p*	Prescribes ingestibles (n=202)		*p*	Prescribes nutrition (n=201)		*p*	Manual (n=202)		*p*	Cultural/ Spiritual (n=201)		*p*
	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR
QLD	0.85	0.67; 1.95		0.67	0.33; 1.33		1.10	0.55; 2.20		1.41	.71; 2.83		0.80	0.40; 1.60		2.05	0.62; 7.47	
Other states	0.95	0.37; 2.36		1.06	0.48; 2.34		1.24	0.57; 2.77		0.98	0.44; 2.14		1.11	0.51; 2.44		0.86	0.14; 4.10	
Practice setting																		
Solo practice	ref																	
Group practice	0.94	0.46; 1.87	0.87	0.77	0.38; 1.59	0.37	0.76	0.42; 1.37	0.09	0.65	0.35; 1.18	0.16	0.78	0.43; 1.41	0.42	0.88	0.25; 2.63	0.82
Years of practice																		
Less than 10	ref																	

	Mind/Body (n=202)		*p*	Movement (n=202)		*p*	Prescribes ingestibles (n=202)		*p*	Prescribes nutrition (n=201)		*p*	Manual (n=202)		*p*	Cultural/ Spiritual (n=201)		*p*
	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR
11 to 20	2.01	0.81; 5.41	0.08	1.76	0.86; 3.66	0.36	1.87	0.90; 3.85	0.31	1.46	0.71; 3.01	0.35	1.81	0.89; 3.76	0.02	11.80	1.38; 1543. 80	0.09
21 to 30	1.87	0.68; 5.38		1.36	0.61; 3.02		1.64	0.74; 3.66		1.11	0.50; 2.47		0.96	0.43; 2.16		10.65	1.09; 1426. 53	
31 plus	3.80	1.36; 11.33		1.94	0.80; 4.82		2.00	0.82; 5.05		2.15	0.87; 5.48		3.14	1.27; 8.16		12.65	1.16; 1723	
AoPE[1]																		
General	ref																	
Clinical	0.64	0.29; 1.39		0.84	0.44; 1.58		0.74	0.39; 1.40		0.73	0.39; 1.38		1.04	0.55; 1.95		0.23	0.04; 0.84	

	Mind/Body (n=202)		*p*	Movement (n=202)		*p*	Prescribes ingestibles (n=202)		*p*	Prescribes nutrition (n=201)		*p*	Manual (n=202)		*p*	Cultural/ Spiritual (n=201)		*p*
	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR
Other	1.87	0.85; 4.15	0.04	3.22	1.49; 7.28	0.001	1.40	0.66; 3.05	0.24	1.59	0.76; 3.40	0.11	2.40	1.14; 5.16	0.04	0.57	0.14; 1.92	0.08
Additional qualifications																		
None	0.61	0.31; 1.18	0.14	0.69	0.39; 1.19	0.18	0.87	0.49; 1.52	0.62	0.82	0.47; 1.43	0.49	0.58	0.33; 1.01	0.05	0.32	0.08; 1.00	0.05
Education	1.15	0.50; 2.48	0.12	1.02	0.51; 2.06	0.005	0.71	0.35; 1.42	0.33	0.95	0.47; 1.92	0.89	0.99	0.49; 1.99	0.99	3.52	1.14; 10.45	0.03
Complementary Medicine	1.16	0.48; 2.57	0.12	1.55	0.75; 3.29	0.23	1.96	0.92; 4.43	0.08	1.67	0.80; 3.59	0.17	1.30	0.63; 2.70	0.47	1.45	0.35; 4.70	0.57
Non-health	2.24	0.96; 5.05	0.05	0.65	0.29; 1.41	0.28	1.18	0.54; 2.69	0.67	0.87	0.39; 1.96	0.75	0.98	0.44; 2.14	0.95	1.16	0.22; 4.19	0.83

	Mind/Body (n=202)		*p*	Movement (n=202)		*p*	Prescribes ingestibles (n=202)		*p*	Prescribes nutrition (n=201)		*p*	Manual (n=202)		*p*	Cultural/ Spiritual (n=201)		*p*
	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR	OR	95% CI	LR
Health	0.97	0.28; 2.76	0.96	1.55	0.59; 4.24	0.81	1.12	0.43; 3.05	0.82	1.61	0.59; 4.72	0.35	1.05	0.40	0.91	3.38	0.79; 11.63	0.09

[1]Area of Practice Endorsement

5.5 Discussion

This is the first study to identify rates of recommending different categories of CM products and/or practices and referring to different types of CM practitioners amongst Australian psychologists in clinical practice. One important finding from this study is that many psychologists appear to be actively engaging with CM in their clinical practice with a vast majority of participants reporting that they question clients about their CM use (95.5%), while a very large majority recommend CM products and/or practices (90.5%), and more than half of the sample refer clients to CM practitioners (57.9%). Although it is important to stress that the sample in our study was self-selecting, it is reasonable to cautiously suggest these levels of CM engagement amongst psychologists may provide first empirical indication of widespread grass-roots CM engagement amongst psychologists in clinical practice in Australia.

This finding from our study is consistent with, and may well be influenced in part by, CM engagement identified amongst general practitioners (GPs) (Adams, 2003; Ostermaier et al., 2020; Pirotta et al., 2010; Schwartz et al., 2021). Some GPs in Australia report a motivation to engage with CM as part of a patient-centred, whole person approach to health care, as well as to meet demand from client groups that are high CM users, such as those experiencing chronic illness and mental health problems (Ee et al., 2021; Mak et al., 2009; Rayner et al., 2011). Given CM use for mental health problems is high (Anderson et al., 2018; McIntyre et al., 2021; Seet et al., 2020) and GPs are the main referral pathway for these clients to psychologists, it may be that GPs are partly facilitating the inclusion of CM in the treatment planning for those clients

also consulting a psychologist. Apart from common legislation around health professionals referring to health professionals (e.g., maintaining client confidentiality) there is no legislation that explicitly discusses the types of referrals psychologists can provide. Perhaps in lieu of CM specific guidelines from psychology associations in Australia (Thomson-Casey et al., 2022), psychologists extend upon GP inclusion of CM to subsequently engage with CM in their own clinical practice with clients. Further research is required to identify what motivates psychologist engagement with CM.

In addition, the present study identified close to 50% of psychologists refer clients to CM practitioners who prescribe nutrition and movement. This may also be influenced by the growth of lifestyle medicine for mental health care among GPs (Egger, 2019; Nunan et al., 2021) that include CM, such as evidence-based social, nutrition and movement approaches (Drinkwater et al., 2019; Firth et al., 2020; Martland et al., 2021; Sarris et al., 2014; Sarris et al., 2022; Wakefield et al., 2022). Wider acceptance of these approaches among GPs may promote discussion with clients, and subsequently influence discussions between these patients and the psychologist (to whom the GP refers them), regarding the role of nutrition and movement as part of mental health care. However, the specific channels by which such lifestyle medicine options may be introduced into the clinical practice of psychologists—introduced by clients, by the psychologist or by other health professionals whom the client may be consulting—remains unclear and requires further investigation.

The results of our study suggest some psychologists are seeking additional training and formal qualifications in non-psychology disciplines, including CM. More

than half (n = 53.5%) of the participants had additional qualifications, including education (n = 19.3%) and CM (n = 17.3%). This is an interesting finding given that the Psychology Board of Australia does not support practitioners holding dual qualifications or applying more than one qualification to care for the same client. Interestingly, in the current study, having an additional qualification in education was associated with recommending mind/body approaches and dietary changes as well as referring to cultural/spiritual practitioners. This finding may be partly explained by psychologists with additional qualifications in education being exposed to CM approaches relevant to student and teacher wellbeing, such as mindfulness, yoga, healthy eating, and positive psychology (Kelly et al., 2022; Mendes de Oliveira et al., 2022; Nguyen et al., 2021), indicating they have greater knowledge of these approaches including potential benefits to clients. Further, as part of their training and work experience in educational settings, psychologists with additional tertiary training in education may also be exposed to the importance of cultural practices to mental health and wellbeing (Bishop et al., 2021; Jones et al., 2022). Research on why psychologists seek additional skills from other non-psychology disciplines may assist our understanding of psychologist engagement with CM as an adjunct to conventional psychology approaches and is a topic requiring further empirical examination.

The current study also found psychologists do not engage with all types of CM equally. Only a small minority of psychologists in our study indicated they engage with cultural/spiritual approaches and clinical psychologists specifically were the lowest proportion of the participating psychologists to engage with recommending or referring to cultural/spiritual approaches. Perhaps our finding, that there is a low rate of

engagement with cultural/spiritual approaches, partly reflects the critique of psychology as presented by some as a hegemonic Westernised approach to mental health (Barimah & Akotia, 2015; Canham et al., 2021; Ciofalo, 2019; Gone, 2016), which potentially minimises the relevance of including cultural/spiritual approaches in client's care. Furthermore, psychologists in Australia may be reluctant to engage with culturally relevant approaches following the introduction of Medicare items for psychologists in 2006. These items include limited approved psychological therapies that are deemed appropriate to apply to all clients *regardless of their ethnocultural background* (King, 2013). Any deviation from the approved listed therapies may result in an adverse outcome for a psychologist if they are audited by Medicare (Mathews, 2018; Stiles & Fox, 2019) and it may be that these circumstances, partly at least, explain the low rates of engagement with culturally relevant or spiritual mental health care approaches amongst our study sample. Ultimately, further investigation is needed to help understand and explain this interesting finding.

The current study also identified psychologists with an AoPE in clinical psychology as less likely to refer to mind/body, movement, and manual therapies. Perhaps there is something unique to clinical psychology training and supervisory programs that influences clinical practice orientations and subsequently reduces engagement with CM. For example, it has been suggested there is risk of a narrowing of the field of psychology, where clinical psychology tertiary programs focus too much on cognitive behavioural therapy (CBT) (Salter & Rhodes, 2018), and not enough on broader social and cultural influences on mental health, as well as the role of client preference and values that might include CM approaches (Browne et al., 2022; Crowe-

Salazar, 2007; Heatherington et al., 2012). The literature also reinforces CBT as the gold standard therapeutic approach for psychologists, and that any drift away from CBT, such as engaging with CM approaches, would be ineffective and potentially harmful to clients (Speers et al., 2022; Waller & Turner, 2016). It may be that clinical psychologists are influenced by their clinical psychologist peers. We know for comparison that GPs report their professional networks as influencing their clinical practice through staying abreast of treatment advances as well encouraging them to stay in their professional niche to feel more secure (Islam & Awal, 2020). Similarly, an Australian study of early career psychologists reported factors including postgraduate coursework and peer supervision as highly impactful on their theoretical and clinical practice orientations (Liao et al., 2022). Further research is needed to understand what influences clinical psychologist's reduced engagement with CM in clinical practice. For now, we can only suggest possible explanations for why clinical psychologists are less likely to engage with CM in their clinical practice than other psychologists in the study, and further research should examine this particular topic in more detail.

5.6 Strengths and limitations

This study is the first to focus on the rates of recommending and referring to CM amongst a diverse range of psychologists in clinical practice (e.g., in terms of years of experience, AoPE). Although the number of participants in the study was small, it is representative of the Australian psychology workforce according to current workforce demographics provided by the Psychology Board of Australia (2022). There is potential for bias in our research due to participants being self-selecting, which may have resulted

in larger numbers of psychologists who have an interest in CM being drawn to participating in the study.

5.7 Future research

Future research is required to identify and investigate what motivates CM engagement amongst psychologists in clinical practice. Questions internal to the ranks of psychology that require further attention include: how do psychologists justify their engagement with CM to their clients as well as to others in their profession; and what do psychologists perceive and experience as the core challenges and benefits of CM integration within their practice and the broader field of psychology? Similarly, with a focus beyond the psychology field, we also need to know more details regarding how different CM providers perceive and understand their role in the care of those with mental health issues who also consult a psychologist. There is also a need to examine the perceptions and experiences of clients receiving concurrent and/or co-ordinated mental health care from both CM practitioners and psychologists, such as any detrimental effects that may have occurred as a result of referrals to CM practitioners from psychologists.

5.8 Conclusion

A large proportion of Australian psychologists report some form of engagement with CM in their clinical practice. Policy and education development focusing upon this area of grass-roots psychology practice may help ensure the care provided by all psychologists remains evidence-based, safe, and optimal for their clients.

5.9 Chapter summary

This chapter presented a published article that explained the development and analysis of a survey to collect data from Australian psychologists regarding their engagement with CM in their clinical practice. This chapter provided the demographics and practice characteristics of participating psychologists as well as the rates at which these psychologists are recommending and referring their clients to CM. These results suggest there is widespread psychologist engagement with CM as part of their clinical practice. In the following chapter, further results from the survey are presented outlining how psychologists' self-rate their knowledge of CM, as well as how they perceive the risk and relevance of CM, in the context of psychology/psychologists in clinical practice.

Chapter 6. PHASE TWO – SURVEY RESULTS: Psychologist recommending and referring, perceptions of efficacy and risk, and self-rated knowledge regarding CM

6.1 Preface

In the previous chapter the statical analysis from the survey data indicated widespread psychologist engagement with CM in clinical practice. While this finding is interesting it is important to extract further analyses from the survey data to explore to what extent psychologists are engaging with CM, and whether this engagement is surface level or complex. It will also be important to understand whether Australian psychologists perceive their knowledge of CM as adequate in the context of their clinical practice. Such data would clarify if the data from the survey is from psychologists already familiar with CM, or whether psychologists generally, including those with limited knowledge of CM are also engaging with CM in their clinical practice. Further, it will be important to understand Australian psychologists' perspectives about the efficacy, risks, and relevance of CM in clinical practice through analysing their relevant responses to the survey questions. Identifying depth and complexity to the nature of psychologists recommending and referring to CM will add clarity to the contemporary landscape of psychologists' engagement with CM.

The current chapter provides additional results from the survey data collected from Australian psychologists. In this chapter, specific survey responses around frequency of engaging with CM, self-rated knowledge of CM, and risk and relevance of CM were analysed. This chapter includes the article published in *BMC Complementary Therapies in Medicine* in January 2024.

Thomson-Casey, C., McIntyre, E., Rogers, K., & Adams, J. (2024). Practice recommendations and referrals, perceptions of efficacy and risk, and self-rated knowledge regarding complementary medicine: a survey of Australian psychologists. *BMC complementary medicine and therapies*, *24*(1), 13. https://doi.org/10.1186/s12906-023-04288-y

6.2 Introduction

The use of complementary medicine (CM) – a range of practices, products and systems of care not traditionally associated with the conventional medical profession or curriculum (Adams, Parker, et al., 2019) – has gained increasing acceptance alongside conventional medical treatments in a number of health settings (Abbott et al., 2011; Brewer et al., 2019; Fernandes-Nascimento & Wang, 2022; Jafari et al., 2021; Reuter et al., 2021; Schaub et al., 2021; Ye et al., 2020). Amongst these developments, some psychologists have reported positive views toward the use of CM as part of, or as an accompaniment to, the mental health care they provide (Liem, 2020; Liem & Newcombe, 2019b; Stapleton et al., 2015).

Some CM approaches such as nutrition, movement therapies, and massage have been identified as effective for addressing certain mental health symptoms (Bayes et al., 2022; Feng et al., 2022; Hall et al., 2020; O'Dea et al., 2022; Sarris et al., 2022; Zhu et al., 2022) and some CM approaches have become more widely accepted amongst psychologists (e.g., eye movement desensitisation and reprocessing, guided imagery, meditation, mindfulness) and integrated into their contemporary practice (Haller et al., 2019; Lorenc et al., 2018; Moir et al., 2019; Novo Navarro et al., 2018). Many

diagnosed with mental health problems are CM users (Chatterjee, 2021; de Jonge et al., 2018; Malhotra et al., 2020; McIntyre et al., 2021; Seet et al., 2020; Wemrell et al., 2020) and a psychologist is likely to consult with some clients who use CM as part of their wider mental health care. For example, a study of Turkish people with mental health problems found 62.2% had used CM in some form in the last 12 months (Avci & Sabanciogullari, 2021). Similarly, a study of Australian adults diagnosed with mental health problems reported 42.4% consulted a CM practitioner, 56.9 % used a CM product, and 23 % used a CM practice in the previous three years (McIntyre et al., 2021).

The *integration* of CM within psychology practice (as within other areas of health practice) can take a number of forms (Adams & Andrews, 2012) including through direct *discussion* about CM with a client in consultation (e.g., discussing potential herb-drug interactions), *recommending* CM to a client (e.g., suggesting the client attend a yoga class for relaxation) and *referring* a client to a CM practitioner (e.g., verbal or written referral to a naturopath to explore evidence-based herbal interventions for anxiety). Integration may also be via *direct practice application* of CM to the client by a psychologist (e.g., explicit instructions regarding a client's nutritional intake/diet in the context of evidence-based nutritional psychiatry).

The safe integration of CM into mental health care is not without challenges. Mental health practitioners, including psychologists, often report gaps in their knowledge regarding relevant evidence-based CM (Baxter & Lovell, 2021; Casbarro et al., 2021; Morkl et al., 2021; Roberts et al., 2021; van Rensburg et al., 2020) associated

with an inability to discuss CM with clients or to recommend or facilitate referral to CM if requested by a client (Liem, 2020; Makarem et al., 2022; Nayda et al., 2021). Further, some psychologists engaging with CM in their practice complain of a lack of explicit policy and guidelines for the safe integration of CM into psychology practice (Hamilton & Marietti, 2017; Kassis & Papps, 2020; Liem, 2020). Analysis of guidelines from Australian psychology professional associations reveals limited mention of CM, nor how psychologists could safely integrate CM into their practice (Thomson-Casey et al., 2022).

Unfortunately, much detail and many issues around CM integration by psychologists remain unexplored including what influences psychologists to engage, or not engage, with types of CM in their clinical practice. Further, we still know little regarding Australian psychologists' perspectives about the efficacy, risks, and relevance of CM in psychology. The study reported here has been designed to directly address these important research gaps.

6.3 Methods

6.3.1 Aims and objectives

The aim of this research was to determine how many types of CM products, CM practices, and CM practitioners are recommended and/or referred by Australian psychologists as part of their clinical practice as well as explore the relationship between psychologists' perspectives about the efficacy, risks and relevance of CM in psychology, and their self-rated knowledge of CM, with the number of types of CM to which psychologists are recommending or referring their clients.

6.3.2 Study design

This study employed an online survey administered exclusively to Australian psychologists who were fully registered and working in a clinical practice setting at the time of survey between February and April of 2021. Email invitations to participate in the study were sent to psychologists whose contact details were collected from their publicly available websites. The recruitment emails contained information about the study, consent forms, and a link to complete the survey online. All participants were sent a reminder email four weeks following the initial invitation email. An advertisement inviting psychologists to participate in the research was also placed on two psychology professional association websites (Australian Association of Psychologists Incorporated and the Australian Psychological Society) and on relevant social media sites including Twitter, LinkedIn, and Facebook. Participants accessed the survey via an anonymous link (embedded in the email, website advert or in social media post), which initially directed the psychologist to the participant information and consent form followed by the link to the open survey using Qualtrics software, Version 2021 (Qualtrics, 2022). The information page at the beginning of the survey included project details such as ethical approval, data protection, and voluntary participation. The information page also served as the participant consent form. Participants indicated their written consent after reading the information and consent page and clicking on the button confirming their agreement to proceed with the survey. Participants who completed the online survey were invited to supply their email address to enter a prize draw to win a gift voucher to the value of $250. Ethical approval was attained from the University of Technology Sydney Human Research Ethics Committee [ETH20-5138].

6.3.3 Sample

The survey was distributed to 1,479 Australian psychologists working in clinical practice at the time of recruitment. All psychologists (psychologists with general registration, and those psychologists with general registration plus an area of practice endorsement (AoPE)) were eligible to participate in the study. However, only responses from those psychologists working in an Australian clinical practice setting (e.g., inpatient hospital, private practice) and directly with clients were included in the data analysis for this study.

All psychologists in Australia (n = 34,872) are considered to hold general registration, which enables them to use the title of *psychologist* (Psychology Board of Australia, 2022). Some psychologists with additional tertiary training in psychology may also hold an AoPE enabling them to use a restricted title (e.g., clinical psychologist). These AoPE titles are clinical neuropsychologist, clinical psychologist, community psychologist, counselling psychologist, educational and developmental psychologist, forensic psychologist, health psychologist, organisational psychologist, and sport and exercise psychologist. A psychologist with an AoPE title has general registration *plus* an AoPE. To clarify, a psychologist with general registration *without* an AoPE (i.e., psychologist) can work in clinical practice settings. However, working in clinical practice does not mean a psychologist is a clinical psychologist.

Psychologists self-selected to participate by clicking on the survey link in the email invitation or on the websites listed above. An initial screening question asked participants if they were a psychologist who undertakes the work of a psychologist.

Participants who selected “No” were redirected out of the survey. The current study focused exclusively on registered psychologists in clinical practice in Australia. The original sample size was planned to be 400, based achieving a 0.10 confidence interval width on estimates of prevalence of binary questionnaire items. As noted above, we were able to recruit 231 participants, of which 201 passed the inclusion criteria and were used in this study. With this sample size we are able to estimate a confidence interval for the prevalence of a single binary item with a CI width of 0.14; or compare a continuous or binary variable between two equally sized groups with 0.8 power and an effect size of 0.39 (Cohen’s d).

6.3.4 Instrument

The construction of survey items was informed by previous literature on psychologist engagement with CM to produce survey items that best captured the ways psychologists might be engaging with CM, including the types of CM products and practices they had ever recommended and the types of CM practitioners to which they had ever referred. Participants were also provided with a definition of CM in line with the World Health Organisation (World Health Organisation, 2013). The 79-item questionnaire aimed to examine psychologists’ perspectives relating to how CM is/is not relevant and/or appropriate to (their) psychology practice, their clients, and the treatment of mental health problems. Prior to recruitment, the survey was tested for face validity and functionality by three PhD students from psychology adjacent fields. As part of this process, any identified necessary changes were undertaken to provide clearer definitions and reduce repetitive questions. Based on survey testing feedback, the time

required to complete the survey was approximately 15 minutes. Where relevant this paper adhered to the CHERRIES checklist for reporting results of internet e-surveys (Eysenbach, 2004, 2012). The study reported in this paper focused on the survey data sections examining psychologist demographics, types of CM products and/or practices recommended, and/or CM practitioners referred to, psychologists' perspectives on CM within psychology, as well as psychologist self-rated knowledge of CM types.

6.3.5 Demographics

Demographic data included year of birth, gender identity, and the predominant state/territory in which they practice. Psychologists were also asked to provide practice characteristics, such as AoPE, their work setting (solo or group setting), and years in practice as a psychologist.

6.3.6 Perspectives on CM within psychology

Participating psychologists were invited to rate their agreement with statements related to efficacy and relevance of CM to psychology and psychology practice. There were two efficacy questions rated on a six-point Likert scale (*strongly agree, agree, somewhat agree, somewhat disagree, disagree to strongly disagree*). Perspectives about the relevance of CM to psychology and psychology practice were addressed across thirteen statements (e.g., It is important for psychologists to understand and engage with their client's preference for CM as part of their mental health treatment). The statements about the relevance of CM were also rated on a six-point Likert scale from strongly agree to strongly disagree. To reduce risk of bias there were six questions across the perspectives categories that described CM as a risk to psychology. For example, "CM is

not a good match with psychology" and "Psychology integrating with CM puts psychology's reputation at risk". Psychologists were also invited to select types and frequency of CM products, practices, and practitioners they had ever recommended and/or referred their clients to as part of their clinical practice.

6.3.7 Self-rated knowledge of CM

This section asked psychologists to self-rate their knowledge across eleven types of CM: Aboriginal and Torres Strait Islander Traditional Medicine /Healing practices, acupuncture, dietary intervention, exercise/movement interventions, herbal medicine, hypnotherapy, massage, meditation, nutrition supplements, probiotic supplements, and yoga. Psychologists could rate their knowledge on a four-point Likert scale from excellent, good, fair, and poor.

6.3.8 Data Analysis

IBM SPSS Statistics Premium Edition Version 27 (Armonk, New York, IBM Corp) was used to analyse the data. Prior to conducting the analyses, raw survey data were screened for any missing or incomplete responses. During this process, nine cases were removed as the data (responses) were incomplete. After removal of the nine cases, 222 cases were included in the initial analyses which identified significant outliers. On review the outlier responses were mostly from cases who did not work in clinical practice settings. These cases were removed resulting in 201 participants in the final data set. Descriptive statistics were used to determine the percentages and frequencies. A Poisson regression model was used to estimate rate ratios between demographic and practice covariates and the outcomes of CM engagement l (number of types of

recommending CM products and practices and *referring* to CM practitioner types, agreement with statements about risks and relevance of CM, self-rated knowledge of types of CM).

Variables and categories were created to best capture psychologist responses to survey items. For analysis the types of CM products and practices were categorised into six groups that were informed by previous literature (Ng et al., 2016; Wieland et al., 2011) and consistent with the definition of CM used in this study: mind/body approaches (hypnotherapy, meditation, yoga), movement approaches (exercise and movement-based activities, such as walking), ingestive therapies (herbal medicine, probiotics, vitamin and nutrition supplements), dietary changes and manual approaches (acupuncture and massage). The sixth category cultural and spiritual approaches included participant's free text responses indicating recommending or referring to music, creative arts, prayer, and spirituality, and Aboriginal and Torres Strait Islander traditional healing. The number of types of CM products and/or practices psychologists recommend to their client was collapsed into three categories: recommended none; recommended one to three types of CM products and/or practices; and recommended four plus types of CM products and/or practices.

Psychologists could also select from six categories of CM practitioners to which they have ever referred their clients. Practitioner types included mind/body practitioners (e.g., hypnotherapists and yoga teachers), movement practitioners (e.g., exercise and movement trainers and/or coaches), practitioners who predominantly prescribe ingestibles category (e.g., naturopaths, herbalists, and traditional Chinese practitioners),

prescribes nutrition (e.g., nutritionists), manual practitioners (e.g., acupuncturists, massage therapists), and cultural/spiritual practitioners (e.g., Aboriginal and Torres Strait Islander traditional healers). The number of types of CM practitioner to which a psychologist referred their clients was combined into three categories: refers to none, refers to one to three types of CM practitioner, and referred to four plus types of CM practitioner.

Variables relating to perspectives about the efficacy and relevance of CM, and self-rated knowledge of CM, were also adjusted for the purpose of analysis. Due to the small number of responses in some categories the statement responses were collapsed into fewer categories. Both categories relating to agreement with perspectives about CM (efficacy and relevance) were collapsed into two responses of either agree or disagree. Finally, the self-rated knowledge category was also collapsed into two responses of either excellent/good or fair/poor.

Count variables were also created for the Poisson regression analyses. A variable representing the total number of types of CM products and practices that psychologists would refer patients to was created, and similarly one for the number of types of CM practitioners that psychologists refer to as part of their clinical practice. For the additional summary data tables, the count variables were converted to ordinal variables (for grouping into three categories) for both recommend or referred; none, one to three types, and four or more types of CM.

6.4 Results

Of the total participants, 66% (*n* = 134) accessed the survey via email invitation link and the remaining 34% of participants (*n* = 68) accessed the survey via website or social media link. A large majority (77%) of people who opened the survey completed it.

6.4.1 Participant characteristics

The study sample (*N* = 201) was comprised of 165 women (81.6%), 36 men (17.8%) and one person who identified as other (0.5%). The mean age of psychologist participants was 48 years (*M* = 48.260, *SD* = 26.53). All of the Australian states and territories were represented within the sample, with highest representation from New South Wales (*n* = 65) and Queensland (*n* = 64), and the lowest from Northern Territory (*n* = 1). Most psychologists in the study identified as having the AoPE as a clinical psychologist (*n* = 79). Psychologists with general registration (*n* = 76) were also represented. There were also psychologists who identified as *Other AoPE* including counselling psychologists (*n* = 25), forensic psychologists (*n* = 8), health psychologists (*n* = 7), educational and developmental psychologist (*n* = 6) and one community psychologist. Solo private practice was the most common work setting reported among participants (*n* = 137). The highest proportion of participants had 11 to 20 years of clinical experience (*n* =72) and the lowest proportion had 31 plus years of clinical experience (*n* =31). Table 6.1 provides a summary of demographic and professional characteristics.

Table 6.1

Psychologist demographic and practice characteristics, by area of practice endorsement (AoPE)

	All (***n*** **= 202)**		**General psychologist** (***n*** **= 76)**		**Clinical psychologist** (***n*** **= 79)**		**Other AoPE psychologist** (***n*** **= 47)**	
	n	**%**	***n***	**%**	***n***	**%**	***n***	**%**
Gender								
Female	165	81.7	62	81.6	68	86.1	35	74.5
Male	36	17.8	14	18.4	10	12.7	12	25.5
Other	1	0.5	0	0.0	1.0	1.3	0	0.0
Age (years)								
18 to 35	20	9.9	7	9.2	13	16.5	0	0.0
36 to 50	66	32.7	30	39.5	26	32.9	10	21.3
51 to 65	76	37.6	23	30.3	27	34.2	26	55.3

65 plus	40	19.8	16	21.1	13	16.5	1	23.4
State and territories								
New South Wales	65	32.3	26	34.2	30	36.1	22	42.3
Victoria	31	15.4	9	11.8	14	17.9	8	17.0
Queensland	64	31.8	28	36.3	29	37.2	3	10.9
Other states	41	20.4	13	17.1	17	21.8	11	23.4
Practice Setting								
Solo private practice	137	67.8	51	67.1	51	64.6	35	74.5
Group practice	65	32.2	25	32.9	28	35.4	12	25.5
Years of practice								
Less than 10 years	51	25.2	19	25.0	23	29.1	9	19.1
11 to 20	72	35.6	27	35.5	31	39.2	14	29.8

21 to 30	48	23.8	19	27.7	16	20.3	13	27.7
31 plus	31	15.3	11	14.5	9	11.4	11	23.4

6.4.2 Psychologists recommending types of CM products and/or practice and self-rated knowledge

Of the 201 psychologist responses included in the analysis, 5% (*n* = 11) reported having not recommended any type of CM, 32% (*n* = 65) reported having recommended one to three types, and 63% (*n* = 126) reported having recommended four or more types of CM products and/or practices (see Appendix O). The rate ratios of psychologist response to statements about efficacy, risk, relevance, and knowledge of CM with recommending and referring to a number of types of CM are reported in Table 6.3. The lowest rates of CM product and practice recommendations were from psychologists who agreed “CM is not scientifically valid” (RR = 0.77 [0.65; 0.93]), and that “referring to CM practitioners puts client safety at risk” (RR = 0.76 [0.63; 0.91]). Of the 23% (*n* = 47) of participating psychologists who agreed with the statement that “CM as not scientifically valid”, some (*n* = 6) did not recommend any types of CM. However, most of those psychologists who agreed with this statement still recommended CM to their clients (*n* = 41).

In contrast, psychologists who agreed with statements describing CM training and integration within psychology as beneficial, had the highest rates of recommending

CM. For example, psychologists who agreed "CM practitioners can play a valuable role in assisting clients with their mental health problems" were more likely to recommend CM (RR = 1.55 [1.24; 1.94]).

The following CM types had the highest proportion of self-ratings as excellent/good among participating psychologists; meditation 88% (*n* = 178), dietary interventions 65% (*n* = 131), yoga 64% (*n* = 129), and exercise/movement interventions 54% (*n* = 110). With regards to the remaining seven CM types, more than half of the psychologists self-rated their knowledge as fair/poor for each type. Aboriginal and Torres Strait Islander Traditional Medicine /Healing practices attracted the lowest self-rated knowledge amongst the psychologists with only 6% (*n* = 12) of participants rating their knowledge as excellent/good for this medicine/healing practices. Psychologists who self-rated their knowledge of meditation as excellent/good had the highest rate of recommending multiple types of CM (RR = 1.51 [1.15; 1.96]).

6.4.3 Psychologists referring to types of CM practitioners

Of the participants, 25% (*n* = 50) had not referred to any type of CM practitioner, 42% (*n* = 84) had referred to one to three types of CM practitioner, and 33% (*n* = 68) had referred to four or more types of CM practitioner. The lowest reported rates of referral to CM practitioners came from psychologists who agreed with the statement "referring clients to CM practitioners or services puts client safety at risk" (RR = 0.39 [0.29; 0.52). Psychologists who agreed with the statement "CM is not a good match with psychology" also reported low rates of referral to CM practitioners (RR = 0.48 [0.33; 0.73]). Of those psychologists who agreed with the statement

“referring clients to CM practitioners or services puts client safety at risk” (*n* = 48), half (*n* = 24) reported referring to one or more types of CM practitioner. Meanwhile, another 10% (*n* = 21) of the study sample who also agreed with the statement “CM is not a good match with psychology”, half (*n* = 11) still reported referring to one or more CM practitioners. Across the demographic and practice characteristics psychologists aged 51 to 65, and those with 31 years plus experience, were more likely to refer to CM practitioners (Table 6.2). Clinical psychologists were the least likely to refer to any CM practitioner types. (See Appendix N).

Table 6.2.

Demographic and practice characteristics of psychologists and recommending and referring to a number of types of CM

		Recommending CM products and practices				Referring to CM practitioners			
		RR	Lower confidence limit	Upper confidence limit	*p*	RR	Lower confidence limit	Upper confidence limit	*p*
Gender*									
	Male	ref				ref			
	Female	0.97	0.81	1.17	0.76	0.94	0.75	1.18	0.63
Age (years)									
	18 to 35	ref				ref			
	36 to 50	0.96	0.74	1.24	0.62	1.34	0.92	1.95	0.03
	51 to 65	1.06	0.82	1.36		1.65	1.14	2.38	
	65 plus	0.95	0.72	1.26		1.42	0.95	2.11	
State and territories									
	New South Wales	ref				ref			
	Victoria	0.94	0.75	1.18	0.93	0.97	0.73	1.28	0.98
	Queensland	1.01	0.84	1.21		0.99	0.79	1.24	
	Other states	1.00	0.82	1.24		1.03	0.80	1.32	
Practice Setting									
	Solo private practice	ref			0.79	ref			0.18
	Group practice	0.97	0.84	1.14		0.87	0.72	1.06	
Years of practice									
	Less than 10 years	ref				ref			

		Recommending CM products and practices				Referring to CM practitioners			
		RR	Lower confidence limit	Upper confidence limit	*p*	RR	Lower confidence limit	Upper confidence limit	*p*
	11 to 20	1.18	0.98	1.43	0.37	1.14	1.10	1.80	0.004
	21 to 30	1.12	0.91	1.38		1.19	0.91	1.58	
	31 plus	1.14	0.90	1.44		1.63	1.22	2.16	
AoPE/Specialty									
	General	ref			0.74	ref			<0.001
	Clinical	0.93	0.78	1.11		0.85	0.69	1.06	
	Other	0.98	0.82	1.18		1.31	1.05	1.63	

*As there were not enough people in the gender category of *Other* to conduct a regression analysis they were not included.

Table 6.3.

Psychologist response to statements about efficacy, risk, relevance and knowledge of CM with recommending and referring to a number of types of CM

	Recommending CM products and practices				Referring to CM practitioners			
	Rate ratio	Lower confidence limit	Upper confidence limit	p	Rate ratio	Lower confidence limit	Upper confidence limit	p
Agreement with statements about CM efficacy								
CM is not scientifically valid	0.77	0.65	0.93	0.007	0.53	0.41	0.68	<0.001
CM is not a good match with psychology	0.76	0.58	0.99	0.03	0.48	0.33	0.73	<0.001
Agreement with perspectives about risk and relevance of CM to psychology								
CM treatments are unlikely to help those who use them as part of their mental health treatment	0.85	0.70	1.05	0.14	0.61	0.47	0.84	0.002
Current psychology ethical practice guidelines are adequate in guiding psychologists on how they can engage with their client's CM use	0.96	0.82	1.12	0.63	0.81	0.66	0.99	0.04

It would be helpful if there were specific guidelines/policy related to psychology	1.01	0.79	1.28	0.93	1.37	0.97	1.92	0.07
Psychology as a field (including professional associations, academia, research) should provide more training on CM	1.35	1.06	1.71	0.01	2.10	1.47	2.99	<0.001
Psychology as a field (including professional associations, academia, research) should provide more research on CM	1.35	1.07	1.70	0.01	1.93	1.38	2.71	<0.001
Psychology as a field (including professional associations, academia, research) should provide more guidelines on CM	1.35	1.06	1.71	0.01	1.75	1.26	2.43	<0.001
It is important for psychologists to understand and engage with their client's preference for CM as part of their mental health treatment	1.36	0.97	1.90	0.68	4.08	2.03	8.21	<0.001
There is potential to improve mental health outcomes with the integration of evidence-based CM within psychology practice	1.45	1.06	1.98	0.02	4.06	2.17	7.60	<0.001
CM practitioners (e.g., naturopaths) can play a valuable role in assisting clients with their mental health problems	1.55	1.24	1.94	<0.001	3.17	2.16	4.64	<0.001
Psychologists should have knowledge of CM	1.35	1.08	1.68	0.008	1.68	1.24	2.27	<0.001
Psychologists should learn about CM as part of their tertiary training	1.35	1.08	1.68	0.008	1.68	1.24	2.27	<0.001
Psychology integrating with CM puts psychology's reputation at risk	0.77	0.66	0.91	0.002	0.42	0.34	0.54	<0.001
Referring clients to CM practitioners or services puts client safety at risk	0.76	0.63	0.91	0.003	0.39	0.29	0.52	<0.001

Self-rated knowledge of CM types as excellent/good								
Aboriginal and Torres Strait Islander Traditional Medicine /Healing practices	1.35	1.03	1.76	0.03	1.71	1.26	2.31	<0.001
Acupuncture	1.22	1.03	1.42	0.02	1.49	1.22	1.83	<0.001
Dietary intervention	1.36	1.16	1.60	<0.001	1.77	1.43	2.19	<0.001
Exercise/movement interventions	1.18	1.02	1.37	0.02	1.26	1.05	1.52	0.01
Herbal medicine	1.26	1.07	1.48	0.005	1.54	1.27	1.87	<0.001
Hypnotherapy	1.19	1.03	1.37	0.02	1.48	1.24	1.77	<0.001
Massage	1.25	1.09	1.45	0.002	1.41	1.18	1.68	<0.001
Meditation	1.51	1.15	1.96	0.003	1.55	1.11	2.16	0.01
Nutrition supplements	1.25	1.08	1.44	0.002	1.39	1.16	1.67	<0.001
Probiotic supplements	1.28	1.10	1.49	0.001	1.28	1.06	1.55	0.009

Yoga	1.25	1.07	1.46	0.004	1.31	1.08	1.60	0.006

Psychologists who agreed with the statement "it is important for psychologists to understand and engage with their client's preference for CM as part of their mental health treatment" had the highest reported rate of CM referral (RR = 4.08 [2.03; 8.21]). Similarly, psychologists who agreed with the statement "there is potential to improve mental health outcomes with the integration of evidence-based CM within psychology practice" also reported high rates of referral to CM practitioners (RR = 4.06 [2.17; 7.60). Similarly, psychologists who self-rated their knowledge of dietary intervention as excellent/good reported the highest rate of referring to multiple types of CM practitioner (RR = 1.77 [1.43; 2.19]).

6.5 Discussion

This is the first study to examine the perspectives of Australian psychologists on CM as part of their clinical practice, and how this relates to the number of a range of CM products and/or practices they utilise and/or a range of CM practitioners they refer to as part of their clinical practice. One important finding from our study is that some psychologists appear to be engaging with CM products and/or practices, and CM practitioners even in those cases where the psychologist reports not perceiving CM as valid or efficacious. This finding – which contrasts with the closely held principle of evidence-based practice (EBP) that psychologists select empirically supported interventions (American Psychological Association, 2006; Ward et al., 2022) – is, nevertheless, consistent with international research reflecting the complex interaction between health practitioner perspectives about CM, their lack of knowledge of CM, and their

recommendations and/or referral behaviour regarding CM (Fay et al., 2016; Makarem et al., 2022; Morkl et al., 2021). For example, research examining general practitioners suggests CM may act as useful resource with which these health professionals defend their clinical autonomy from what they perceive to be the threat of evidence-based medicine (Adams, 2000). It may be that the psychologists in our study are engaged in a similar stance in relation to clinical autonomy and EBP. However, further research is required to fully examine the validity of such an interpretation.

This finding from our study - that some psychologists appear to be engaging with CM products and/or practices, and CM practitioners even in those cases where the psychologist reports not perceiving CM as valid or efficacious – also appears to potentially add weight to the argument that engagement with CM may well be substantial across the psychology field (Liem, 2019b; Liem & Newcombe, 2019b; Ligorio & Lyons, 2018; Stapleton et al., 2015). Identifying CM engagement in those critical cases where it is reasonable to consider it less likely (i.e., amongst psychologists who do not see CM as valid or efficacious) suggests the phenomenon may be widespread across other sections of the profession. This finding also suggests CM engagement amongst these psychologists may reflect, in part at least, a response to patient-led demand; while not necessarily seeing CM as valid or efficacious, it may be that some of the psychologists in our sample are driven to engage with CM as a result of repeated client request. Indeed, to this last point, our study findings also show psychologists who perceive engagement with client preference for CM as important, report the highest rates of referral to multiple types of CM

practitioners. It may be that these issues are driving the level of engagement with CM amongst our sample. Unfortunately, our analysis is limited in its ability to validate such explanations and future research is required to further explore and test such explanations for CM engagement amongst psychologists.

Our study shows that a psychologist's self-rated knowledge of dietary interventions as excellent/good predicts an increased likelihood of them ever referring clients to one or more CM practitioner types. This finding supports the observation that the role of nutrition in mental health care has recently emerged as a paradigm shift (Allen et al., 2016; Mörkl et al., 2020; Teasdale et al., 2020) with psychologists perceiving diet as an important part of their mental health care offerings (Baxter & Lovell, 2021; Nayda et al., 2021). It may well be that the client referrals to nutrition-related CM practitioners (e.g., nutritionist, naturopath) identified in our study fit within this wider trend. However, our study data does not allow us to directly test these connections and further research needs to explore these issues in more detail.

The current study highlights that psychology professional associations may need to provide further CM relevant training for psychologists, given both a high level of psychologist engagement with CM and that 87% of surveyed psychologists perceive psychology as a field should provide more training on CM. Our findings relating to these specific issues have some similarities to the findings from studies of student doctors in Australia, where it was highlighted that nutrition education, for example, may not be

sufficient to support nutrition related competencies in medical training and subsequently in their clinical practice (Lepre et al., 2020; Perlstein et al., 2021). Findings reported in previous literature, as well as those identified from the current study, highlights that psychologists perceive gaps in their knowledge about a number of CM approaches, including nutrition, and how to integrate them into practice (Baxter & Lovell, 2021; Davison et al., 2017; Nayda et al., 2021). For example, discussing potential herb-nutrient-drug interactions when psychologists are educated and aware of potential risks may improve client safety. These findings, that psychologist perceive a need for more education in relevant CM, have implications for the field of psychology, how it manages scope of practice for psychologists, the inclusion of CM in psychologist tertiary training, as well as the provision of CM relevant professional development activities for psychologists. All these areas require further attention and empirical investigation to help understand the current implications and prospects of CM engagement amongst psychologists in clinical practice.

The current study suggests psychologists hold generally positive attitudes toward CM, despite limited knowledge of CM, a finding consistent with insights from previous research from Australia and abroad (Fay et al., 2016; Liem & Newcombe, 2019b). This finding is important. Having limited knowledge of CM, yet recommending and referring to CM practitioners, may be problematic for psychologists in the context of contingent liability if they are unable to adequately explain or justify their referral to a CM practitioner. Perhaps psychologists do not see their self-rated knowledge of CM (as

fair/poor) to be a barrier to referring their clients to CM practitioners. Perhaps at the interface of client preference for CM and their own, possibly conflicting, perspectives about efficacy, risk, relevance and self-rated knowledge of CM, psychologists prioritise the client's preference for CM. Adding to psychologist's dilemma regarding CM within clinical practice are other findings from the current study, that substantial numbers of psychologists perceive their knowledge of some CM types as fair/poor. This is consistent with Australian and international research that identifies limited guidelines and education for psychologists wishing to engage with CM in clinical practice in a number of jurisdictions (Kassis & Papps, 2020; Liem, 2020; Medeiros et al., 2019; Morkl et al., 2021; Nayda et al., 2021; Thomson-Casey et al., 2022). Again, further research is required to tease out and more deeply explore these and competing understandings and explanations around psychologists' CM engagement.

Based on the findings from the current study, CM recommendation and CM practitioner referral are reported amongst those psychologists who perceive risks related to CM. It is unclear how psychologists reconcile and justify their risk perceptions regarding CM alongside their active recommendation of CM and referral to CM practitioners and this is an important area that requires further in-depth empirical enquiry. Within the framework of EBP, psychologists are advised to use the best research evidence in conjunction with clinical expertise and clients' values, culture and preferences to inform mental health care (Stewart et al., 2018). It is unclear how psychologists interpret risks and evidence in CM without relevant CM guidelines, knowledge, and competencies, as these are the devices

through which evidence is supposedly interpreted into clinical practice. Further research may identify what motivates psychologists to engage with CM in clinical practice and how they reconcile limited relevant guidelines and related gaps in their knowledge.

6.6 Limitations

This study is the first to focus on the rates of recommending and referring to types of CM amongst a diverse range of psychologists in clinical practice (e.g., in terms of years of experience, AoPE) in the context of psychologist perceptions of the risks and relevance of CM, and their self-rated knowledge of some types of CM. Although the number of participants in the study was small, it is representative of the Australian psychology workforce according to current workforce demographics provided by the Psychology Board of Australia (2022). Although the study participants were from some AoPE, not all psychology AoPEs were represented. Further, when interpreting the results, it is important to be mindful that most participants were either psychologists with general registration or psychologists with an AoPE in clinical psychology. Caution is suggested when interpreting the results as there is potential for bias in our research due to participants being self-selecting. Those who have strong opinions on the relationship between psychology and CM are likely to respond.

6.7 Conclusion

There are risks associated with psychologists engaging with CM in clinical practice when psychologists also perceive their self-rated knowledge to be poor. The findings from

this study provide insights into psychologist perceptions of CM within psychology practice and how these perceptions are associated with rates of recommending and referring to CM as part of their clinical practice. These findings may well inform the development of CM relevant education and guidelines for psychologists. Further research is needed to determine what motivates psychologists to engage with CM (via recommendation or referral) in their clinical practice, how they justify such engagement and how they facilitate and accommodate such engagement for their clients.

6.8 Chapter summary

This chapter extended upon the findings from the first round of statistical analyses of the survey data (Chapter 5) to provide granular detail around psychologists recommending and referring to CM as part of their clinical practice. The findings presented in this chapter suggest that the widespread psychologist engagement with CM is not superficial, as some psychologists are engaging with CM even when they perceive CM as not scientifically valid. The next chapter will explore how psychologists justify their engagement with CM, even when they describe their knowledge of CM as poor and that referring to CM practitioners is risky.

Chapter 7. PHASE THREE – QUALITATIVE INTERVIEW RESULTS
Justifications for CM engagement

7.1 Preface

The previous two chapters presented the results from the second phase (survey data) of the research, indicating that some psychologists are highly engaged with CM, in some form, in their clinical practice. Further, the complexity of psychologist engagement with CM in their clinical practice (Chapter 6) suggests psychologist engagement with CM is not superficial or limited to psychologists who have sound knowledge of CM. Interestingly the widespread psychologist engagement with CM is in the context of some of the psychologists describing their knowledge of CM as poor and that some psychologists have the perception that CM is not scientifically valid (Chapters 5 and 6). Given these contrasts, it will be important to understand what motivates these psychologists to engage with CM, even when thy have doubts about the validity of CM. The third phase (interviews and qualitative analysis) aims to directly discuss with psychologists in clinical practice how thy justify their engagement with CM, particularly given there are no explicit guidelines relating to CM for psychologists in Australia (Chapter 4). This third phase of the thesis draws upon new empirical data collected via semi-structured interviews with psychologists in clinical practice in Australia. The current and subsequent chapter present the results of the qualitative analysis of interviews with Australian psychologists, which aimed to understand how psychologists, describe their justifications for, and challenges to, the integration of CM within psychology.

The following results are from in-depth qualitative data collected via 19 one-on-one semi-structured interviews with psychologists. The interviews explored the perceptions and experiences of psychologists with regard to CM in their clinical practice and some major themes that were identified from the interview data. A full description of the recruitment, methods and fieldwork employed for this phase of the thesis are outlined in the method section (Section 3.8).

When the overall data from the interviewed psychologists was considered, two overarching themes that exemplified psychologist engagement with CM were identified, *justifications* and *challenges*. To facilitate the exploration and understanding of the qualitative data, these results have been organised around this dual schema of justifications and challenges. The current chapter delves into interviewed psychologist's justifications for engaging with CM in their clinical practice. The subsequent chapter proceeds to examine psychologist's perceived challenges to their engagement, or lack of engagement, with CM in their clinical practice.

7.1 Justifications for CM engagement

One major theme identified from the psychologists' explanations and descriptions in the interviews concerned their outline of *justifications* for engaging with CM in both *their* clinical practice and within the wider clinical practice of psychology as a profession. As this section explores, a varied number of justifications were articulated by the

psychologists, and these have been further grouped around prominent sub-themes for heuristic clarity. The first subtheme, *client-based justifications*, refers to how some psychologists describe and justify their engagement with CM in terms of aligning with client behaviours and benefits, both with reference to direct experience of their clients/clinical population as well as wider societal/cultural trends. The second sub-theme relating to the interviewees' expression of CM engagement justifications focuses upon benefits for themselves as individual psychologists, labelled *psychologist justifications*. A third identified subtheme highlights how some of the psychologists justify their engagement with CM in relation to wider *clinical practice justifications* and related features, processes, and benefits to their clinical practice decision making and behaviours. For example, in relationship to clinical decision-making, treatment selection, planning, and notions of positive client outcomes. The final justification subtheme is orientated around how some psychologists explain their engagement with CM in terms of broader benefits for, and in the context of, the *profession of psychology* highlighting an alignment between psychology and CM philosophy on client care, presenting CM engagement as providing one powerful avenue for ensuring essential innovation for the psychology profession, and maintaining relevance in the face of or in response to wider client-led innovation.

7.1.1 Subtheme 1 Client-based justifications

"I think [it's important] having some basic understanding that complementary therapies…could actually be something that clients might choose to value. And that as psychologists, I'd like to see that we can show respect for that." (Juliette)

A vast majority of the psychologists interviewed described their CM engagement with reference to a range of client-based justifications. As one example of how these justifications were presented, one psychologist explained CM engagement in terms of responding to what they identified as increasing demand for CM from the general population and thus client preferences and demand for CM within clinical practice:

"Well, I think that various forms of complementary medicine, are already widespread in the society, in the belief that they aid in wellbeing, and probably we ignore that, we'll be a bit like sort of heading towards extinction or something if you ignore what's actually happening around you. So I think I think they do have a place. And I think we need to embrace it." (Marie)

Another psychologist explained that consumers are researching CM and will introduce CM into discussion in therapy based on their own research on relevant CM, and thus the psychologist will need to be engaging with CM approaches via client demand:

"*I think [CM] is going to be more, more at the frontline is where it's, it's going to develop more, I think it's going to be more push from consumers for what, what they're interested in and what they're researching and what they're talking about. And then I see it as kind of like a bit of a flow on effect."* (Carla)

The psychologist in the quote below also described client preferences and demand for CM and a (growing) appetite amongst clients of psychologists for the inclusion of CM as part of their overall mental health care.

"It's [CM use is] *client driven. So, the more normalised it is for clients, or more demanded by clients, that also pushes to mainstream and, and forces us as … as … as clinicians to catch up with what the population are demanding."* (Sarah)

In the quote above the psychologist indicates a "push" and "force" upon mainstream psychologists to keep up with demand for CM. Similarly, another psychologist justifies their engagement with client demand for CM as being open and accepting of the needs and wants of specific clients:

"I might have a client who is deeply into spiritualism and different healing modalities. And I might not personally agree with everything, like I personally might not approach my life in the same way. But I'm going to approach this conversation with a great deal of curiosity and explore exploration and acceptance." (Joan)

As this quote above illustrates, the desire to facilitate and respond to client preferences and demand is sometimes expressed by the psychologists as a fundamental drive for considering CM in their practice, even in circumstances where they may not necessarily share the patient's worldview or opinion of the specific CM. It is interesting to note how this, and other quotes, position the psychologist as accepting, curious and to some

degree flexible to client needs – all representations that are identified elsewhere in the analysis of this qualitative interview data. This same psychologist, Joan, also claims that an interest and openness to CM engagement and considerations will also by default be more likely to embrace and support client experiences and evaluations, as a clinical practice guide. She states:

“I think if you're accepting of complementary therapies, within the realm of psychology, you're more likely to be accepting of clients who are wanting to use whatever works for them. And so, you might have a complementary or alternative therapy or something that, you know, they might be hopping on one leg, but if it's therapeutic for them, and I'm open to … Hey, what's therapeutic for you? They're not doing any harm, then I think that the psychologist that embraces different modalities is going to be more embracing of that.” (Joan)

Some psychologists extended this argument further explaining that while client experience and interest in certain CM did not necessarily resonate with their own experiences, the clients' personal experience and perceptions of benefit outweigh any hesitation or negative feelings towards the CM on the part of the psychologist. A good example is an excerpt from one psychologist who elsewhere explains that Reiki and other CM modalities are not necessarily their treatments of choice, or for which they have the strongest faith, but then later explains how clients' past and current experiences of the

benefits of CM nevertheless need to be respected and utilised in their own clinical approach:

"She was telling me that she was doing Reiki. And my posture toward that, at least outwardly, is always like, if it's working for you keep doing it. And if it's not … don't … like … if she believes that it's helping her then who am I to say it's not? And then by all means, keep doing it." (Edith)

And then goes on to explain further:

"I think it's the same thing with you know, religious or spiritual beliefs, I might practice with people who have very different beliefs than I do. But my… I see my job as a psychologist to support them, in their … you know, in whatever their beliefs are, so long as it's not doing them any harm." (Edith)

Another psychologist purports a similar approach to clinical practice based upon an acknowledgement of the power and importance of the clients' experiences and desires. In this case, however, it is also important to note that CM engagement driven by the client's needs does not always have to follow the lead of the client's experience of CM, but can also include the psychologist realising and introducing the idea of specific CM as suitable based upon the more general orientation and desire of the client. As the psychologist Sarah explains:

"So, in my model of therapy, our job is to understand the outcomes desired by the client, and to facilitate them to achieving those outcomes. So, if those outcomes involve improvement of their mental and physical health, or whatever it is, it's going to help them towards that, to have a knowledge base to draw on around CM means that if there is something they haven't explored, I can suggest … Have you explored this yet. So, it gives them other avenues for achieving the outcomes that are meaningful to them." (Sarah)

And Sarah continues:

So, it is a unique position, because we're not pushing our own agenda, as psychologists, but we see the bigger picture for a client's journey in terms of their health and wellbeing. And I think it's a great opportunity for psychologists to get interested and involved in how our clients are getting serviced by other modalities as well." (Sarah)

This last excerpt also provides a clear example of how this psychologist, and many of their peers who participated in the interviews, position their CM engagement as embracing and aligning with their wider position, and role as a supporter of their client's health seeking more generally, and how this is presented as based squarely upon client-interest rather than professional-interest. In the quote above, the psychologist suggests that this 'unique' supporting role implies being open to CM as a possible clinical option, but also in terms of the psychologist being aware of the wider range of treatments and modalities available and potentially utilised by the client, including those well beyond the professional territory of their own psychology practice.

Another psychologist outlines this position in similar terms and also highlights the centrality, as they perceive it, of the psychologist expanding their engagement and general familiarity with regards to the CM field – this expansion of their engagement with CM is seen as one important way to maintain their supportive role based around client experiences and needs:

"I think [it's important] having some basic understanding that complementary therapies…could actually be something that clients might choose to value. And that as psychologists, I'd like to see that we can show respect for that. And maybe also, that we can develop some awareness of what some of those options are and… and listen to our clients tell us what has been beneficial and educate ourselves to understand that." (Juliette)

Another example of client-based justifications is what one psychologist highlights as the importance of interacting with the cultural relevance of some CM. In the example below the psychologist Anne acknowledges that some cultures may view CM as more part of mainstream health care than in Western health care systems:

"You know, that's been, you know, the traditional way, we've seen health care, at least in the West in the last 100 years. And so, you know, I understand that [CM] has been seen as an adjunct, kind of to that, you know, it has actually, as I understand it, you know, traditionally been the mainstream form of health care in many other cultures, and, you know, many other periods of time." (Anne)

In the above quote Anne justifies her acknowledgement of CM in clinical practice as beyond client preference and acknowledges that for some clients their engagement with CM is embedded in a long history of culture and health care traditions. In the quote above Anne justifies her engagement as moving beyond a Westernised approach to psychology to accept client preference in the context of the client's own values and culture. In the quotes above the psychologists appeared to leverage these client-based justifications toward the psychology profession itself. These justifications may be interpreted as an attempt to normalise their own CM engagement as central to good psychology practice, that is client centred. Further, they may be presenting these client-based justifications to alert the psychology profession as to the importance and relevance of engaging with client preferences, including a preference for CM.

7.1.2 Subtheme 2 Psychologist-based justifications

" … to incorporate some of those different techniques or the CM approaches, allows for more flexibility and openness and, and diversiveness away from just those traditional techniques that I don't know, for me feel sometimes a little bit bland, or surface level or Band Aid approach." (Carla)

In the interviews a number of psychologists explained their engagement with CM in terms of what they perceived to be benefits and positive outcomes for them personally. Their experience of CM flowed back to influence their own therapeutic approach, and thus the ways in which they support clients in vivo, which includes CM. The psychologist in the quote below, Carla, reflects on her own positive personal experiences of using CM and how this has enhanced her engagement with clients through the therapeutic relationship and interpersonal transactional processes:

"I think for me, as for my own practice, and my self-care, like it's really, it's, it's enhancing my ability to be present and practice these strategies and gain with my own wellness. And then I think it's got that transactional effect through… through therapy with clients." (Carla)

In the quote above Carla describes her own positive experience of CM as a form of evidence of the potential benefit of CM and thus she may present this to a client as means of demonstrating the efficacy of CM. In the quote below another psychologist, Marion, draws on her personal experience of the efficacy of CM to address her own experience of anxiety, and explains how she uses her personal experience as a form of self-disclosure to encourage clients to implement CM strategies, such as yoga and meditation:

"[CM] works. It supports, it supports the other work that we do and complements it. There you go. And also, because I've experienced what it feels like, down the track when

you implement this stuff in your life, and I remember what I used to be like, and how anxious I used to be. And so, yeah, I just believe I have faith, I suppose." (Marion)

Another psychologist, Gabriel, detailed the skills and value of a CM practitioner who he had direct experience of. The psychologist explains how impressed he had been with the methods and results of the CM practitioner, specifically how the CM practitioner assisted the psychologist with his own processing of emotions. What is interesting about Gabriel's quote below is the acknowledgement of the CM practitioner's expertise in areas that overlap with areas of expertise for mainstream psychologists, such as addressing "underlying emotional issues":

"I have a psychotherapist, who I see every couple of months. Now, the psychotherapist is a neuro-kinesiologist. So, he works with the somatic sense, he works with a body who uses muscle testing. But he's so sensitive, so exquisitely sensitive to pick up a whole series of underlying emotional issues, he's picking up actually schemas without calling them then he's picking up, you know, subconscious patterns, and then bringing them up, we're able to look at them, and we can actually collapse the patterns that are generated in the body that are producing those emotions. I think that's just extraordinarily sensitive work. I know, I'm not the only psychologist who consults him, I know, there are lots of psychologists who go see this guy, because he's so damn good." (Gabriel)

In the quote above, Gabriel further validates his engagement with CM by also explaining how he knows of other psychologists who also engage in personal therapeutic

work with the same CM practitioner. Gabriel presents two justifications, firstly his positive experience of the CM practitioner and secondly the influence of knowing other psychologists are also engaging with the CM practitioner. The influence of professional peers is also noted by another psychologist, in the quote below, who explains her personal use of CM. It is important to note in Carla's quote below that her justification for CM being used is framed, or authenticated, in terms of the CM being delivered by another psychologist:

"*Yes, so so things like yoga. I like doing a lot of mind body work. And I it's interesting, because I've even engaged in my own psychology, where they'll do mind body work and talk about chakras... and from [the therapy is delivered by] an experienced clinical psychologist as well."* (Carla)

The psychologists in the quotes above are justifying not just their own experiential relationship with CM, or the efficacy of some CM, they are also describing the validation and influence of having a psychologist peer who also utilises CM approaches in the context of self-care and mental health care. Although it is not said explicitly, their justifications for their own engagement with CM may be positioned as form of social proof. They use the shared acceptance of CM, with other CM engaged psychologists, as social proof or as leverage to justify their own engagement. In the above quotes Carla and Gabriel's justifications could possibly be directed at their psychologist peers, or the psychology profession. Their justification not only illustrates how they have been influenced, but it may

also be an attempt to persuade or influence psychology and psychologists. Carla and Gabriel's description of other psychologists who also engage with CM validates their own engagement with CM. Further, they may also be attempting to influence the profession's acceptance of CM by framing CM engagement as not just a handful of psychologists on the fringes. It is as if the interviewed psychologists are aiming to provide social proof of the acceptability of CM among psychologists, and therefore within the psychology profession. The influence of psychology peers will be discussed further in the *profession of psychology* subtheme below.

Beyond the personal health benefits psychologists ascribe to CM, they also outline personal career benefits derived from their interactions with CM, which they argue also motivate their CM use as part of their clinical practice. The psychologists describe their interaction with CM, as part of their clinical practice, as energising and providing a sense of satisfaction in their work as a psychologist. One psychologist positions her personal career benefits of engaging with CM in the context of satisfaction in meeting her clients' needs. The psychologist described a sense of satisfaction when her clients reported back that they feel safe to engage with CM as part of therapy, and subsequently this responsiveness to client preference for CM is presented as resulting in increased referrals among like-minded clients:

"So, I personally get really very satisfied, I get more personal satisfaction in my work, because people tell me they feel safe, that they are getting … I'm getting great

recommendations and it's supporting my business, and that I'm actually able to talk to them in a way that no other health professional has about things that matter to them, that's important to them …" (Sarah)

One psychologist, Carla, outlined a similar sentiment, that engaging with client preference for CM creates a dynamism in the therapy room:

"Yeah, it's more, it's more motivating for me. And it's more enriching, in my practice, to be to be open and to be having some of these conversations with my clients and doing these things in, in practice, and drawing on it in practice, as well, even if it's, you know, like yoga poses and doing those in the therapy room, like it's bringing back to me, and it's energizing me in that room, which is … the benefit for that is, it's great for, for me and what I'm doing for my client, and what they gain from that as well." (Carla)

Carla extended her explanation and also described her engagement with CM as juxtaposed with "bland" and "surface level" CBT. Carla explained how she met client demand for approaches beyond just CBT by offering clients choice and diversity in treatment approaches.

"I think my mind goes to like, you know, like, traditional CBT techniques. And this, I think there's so much out there for people to consume and find themselves that they're wanting a little bit more than that in therapy. And I think it allows for … to incorporate some of those different techniques or the CM approaches, allows for more flexibility and

openness and, and diversiveness away from just those traditional techniques that I don't know, for me feel sometimes a little bit bland, or surface level or Band Aid approach." (Carla)

Another psychologist, in the quote below, added that another benefit is when the client's function [physical] improves through engagement with CM and how this makes the psychologist's work easier by allowing the psychologist to focus on the client's psychological issues.

"It benefits me because that then means that if they actually seek some complementary therapy, then when they come back to me, there are some levels of function that are improved, which means then, working on more of the psychological issues, it's easier." (Juliette)

In the quote below, George echoed the justifications of the above psychologists, positing that psychologist engagement with CM in clinical practice had a number of mutual benefits. However, this presentation also placed the psychologist as a resource for clients who had a preference for CM as part of their health care. In particular, the quote below illustrates how psychologists who have CM relevant knowledge may have felt a sense of satisfaction in providing CM relevant information to their clients:

"I love sharing, sharing knowledge. And if I can help someone with that knowledge, there is a certain satisfaction, particularly if it works, if it helps. If they go on, try that and they come back and said, Yep, this is awesome." (George)

The psychologist in the quote below described her sense of joy when she has the flexibility to engage with CM in her practice:

"I feel like a happy therapist, is a good therapist. And it makes me happy to have that flexible approach and works for most of my clients." (Joan)

And Joan expanded on her above statement:

"I have more fun working with clients, when I'm able to say, "Hey, have we considered this" ... and be really flexible. And so that makes me a happier, more balanced human being. And when I'm having fun as a therapist, I think better therapy happens, and that the other person's enjoying it, too." (Joan)

Joan's statement above about "better therapy happens" when she was able to engage with CM is an important extension of the psychologist-based justifications. Joan described global benefit when she engaged with CM in clinical practice to herself, the client's engagement with therapy, as well as benefits to clinical practice and client's therapeutic outcomes.

7.1.3 Subtheme 3 Clinical practice justifications

"… I know some people just get such benefit from that. And I guess my opinion is the more support the better. So, like, I don't really have a problem with people get better from massage and not psychology, that's fine as long as they're better." (Eleanor)

The third subtheme, clinical practice justifications, related to the individual psychologist making clinical decisions about client care that included CM. The vast majority of psychologists described their utilisation of CM as an additional therapeutic tool and their justification related to the flexibility, utility, and efficacy of CM in some form in their clinical practice. These justifications mostly appeared to be directed at the psychology profession, perhaps as a means of addressing any contentions around acceptance of CM in mainstream psychology practice. These contentions will be discussed in the next chapter in the context of challenges to engaging with CM in clinical practice. Some psychologists described their engagement with CM as falling outside of mainstream psychology, however they provided justifications around their engagement with CM in the form of an additional clinical tool. In the quote below Marion exclaimed:

"Who are they [psychology professional associations and regulatory bodies]to say psychology is enough? I don't mean to be snappy, but it seems a little bit arrogant." (Marion)

In the quote below, Sarah in effect extended upon Marion's words suggesting that her justification for engaging with CM is a component of being inclusive of other approaches to mental health care, rather than subscribing to the idea that psychologists have a monopoly on mental health:

"Like, we don't have the monopoly on mental health care…Yeah, look, I think it's, it's easy when you're going through psychological training, through your undergrad and into your post grad, to think that psychologists have a monopoly on mental health and this this kind of psychological intervention." (Sarah)

The quote illustrated a focus suggested by a number of the psychologists, that there was not only contention, but also risk associated with engaging with CM. The risks associated with psychologist engagement with CM will be discussed in detail in the next chapter.

For clarity here, one type of risk associated with psychologists engaging with CM in their clinical practice might be in terms of clients. There are risks if clients utilise some CM without relevant information from a CM informed clinician, such as their psychologist. There are also risks to the client of potential drug interactions with some forms of CM. There may also be risks associated with power imbalances if a clinician is recommending CM that are expensive, or where the clinician profits from the client's use of some CM.

In the quote below Genevieve referred to risks to her professional registration. Many of the interviewed psychologists described feeling at risk of a punitive response from psychology's professional associations, regulatory bodies, and psychologist peers who may not have approved of psychologist engagement with CM. A psychologist who engaged with CM in their practice may be considered to be in breach of psychology's ethical and clinical practice guidelines. Previous research also describes a lack of clarity on whether some, or none, of the CM approaches would be considered to be acceptable within conventional psychology practice. An issue which will be discussed in the next chapter. Here, Genevieve, like many of the other interviewed psychologists, acknowledged these risks, however they justified their engagement with CM in the context of perceived clinical benefit. Genevieve explained,

"I know it's a risk to suggest to people to utilise these things, I take that risk openly." (Genevieve)

Psychologists also described a rejection of the standardised approach to psychological therapies they provide, preferring to have a more flexible and diverse approach. In the quote below, which illustrated a viewpoint intimated by a number of the psychologists, Gabriel describes his rejection of narrow adherence to conventional mainstream psychology approaches and practice. Here Gabriel described psychology in clinical practice can be overly focused and narrow.

"I would say that we need to be more integrative in terms of other complementaries, and that we need to bring those into our practice, that we… we can't be so single focused and fixated on the tools of our trade that were not able to understand and incorporate other approaches." (Gabriel)

In the quote above Gabriel described his utilisation of CM as a broad and flexible alternative to psychology's narrow conventional approach to clinical practice. Gabriel, and some of the other interviewed psychologists, suggested their justification of CM engagement was being part of a more integrative approach, which is interesting as it suggested a less conspicuous means of including CM. The interviewed psychologist's justification of a more integrative approach may be directed to the broader psychology profession, and beyond, in the face of any criticism about including CM. In another example, Joan also described her rejection of the psychology profession being overly focussed, in this instance, on cognitive behavioural therapy (CBT).

"I think the vast majority of psychologists are sitting in windowless rooms, that are the size of a pocket handkerchief, that have two chairs, and a table with a coffee table with a bunch of flowers, and the tissue box, and are sticking very, very closely to your standard CBT model. And then when someone, a client walks in the door, who doesn't fit that, or isn't responding as they should, oftentimes, that psychologist in that model is at a bit of a loss as to where to go, because the client is not fitting with their model of how psychology should look." (Joan)

Adding to her previous comment, Joan continued to describe the perceived limitations of what she terms a 'manualised approach' and how in contrast she prefers an ability to select from a broad range of practice tools that include CM.

"So, I guess the advantage I see of complementary therapies is it provides a broad number of tools, and types of tools to support wellbeing and our clients. And I would hate to be sitting in a manualised approach, when something outside of that manual is going to be what is going to support that client at the end of the day." (Joan)

In the above quote Joan positioned her rejection of a standardised view of psychological therapies in clinical practice as important to achieving client-centred care and being responsive to client preferences, values, and characteristics, by being able to draw on other approaches, such as CM. What is interesting in the quotes above is how the psychologists project notions of flexibility and their accommodation of a wide range of practices, technologies, and approaches as essential to what they see as good psychology. In relation to this broader vision, many of the psychologists also described their utilisation of CM as justified in terms of filling or addressing what they may identified as gaps in the psychological services as part of their clinical practice. Extending upon this flexibility, in the below example, the psychologist described the importance of the flexibility of being able to draw upon knowledge and/or skills in CM as a tool that helped to address any shortfalls in the psychological therapies she is able to offer.

"… and I also think when you're working with clients, and you get stuck, you know, what am I going to do with you … doing what you know, and what you believe in, but it's not enough. And then you start looking for what else could I do? So, whether that … what else is … somatic psychotherapy, or the what else is … naturopathy." (Audrey)

The vast majority of psychologists described the utilisation of CM as an additional therapeutic tool that provides them with diversity and flexibility in their clinical practice.

"It's another tool in your toolkit, basically, you don't take out every tool for every person." (Audrey)

In the quote above, it is also worth noting that Audrey explained that not every tool necessarily fits with every client, indeed this understanding can be seen in part to further strengthen the justification for CM to be included in psychology practice – if a different specific mix of tools or practices is required for each client, then best to have as wide a range of such tools or practices at your disposal. Following on from this, while the psychologists explained the added flexibility of introducing CM as a clinical tool, they remain selective as to whether to use it and use their clinical expertise to establish whether CM is relevant to client needs and preferences on a case-by-case basis. As George explains,

"I wouldn't like to see CM come in as a blanket approach. But more again, to have to be discerning as to, okay, what's needed in this particular person for this particular time for this client." (George)

In the quote above George’s description of CM gave a notion of flexibility and a judicious approach to treatment selection, that included CM while not being wedded to CM. Helene also described being selective about CM.

“I do have quite a broad notion of what complementary medicines or therapies would include. However, that doesn't mean that I would necessarily use or recommend all of those.” (Helene)

The interviewed psychologists described the ways in which the relevance, risk (as described above) and evidence for CM are all part of their considerations and they often explicitly reject an uncritical acceptance of *all* CM. For example, Marie below justified her engagement with CM as a ‘clinical judgment’ regarding the possible health risks and health benefits of CM for a client:

“I think I would be making a clinical judgment that they would do no harm and might possibly do some good.” (Marie)

In the quote above Marie moderated any risks associated with CM use for clients as filtered through her own clinical judgment of CM. A number of the psychologists described this level of discernment and a critical approach to the use of CM approaches in their clinical practice. For example, they highlighted the importance of examining the evidence for relevant CM and the applicability of a specific CM to match their client’s needs, Genevieve explained:

"My interest is in the aid of the client's welfare and not in a fixation I have around, you know, the usefulness of CM. And I, so, I tried to always hold the suggestion and the formulation are very clearly linked with, you know, how I am looking to treat the circumstances of which they've come from… Yeah, I mean, it feels to me that I'm looking at the individual and thinking what … what do they need to know? So, it's like a, you know, what, what does this person need? How? How can in my formulation of where they're at? What is the most valuable thing I can offer them? In my knowledge, and, and I find often, at some point, it will emerge, there will be a reason to introduce a complementary therapy." (Genevieve)

Gabriel also described his discernment around the utilisation of CM and justified any CM selection in his clinical practice as drawing on psychology's "scientist-practitioner model", where he selects CM as part of an evidence-based approach.

"Well, I'd say that just as we would base our practice on evidence, and that we're trained in the sort of scientist-practitioner model, that we bring the evidence to bear, and we apply that to the practice. So, there's a creativity to it, but there's also an evidence base to it, then there is a very strong and deep evidence-based practice of nutritional therapies of herbal medicine." (Gabriel)

In the quote above Gabriel utilised his scientific training (from psychology tertiary education) to assess evidence for CM. In applying this scientific knowledge to CM, Gabriel is justifying the strengths his psychology training brings to his discernment and

engagement with CM. Charles also described a considered approach to recommending CM, specifically psychotropic herbs, and that he would not make such recommendations to clients lightly.

"… if someone had depression, I wouldn't say to them, Look, why don't you try St. John's wort? And leave it at that. I wouldn't, I'd never do something like that. Because I know the consequences could come back on me and it could hurt. You know, there may be some side effects of that medication. So, I wouldn't … I'd never throw one liners out to them." (Charles)

In both quotes above Gabriel and Charles's reasoning is interesting as they positioned their considered and discerning approach to CM as a justification for the integration of CM. These kinds of arguments may well do work for them, and other psychologists who engage with CM, on a number of fronts. For example, this kind of reasoning presents a justification for where CM might sit within psychology (if at all), as well as projecting why its rigorous practice for some psychologists to engage with CM as part of their clinical practice. There is a suggestion that psychologists are well positioned to engage with CM in the context of the provision of mental health care, given their training in evaluating the evidence for approaches. The above quotes also provide a justification that situates the psychologist in a unique position, because of their specialised training and clinical skills, assist them to evaluate the evidence and clinical utility of CM for the client. The psychologists described their clinical reasoning and mental health expertise as an

advantage which may set them apart from CM (only) practitioners, who are exclusively CM focussed. Further, the psychologists explained that they are not fixated or wedded to CM as a singular approach to mental health care, which is also an advantage over a CM practitioner.

In the quote below Gabriel also described a balanced view of utilising CM where he exercises caution in the context of potential herb interactions, and this is again justified through his expertise as a psychologist and being able discern any potential contraindications.

"I don't want to do any more harm to the patient by recommending a herb or a substance that I think would be benefit that turns out to be contraindicated for some reason that I'm not aware of that that's the concern." (Gabriel)

In the quote above Gabriel presented a balanced and critical approach to clinical decision making around the utility of CM for clients. In the quote below Simone also described tailoring CM recommendations to individual clients while considering the evidence. Of note, these justifications of CM that include discernment about efficacy, type and suitability of CM continue to align with a client-centred and evidence-based approach that fits with mainstream psychological practice.

"So, we've got to fit in with, with what that particular person needs. And based on evidence, because I'm still think that we need to go according to what the evidence tells us,

you know, not any, any old airy, you know, airy fairy type of therapy that hasn't got any … any, you know, any evidence there." (Simone)

In the below quote Catherine described being selective and discerning about the types, and the professionalism, of the CM practitioners that she refers clients to.

"I'm not prepared to put my name to referring somebody to somebody unless I feel very, very comfortable with what they're practicing and who they are." (Catherine)

In the quotes above the psychologists portrayed themselves as potential gate keepers of their clients CM engagement. The psychologists utilise their skills to assess the risks associated with CM on behalf of the client. For example, in the quote below Sarah utilised her knowledge of CM to assist clients traverse the risk and benefits of CM. Sarah described how she would encourage clients to also take a balanced and critical view of the utilisation of CM.

"What benefits are you getting from that? What side effects are you experiencing from that, we actually get to have a more full, rounded, holistic approach that also includes, you know, is this actually meeting their desired outcomes and needs? Or is that potentially something they're not seeing there, because they don't have the education or the knowledge to be able to look at things from that critical perspective. So, I think it's also about helping mitigate risks, or any detriment that could also be caused or if something is

ineffective to be able to pick up on that and to suggest there may be another option available to you to achieve your outcome." (Sarah)

The vast majority of psychologists describe CM as an additional tool they draw upon as part of their therapeutic repertoire. However, they are discerning about CM and consider the risks, benefits, evidence, and relevance of the CM they recommend and refer to. In the above quotes these justifications could be used to assist clients to understand the role CM may have in their mental health care. However, these psychologists may also be positioning these justifications toward psychology's professional associations and regulatory bodies to address contestations that psychologists who engage with CM may be biased in favour of CM. The quotes above illustrate a more nuanced and considered view of the role of CM as an additional clinical tool within their psychology practice.

Many of the interviewed psychologists described their CM engagement, not just as an additional tool, but also as providing them with a more robust and diverse 'tool kit'. The addition of CM as a tool was justified in the context of the provision of a broad holistic and integrative approach, including specific ways CM is utilised in clinical practice, such as how they assess client need. For example, in the quote below Carla described using the client's own preference for CM as strength to draw upon.

"But I think meeting the clients and what their, their needs are as well. So really honouring where, where their strengths are, what they draw on, whether it's like, CM, you know, spirituality, faith, all of those things. So, yeah, I think for me, the most important is

the connection with the clients and, and relating to them in a way that connects or resonates for them." (Carla)

In the quote above Carla's knowledge and acceptance of CM is utilised for validation and rapport building. In the quote below, Sarah described drawing on client strengths, including a preference for CM, allows her to provide personalised care that assists client adherence to treatment and potentially improve client outcomes.

"And so, with that, care to understand and explore those topics with them, we're able to then more likely get better outcomes and greater adherence, because we're tapping into the things that do genuinely interest, motivate them and so on." (Sarah)

In the quotes above the psychologists presented their justification in the form of mitigating risks and assessing the efficacy of CM for their clients, with the downstream effect of improving clinical outcomes. In the quote below, Joan explained matching individual client need, proposed benefit, and the efficacy of certain CM, as part of a progressive client centred approach.

"Like, we want to find out what is going to benefit our clients, what's going to benefit the individual that's walked in the door and share that with them. And the more that we explore and find things that like, oh, look, here's a tool that we didn't know about last week that actually has a, you know, 45% efficacy. Let's add that to our toolbox." (Joan)

In the above quotes the psychologists framed CM in the context of evidence-based practice where the client's preferences, including CM, are acknowledged. This argument is important as it framed these justifications within the central tenet of psychology practice, which is that clinical practice is evidence-based practice. Evidence-based practice is tripartite model that incorporates best available evidence, clinical expertise, and the clients' values and preferences. In the following quotes the psychologists explained their engagement with CM as if CM is now inextricable and indeed complementary to their psychology practice. Helene described CM as adding an additional "lens" to how she assesses client need. The justification is positioned as CM enhancing the breadth of the psychologist's assessment skills.

"It's about pieces of the jigsaw in that sense, you know, so I'm not just looking at one aspect of, or I'm not just standing looking at this client with one perspective, you know, or, you know, through one set of lens, I can move around, climb, go, oh, okay, there's this bit. And then there's this bit." (Helene)

In the quote above Helene described CM as adding a different perspective and a flexibility, beyond psychological therapy tools, to view client's presenting problems through a different "lens" with which she can explore and assess client needs. In the quote below George described being able to move across both psychology and CM skills.

"So, flexibility for me would be to, as I said earlier, to really listen to the client, and then really assess their need, and then be flexible. What's the best here and try something

and if it doesn't work, then be flexible to try something else. And something else until something works." (George)

In the above quote George described having knowledge and or skills in a CM approach means he has more latitude and flexibility in clinical practice. This notion of flexibility and judicious use of CM may be a persuasive argument to advocate for CM engagement to psychologists who are looking for something, an additional clinical tool, which adds to their existing psychology tool kit. In the above quotes Helene and George appear to be relieved that CM was an additional tool available to them in clinical practice. In the quote below Sarah added that the combination of a psychologist's education and the flexibility provided by CM, allows her to provide a holistic client-centred treatment approach. In the below quote, Sarah explained that a client centred approach, which included CM, can also empower clients. The justifications in this context appear to again arise from psychologist perceptions of evidence-based psychology practice principles which draw on client preferences and values, which is considered standard practice in psychology.

So, if we look at patient or person-centred therapy, or medicine, as a way of honouring and empowering the individual, and their preferences and values and interests and beliefs into the space, then we are creating a personalised approach... So, I think that when we are doing a person-centred approach, and we're asking about these things, we're empowering that person to also feel safe in that space." (Sarah)

Sarah expanded on her above quote by adding that psychologists' education, paired with CM tools, puts psychologists in a position to be able to make recommendations about holistic interventions.

"And so, I think we're, we're educated enough, but also we don't have ... we're not too boxed into one way of being or one particular focus, that we can look at the person holistically, and holistic interventions should include CM." (Sarah)

In the quote above Sarah captured the sentiment of many of the interviewed psychologists. Sarah suggested psychologists are in a unique position to offer CM to their clients, and that the practice of psychology provides a flexibility to draw on other approaches, such as CM. Sarah positioned her justification as being client led and client centred. Sarah may also be describing a rejection of narrow, or manualised psychology approaches employed by mainstream psychology, and describing a preference for a more flexible approach to psychology practice. Josephine, below, echoed Sarah's words, agreeing that utilising client preference for CM and directing clients to engage with their interest in CM is empowering for clients. However, Josephine added the caveat that she extends her own discernment about CM approaches, and she encourages clients to assess the suitability of CM.

"The function of that [encouraging clients to research CM] for me is that I just feel that…I'm trying to empower people a little bit, you know? To sort of take some

*responsibility for their own health, and not just blindly take things that are suggested.” (*Josephine)

In some ways the quotes above may be a way of empowering and informing clients to be selective about their health care, including CM. The psychologists described how they justify and clarify the potential role of CM in the client’s health care. However, in the quote below, Sarah extended upon these justifications, and we see how the psychologist may be viewed as a gatekeeper or case manager that assists the client to navigate CM. Sarah added that psychologists are in a position of trust and can be the conduit for clients wishing to engage with CM.

“But I feel that because we are trusted for people to talk through their challenges in their journeys with their health, as well as their mental health, that we do have the opportunity to understand more deeply people's health beliefs, their health behaviours, their values, the… previous experiences they've had both good and bad with health professionals, and how that changes and guides the decisions and actions that they take.” (Sarah)

In the quote above Sarah described that psychologists are trusted health advisors and as such they are potentially persuasive and influential in how CM is utilised in the context of mental health care. In the below quote Charles reiterated the role of psychologist as the balanced and critical guide for clients navigating CM and any associated risks.

"I could help them in some way, in some, in some in some way to engage with or to continue on their search in that area [CM]. I may be able to help them. I would occasionally perhaps give some of my experience [of CM], but I would be ... in saying all this... I would be I would be cautious." (Charles)

Several psychologists expanded on the ways in which their engagement with CM is used as a therapeutic tool encouraging the utilisation of client's preference for CM as activating the client's agency to explore wellbeing approaches that include CM. Genevieve likened this guidance to being a street sign that points clients towards self-care approaches that empower clients and give them a sense of agency.

"And so in this space of inquiry, and in looking for transformation, when somebody is willing to take an experiment, that is a big leap, and that is owned by their courage, and I really only want to have the, you know, the fact that I was a street sign pointing in the direction, I don't want to be more than that, because I want their their… their… their journey of therapy to bring them into their own agency of how to manage their wellness for the rest of their life, not dependent on coming to see me." (Genevieve)

In the quote above Genevieve described herself as providing direction to clients and ways in which the client can develop self-care skills. In some ways Genevieve described creating distance from her potential influence over the client's choice to engage with CM. Instead, Genevieve positioned CM as just a tool, which may be used with such benefits that include client empowerment, highlighting client strengths, and mobilising clients to use

their existing resources, including CM. Many of the psychologists claimed that an acknowledgement and acceptance of client CM use can often lead to other benefits, primarily for the client, but also ultimately in service to good effective clinical practice.

In several of the quotes above the psychologist's view of CM appeared to align with psychology as a profession. The psychologists described their perceptions of similarities between psychology and CM in terms of shared philosophies, principles, and practices. For example, Helene described the "nexus" between emotional and physical health.

"Because for me, it's that really nice nexus of where the mental, the emotional, the behavioural meets the physical and the physiological, let's say, you know, because complementary medicines are usually … the main focus might be on the physical and the physiological, but they also take in some of that mental and emotional." (Helene)

Beyond clinical practice justifications, where CM in some form is used a as a tool, some psychologists justified their interaction with CM in their clinical practice as part of their core responsibility as a health professional and part of providing good mental health care. In the quote below Edith described that those psychologists who are trained in evidence-based approaches, including CM, have an obligation to provide at least information to clients on those healing modalities where relevant.

I think is so long as… as you're trained in the provision of a specific service. There's … and again, supported by research. I don't … I almost feel like it's an obligation to provide it if you think it's going to help the person in front of you." (Edith)

The quote above is important as it moved beyond the grit of the argument for CM as a specific tool in clinical practice toward the responsibilities of psychologists/psychology as part of broader health care obligations. Indeed, the World Health Organisation (WHO) encourages member states to support the integration of CM into health care settings and improve client access to equitable health care. In the quote below Sarah described a similar sentiment that psychologists have a responsibility to have sound general knowledge of all the ways in which a client can improve their mental health and well-being.

"Look, I, I probably would start with something less exciting, which is that I think it's actually our responsibility as clinicians to have a broad knowledge of all the different ways that people can improve their health and well-being and understanding the preferences of the general population." (Sarah)

In the quote above Sarah, linked the responsibility with wider consumer demand for CM approaches as part of their mental health care. Sarah's quote echoed the talk from many of the interviewed psychologists, which appeared to be aimed directly at the psychology profession, as it positioned and justified their engagement with CM as part of client centred, informed and responsible health care.

In the quote below Helene justified her engagement with CM practitioners, as a means of addressing gaps in what she can offer to her clients as a psychologist. In the quote below Helene acknowledged shortfalls in what she can address as a psychologist and highlighted how she values referral to CM practitioners, as a concurrent treatment option, to address the client's somatic complaints.

"I've worked with anxiety for years, but I can't imagine the, you know, the best results are the people who are willing to go in and start to explore yoga, and then work with that self-regulation and meditation and come back and work on their schemas and the things that they now have more access to, because they can listen to themselves. I couldn't have taught them in the office in their extreme anxiety, how to listen to themselves in the same way. There's just no way." (Helene)

Genevieve concurred with Helene's justification and described psychologists as conduits of CM approaches for their clients. Genevieve said it is a psychologist's responsibility to apprise a client of all the available treatment options, including CM, where relevant and allowing the client to choose.

"And I also feel like I have the I have the responsibility to offer them the options of the best kind of healing I can… I can think about for them. And if that is something they want to take up and take the experience, the expense and the risk or whatever it is and take that on their own. Then, you know, maybe it builds efficacy in that way, but I have to feel comfortable." (Genevieve)

The quotes above may also be justifications aimed at the psychology profession, to encourage consideration of these arguments beyond the boundaries of the psychology profession and the potential importance of CM engagement to the profession as whole (which will be discussed in the next section). Many of the psychologists explained their engagement with CM with direct reference to the potential of these therapies and modalities to improve therapeutic outcomes for their clients. These justifications included descriptions of perceived benefits for clients, which contributed to positive therapy outcomes, when CM was included in the client's care. In the quote below, Sarah justifies her engagement with CM practitioners as part of communicating and collaborating with modalities relevant to the client. This is also justified and positioned as resistance to an observation that psychology as profession may be too "internally focused".

"And like a lot of well, I guess, a lot, not just psychology, I think there's probably a lot of disciplines that are guilty of being internally focused, and not doing enough integration across disciplines and modalities for broader communication, collaboration and awareness raising." (Sarah)

In the quote below we return to Genevieve's talk of risk in the context of prioritising client benefit. Here Genevieve added that there may be risks associated with engaging with CM, and that the risk feels like resistance to mainstream psychology. However, Genevieve said she believes so strongly in prioritising client need, and if the client's need can be met by the services a CM practitioner offers, she is willing to take the

risk. The risk Genevieve described here is related to concern about a punitive response, from psychology's professional associations and regulatory bodies, for engaging with CM.

"I have understood it as a psychologist as being somewhat risky to recommend these kinds of therapies in a traditional sense, and part of many different supervision groups and most, many of my colleagues will not do… so I believe in it so strongly that I can completely disagree with that, but it to me, you know, the practitioner themselves is probably the strongest reason I make the referral, because of having a sense of confidence in what they can offer." (Genevieve)

Genevieve's quote above is important as she directly described having a strong belief in her engagement with CM that she is willing to disagree with her psychologist colleagues. Genevieve described an extension of the discernment of CM approaches discussed earlier in this chapter. Here this discernment was regarding a CM modality and the CM practitioner providing the direct application of that CM modality. It was as if Genevieve was trying to single handedly use her conviction and confidence in specific CM practitioners to be persuasive of the value of CM for psychology.

A number of the interviewed psychologists justified their engagement with CM practitioners as part of interdisciplinary/interprofessional communication. Psychologists discussed the value for both clients and themselves (as treating practitioner) when CM practitioners are included as part of interdisciplinary collaboration around the client's care. Interdisciplinary communication and interprofessional relationships are considered a core

competency, essential psychologist skills, and are taught as part of the psychology curriculum (Australian Psychology Accreditation Council, 2019, 2023).

In the quote below Eleanor described an experience that changed how she perceived the value of CM practitioners' contribution to client care.

"*I guess, before that, I was sort of like, okay, you can go see crystal healer, but I don't. I don't find that very scientific, I suppose. And I hope that doesn't kind of, in my head, this is what I was thinking, I hope that doesn't interfere with our therapy. But then, that was all inside my head. I kind of kept it all to myself. But then over time, over the months that she was seeing all three of us, it just we just kept saying the same things. So, I guess it was a revelation that I shouldn't be too judgmental."* (Eleanor)

Elanor's statement is significant as it highlighted reasons why she, and other interviewed psychologists, engage with CM despite her personal reservations about its validity. She emphasised the impact of a single experience on her perception of CM's potential benefits. Eleanors justification, like those above, placed the client and their preference for CM at the forefront. Eleanor expanded on her change of opinion and her reflection on the potential benefits of CM in the below quote.

"And then I guess probably more the alternative … alternative therapies like massage and acupuncture… to see … I know some people just get such benefit from that. And I guess my opinion is the more support the better. So, like, I don't really have a

problem with people get better from massage and not psychology, that's fine as long as they're better." (Eleanor)

What was interesting about Eleanor's quote is that she relinquished ownership over her client's recovery and placed importance on supporting and acknowledging the client's preference for CM. Eleanor also justified her change of opinion about CM in the context of incorporating feedback from client's engagement with CM. Eleanor also demonstrated willingness to be open to the potential benefit of CM, which was expressed by a number of the interviewed psychologists. An intriguing aspect of Eleanor's excerpt was her portrayal of a distinct separation, or even an explicit boundary, where client outcomes are attributed to either psychology or CM. Eleanor stated she is willing to relinquish that psychology alone may not have led to the positive outcome for the client. While Eleanor created a separation between psychology and CM, other psychologists described their engagement with CM practitioners as being part of an integrative and collaborative approach. Simone justified her inclusion of CM practitioners, as being part of establishing a collaborative health care team.

"And also, it's good practice to have a team around you. So yeah, I mean, I think that they, they can you know, that, that that indeed, that complementary medicine kind of covers that as well." (Simone)

In line with other quotes that quietly justified the inclusion of CM as part of client centred care, here Simone described the inclusion of CM as good psychology practice. In

the quote above Simone's inclusion of CM practitioners, is framed as part of good psychology practice and shared care, rather than about separation or professional territory. In the quote below, Charlotte also justified her engagement with CM practitioners as part of good psychology practice.

"I do find it to be a good fit, I find for someone to really be able to feel better and have improved wellbeing and to reduce mental health issues and to improve relationships, etc. The broader support such as complementary therapies can give is a very big factor in their … their recovery or their improved health." (Charlotte)

In the above quote Charlotte described CM as fitting well with psychology and collaborating with CM practitioners had a positive impact on clients through shared goals to improve health for their mutual clients. A number of the interviewed psychologists acknowledged the expertise of some CM practitioners, and the value of collaborating, and highlighting that collaboration provided mutual benefits for both practitioners as well as a holistic approach for their shared clients.

"Yeah, so I would say psychologists have got a better understanding of the mind aspect. Naturopaths have a better understanding of the body and biochemistry and those sorts of things. And together it would blend better to get a whole picture." (George)

In the above quote George also highlighted how CM and psychology work well together for client benefit.

Similar to talk above where the psychologists described being discerning and selective about CM approaches, Genevieve, below, described being selective about CM practitioners. Genevieve described the intention of selecting “masterful” CM practitioners, rather than dabbling in these CM approaches herself.

“I basically put it to them to explore. But when people practice regularly, something like acupuncture like you really … it's it’s an art form. It's you know … If you really … you need to be a master to be as valuable as I want that for my client. I want masterful CMs for my clients, I don't want to be … no matter how masterful I might think I am in whatever it might be … if it's not what I'm practicing all the time, then I can't be as masterful as the thing that I do practice all the time.” (Genevieve)

In the quote below Sarah extended upon the above justification that engaging with CM is part of good psychology. Sarah described herself as having a more “expanded” view of mental health care. However, Sarah also described there may be professional risks and she may be considered on the “edge” for having this “expanded view”.

“Yes, it does feel like I'm on the edge as a Ahpra registered health professional. There is scrutiny and there are certain things that we need to do inside the box to meet our legal obligations. And that that is something I've always grappled with. Because what I consider best practice maybe more expanded than the version that is part of these licensing considerations.” (Sarah)

In the quote above Sarah signalled her engagement with CM in her clinical practice is also justified as part of innovation of what is currently considered conventional and mainstream practice in psychology. Several of the interviewed psychologists saw themselves as grass-roots innovators. For example, in the quote below Helene talked about her engagement with CM as part of pushing at the edge of what is known in psychology practice.

"However, if we only ever go with what's already known, and we don't budge the edge, we're not going to develop a new evidence base for anything." (Helene)

Helene and Sarah's except above introduced a justification for CM based on bringing innovation into clinical practice. Helene and Sarah may be aiming this justification at other psychologists and the psychology profession who may be critical of their engagement with CM. Juliette also described her engagement with CM as part of innovation in her clinical practice and a rejection of conventional mainstream, and potentially narrow, evidence-based approaches in psychology.

"And the problem is, if we're just waiting for the evidence base, then there's never innovation. There's, there's never a way that's new or forward, we'd be still looking at the wheel and thinking, well, we can only make a wheel because our evidence shows us, we have made a wheel, not working out how can we apply this?" (Juliette)

Similar to the excerpts above, where psychologists described professional risks associated with engaging with CM, Anne added that her engagement with CM felt like being part of a resistance movement.

"But I, I just want to say that yeah, it was like being part of a resistance movement being around for a long time, I did not say that I work this way." (Anne)

Anne extended her idea of being part of a resistance movement to describe feeling as though she was in the wake of a potential era of innovation. Anne described engaging with CM in clinical practice as one way for psychologists, and psychology, to remain relevant. Further, her engagement with CM is positioned as fulfilling the need for flexibility across diverse therapeutic approaches, that include CM. Anne described her, and other psychologists, engagement with CM as necessary for psychology to be responsive to emerging health care challenges.

"We become better able to respond to the, you know, emerging challenges of our time, you know, we have the symptom profiles, and so on that present these days, you know, kind of quite different even to 20 years ago, and what turns up in our practices, and from my point of view, the more tools you've got in your toolbox that you know how to use the better practitioner you're going to be, and you know, if all you've got is a hammer, everything looks like a nail, right?" (Anne)

In the above quote Anne moved psychologist engagement with CM beyond client benefit, beyond psychologist and clinical practices justifications, and toward benefits for psychology as a profession. Justifications in the context of the profession of psychology are discussed below.

7.1.4 Subtheme 4 Profession of psychology justifications

" *… but a few people push the boundary and create some evidence and then everybody goes oh, we can use it. Now there's an evidence base. But at the time when you're pushing a boundary, boy oh, boy, you can be the witch in town*." (Helene)

Many of the psychologists justified their engagement with CM as having benefits for the broader psychology profession. The psychologists expressed their engagement with CM as being part of innovation for the field. Some of the psychologists situated this innovation as a response to concern that psychology's relevance was at risk if it does not broaden and diversify its response to mental health care, including engaging with diverse approaches, such as CM. The interviewed psychologists described their interpretations of approval of CM within clinical practice as coming from adjacent health fields/health fields acceptance of CM, as well as their professional psychology peers, and their psychology supervisors expressing interest and support of their engagement with CM. The interviewed

psychologists explained this sense of approval provides justification for their engaging with CM as part of their clinical practice. For example, some of the interviewed psychologists used instances of therapeutic approaches, previously considered fringe, gaining approval and acceptance within mainstream mental health care and psychology. A number of the interviewed psychologists offered Eye Movement Desensitization and Reprocessing (EMDR) as an example of CM being integrated into mainstream psychology practice. Helene explains,

"Classic example of this, I think, is using EMDR. Okay, we go back 10 or 15 years, and the Australian Psychological Society and various other psychological bodies and institutions did not recognise EMDR. And in fact, thought field or emotion focused therapy, that kind of thing. It was just like you were riding your broomstick in. And whereas now they're on the list." (Helene)

Catherine also drew on another example of the use of nutrition, as part of an emerging phenomena of nutritional psychiatry to improve mental health, as having increasing acceptance in mainstream psychology.

"What has happened over the years is that a number of things that were in the camp of complementary medicine – like nutritional medicine, for instance – have become incorporated into mainstream practice, but that's been a pretty slow process." (Catherine)

In another example, Edith described her engagement with yoga and meditation as justified through her perception of these approaches having increasing acceptance from mainstream psychology. Similar to other psychologists, Edith also described being discerning of CM, and being willing to integrate CM approaches, providing there is sufficient training and evidence.

"So, I know, there's a lot of evidence, for example, yoga, meditation used to be more fringe, it's very much mainstreamed in psychology now. So, I guess that's my main thing I would be willing to incorporate provided that will that I were well trained in it, I'd be willing to incorporate anything into my practice that's got some solid research evidence behind it." (Edith)

In the above examples, the psychologist's awareness of a fringe practice now becoming accepted within psychology appears to be used as leverage to justify CM within psychology practice. However, the leveraging of increasing acceptance may not only be acceptance from psychology in Australia. These arguments are also interesting as the psychologists' positioned the acceptance of CM as coming from other health care professions, and mental health care organisations, that are not specifically related to psychologists and psychology practice, nor necessarily in Australia. In the quote below Charlotte, while discerning about the evidence for CM, also described the impression that what psychology finds "acceptable" is always broadening. She went on to give an example of a mental health organisation including CM in their professional development materials.

"I think it just would say only anything that is research based and considered acceptable by psychology… But then that's broadening all the time because then I read things from say, The Black Dog Institute, the organisation are talking about nutrition and sunshine and you know, omega 3 and so I'm saying it's a bigger field." (Charlotte)

In the above examples psychologists justified their engagement with CM based on various resources that indicate increasing acceptance of CM. Several of the interviewed psychologists also described other adjacent health field's approval of CM as a signal of approval for psychology and psychologists. For example, Carla explained,

" … like other … other modalities and incorporating things into treatment, whether it is things like acupuncture, whether it's things like yoga all over, that's getting a bit more of a movement based and it's becoming more accepted." (Carla)

These arguments were interesting as they described a convergence between other health professions and psychology. Although not explicit, the psychologists used the convergence of mental health care approaches to justify the importance of psychology's engagement with CM.

For some of the psychologists this perception of increasing acceptance of CM was a welcome relief from past feelings of being fearful about engaging with CM. For example, Carla acknowledged a previous time when there was fear of getting in trouble for engaging with CM.

"I feel … I feel less threatened about talking about the … the different techniques and approaches that I'm interweaving into therapy now than what I did 12 months ago. Because I don't fear as much judgment or punishment, or you're gonna get in trouble for these things. Because it is becoming, I think, more accepted, like a fear is … is subsiding a little." (Carla)

In the quote below Helene also described professional risk, initially feeling like the "witch in town" until she felt there was more acceptance of CM within psychology.

"Now once upon a time everybody would have gone oh my god, no, we can't do that. You know, but a few people push the boundary and create some evidence and then everybody goes oh, we can use it. Now there's an evidence base. But at the time when you're pushing a boundary, boy oh, boy, you can be the witch in town." (Helene)

Here Carla presented her professional peers as appearing to be more embracing of CM and that she has found a professional peer network that shared her interest in CM and are supportive of CM within psychology.

"But the more that I've delved into it, and opened up my networking to other areas, and following different things, I'm seeing that it's been more widely accepted. So, it's, it's shifted, it's changed a little bit for me over the past, say, 12 months." (Carla)

In the above quote Carla described being drawn to like-minded professional peers. Carla also appeared to leverage this mutual interest as a signal of increasing acceptance of

CM among her psychology peers. This was also noted earlier in the results section with examples of social proof where psychologists' engagement with CM was influenced by finding other psychologists peers who engage or endorse psychologist engagement with CM. Many of the interviewed psychologists caveat this peer influence with their discernment of CM. While they appeared buoyed by increasing acceptance of CM, they explained that they drew on evidence-based practice principles, such as reviewing the evidence for the CM approach, and using their clinical judgment to assess the suitability of CM and client preference for CM. For example, Eleanor described a sense of approval of CM as coming from her professional peers, particularly when these professional peers also discussed CM as having a clinical benefit for clients.

"It's more been colleagues or other people in the profession, either having a client who's tried this or trying something with a client or referring them for something, and it's had a good outcome. Yeah, I'd say it's more colleague driven." (Eleanor)

Some of the interviewed psychologists described experiences where their engagement with CM is supported by their psychologist supervisors, thus providing approval and justification for their own engagement with CM. In the quote below Carla described feeling motivated and inspired when her supervisors are open to CM, adding that it feels like "permission".

"Yeah, I think for me, it's been different supervisors. And their openness or their introduction, or discussions about different approaches, is almost like motivating, or a little

bit inspiring, or it gives a little bit of permission, you know, especially over the last 12 months to go, okay, I can… I can… I can start to incorporate this stuff into my … my practice." (Carla)

Carla's quote is important as it highlighted the influence psychology supervisors have over their supervisees. Most of the interviewed psychologists described the importance of the supervisory relationship in psychology, particularly as a source of information and expertise in relation to clinical practice. A number of the interviewed psychologists expressed that supervisor support of CM was a signal of acceptance from the profession broadly. For example, George explained the importance of his psychology supervisor's validation of his engagement with CM.

"Yeah, two to three of my supervisors, they've been very, very open to, to that element in terms of like, not criticizing it. Even inviting, inviting some… some ideas around that." (George)

While some psychologists felt there was increasing acceptance of CM by their psychologist peers, and ipso facto psychology, others felt the acceptance of CM within the profession of psychology was still unclear. However, this lack of clarity does not dissuade them from engaging with CM. For example, Helene explained her engagement with CM as her pushing the boundaries of psychology practice and offering innovation to the field of psychology.

"I think sometimes you've got to step outside a blurry boundary of an evidence base and go this might just work for you. I think it is important to be to be innovative to be creative to be …'it's a solution focus in that sense." (Helene)

Helene's quote aligned with other quotes above that justified engagement with CM as pushing the boundaries. While Helene described a lack of clarity as a "blurry boundary", she justified pushing outside this boundary as part of innovative practice. Several of the interviewed psychologists also justified their interaction with CM as part of innovation for the field of psychology. These arguments are interesting as the psychologists justified their engagement through the lens of being grass-roots pioneers, exploring CM in their clinical practice on behalf of psychology. This boundary pushing argument also aligns with the psychologist's pursuit of innovation in the context of evidence-based practice, where ultimately it is about achieving clinical outcomes for their clients. For example, George explained,

"I'm very much of the belief if we can serve the clients better? Let's find out how." (George)

A number of the interviewed psychologists also saw this innovation as vital to creating shifts within, and for, the profession of psychology. Carla described her grass-roots engagement with CM may influence the acceptability of CM engagement within psychology and among psychologists.

"I feel that more … more therapists are going to be open to taking it on board and exploring it. And starting to interweave it into practice, I think it will become more popular with … with therapist incorporating whatever it is within in regards to the CM but incorporating different … different approaches into … into their everyday practice." (Carla)

In the quote above Carla seemed to appeal to her like-minded CM engaged psychology colleagues as a call to action to create influence toward CM acceptance in psychology. Further her quote positioned CM as having the potential to be part of mainstream psychology practice. In the quote below Anne's sentiment also added to the importance of this grass-roots movement to influence how psychologists and psychology engages with CM. In the quote below Anne drew on justifications that positioned CM as part of innovation and as a contribution to the field of psychology.

"It's not for me to say what, you know, is up for grabs or not, and to remain open to the fact that we don't, you know, have possession of all the knowledge about what is curative for people. I mean, who operates with that kind of arrogance that there's one kind of model of treatment for anything. It's just not the world we live in. And you know, that. The task then is, you know, and the great discoveries we've made which have led to the recognition of a plurality of approaches, you know, given, we have billions of people with, you know, a different, unique mindset and different things help different people. And so, the great contribution is that the leaders in the field have founded those fields because they

discovered something that no one else was thinking about. And they had the fortitude to pursue it, and get it established, and then create a community around that. And then that's how whole approaches get established. And that's a good thing that we keep doing that not closing that down.” (Anne)

In the quote above Anne drew on a number of justifications as outlined throughout this chapter. Anne described caution to psychology if it remains narrow or closed, an encouragement to seek innovation and integration across professional boundaries, and she acknowledged the potential of the grass-roots movement to create change. The change, to be open and flexible toward diverse approaches including CM, is again justified as part of establishing innovation in the profession of psychology.

While the above quotes described psychologist engagement with CM as justified through the importance of innovation, other psychologists described this innovation, that included CM, as an antidote to their boredom with mainstream clinical practice, and/or psychology becoming less relevant. In the quote below Joan explained that a lack of innovation in the field of psychology, or a lack of psychologists willing to innovate and push at the boundaries of psychology, may lead to the profession becoming “stagnant and dying”,

“It's [CM engagement] about … we need to add to the boundaries of our knowledge. And the more that we get particular studies that support something, then the

more that we can say, all right, we can now integrate this in the bubble of what psychology is. So, without that we're stagnant and dying." (Joan)

In the quote above Joan believed CM engagement provides innovation which will be important for the profession of psychology to maintain relevance in mental health care. Sarah also explained that psychology needs innovation to remain relevant.

"But psychology is, is one of many disciplines, that requires innovation to stay relevant. And to meet the ever changing needs of the population. So I absolutely have values of innovation, I think that it's very, very important in the space, I like to push into territories and explore territories in discourse, initially, but eventually, in some form of research or practice, to say, you know, what, there is other [CM] options that we also know we can show are effective in the space." (Sarah)

In Sarah's quote above she explained that psychology needs to become more curious and inclusive, and this can be demonstrated by engaging with other approaches, such as CM. Many of the interviewed psychologists expressed their engagement with CM as part of innovation and opportunity. In the quote below Edith positioned CM engagement as adding to mainstream psychology approaches.

"I think it could be an opportunity for us to again, take a more integrative view of mental health, and expand our practice to encompass other therapies that might actually really help people in conjunction with the work that we traditionally do." (Edith)

What is interesting in the above quotes is how the psychologists continued to highlight the importance of the flexibility to select evidence-based and client centred approaches, including CM. In our interviews, many of the psychologists described the utilisation of CM as a justified addition to their clinical practice which subsequently adds to the expansion and innovation of psychology as a profession. For example, in the quote below George described including CM is also part of improving psychology's cultural awareness. These justifications around improving psychology's cultural awareness make sense in the context of psychology (broadly) being accused of cultural and epistemic exclusion. In the quote below Gabriel acknowledges the contribution of Indigenous knowledge to healing and health care. Further, Gabriel leveraged the similarities between the philosophies as a justification.

"And in Indigenous societies, there's a long history of this, of course, it just goes way back, you know, the sharman in any Indigenous society you care to name was working with the essential elements and working with the healing power present in the village or present in the ground or in the trees or in the spirits, you know, you've got that long history and that long background in a very real sense, psychology comes from a similar philosophy, which is to work with the implicit experience of the patient." (Gabriel)

In the quote below Sarah also aimed to justify her engagement with CM and described the similarities and relevance of a holistic view of mental health care to the profession of psychology. Sarah's quote appeared to be appealing to the profession of

psychology by relaying the importance of understanding CM, as a holistic approach, and its contribution to understanding mind body connections.

"And I would also preface that as a health psychologist, which is my endorsed specialised area of practice, that is absolutely relevant to the health psychologist's role as well, because we are supporting people with their physical health as well as their mental health. Because I mean, the mind and body are the two sides of the same coin. Any psychologist in practice, in my opinion, should have a robust understanding of the multitude of ways in which the health space is also supported or not supported. So, I do believe it is appropriate for us to get at least a baseline knowledge of a range of complementary and alternative medicines to practice well." (Sarah)

7.2 Chapter Summary

In this chapter the interviewed psychologists provided a range of arguments in support of their engagement with CM including justifications in the context of acknowledging client preference for CM, enriching their role as psychologist, client benefits from CM integrated clinical practice, and innovation for the discipline of psychology. An important thread through the psychologist's descriptions and perceptions was the notion of flexibility and being able to be knowledgeable of, and responsive to, client preference for CM. Further the psychologists drew on evidence-based practice principles that not only acknowledged client preference and values, but also the utilisation of their knowledge and skill to critically evaluate the relevance of CM to support their

client's needs. The interviewed psychologists were not deeply committed to CM, rather they preferred to be flexible and may opt to include CM based upon their professional discernment, and dependent on client needs and interest. The capacity to draw upon or dismiss CM sets psychologists apart from CM (only) practitioners. Further the interviewed psychologists explained the importance of embracing the diversity of mental health care approaches, including CM, as essential innovation for psychology as a profession.

Chapter 8. PHASE THREE – QUALITATIVE INTERVIEW RESULTS
Challenges to CM engagement

8.1 Preface

In the previous chapter, the reflexive thematic analysis of semi structured interviews was interpreted under the broad theme of justifications. Psychologists justified their engagement with CM in clinical practice as part of responding to client preference for CM, CM as an additional tool, and engaging with CM as adding to the enrichment and enjoyment of their work as a psychologist. Having outlined the theme of justifications in the previous chapter, the current chapter will focus upon outlining extracts of dialogue from the interviewed psychologists where they describe a number of challenges and barriers, to their engagement with CM in their clinical practice.

8.2 Challenges to CM engagement

The subthemes below sit under this broader theme of *challenges.* The first subtheme, *client challenges*, focused upon how some of the psychologists describe and highlight client-based challenges relating to their engagement with CM. The theme of challenge was expanded to explore a second subtheme relating to what can be interpreted as *psychologist-based challenges*, where barriers and challenges to engagement with CM were presented by participants as relating to themselves as psychologists, working in the role of a psychologist. Third, psychologists described *clinical practice challenges*, where challenges were positioned within the context of the psychologist's clinical practice behaviours, such

as treatment selection, planning, and the psychologists' perspectives of risk associated with CMs and client outcomes. The final subtheme, under the challenges theme, captured psychologists' perspectives and experiences relating to their engagement with CM in the context of the broader *profession of psychology challenges*, such as lack of CM relevant policy, education, and research.

8.2.1 Subtheme 1 Client-based challenges

"*And, again, that's respecting their stance, if they're not interested in it, you know, just like, definitely not, don't go there*". (Audrey)

The interviewed psychologists described only a limited number of client-based challenges. These client-based challenges are situated as barriers for clients who may otherwise wish to utilise CM. For example, one of these client-based challenges was the cost of accessing CM, such as the financial expenses associated with CM products and practitioners. In the quote below Charlotte observed that some CM was not accessible for a number of her clients due to costs.

"So, the fact that in daily life, it's not really being made accessible to people and talked about and, you know, if people know, individuals might be open to something, they

can't maybe afford it, because it will be expensive, and there's no rebates and so on." (Charlotte)

The psychologists described that even when they recommended or referred clients to a CM practitioner the costs could be prohibitive. For example, Josephine described affordability as a challenge to her clients wishing to access CM.

"The Biobalance doctors. I've got a couple of them that I work with as well. So, they're GP's who have just been trained, almost like a naturopath GP, I guess. And that's pretty good except that, again, it's affordability to get assessments done with them." (Josephine)

Another client-based challenge is client disinterest in CM. Several of the psychologists explained the importance of respecting the wishes of clients who may be uninterested or opposed to CM as part of their care. For example, Audrey explained,

"And, again, that's respecting their stance, if they're not interested in it, you know, just like, definitely not, don't go there. No, just that's, that's to me, being respectful of who they are and where they're at. And yeah, there's some and I suppose to, once people trust you, they're more once you have a solid relationship that they sometimes are more open to other ideas, and other times now, that's just that's … Don't go with that. It's just part of it. It's another tool in your toolkit, basically, you don't take out every tool for every person." (Audrey)

Audrey’s quote above is interesting as it linked with the previous chapter, on psychologist’s justifications for their engagement with CM, which identified that psychologists are not wedded to CM approaches (with the psychologists presenting their broader engagement and practice in terms of flexibility and discernment based upon reasonable judgement). In tune with such presentations, in the quote above Audrey was willing to let go of engaging with CM if the client was not interested in CM. Further she explained that letting go of an approach, such as CM, enhanced trust and the therapeutic alliance by respecting client preferences. While Audrey expressed client disinterest in CM as a challenge in the above quote, she also indicated a flexibility to adopt or dismiss CM, dependent on client needs and interest. It also aligned with psychologist discernment about the suitability of CM for clients as outlined in the previous chapter. Apart from client disinterest, and the prohibitive cost of some CM, there were no other client-based challenges described by the participating psychologists.

8.2.2 Subtheme 2 Psychologist-based challenges

“*I think the competency issue is a big one. I think psychs are pretty risk averse, which is probably good. But that's probably a barrier to competency*”. (Eleanor)

The interviewed psychologists also indicated that they experienced several challenges to their engagement with CM, arising from their own personal challenges as a psychologist. For example, Edith explained a lack of enough time to participate in CM training, and the limited availability of professional development for psychologists to develop competency in relevant CM.

"… but the barriers for me have been, you know, you get busy and you think, Well, that would be nice, but then, you know, it's a lot of effort to find a training program." (Edith)

Another challenge that was described by a number of the interviewed psychologists was defining what constitutes competency in CM. For example, Eleanor explained challenges regarding access to appropriate CM training that would be considered sufficient to build competency in CM.

"I think the competency issue is a big one. I think psychs are pretty risk averse, which is probably good. But that's probably a barrier to competency. I guess just access to a training. So, I think if there was a training available, or if APS was advertising a training that might help." (Eleanor)

The above quote was interesting as it highlighted a number of challenges, including a perception of risk associated with being a CM engaged psychologist, limited CM relevant training for psychologists, and the absence of wider support or infrastructure from

Australian psychology professional associations, such as the APS, and ultimately the need for formal acknowledgement and support from psychology's professional associations. These types of identified challenges may also explain why CM engagement may not be more widespread among psychologists. These issues were expanded in the subtheme below relating to clinical practice challenges.

8.2.3 Subtheme 3 Clinical practice challenges

"*It's like an artist that that has got, like a huge palette of paint, but is only allowed to use one side and not allowed to use the other side. That would be very limiting to that artist to … to sort of express that art*." (George)

The interviewed psychologists described their experiences of a number of clinical practice challenges to engaging with CM, such as lack of knowledge of relevant CM, feeling conflicted about whether to use CM, and challenges to collaboration with mainstream health professionals. Of note, the clinical practice challenges were mostly downstream from the context of the broader profession of psychology (discussed in the context of broader *profession of psychology challenges* described below in subtheme 4). For example, in the quote below Audrey explained challenges relating to her lack of

knowledge of CM, and therefore difficulty in evaluating the potential utility of CM for her clinical practice.

"So, if you don't have any knowledge of, say complementary medicine, since that's what we're talking about, how do you choose whether it's appropriate or inappropriate or what? What aspect of it could be appropriate if you have no knowledge?" (Audrey)

In the quote below, Edith also described the lack of relevant CM education available for psychologists. In addition, Edith asserted that there is an intersection between psychology and CM, however psychologists don't have appropriate training about the intersection between the disciplines.

"And there probably just isn't a whole lot in terms of training out there that addresses the intersection of psychology, and you know, other therapies, there's probably quite a lot of reasons." (Edith)

In the quote below Marie also provided a presentation that could be seen to support a similar position to that outlined in the quotes above from Edith and Audrey. Marie described a lack of clarity on what is included under the banner of CM, which she suggests may contribute to uncertainty for psychologists with regards to how they assess the efficacy and relevance of CM in the context of their evidence-based practice.

"The difficulty there is that I think there's just so many different things that can be embraced in this term complementary medicine, some of which I would regard as

potentially very beneficial, depending on the circumstances, the individual, and what the issues are, they're presenting with, and other aspects that I think, [is] untested, unfounded, and others that I think are quite dangerous. So, I don't see how I can actually come to a position of yes I am for or no I'm against." (Marie)

The quote above also highlighted a clinical practice-based challenge for psychologists who wish to apply clinical expertise and to be discerning when selecting any approach for their clients. Marie described how a lack of clarity made it difficult to apply the required level of discernment to achieve sound evidence-based practice. Marie indicated that such lack of clarity may lead to her, and potentially other psychologists, dismissing CM. Furthermore, Marie's quote spoke to the earlier subthemes around discernment and flexibility, that were identified in the previous chapter.

In the interviews some of the psychologists expressed practical challenges relating to CM within their clinical practice, such as lack of clarity on how they might integrate CM into their everyday clinical practice operations. For example, in the quote below Charles explained what he saw as a lack of clarity on how to introduce CM into his clinical practice, both with reference to how to introduce CM to clients, and how a psychologist (with skills and/or qualifications in CM) might be paid. Charles questioned whether undertaking formal training in CM would be of value. When asked what kind of things he would look for, that would be indicative of a benefit for training in some form of CM, Charles replied.

"Well, what you'll be paid? I mean, let's say you're going off and did some training for a year in an area of orthomolecular medication, and a client's coming out… How often would you use it? That would be … have to be … you have to think about that? How often would you actually get to use it? That's because you just couldn't start bringing … you couldn't bring it up with a client and you're unlikely to bring it up. I think most clients would be unlikely to bring it up. "I've just done a course… Let me tell you about this". What about the practical thing? Really. I don't know if it's … it's a nice idea. But … But in practice, I don't know what's the benefit." (Charles)

In the quote below George introduced another clinical practice challenge shared by a number of the psychologists, not just in the current study, but in the wider literature. George described one of the most significant challenges to engaging with CM is a lack of clarity on whether engagement with CM is acceptable by professional and regulatory associations within psychology/psychologist's clinical practice in Australia. This challenge is downstream from the *profession of psychology challenges* (discussed in the next subtheme) where clinical practice is influenced by Australian professional and regulatory bodies. As noted in the previous chapter, the wider literature, and the current thesis, reports that there are currently no explicit CM relevant guidelines for psychologists in Australia (see Chapter 4). A further complication, that adds to the lack of clarity on CM in clinical practice, is that the current Australian code of conduct and guidelines prohibit psychologists from integrating a second qualification, from any other profession, into their clinical practice. Effectively, the more competence a psychologist has in a separate

discipline (such as a degree qualification in education) the less able they are to draw on that skill as part of their clinical practice – based on current psychology policy and guidelines. To clarify, under Australian psychology policy and guidelines, psychologists are not able to apply skills from a second qualification with their psychology clients, whether that is CM or not. Further, there is a lack of clarity whether CM in any form is allowed within clinical practice. Thus, the interviewed psychologists described a lack of clarity on what level of CM training would be acceptable, if any. In the context of any relevant CM training for psychologists, some of the interviewed psychologists described difficulty interpreting what could be a potential role for CM in their clinical practice, based on existing clinical practice frameworks. For example, George explained his difficulty interpreting psychology's relationship with CM in the context of his formal education.

" ... this is really difficult, mainly because of the current sort of legal framework, or practice frameworks, that are around psychology. I was very acutely aware that during my training initially in psychology, which I did as a mature age student, I thought I'd be able to combine the two. I had this idealistic view that, yes, that's the perfect way! And then realised there's a lot of ethical issues that sort of came up. Because of that, I sort of separated the two practices. I'm not utilising two practices together." (George)

George's description above summarised many of the interviewed psychologist's sentiment. The psychologists described having interest in the utility of CM as part of their clinical practice, only to discover to engage with CM in their clinical practice may be a

potential breach of the code of conduct and ethical guidelines laid down by the profession – a breach either by obtaining a second qualification or a breach due to a lack of CM relevant guidelines to endorse and inform how to safely integrate CM into their clinical practice. This was further illustrated by the interviewed psychologist's uncertainty and confusion in trying to interpret psychology's relationship with CM. For example, Carla described challenges shared by a number of the psychologists that CM may be perceived, by Australian psychology professional associations and regulatory bodies, as being outside of conventional psychologist training and scope of practice and that she should only "stick" to what is included in a psychologist's scope of practice, and not utilise CM tools.

"Yes, it's hard, it's almost like it's almost like an inner conflict in your mind because your training is to stick here[psychology]." (Carla)

In the quote above, despite having knowledge of CM, Carla expressed an "inner conflict" because she is unable to include what she has learned outside of her formal psychology training in her clinical practice, such as CM. More generally, the interviewed psychologists suggested that a lack of guidelines (from psychology professional associations such as the Australian Psychological Society or the psychology elite) on an appropriate level of CM engagement, could in itself be interpreted as a defiant position towards CM use by psychologists in their clinical practice. As such, psychologists described being fearful that engaging with CM may have a negative impact on their career.

"*I've locked the box up [CM], because there's a bit of fear there for me because otherwise I can't, I can't do the work I do [risk of losing registration]*." (Josephine)

In the quote above Josephine extended the talk, on the lack of clarity on what type of engagement with CM is allowable in her clinical practice, toward a fear of negative appraisal by their peers. Some psychologists described being worried, if they do engage with CM in their clinical practice, about negative impacts on their reputation if their professional peers also perceive that engaging with CM was not allowed. For example, Audrey explained that her reputation as a psychologist might be at risk, not just from the psychology profession, but also from other mental health care professionals, should she engage with CM in her clinical practice.

"I don't want that reputation, that I use something [CM] once for a reason that … that psychiatrists didn't even understand what I was doing. And it was helpful, by the way. Yeah, but not I. So, I don't go there." (Audrey)

Beyond what the interviewed psychologists described as being clinical practice barriers and limitations to their engagement with CM - they also expressed feelings of loss and disappointment when they perceived there are rules that prevent them from engaging with CM in their clinical practice. In the quote below George shared a sentiment shared by many of the interviewed psychologists. George expressed a sense of loss at not being able to utilise CM in his clinical practice. George described this as a loss of creativity and

feeling very limited in his clinical practice if he is “not allowed” to have choice and flexibility to incorporate CM.

“It's like an artist that that has got, like a huge palette of paint, but is only allowed to use one side and not allowed to use the other side. That would be very limiting to that artist to … to sort of express that art. Or if you're only allowed to use the non the white keys on the piano, but not the not the black ones.” (George)

In the quote above George’s comment also reflected rejection of a narrowed practice of psychology as described in the previous chapter. George also recalled feeling restricted when not being able to draw upon CM as therapeutic tool in his clinical practice.

“… it's having this amazing toolbox there, and I'm not allowed to open it.” (George)

Charlotte also expressed she was angry at not being “allowed” to engage with CM, particularly when psychologists in other countries do not face the same barriers and challenges as psychologists in Australia.

“… I already feel angry at times, with not being allowed to be doing certain therapies that aren't accepted yet in Australia, that are overseas.” (Charlotte)

This sense of CM not being allowed is curious given there are no explicit psychology guidelines relating to CM in clinical practice in Australia. In the below section the potential origins of these perceptions that CM is "not allowed" are outlined.

8.2.4 Subtheme 4 Profession of psychology challenges

"*I think oftentimes, there's a culture that is not … it's not accepting of anything outside of you're sitting in a room opposite a person at this angle, having this formula conversation with a CBT or other framework, and if you step outside of that, then you're somehow kind of breaching what's expected*." (Joan)

While the previous subtheme outlined challenges directly related to psychologist engagement with CM in their clinical practice. This subtheme, *profession of psychology challenges*, describes the barriers and challenges to psychologists engaging with CM stemming from the Australian psychology profession, including academia, professional and regulatory associations, and the professional elite (executives, board members and chairs of Australian psychology's professional, regulatory and academic bodies). Many of the interviewed psychologists perceived the previous clinical practice challenges as originating from the influence of the broader discipline of psychology in Australia. For example, they highlighted the absence of specific endorsement of CM, a dearth of CM relevant guidelines

for psychologists, and the limited offerings of relevant CM education. In the below quotes there was suggestion that these factors contribute to a sense of isolation and apprehension among psychologists who may wish to engage with CM. Further, they expressed concerns about the potential for negative evaluation from their professional peers, who might view psychologist engagement with CM as a departure from acceptable conventional psychological approaches. Overall, the interviewed psychologists described a lack of clarity on whether the profession of psychology accepts CM, in some form, as having a potential role in psychology and in psychologist's clinical practice. In the quote below Eleanor described an absence of clear statements from the APS, or academia, regarding CM in clinical practice.

"Let's say the APS released a position statement that sort of gave it a thumbs up, then I think psychologists would just say it was a matter of course, to everyone, you know, if you present it …. If you said to a psychologist, I don't know acupuncture helps 25% of people with depression, they're probably like, Okay, I might mention it more to my clients. But I think because there's no… it's just little individuals kind of looking into it or researching it or suggesting it… rather than it coming from either the teaching or the APS." (Eleanor)

In the quote above Eleanor appealed to psychologist's desire to work from evidence-based practice principles and to be discerning about selecting treatment approaches, however the absence of a "thumbs up" is interpreted as a lack of approval from

psychology's professional associations. Of note, Eleanor also described a lack of clarity on how she came to "know" CM engagement by psychologists is not approved of.

"I don't know how I know that's not my place. I don't think I've ever…I must know that from somewhere. Maybe it's – I don't know. Did it ever come up in ethics? … Even though I have knowledge that could help someone, I'm not to use it in therapy." (Josephine)

The psychologists described a number of different challenges to psychologist engagement with CM that stem from a lack of clarity on the "rules" from the profession of psychology. Just as in the quote above from Josephine, other psychologists also explained awareness of rules about how psychologists engage with CM, but they were less sure about what the specific details of those rules are. As Edith outlined,

"I mean, I guess there's some rules? Well, I mean, I suppose APS you know, has their code of ethics. And that's been widely adopted. And that's kind of considered to be your rulebook. But more of a guideline I suppose. There really aren't any." (Edith)

In the quote below Marie admitted to not looking at the APS code of practice or ethical guidelines for some time, however in contrast to Edith, Marie perceived there to be broad parameters of practice that might include CM in the APS code. In her interview, Marie described that while she may be open to CM in her personal life, she is more

"inhibited" in her professional clinical practice. When asked where her inhibition for engaging with CM comes from, Marie replied,

"Well, the Australian Psychological Society has a clear code of practice. I haven't looked at it for quite some time, so I can't actually tell you exactly how it reads possibly it's differently from when I last looked at it. But I think they're the broad parameters for psychological practice." (Marie)

The quote above emphasises that the interviewed psychologists were not clear about psychology professional associations' codes of practice or ethical guidelines in general and regarding psychologist engagement with CM. Charlotte, below, also explained a lack of clarity on what is allowed in clinical practice, and in addition suggests that these challenges and issues arise as a result of the boundaries around psychologists' scope of practice.

"I'd have to read again, exactly about, you know, suggesting things outside our field, which I understand is … can be problematic and wouldn't be desirable… Because they [Australian psychology professional associations and regulatory bodies] don't know a lot about complementary therapies, I'm not quite sure about ethics and so on in terms of … what we're meant to be doing. I haven't picked up that we're not able to suggest … suggest doing more exercise or being out in the sunshine more." (Charlotte)

Helene also described psychologist engagement with CM as falling into a "blurry" boundary under APS guidelines.

"Well, just in terms of the APS has guidelines around not, you know, about … it was very blurry about what you could and couldn't [do]? Well, they were … you could step over a line quite quickly was my sense with it. So, it was almost easier to just say, you know, I'm not going to do any of that [CM]." (Helene)

In the quote above Helene described the lack of clarity and "blurry" boundary has led her to conclude that it is easier not to engage with CM. In the quote below, Helene also described that there is clear APS policy that does state psychologists are not allowed to practice from dual qualification, such as naturopathy, and that this is a signal she cannot engage with her CM qualifications in her psychology practice.

"The APS is very clear on you're not multi-disciplinary in this sense, you know, you can't do both. You can't wear both hats with the client. And it's kind of a case of them or how do you take one hat off … if you know that information." (Helene)

The distinction made by Helene is important. While some of the psychologists, as above, query whether they can discuss, recommend or refer to CM, Helene described a specific rule that psychologists cannot directly apply a CM approach in their clinical practice, where they may hold a qualification in CM (e.g., naturopathy). In contrast to the lack of clarity described by the above psychologists, Genevieve (below) believed there are "black and white" rules that present as a clear barrier to psychologist engagement with CM in clinical practice.

"It's it, you know, it's just very, they're very, very, very black and white, that this is, you know, this is not your area of expertise, and therefore, you need to not bring it into treatment. It's very, very clear in the guidelines, you know, in the ethical guidelines from APS and from AHPRA. So, I, obviously, I'm trans, like, I am transgressing that, because I can't not do the next best, most right thing to assist people." (Genevieve)

In the context of challenges from the profession of psychology, some of the psychologists described a sense that the profession of psychology discourages/prohibits their engagement with CM, however they openly contest that challenge. What is interesting in the quote above from Genevieve is that she also introduced that she openly defied any "rule" from the profession of psychology and that she was willing to break the rules in order to incorporate CM that she considers to be the best treatment for her client. Here Genevieve was describing a sentiment shared by a number of the psychologists that while the "rules" present challenges to their engagement with CM, they ultimately prioritise their client needs over these "rules".

In the quotes above, psychologists described the challenges to their engagement with CM around the lack of clarity on what is allowed and what is included in psychology associations' code of practice or ethical guidelines on how to safely engage with CM in their clinical practice. They described experiences that range from frustration with a seemingly agnostic stance from the psychology professional associations through to experiences of explicit disapproval.

The interviewed psychologists also described challenges relating to their health professional peers. The interviewed psychologists described fears that other psychologists and/or other mental health care professionals may be critical of psychologists who engage with CM as part of their clinical practice. The quotes below are examples of the psychologists' talk about a sense of disapproval from their professional peers. Helene described that she felt she had to be discrete about having CM qualifications out of fear of how that would be perceived among her wider health professional peers in a hospital setting.

"I don't think anyone knew that I also had naturopathic qualifications. Because it would have been like turning up to work on a broomstick, as you know, it would have been just a tad too much for… for some of them, but not all of them." (Helene)

Helene's quote above provided fascinating imagery and a perception that her peers see her engagement with CM as being aligned with witchcraft. However, Helene also qualified that not all her peers would have this view of her engagement with CM and alludes to some level of acceptance of CM among her peers. In the quotes below the psychologists described a sense of disapproval specifically from their psychology peers. A number of the interviewed psychologists described their professional psychology peers and/or supervisors as somewhat unconvinced or agnostic regarding psychologist engagement with CM in clinical practice. For example, Genevieve described some of her professional peers as not engaged with CM.

"Well, I have a really wonderful supervision group of very seasoned practitioners, which include a professor and people who have written, you know, programs for (organisation name), and who, you know, these clinical PhD psychologists that I have been having supervision with for about 20, probably close to 20 years that I like, well, maybe no 15, maybe it's like 16. Anyway, many, many years, and I respect them all, but none of them, none of them would promote CMs." (Genevieve)

In the quote above Genevieve's experience sounds moderated, her professional peers are indifferent to her engagement with CM. This is in contrast to other interviewed psychologist's experiences where their professional peers are less tolerant of psychologist engagement with CM. For example, in the quote below Carla relayed a more serious response from her professional peers who may be critical of CM engagement and may even take action.

"Yes, the fear of, I guess, just that with, you know, like with the with the chit chat amongst the profession that you might be reported, or people might talk negatively of you." (Carla)

Extending upon these comments Carla also described ways in which social media can be one powerful avenue for others in the profession to critique and attack CM engagement by psychologists.

" … the social media platforms as well have been quite a big one for me, too, I think, you know, seeing comments and, you know, people asking questions about certain approaches or modalities and, and people having rants on there that, you know… that [CM] is not appropriate." (Carla)

Another challenge arising from the profession of psychology that impacts psychologist engagement with CM was the fear that that their psychology and health professional peers may form a negative opinion of them. While such descriptions focus upon how psychologists' resistance to and/or disapproval of CM engagement shows itself, other psychologists in the study also provide some provisional explanation(s) from their perspective as to why such disapproval may exist. In the quote below Helene positioned other psychologist's disapproval of CM as their lack of understanding of CM, and that these disapproving psychologists may only consider CM as an umbrella term, and therefore reject all CM without having an understanding of specific, relevant, and efficacious CM.

"They don't want a bar of it because they don't understand it, or they've fallen into the stereotype view of what complementary medicine is, or they kind of lump a whole, like, for some people, you know, Reiki might be a bit too out there as a complementary medicines, but they could possibly see the value of chiropractic, let's say, because they got that actually does something, you know. And, and whereas what they do is they'll often lump everything in and go on, it's all rubbish." (Helene)

Moving from practice to the educational setting, Juliette also described what, from her perspective, is a disconnect between how university psychology lecturers perceive CM in clinical practice and how this may contrast with grass-roots psychologist and client interest in CM.

"You get people that are sitting in universities that are not necessarily practicing psychologists that sit and read papers that reinforce their perspective [against CM]. So then, they're the ones that have the time to be on committees. And influence the direction that psychology goes on. Whereas a lot of practicing psychologists, they actually … they haven't got time. It's hard to read what research you are interested in, let alone try to find anything else. And if you're practicing, you're actually practicing, you're there on the ground with the people that have got the issues." (Juliette)

As the quote above revealed, Juliette highlighted here what she sees as the difficulty for those CM-engaged psychologists due to the demands of their psychology practice to participate in formal leadership and wider influential roles (such as committee work) where they might have influence and introduce the relevance of CM to the wider profession and professional elite. Indeed, beyond negative experiences with their professional psychology peers, a number of the interviewed psychologists also described a sense of disapproval from the broader field of psychology including professional associations, regulatory bodies, and academia. Carrying on this focus upon education, George explained that his university

psychology lecturers were his first experience of challenge to his engagement with CM in his clinical practice.

"That's where [university] I gained the impression that, like, it's a no-go zone. That it's written off as a not evidence-based medicine." (George)

In addition to fear of negative appraisal, a number of the interviewed psychologists relayed a sense of fear of negative professional consequences should they engage with CM in their clinical practice. In the quote below, Josephine described being afraid of punitive consequences from the APS if she engaged with CM.

"I was afraid more that I would get in trouble from APS rather than – I wasn't afraid that they [GPs] would stop referring. … Why was I feeling a bit afraid that there would be a complaint made against me, and I'd have to justify that, and maybe I'd get rapped over the knuckles. Probably old conditioning of my own, you know. Yeah. That worry that I'd done something wrong. APS, or, yeah, AHPRA, I guess. I don't know if there's anything that would be wrong, but there could be, and I got a bit worried about that." (Josephine)

In the quote above, Josephine described not being fearful of how her professional peers view her engagement with CM. However, Josephine's quote is powerful as she described being fearful that she will be punished by psychology professional associations and regulatory bodies – that engaging with CM in her clinical practice is "wrong".

Josephine's quote highlighted a disconnect between those in clinical practice and those not positioned in clinical practice yet are influential over how psychologists engage in their clinical practice. In the quote below, Helene also expressed that engaging in CM may put her registration as a psychologist at risk.

"And at times you kind of might be a little bit at the it might be a difficult, squeezy space, you know, and then you go, No, I'm just gonna say and then and other times, it's quite a clear line, you know, bottom line is, if the if the psychology board or Ahpra say, you do or don't, then you do or don't, because your registration is on the line at that point." (Helene)

In the context of profession of psychology challenges to psychologist engagement with CM, some of the psychologists mentioned specific actors and influences on their clinical practice. For example, some of the interviewed psychologists viewed the APS as a powerful influence over their practice, including their consideration of engaging with CM.

"If the APS says this is what you should do, I'd do it. And if they said never do this again. I go, Okay, I'll never do that. So, I don't know if that's too much trust to place in that." (Eleanor)

While Eleanor (above) explained that she will self-police her interpretation of the APS' rules, in contrast Genevieve (below) describes the APS as policing psychologists. In the quote below Genevieve explained that even though she is not a member of the APS

herself, her peers have warned her that the APS is "strict" and engaging with CM as "too risky".

"I've brought it up in the past, they just think that it's too risky. And that it's not it's I mean, the APS is pretty strict, but I'm not a member of the APS anymore." (Genevieve)

The quote above is important as it highlighted how these psychologists portray and internalise a sense of potential power and influence of the APS and APHRA with regards to their practice and that of other psychologists. In the interviews a number of psychologists described a sense that although APS membership is not mandatory for psychologists, the APS has significant influence over psychologist's clinical practice, and as such a psychologist's selection and engagement with different approaches including CM. In the quote below Charles indicated approaches, such as CM, would need APS approval in order to be legitimately included in the psychologist's tool kit.

"Well, if the APS if the APS said that this was viable, and that they are training or people could be trained in certain areas, then you might say, you might pick it and say, Yeah, okay, well, I'll get trained in this area. But otherwise, you probably wouldn't do it. So, you'd have to get, you'd have to get approval from the APS, and approve something like this. And then… And then you'd have to be suitably trained. And if the APS was … the APS we're instigating this, then you would probably do some training through… through them, they probably have some training to do." (Charles)

In the quote above Charles advised that it would be the APS that ultimately provided approval to psychologists who wish to engage with CM. Meanwhile, Joan (below) adds the Australian professional psychology associations are disconnected from grass-roots interest in CM. In the quote below Joan responded to a question that asked her to explain her perceptions of the barriers and politics that might limit or prevent psychologist engagement with CM.

"So, people who are sitting in AAPI, or the APS or whatever, are the ones that we're leaving it up to them to be the voice. And that voice is not necessarily a reflection of what the psychologists in private practice would prefer." (Joan)

In the context of profession of psychology based challenges to psychologist engagement with CM, some of the psychologists expressed feeling unable to voice their perspective on CM to the elite, or unable to influence and create change in terms of psychology's acceptance of CM. Joan described that grass-roots psychologists may not have the opportunity to express their perceptions and experiences to those in power and influence over psychology and that it is left up to psychology professional associations to determine how psychologists engage with CM. In contrast to the quotes above where psychologists place professional associations, such as APS, as a strong influence of whether psychologists may engage with CM, others believed Ahpra to be the authority. A number of the psychologists explained that engaging with CM not only invited disapproval from their professional peers but also presents a possible risk to their professional

registration. In the quote below Sarah described feeling as though she is venturing into the margins of psychologist's scope of practice, in relation to the standards set out by psychology regulatory bodies and grappling with her registration obligations.

"Yes, it does feel like I'm on the edge as a Ahpra registered health professional. There is scrutiny and there are certain things that we need to do inside the box to meet our legal obligations. And that that is something I've always grappled with. Because what I consider best practice maybe more expanded than the version that is part of these licensing considerations." (Sarah)

Sarah's quote above added to the challenges associated with incorporating CM, when there is a lack of clarity as to what the professional bodies approve of in clinical practice. In the above quote Sarah also described her view of CM in clinical practice as an "expanded" version of clinical practice. This expanded view links back to psychologist descriptions of CM giving them more breadth and flexibility in the tools they can draw upon in their clinical practice, contrasting such a position to what Sarah above describes as a sense of being scrutinised and working "inside a box" that is overly limiting to her practice.

As this subsection has outlined some of the challenges to engaging with CM in clinical practice, several of the psychologists offer specific challenges originating from the broader profession of psychology including professional associations, regulatory bodies and academia. They make specific reference to CM being outside of the psychologist's

scope of practice, or a breach of scope of practice, regardless of whether the psychologist had training or formal qualifications in CM.

Many of the interviewed psychologists offered hypotheses as to why there is a sense of disapproval among the broader psychology discipline. The interviewed psychologists described professional territory marking and epistemic exclusion. In terms of territory marking, the interviewed psychologists described that the profession of psychology in Australia has been increasingly narrowing or delimiting the boundaries of the profession. The interviewed psychologists also described epistemic exclusion, where psychology creates barriers to psychologists engaging with other disciplines, including CM. For example, George described this exclusion of CM as a demonstration the profession of psychology rejects CM because of the misconception that CM is not evidence-based.

"Well, I think there is a big, big push to this evidence-based practice, which is beautiful. But then there is a big selection of what we accept as … as … as evidence-based. And what we don't, which is more based, I would say on maybe a bit of dogma rather than real science." (George)

Marion also described this exclusion as psychology's elite being "arrogant".

"Who are they to say psychology is enough? I don't mean to be snappy, but it seems a little bit arrogant." (Marion)

Juliette also described profession of psychology based challenges relating to professional territories. Juliette framed this as psychology excluding other mental health care approaches, such as relevant CM, as being outside of psychology.

"Because I feel psychology in general, and the expectations that I understand from my professional associations, is that complementary therapy is something that belongs outside psychology. And that if you're a psychologist or a psychologist, and if you're a natural health practitioner, you're sitting outside that circle. And… and so I don't see that it's actually included at all." (Juliette)

In the quote above Juliette highlighted an important observation shared by a number of the interviewed psychologists, that the profession of psychology may perceive CM as located outside the boundaries of legitimate or authentic psychology. Juliette described a culture of exclusion, not just exclusion of CM, but exclusion of anything that does not look like mainstream psychology and cognitive behavioural therapy (CBT). In the quote below Joan added that this exclusivity may be part of psychology's culture.

"I think oftentimes, there's a culture that is not … it's not accepting of anything outside of you're sitting in a room opposite a person at this angle, having this formula conversation with a CBT or other framework, and if you step outside of that, then you're somehow kind of breaching what's expected." (Joan)

Joan’s quote is interesting as it introduced another aspect of the challenges arising from the profession of psychology. Many of the interviewed psychologists expressed a sense that the discipline of psychology in Australia is not only exclusive, but also narrowing. Joan described a narrowing in terms of it being suggested that psychologists adhere to a formulaic or manualised therapy approach to psychology practice. The interviewed psychologists believed there has been an overall narrowing of the profession, or a narrowing of interpretation of clinical practice ordinance, by psychology associations and academia, as to what is good psychology practice. There was a sense that the interviewed psychologists view the formulaic approach to psychology practice as bland and restrictive, which is in contrast to a more creative and flexible approach to psychology practice. For example, Gabriel explained,

“… but it's gradually become narrowed down to a prescribed set of areas of practice endorsement. That's it… Thou shall not practice anything other than your area of practice endorsement. And I think it's very sad that it's changed that way in my lifetime.” (Gabriel)

In the quote below Genevieve also described this narrowness as “very vanilla” and “under evolved”,

“I feel that Ahpra does and I feel that it's very vanilla. Like it's very, it's very, it's very clinical. And its very fear based and it's very, you know, it's probably very under evolved.” (Genevieve)

The above quotes reinforced a sense that there has been a constriction of the psychology profession in Australia toward a formulaic approach that limits psychologists' independence to be creative and flexibly select approaches in their clinical practice. The interviewed psychologists also expressed concern about this narrowness, not just a challenge to their engagement with CM, but also the implications for the profession of psychology. Juliette explains,

"But I do feel that they will be it'll become narrower and narrower as to what you're allowed to do. Yeah, what professional development is acceptable. And in I'm grateful some days that I'm actually at the end of my professional life." (Juliette)

Here the quotes from the psychologists also illustrated a sense of loss if they cannot engage with CM and extend the diversity of their practice. The challenge is situated within the profession of psychology becoming narrow and prescriptive about what good psychology is and is not. For example, Gabriel predicted lost opportunities for innovation and affirming psychology's relevance, if the profession narrows.

"So, if psychology persists, and being narrow focused and insists on being evidence-based to within an inch of its life, and closely prescribes what psychologists who call themselves psychologists can and can't do, then we lose that opportunity." (Gabriel)

Josephine also described a perception that psychology had become narrow and was exhibiting epistemic exclusion of traditional and cultural concepts of health and wellbeing.

"… we're having a … a narrow view of … psychology and I … I've worked I work with a lot of Indigenous clients, and so … what's culturally appropriate … And what their, their belief systems are, and the … the richness of that in their stories, and, and their, their, their medicines…" (Josephine)

In the quote below Joan also expressed caution if psychology continued on the path of epistemic exclusion, including the exclusion of CM approaches, and the narrowing of the profession. Joan explained her perception of the implications for the field of psychology, such as falling behind other health professions and lacking in innovation.

"It's about we need to add to the boundaries of our knowledge. And the more that we get particular studies that support something, then the more that we can say, all right, we can now integrate this in the bubble of what psychology is. So, without that we're stagnant and dying." (Joan)

The quote above is important as Joan's sentiment was shared across a number of the psychologists. They expressed concern that this exclusion also leads to a lack of innovation, which may have a negative impact on psychology as a professional discipline. In the quote above Joan believed psychology will become "stagnant and dying" if it does not become more inclusive of approaches, such as CM. In the quote below Charlotte also expressed concern that psychology may be excluding the relevance of CM and may not be keeping pace with relevant CM research. Charlotte described that psychology's lack of engagement with CM research and CM approaches may limit how psychologists support their clients.

"… psychology itself needs to be up with what research is telling us with what will be helping people with wellbeing and I believe that's really what we're doing. So, if … if the field itself isn't keeping up with new therapies, psychological therapies, trauma therapies, somatic therapies, and then the ones outside our field or other complementary therapies, then it can't be considered a profession that's able to support people in the fullest way." (Charlotte)

Charlotte, in the above quote, also claimed that the latest research is not necessarily against, but may actually be supportive of, a wider framework or approach for psychology practice that might include CM. Charlotte's quote also linked with talk where psychologists make appeal to being client centred and perhaps engaging with client preference for CM means that these psychologists are also engaging with current research on CM.

In the quote below, Helene positioned psychology's exclusion of some approaches in the context of evidence-based practice. However, she cautioned that this exclusion of other health care approaches based on variable evidence may limit innovation. Helene explained one of her frustrations with the discipline of psychology in Australia below,

"But one of them is when you know, when people start banging on about the evidence base, you can only use evidence-based treatments. Now I understand the importance of an evidence base, don't get me wrong. However, if we only ever go with what's already known, and we don't budge the edge, we're not going to develop a new evidence base for anything." (Helene)

In the quote above, Helene appealed to the core features of evidence-based practice as mechanism for innovation, and to stifle this innovation may impact psychology's relevance. Juliette (below) echoed Helene's statement,

"And the problem is, if we're just waiting for the evidence base, then there's never innovation. There's, there's never a way that's new or forward, we'd be still looking at the wheel and thinking, well, we can only make a wheel because our evidence shows us, we have made a wheel, not working out how can we apply this?" (Juliette)

Gabriel also shared a similar feeling, and expressed concern that psychology will be left behind it if does not engage with innovation, such as including CM approaches.

"Or are we going to become, you know, the outliers? Are we going to become, you know, the sorcerers, the ones that get left behind because all we've got to offer is some sort of incantation, you know, we become, you know, the religious institutions that haven't got anything meaningful to say about modern society anymore, but we still continue with our incantations, and we have our churches devoted to evidence-based practice and gradually they gather dust." (Gabriel)

Here Gabriel described a perspective where the psychology profession is losing relevance, if there is not inclusion, diversity, and innovation. In the above quote, Gabriel likened the profession of psychology to a religious institution that has lost touch with "modern society", client demand, and grass-roots interest in CM. Marie took this fear of the

psychology profession’s irrelevance further and explained that psychology’s exclusion of CM may lead to “extinction” for the field.

“Well, I think that various forms of complementary medicine, are already widespread in the society, in the belief that they aid in wellbeing, and probably we ignore that, we’ll be a bit like sort of heading towards extinction or something if you ignore what's actually happening around you. So, I think I think they do have a place. And I think we need to embrace it.” (Marie)

The quotes above are interesting as they also complemented how the psychologists justified CM engagement in the previous chapter, and how they described themselves as innovators when they do engage with CM in their clinical practice. The interviewed psychologists also extended the talk of challenges to how psychology in Australia is perceived to be performing in contrast to other health professions. The challenges are not only within the profession, but also extend to how psychology is positioned alongside, and within, a wider framework of other health and health practice disciplines in the context of CM engagement. A number of the interviewed psychologists described the challenge of psychology not keeping pace with consumer demand for CM as seen in other health care professions. In the quote below Catherine expressed that she believed psychology is behind medicine and other health care disciplines.

"So, to my mind, psychology is just so far behind even what other areas of, of medicine and health have been just moved way past us? They've gone way past us." (Catherine)

The psychologists also described these profession of psychology based challenges as unique to the profession of psychology in Australia. Specifically, that Australian psychology professional associations and regulatory bodies are not keeping pace with psychology in other geographical jurisdictions. For example, Joan said,

"And I just think there's a lot of places in the world that are strongly moving in that direction [engaging with CM], and that it wouldn't take too much for Australia to be moving more strongly in that direction." (Joan)

A number of the interviewed psychologists described the implications for psychology in Australia if it does not keep pace with other jurisdictions and health care discipline's engagement with CM. Catherine portrayed the wider psychology profession's lack of engagement with CM as "negligent".

"They have been utterly negligent in keeping up to date with even the mainstream research, and were quite happy – I attended something recently with health psychologists about psychologists who were using concepts of clinical nutrition and diet and that in their work, and the moderator who was running it, who was an academic, was quite concerned

that psychologists were "dabbling", as she put it, in this particular – APS would not allow this, and this was not an agreed form of psychological treatment." (Catherine)

Adding to psychologist's perspectives on challenges, was that this lack of engagement with CM may impact psychology's relevance. The psychologists' expressed concerns for the psychology profession if there is no innovation and if there is continued epistemic exclusion. Gabriel's description of these circumstances was shared by a number of the interviewed psychologists. In the quote below, Gabriel referred to what he described as the exclusion of other health approaches perpetrated by the powerful, or elite, in psychology.

"It's always fear, fear of loss, fear of relevance, you know, losing relevance in a way, the more you can protect your boundary, the more important, you must therefore be because you restrict who can come across the moat, into your castle and who cannot. So, it confers an element of power. And with power, there's always fear of losing power." (Gabriel)

Gabriel continued,

"If we persist on keeping the drawbridge up then we'll find ourselves in a castle with … with no one else interested in attending everybody else will be off somewhere else…" (Gabriel)

In addition to the above challenges, there was a sense of collective grief and loss among the interviewed psychologists. For example, in the quote below, Helen described the narrowness and exclusion has led to a sense that something will be, or is, "lost" from the psychology profession in Australia.

"I suspect, if psychology … if psychologists were told you can't talk complementary medicine, but you can still talk traditional GP hospital medicine, I don't think psychology will disappear. I think it'll just end up jamming itself, you know, in the medical model, and will kind of lose some of its uniqueness, some of its capacity to work with, with people at an individual level, rather than you just have to fit this. Yeah, I think that something would be lost." (Helene)

The above quote is important as it moves the argument, from CM as a consideration, to CM as being vital to the relevance of psychology. A number of the psychologists described this sense that the psychology profession in Australia had changed, and something has been lost. For example, Gabriel reported his observation of these changes.

"And I know prior to 2010, when I go back to my earlier years in practice, I was able to quite fluidly move between being a naturopathic practitioner being a professional psychologist. And … and to actually explore the relationship between both of those and to explore the mind body potential, and to be treating patients across both across both domains." (Gabriel)

Gabriel continued,

“And so, the opportunity to cross disciplines and across professional boundaries, I fear has been lost.” (Gabriel)

Juliette also described this sense of loss.

“I actually think something's been lost. Because the more you narrow the field, well, then, the less inclusive it is.” (Juliette)

The quotes above reflected the views of a number of the interviewed psychologists in the context of profession of psychology based challenges. Some of the interviewed psychologists felt so strongly about their sense of loss and disappointment in the narrowness and exclusivity of the psychology profession, that they would forego their registration as a psychologist – just so that they could escape these rules of psychology registration as outlined above. In the quote below, Genevieve described not wanting to be part of the “elitism” and exclusion of other healing approaches to mental health care,

“But really the elitism in that subset. I found nauseating; I didn't want to be a part of that. I just simply think that we all have things that we can offer. And I just don't like separateness.” (Genevieve)

Gabriel also indicated he would let go of his psychology registration so that he could practice more flexibly.

"I would like to see a more enlightened PsyBA, I've seen some loosening of the regulations recently. So, I see that they might be heading in that direction. But there is, you know, there is a view that, that if you actually let go of all that registration, and an even professional association, you ought to be able to practice as, as what I don't know, as a psychotherapist, who uses nutrition. And you will be subjected to, you know, to ordinary common law in terms of whether you cause harm to somebody, it might be a freer way to practice." (Gabriel)

In the quote below, Catherine expressed a similar view, describing the implications if psychology is "left behind". In the quote below, Catherine shared a belief that convergent approaches, or those health care approaches that offer a broad and inclusive range of approaches to mental health care, will become sought after by CM informed consumers. Catherine explained,

"I think what will happen is what's already happening is people will drift more towards counsellors who are happy to sort of do a little bit of this and a little bit of that, they'll drift towards yoga teachers who are doing a little bit of this and a little bit of that, I think it will actually encourage people … because people are becoming more educated now to about what's possible." (Catherine)

8.3 Chapter summary

This chapter presented the results from the thematic analysis of the interview data collected from 19 psychologists describing the barriers and challenges to their engagement with CM in their clinical practice. The excerpts from the transcripts help provide insight into the psychologists' perspectives and experiences. The previous chapter highlighted justifications for their engagement with CM, including client based, (e.g., responding to and accepting of client demand for CM), psychologist based (e.g., career satisfaction when engaging with CM as part of their clinical practice), clinical practice based (e.g., engaging with client preference for CM was seen as culturally responsive practice), and profession of psychology based justification (e.g., engaging with CM had potential to bring innovation to the profession of psychology). In contrast, the challenges reported by psychologists include client based, (e.g., cost of accessing CM practitioners), psychologist based (e.g., time and cost of relevant CM training), clinical practice based (e.g., lack of clarity how to safely engage with CM in their clinical practice), and profession of psychology based justification (e.g., perceived agnostic stance or epistemic exclusion when it comes to psychologist engagement with CM). How psychologists navigate these justifications and challenges, and decide whether to engage with CM, or make the decision not to engage, or limit their engagement with CM in their clinical practice will be discussed in the next chapter.

Chapter 9. PHASE THREE – QUALITATIVE PHASE DISCUSSION

9.1 Preface

The previous two chapters presented a thematic analysis of qualitative data drawn from interview fieldwork that relates to psychologists' engagement with CM as part of their clinical practice. These qualitative results are here discussed in a wider context with reference to insights from previous research on the clinical practice of psychology in Australia, as well as insights from previous research and debate around health care professionals' engagement with CM – both including and beyond psychology. The results of the thematic analysis (as presented in Chapters 7 and 8) were organised around two main themes, *justifications* and *challenges*. Four subthemes were presented under justifications and challenges, including the client experience, the psychologist themselves, the psychologist's clinical practice, and the profession of psychology in Australia. Building upon the presentation of results and thematic analysis (Chapters 7 and 8), this discussion chapter outlines a number of key findings that are considered especially important and significant.

Firstly, this discussion chapter provides an interpretation of how the psychologists justify their engagement with CM with reference to actors extrinsic to their own interest in CM – including how the psychologists justify CM engagement in terms of responding directly to client interest in CM, and that the psychologist's engagement with CM in their clinical practice is presented as providing innovation for the field of psychology. Following

on from client-based justifications, the chapter explores factors secondary to these extrinsic motivators, the psychologists feel their work is enriched when they are able to flexibly include CM in the clinical practice. The chapter then moves on to explore challenges to engaging with CM, and another major finding, expressed by the interviewed psychologists, which related to the lack of clarity on the role of CM within psychology practice, the permissibility of CM, and how to safely engage with CM. Finally, the chapter moves to an interpretation of another important finding, that the psychologists perceive psychology practice in Australia has narrowed and the loss of creativity and flexibility in their practice has had negative implications for psychology as a health care discipline in Australia.

9.2 Justifications for psychologist engagement with CM

To begin with, there were a number of justifications that are worthy of further discussion. Firstly, the psychologists are attempting to prioritise and be responsive to their client's preferences. Specifically, the psychologists prioritise responding to the client's preferences and values, that include CM, as part of their client's health care. The discussion will examine how psychologists drew upon their clinical expertise to be i) selective about, but not wedded to CM in their clinical practice, and ii) how psychologist perceived their knowledge/skills in CM provide an additional tool that they could flexibly draw upon in their clinical practice. Another important finding was that the participant psychologists justified their engagement with CM in the context of enriching their career satisfaction, in that they could supplement a conventional "bland" psychology approach by flexibly

selecting from, and including, CM in some form. The last justification to be discussed in the following section is how the psychologists situate these justifications in the context of benefits for the Australian psychology profession and feeling that their engagement with CM was "pushing a boundary" that ultimately provides innovation and moves the discipline of psychology forward.

9.2.1 Client preference for CM

One way psychologists justified their engagement with CM was through prioritising client preferences and values, irrespective of the psychologist's inadequate knowledge of CM or their consideration of associated risks of engaging with CM (discussed in Chapters 5 and 6). This justification appeared to be underpinned by the psychologists' attempt to be inclusive of the client's preferences, values and characteristics. This argument, presented by the psychologists, is important as it identified the psychologists' primary motivations for engaging with CM as being rooted in perceived client benefits. The ways in which the psychologists justified this motivating force is through the perceived benefits to the client when the psychologist acknowledges client preference for CM. Acknowledging client preference for CM was through the psychologist adopting a respectful and affirming response to client interest in CM, rapport building that incorporates CM, the role of being an open and accepting clinician, as well as acknowledging the cultural/spiritual significance of CM for some clients. In wider literature, engagement with client preferences in psychological therapy has been described as an ethical imperative (Norcross & Cooper,

2021) and previous studies highlight the importance of psychologist's sensitivity to client preferences in therapeutic settings (Sandage et al., 2022). Further, acknowledging client preference has indeed been associated with improved therapeutic alliance and therapeutic outcomes (Captari et al., 2022; Cooper et al., 2022). The findings from the current study align with Captari and colleagues' (2022) research on best practice for therapists responding to client culture/spirituality, which highlighted the importance of curiosity about, and the inclusion of, client preferences for culture/spirituality, which assists understanding the client's lived experience, vulnerabilities, and identifies their resources. Similarly, contemporary research supports the development of competencies for psychologists in responding to client culture/spirituality (Currier et al., 2023; Sargeant & Yoxall, 2023; Vieten & Lukoff, 2022). The alignment between existing research, and the arguments projected by psychologists in the current study, support the psychologist's justifications for their engagement with CM, particularly as grounded in responding to client preference for the cultural/spiritual relevance of some CM. This may have implications for how Australian psychology curricula, and how psychologists learn about how to acknowledge, and integrate, client preferences in clinical settings, including in the context of client preference for CM.

Acknowledging client preference for CM was also described by some of the psychologists as a tool to encourage the client toward self-care that utilises the client's preferred CM. For example, the client may be encouraged to return to a massage therapist that was mentioned favourably by the client. This form of engagement with the client's

preference for CM was also seen by the psychologists as a means of empowering the client to manage their own health care. The use of the client's existing strengths, a type of therapeutic empowerment, aligns with previous research on the benefits of therapists drawing out and mobilising client internal and external resources (Niemiec, 2019; Niemiec et al., 2020; Weziak-Bialowolska et al., 2023). There is also specific research supporting client engagement with their preference for CM utilised as a means of empowering clients (Clossey et al., 2023), particularly in mental health settings (Jay et al., 2023; Wemrell et al., 2020). This finding is important as it may lend traction to the psychologists' arguments regarding the merits of engaging with client preference for CM in clinical practice. These types of arguments, as projected by the psychologists, may influence how psychology, as a health care profession in Australia, views the role of psychologist engagement with CM.

These findings, around client benefit, where psychologists are engaged with CM, extend and add texture to previous qualitative research that has identified Australian psychologist's interest in CM in the context of holistic and client centred care (Hamilton & Marietti, 2017; Kassis & Papps, 2020; Wilson & White, 2011). In the current study, the psychologists offered deeper insights, that their interpretation of holistic and client centred care was positioned as being grounded in the psychologists responding to both the client's preference and demand for CM as part of their psychological therapy. This is important and a significant shift away from previous research that seems to position CM within psychology practice as mostly driven by the psychologist's own interests in CM. These client-centred reasons for engaging with CM, as described by the psychologists in the

current study, are also consistent with research examining broader health practitioner (e.g., nurses, medical specialists, physicians) engagement with CM (Hall et al., 2017; Phutrakool & Pongpirul, 2022; Tekin et al., 2021). As noted above, the picture that emerges from the current analysis is one of Australian psychologists in clinical practice engaging with CM, and this engagement is driven by the client – the psychologist justified this engagement as being responsive to client preferences. Many of the psychologists described this client led preference for CM as putting the psychologist in a "unique position" to support the client to navigate CM, such as bringing attention to any potential contraindications and identifying reputable CM practitioners. This argument from the psychologists, that they are in a special or unique position, by engaging with CM in the clinical practice, will be explored throughout the discussion sections below.

What is also compelling about this justification provided by the psychologists in the current study, that CM within clinical practice is driven by the client, is that it presented an argument for engaging with CM that aligns with established principles of evidence-based practice (EBP), specifically evidence-based practice in psychology (EBPP) (American Psychological Association, 2006; Australian Psychology Accreditation Council, 2019), which will be discussed further below. In brief, responding to client preferences and values is considered an essential element of EBPP (see Section 1.6.6). This alignment with EBPP principles provides a clever and persuasive argument for the integration of CM within psychology practice, wherein responding to client needs and EBPP principles converge. This argument suggests psychology, as health care profession in Australia, may need to

consider the relevance of CM within psychologists' clinical practice, in context of acknowledging client preferences and demand, and as part of EBPP. As noted above, psychologists are in a "unique position" to respond to client preference for CM, and respond to client query about CM, in the context of providing their clients with sufficient information to allow them to decide what is their treatment preference, and thus potentially what is included in their course of treatment (Wardle et al., 2014; Weir, 2003, 2022). These kinds of arguments, as presented by the psychologists, may be directed toward their psychologist peers, to signal that their engaging with CM, aligns with EBPP through responsivity to the client, and by offering a personalised response to client's needs, and in the context of informing the client of their mental health treatment options (Australian Psychological Society, 2007a; Deisenhofer et al., 2024). Australian psychology may need to consider the inclusion of CM in tertiary psychology curricula to assist psychologists to not only be responsive to client demand and preference for CM, but to also apprise clients of alternative treatment options.

The arguments presented by the psychologists in the current study provided a number of justifications for the inclusion of CM in tertiary curricula. Specifically, CM relevant education for psychologists may provide them with additional skills, particularly in the context of responsivity and sensitivity to the cultural relevance of some CM for some clients (Crowe-Salazar, 2007; Curtis et al., 2019; Smith et al., 2022). The World Health Organisation (WHO) also encourages, and provides resources, to assist health care providers internationally to respect the role and cultural relevance of some CM in health

care systems (World Health Organisation, 2023). The psychologists in the current study described the importance of responding with curiosity, respect and acceptance when engaging with client cultural and spiritual beliefs in the context of their wellbeing and health care. This argument extends upon the above justifications in the context of acknowledging client cultural/spiritual preferences, and as a form of client empowerment utilising the client's existing resources. Here, engaging with client cultural/spiritual preferences appeared to be presented as the psychologists attempt to be culturally responsive. These attempts to be culturally responsive align with the mandate from psychology in Australia that psychologists undergo training and demonstrate cultural competence in their clinical practice (Australian Psychology Accreditation Council, 2019, 2022). In addition, the Psychology Board of Australia National Psychology Examination includes assessment tasks related to working in cross-cultural contexts (Psychology Board of Australia, 2020). Of note, the inclusion of the importance of being culturally responsive was only formally introduced/mandated in Australian psychology tertiary curricula in 2019. Although, sensitivity to client's cultural/spiritual preferences would be axiomatic, the literature demonstrates growing themes of interest in mental health care and psychology (Brockman & Dudgeon, 2020; Ciofalo et al., 2022; Sandage et al., 2022). This form of responsivity to client preference for CM, in the context of the cultural/spiritual relevance of some CM for some clients, is also potentially persuasive. This line of argument suggests the inclusion of CM within clinical practice is situated within Australian psychology's own mandates around psychologists being culturally responsive. Psychologists already engaging

in cultural and spiritual responsiveness may find themselves well positioned and demonstrating fulfillment of this mandate. The CM engaged psychologists' clinical practice behaviours already align with the growing recognition of the importance of cultural competence in the field of psychology. This responsiveness may provide the psychologists with a sound argument for the relevance of CM within psychology, where their nuanced understanding of diverse cultural and spiritual perspectives not only complies with professional standards but also fosters a more inclusive clinical practice. These findings, that the psychologists engage with the cultural/spiritual relevance of CM, lend additional support to the potential role of CM within psychology. Further, these findings may assist CM to find a place within Australian psychology tertiary curricula in the context of diversity, sensitivity and responsivity to client cultural/spiritual preferences. For example, psychologist tertiary training may include the provision of case studies where psychologists role play engaging with an Aboriginal person's interest in culturally relevant traditional healing practices (Culbong et al., 2022; Jones et al., 2022).

Beyond their direct response to client preference and demand for CM, these client-based justifications may also be explained as the participant psychologists' interpretation of what is good psychology practice. The psychologists may be aiming to be client centred, which is enacted through acknowledging client's preferences, characteristics, values and any barriers to health care. Responding to client preferences is part of psychology's evidence-based practice in psychology (EBPP) mandate (American Psychological Association, 2006; Australian Psychological Society, 2018; Tompkins et al., 2013). EBPP

directs psychologists to integrate the best available research/evidence, utilise their clinical expertise, as well as acknowledge the client's preferences, values, and social and cultural factors (Melchert et al., 2023; Ward et al., 2022) into their clinical practice. In Australia, an earlier qualitative study of consumers of primary health care services described the expectation that their health care provider would respect the consumer's opinion on their own health care, particularly in the context of chronic conditions (i.e., mental health problems) and lived experience (Song et al., 2020). This may also explain the interviewed psychologists' attempt to be inclusive of client's opinion and autonomy about their health care in the context of EBPP principles. Previous research, related to the current study, has also focussed on psychologist's perspective on the efficacy and evidence for CM (discussed below), rather than the inclusion of client preference for CM, as part of enacting EBPP principles. This nuanced justification may be an astute tactic of these psychologists to place their engagement with CM along a distinct line of clinical reasoning. This line of reasoning drew on, and aligns with, EBPP principles at the core of psychology practice in Australia. To clarify, the psychologists appeared to, consciously or unconsciously, frame and position their engagement with CM as part of evidence-based practice in psychology (EBPP) principles, thus their engagement with CM as reinforcing their commitment to the empirical foundations and rigorous standards that characterise contemporary psychology practice in Australia. In this context, the argument proposed by the psychologists was that their engagement with CM in clinical practice is authenticated and legitimised via psychology's own EBPP principles. This argument is compelling, given the historical absence of CM

from mainstream Australian psychology's policy and guidelines (Chapter 4). It may be difficult for those in positions of power and influence in psychology in Australia to ignore arguments that position psychologist engagement with CM as part of EBPP. The findings from the current study suggest psychologists engage with CM in their clinical practice justified through being responsive to client preferences, including acknowledging the cultural/spiritual relevance of some CM, all of which align with EBPP principles as mandated by psychology.

The psychologists extended upon these EBPP principles, and client-centred justifications to add that engaging with their client's preference for CM was founded in a sense of "responsibility" (Josephine, p. 245, Sarah, p. 249, and Genvieve, p. 250) and "obligation" (Edith, p. 248 and Sarah, p. 299) to provide information to clients on relevant healing modalities. Of note, some of the Australian state/territory based Mental Health Acts describe adequate informed consent as including an explanation of any beneficial alternative treatments that are reasonably available (*Mental Health Act 2007*, NSW; *Mental Health Act 2016*, Qld; *Mental Health and Wellbeing Act 2022*, Vic). This justification, around obligation to apprise clients of alternative health care approaches, also aligns with World Health Organisation (WHO) guidelines that encourages member states to work toward the integration of CM into health care settings (Zhang et al., 2019), as well as broader arguments that encourage a more integrated and multidisciplinary approach to health care (Leijten et al., 2018; Winkelmann et al., 2022). Previous research indicates there are a number of benefits when multidisciplinary teams are engaged in mental health care

(Colizzi et al., 2020; Garrett et al., 2020; Henderson et al., 2023; Hetrick et al., 2017; Settipani et al., 2019), including from the perspective of clients (Kehoe et al., 2023). The psychologists in the current study described their perception of the potential benefits when they engage in a multidisciplinary approach, that includes engaging with CM practitioners. The perceived benefits of engaging with CM practitioners were presented as the psychologists' efforts to address the client's broader health care needs, including, sharing client care responsibilities, addressing gaps and limits to services the psychologist can provide, and addressing gaps in service delivery when there is high demand for psychology services. These types of justifications are important, not just in the context of client benefit, but also in the context of enacting a multidisciplinary approach that is inclusive of CM practitioners and the health care services they provide.

The advantages of adopting a multidisciplinary approach, inclusive of CM practitioners, as described by the interviewed psychologists, resonate with existing literature that emphasises the benefits of a multidisciplinary approach to mental health care (Flies et al., 2023; Foroughi et al., 2019). Of note, the psychologists in the current study appeared to acknowledge the value of, and described their attempts to, enact a multidisciplinary approach that incorporates CM. The psychologists positioned themselves as a resource, guiding clients to identify suitable CM practitioners. This proactive role not only aligns with evolving trend towards multidisciplinary care, uniquely positioning psychologists as facilitators guiding clients through the landscape of relevant CM, it also appears the psychologists leverage their skills and scientific training to critically explore the

evidence for CM on behalf of their clients. This is an interesting argument, as it distinguishes the psychologists from those who lack training in scientific and critical examination of evidence for health care approaches, especially in the realm of mental health care. By incorporating scientific scrutiny into their approach, the psychologists may gain a unique and distinct advantage compared to other health care providers, including CM practitioners. This kind of presentation is important and highlights psychologists could hold a distinctive role as knowledgeable facilitators, guiding clients to navigate CM in the context of mental health and broader health care needs. This kind of presentation may assist the argument for psychologist engagement with CM, as part of responding to client needs and assisting the client to safely navigate CM. For example, assisting the client to identify any risks and/or contraindications with CM products or how to avoid underqualified CM practitioners. The potential value of these types of arguments, as projected by the psychologists, may be important in demonstrating how Australian psychology's own clinical practice tools, mandates for interprofessional communication, and importance of multidisciplinary approaches, may justify a role for CM within psychology. Further, these presentations and arguments may do some work toward persuading psychology to consider the development of CM relevant education for psychologists in psychology tertiary curricula, such as how to safely identify and refer to CM practitioners, in the context of the benefits of multidisciplinary mental health care (Ligorio & Lyons, 2018; Moxham et al., 2017; O'Donohue et al., 2023; Singer & Adams, 2014; Vijayakumar & Sivakumar, 2022).

9.2.2 Clinical expertise and being selective about CM

All of the psychologists in the current study qualified their engagement with CM as including their employment of clinical judgment about the utility and efficacy of CM, and being selective and discerning about whether they include CM, as part of their clinical practice. They did not see CM as a "blanket approach'' (George p. 235). They described considering a range of factors before engaging with CM, including the risk and relevance of CM in the context of the client's needs and preferences (values, social and cultural factors). For example, the psychologists described being "discerning" (George, p. 235) about the costs and availability of CM practitioners, before recommending or referring their clients to CM. This is consistent with previous Australian research where psychologists describe being discerning when considering the inclusion of CM, and its potential benefit for their client (Hamilton & Marietti, 2017; Kassis & Papps, 2020). For example, the interviewed psychologists described familiarising themselves with local expert CM practitioners to orientate and evaluate themselves to the services that they provide.

The psychologists also described being engaged with professional development in CM (outside of psychology) and familiarisation with relevant CM research. There is literature exploring the efficacy and potential benefits of some CM for mental health (Malhi et al., 2021; Sarris, 2018; Sarris et al., 2022), and interestingly some of this research is now being published in international psychology journals (Abrantes et al., 2017; Mattar & Frewen, 2020; Qi & Jones, 2023; Zhao, Kennedy, et al., 2023; Zhao, Xu, et al., 2023). The

interviewed psychologists described critically considering the evidence for some CM, and importantly, they are also willing to disregard CM. The psychologists again presented an argument for their unique position, where they leveraged their critical thinking and scientific skills to examine the utility of CM, while also holding the power and discretion to engage with CM, or not. This type of argument may be another powerful tool, as it suggests these psychologists are not uncritical devotees of CM. Rather it presented a considered and powerful contrast, potentially providing a counter argument to those who might consider that psychologists who engage with CM are inherently biased toward CM. There has been publications that infer psychologists who engage with CM in their clinical practice are imposing their own interests in CM upon their clients (Swan et al., 2015), and/or that CM simply does not belong in psychology (Fasce & Adrián-Ventura, 2020; Swan et al., 2015). The findings from the current study are an important contrast and suggest that psychologist’s engagement with CM resides mostly within extrinsic and client centred reasons, and that these reasons align with Australian psychology’s own EBPP mandates. These findings are also important as they clarify CM engagement is not restricted to a small group of CM invested psychologists. Rather, psychologist engagement with CM is likely driven by psychologists attempting to adhere to psychology’s own EBPP mandates. Further these psychologists appeared to be drawing upon existing Australian psychology professional association regulations and policy in the absence of any CM specific regulations and policy for psychologists. Paired with the discernment described above, these presentations may provide alternative arguments, that work to demonstrate the

psychologists' credibility in the eyes of their psychologist peers, those with power and influence in the field of psychology, and health care professionals broadly, to present these psychologists as bona fide providers of CM within their clinical practice.

The participant psychologists also described their engagement with CM as part of an "obligation" (Edith, p. 248) to apprise clients of all evidenced-based approaches relevant to addressing mental health concerns. This again highlights the argument that psychologists are in a unique position to explore the evidence for CM through the lens of their scientific training, yet they are not inherently committed to CM. This sense of obligation underscores an important argument, that these psychologists are not merely experimenting; instead, they present themselves as health professionals providing an "expanded" (Sarah, p. 256) evidence-based approach to their client's care. The argument, that it is important for psychologists to apprise clients of all relevant mental health care approaches, including CM, also plays a substantial role in advancing the cause of these psychologists who may be aiming to affirm a role for CM within psychology. These justifications may be useful in trying to convince Australian psychology's elite, and other stakeholders, that psychologist engagement with CM aligns with a number of EBPP principles, as well key mandates around how psychologists in Australia engage in the assessment and treatment of their clients.

The interviewed psychologist's argument, that they are discerning about CM, is in contrast to previous findings that psychologists engage with CM even when their

knowledge of CM is limited (see Chapter 6). However, the above arguments, around the psychologists being responsive to client preference, as well as obligations to inform clients on a range of mental health care options, may facilitate our understanding of how these psychologists reconcile any lack of knowledge of CM with their active engagement with CM in their clinical practice. These results offer a potential explanation for psychologist engagement with CM, despite a lack of knowledge of CM. The results suggest the psychologists who are engaging with CM are justifying this engagement by aligning with, and enacting, elements of EBPP principles via the integration of client characteristics, culture and preferences, along with the psychologist's clinical expertise to be discerning about the best available CM relevant research. As noted previously, EBPP is a tripartite model: client preferences, clinical expertise, and evidence-based interventions. It appears the arguments and justifications presented by the psychologists are not an attempt at subversion, rather an appeal to Australian psychology's elite urging recognition of these psychologists' endeavours to embody principles of culturally competent and effective psychology practice.

9.2.4 Engaging with CM enriches work satisfaction

There were other justifications offered by the psychologists that were not centred within responding to client needs and preferences. The psychologists also explained their engagement with CM was like having an additional therapeutic tool to draw upon, and the possibility of engaging with CM, in some form, within their clinical practice gave them a

sense of flexibility. This flexibility was described as both being responsive to client preference for CM and having a sense that they had the choice to flexibly move between conventional psychology approaches and CM in their clinical practice. For example, incorporating yoga or meditation techniques during a psychology consultation to assist a client recover from an acute anxious state (Bukar et al., 2019; Cramer et al., 2018; Wankhede et al., 2020). This sense of flexibility, and professional autonomy, were positioned by the psychologists as an important element in their clinical practice, where they were not limited to only selecting from standard conventional psychological therapeutic approaches. Previous research has also highlighted forms of flexibility in work roles (within health care broadly) as important for reasons including; adapting to client needs, (Leijten et al., 2018), work satisfaction (Gagné et al., 2022), and reducing the incidence of burnout among health professionals (Johnson et al., 2020; Lee & Chang, 2022). It appears the psychologist's sense of flexibility meant they were able to select from a range of other therapies and health care approaches freely and creatively, including CM. Some of the interviewed psychologists nominated this sense of flexibility, to draw on CM in clinical practice, as directly contributing to their work satisfaction. In the context of high demand for, and on psychologists (Chhabra & Dhingra, 2023; Davis-McCabe et al., 2019; Macleod et al., 2023), it may be important for Australian psychology to consider how access to diverse techniques, and the flexibility to select from those techniques, may improve job satisfaction. Future research may also consider the importance of having a sense of flexibility to draw on non-standard psychology therapeutic tools, including CM,

and how this might contribute to psychologist wellbeing, job satisfaction, and work role retention.

In addition to fostering a sense of flexibility, the psychologists also described the incorporation of CM into their clinical practice as providing them with additional therapeutic tools to assist their clients, beyond standard conventional psychological interventions. Indeed in Europe there is acknowledgement of additional specialisations in psychology (e.g., somatic psychology) beyond traditional areas of speciality (e.g., clinical psychology, counselling psychology etc.) and that specialisation is important to the development of health fields (Dias Neto et al., 2020). Further, in America there are specialities and subspecialties, where the subspecialties exist within a recognised (parent) speciality, require additional education, training, and involve specific problems, populations and/or circumscribed approaches (American Psychological Association, 2020). This type of justification presented by the psychologists in the current study, of CM specifically as an additional tool or speciality to augment conventional psychology approaches they provide to their clients, is shared by other health professionals such as GPs (Ee et al., 2021; Ostermaier et al., 2020) and psychiatrists (Schaub et al., 2021). A qualitative study of GPs perception of CM also identified that including CM offers them an additional skill or tool to address any gaps in conventional or allopathic approaches to health care (Adams, 2000; Adams, 2003; Pirotta et al., 2010). While GPs and psychologists work in distinct health settings, and are different health professions, there are similarities in how they engage with clients in their practice, including being responsive to the individual client, as well as

collaboration and shared decision making on treatment goals and planning with their clients. Psychology in Australia may need to consider how subspecialities and additional tools, such as CM, enhance and extend the specialty services psychologists can offer their clients and how the addition of these tools serves to enrich psychologists work in their clinical practice.

In addition to offering flexibility and an additional tool, the interviewed psychologists described their engagement with CM as energising, as adding a sense of “satisfaction” (Sarah p. 226 and George, p. 229) in their career and feeling like a “happy therapist” (Joan, p. 229). Perhaps these psychologists find the addition of CM in their clinical practice meaningful. Further this sense of satisfaction was in contrast and juxtaposed to “bland” and “surface level” (Carla, p. 222) approaches to psychology practice, such as CBT. However there needs to be some caution interpreting the data as the interviewed psychologists work in different settings, which may influence the therapeutic approaches that they can select from. Further, of the interviewed psychologists (N=19) most were clinical psychologists (n=8) and the sense that conventional psychology practice is bland may come from the usual work role of a clinical psychologist. Given the difficulty and demands on psychologists, the perceived benefits of integrating CM (drawing on skills and approaches the psychologist finds energising and meaningful) may be valuable to understanding how to improve psychologist job satisfaction and work role retention. Specifically, the findings from the current study not only highlight the importance of a sense of flexibility in their work role, but also the unique contribution of engaging with an

additional skill, such as CM, in their clinical practice. Other fields have also identified skill diversity as important to job satisfaction (Ara & Akbar, 2016). For example, a study of European GPs found that having specialised skills was associated with job satisfaction, in addition to having the freedom to adapt and design their clinical practice to suit themselves (Le Floch et al., 2019). The addition and contribution of CM skills to psychologists in clinical practice may involve nuanced benefits, such as adopting a whole person approach and enhancing client engagement (Hamilton & Marietti, 2017; Kassis & Papps, 2020; Liem, 2019a; Liem, 2020). Previous research has also identified other health professionals who integrated CM into their clinical practice have high rates of job satisfaction (Kaitz & Ray, 2021). For example, a study of German GPs found those who has had positive attitude towards CAM, and held special qualifications in CM, had higher job satisfaction than those with a neutral or negative attitude toward CM (Joos et al., 2011). Interestingly, innovation (discussed below) and the capacity to be creative in one's work roles has also been identified as a component of job satisfaction (Tang et al., 2019). The role of specialised skills, including competency and credentialling in CM, may be worthy of further research. It would be valuable to determine if being able to draw flexibly upon CM in their clinical practice truly contributes to psychologist's work role satisfaction. In the context of high demand for service provision, and burnout experienced by psychologists (Chhabra & Dhingra, 2023; Macleod et al., 2023; Turnbull & Rhodes, 2021), the findings from the current study may have implications for how to prevent burnout among psychologists and improve their career satisfaction. Psychology in Australia may need to consider these

broader benefits to the field of psychology, and psychologists, when psychologists engage with CM.

9.2.5 Engaging with CM provides innovation for the field of psychology

Another interesting finding from the current study was that most of the interviewed psychologists perceived psychologist engagement with CM in clinical practice as pushing at the "fringes" (Edith, p. 2660) of the field of psychology. The psychologists presented their engagement with CM as being creative and problem solving with and for clients, despite feeling they are pushing at the fringes and extending the boundary of the profession, and what is considered standard conventional psychology in Australia. The idea of innovation was often presented with an example of once-fringe or controversial therapies, or CM eventually being accepted into psychology or another health discipline. For example, the psychologists in the current study most frequently provided Eye Movement Desensitization and Reprocessing (EMDR) as an example of an approach once considered fringe, but now accepted into mainstream psychology. Some of the psychologists also used the acceptance of CM by other health care professions as a form of approval for their own engagement with CM. For example, the increasing acceptability of CM has been noted across health care disciplines internationally (Hermanson et al., 2021) including in medicine (Frass et al., 2012; Phutrakool & Pongpirul, 2022), psychiatry (Malhi et al., 2021; Sarris et al., 2022), and broader fields such as public health (Nailwal et al., 2021; Seetharaman et al., 2021). Further, research supports the broader benefits of flexible scopes

of practice in health care (Kooreman & Baars, 2012; Leslie et al., 2021; Settles et al., 2021). All of which align with arguments put forward by the psychologists in the current study. It is as if the psychologists in our study are attempting to keep pace with other health professionals' adoption of CM within their clinical practice.

This pushing at the boundaries provides a clever justification where engagement with CM is positioned as having benefit, not just for the client and psychologist, but also the psychology as a health care profession in Australia. The psychologists perceive their engagement with CM as a manifestation of innovation within the discipline, and they position themselves as pioneers pushing at boundaries of conventional clinical practice. Further they appear to be appealing to the psychology profession and insisting their engagement with CM is indeed their attempt at trailblazing on behalf of the profession. Some of the psychologists even extend the argument, that this innovation provides benefit beyond the internal dynamics of the psychology profession, by justifying their engagement with CM as a strategic response to the perceived risk that psychology may lose its relevance within health care if it is unable to innovate and evolve. Indeed the literature recognises psychology needs to innovate in order to remain relevant and contribute to contemporary health care needs of the communities it serves (Clinton, 2020; McLeod, 2015). This kind of innovation is important to all fields (Bradley et al., 2019; Chandra et al., 2021; Olsen et al., 2020), and relevant fields, such as psychiatry, consider the inclusion of CM approaches as part of contemporary innovation (Malhi et al., 2021; Sarris, 2022). If one considers the range of justifications provided by the psychologists above, it may be

critical that psychology considers the role of CM within psychology as fertile ground for innovation, evolution, and maintaining relevance. Ultimately the data from the qualitative interviews contributes to a broader narrative of innovation, flexibility, and responsiveness within the evolving landscape of mental health care and psychology. These findings provide further qualifications, and collectively a firm signal to the Australian psychology profession, that there is a need to be responsive to client and psychologist demand for CM within clinical practice in Australia. Importantly many of the client-based justifications described above position psychologist engagement with CM within psychology's own mandates of EBPP. However, the interviewed psychologists also described challenges to their engagement with CM that were mostly situated within the discipline of psychology, which will be discussed below.

9.3 Challenges to psychologist engagement with CM

To begin with, the interviewed psychologists described only a few challenges situated in the context of the client, compared to those situated within psychology as a discipline (discussed below), and these were mostly related to their client's lack of interest in CM, or the financial cost and availability of CM practitioners as barriers to accessing CM. Similarly, there were few challenges related to the psychologists themselves, and these were mostly related to financial costs associated with attaining competency (skills and/or knowledge) in CM, and/or limited availability of training in relevant CM. The most powerful challenges described by the psychologists related to uncertainty about how to

safely integrate CM (discuss, recommend, refer, direct application) into their clinical practice. These clinical practice challenges were mostly downstream from what the psychologists perceived as challenges arising from an agnostic stance from the profession of psychology in Australia (including professional associations and regulatory bodies). Specifically, the interviewed psychologists pointed to the absence of a firm position or stance on CM within psychology from psychology's professional associations, limited or no CM relevant resources for psychologists, and a sense of fear of negative appraisal from their psychologist peers should they choose to engage with CM in their clinical practice.

9.3.1 Problems related to limited CM resources for psychologists

One of the most significant challenges to engaging with CM in their clinical practice, as put forward by the interviewed psychologists, was a lack of CM relevant resources. The psychologists projected an expectation that these CM relevant resources, such as education (formal and informal) and clinical practice guidelines, should be provided, or at least endorsed, by Australian psychology professional associations and regulatory bodies. The psychologists describe this lack of CM relevant guidelines for psychologists as negatively impacting on their knowledge, competency, and understanding of how to safely integrate CM into their clinical practice. This lack of CM resources was also viewed by the psychologists as an example of their perception of psychology's dismissal of the relevance of CM to psychology. The lack of CM resources appears to be interpreted by the psychologists as demonstrative of psychology's lack of interest in CM or

lack of understanding of the relevance of CM to psychologists in clinical practice. This lack of CM resources is not unique to psychology in Australia. The lack of CM relevant guidelines for a range of health care disciplines is acknowledged internationally (Zhao, Kennedy, et al., 2023). The lack of CM relevant resources for psychologists in Australia has also been previously noted (Hamilton & Marietti, 2017; Kassis & Papps, 2020). This lack of relevant resources may contribute to the psychologists' uncertainty on the level of acceptance of CM from psychology's professional associations. The lack of CM relevant resources may also reflect an underestimation, by the field of psychology in Australia, of the high CM use by people with mental health problems (Harnett et al., 2023; Steel, McIntyre, et al., 2018) and thus demand from both clients and psychologists for CM.

Due to the lack of CM resources, psychologists in the current study, describe being unable to firmly establish whether engaging with CM would be considered a breach of their scope of practice, even if they were well trained in CM. This type of argument aligns with international studies that also report challenges for psychologists wishing to engage with CM, such as gaps in their knowledge regarding relevant evidence-based CM (Baxter & Lovell, 2021; Casbarro et al., 2021; Morkl et al., 2021; Roberts et al., 2021; van Rensburg et al., 2020), lack of clarity on how to recommend evidence-based CM to their clients, or how to facilitate referral to a CM practitioner if requested by a client (Liem, 2020; Makarem et al., 2022; Nayda et al., 2021). It appears the complaint around a lack of clarity on CM's role within psychology in Australia is not new (Stapleton et al., 2015; Wilson & White, 2007; Wilson et al., 2013). Interestingly these arguments, around a lack of CM

resources for psychologists, were first published in the APS's own journal over a decade ago (Wilson & White, 2011) and similar articles relating to Australia's lack of CM relevant resources for psychologists have been published in other journals almost continuously year on year since then (Fay et al., 2016; Hamilton & Marietti, 2017; Kassis & Papps, 2020; Liem, 2019b; Stapleton et al., 2015; Wilson et al., 2012a). Further, this complaint regarding a lack of CM relevant resources was substantiated by the analysis of guidelines from Australian psychology professional associations that reveal limited mention of CM, nor how psychologists could safely engage with CM in their clinical practice (Chapter 4). Of note is the psychologists in the current study positioned the lack of CM resources, as a barrier to engaging with CM in their clinical practice, and this problem appears to dominate previous literature regarding Australian psychologists engagement with CM (Hamilton & Marietti, 2017; Kassis & Papps, 2020; Stapleton et al., 2015). This may be a reflection of, not just the lack of CM resources, but a reflection of parochial issues for the field of psychology in Australia (discussed below).

Interestingly the interviewed psychologists appeared to position the blame for the lack of CM resources on Australian psychology's professional associations, more so than on psychology's regulatory (Psychology Board of Australia) or academic (HODSPA, APAC) sources of power and influence over the profession of psychology in Australia. Nonetheless, the oversight of the relevance of CM, by psychology, could indeed be indicative of psychology's failure to recognise the intersection of psychologists responding to client preference for CM and psychology's own mandates and EBPP principles. This

oversight appears distinct from any epistemological commonalities, differences, or exclusions (intentional or unintentional) that may have been discussed in previous literature. Particularly literature that dismisses the relevance of CM to psychology (Fasce & Adrián-Ventura, 2020; Swan et al., 2015). Thus, it may be important for psychology to consider this intersection and provide relevant CM resources in the context of psychologist engagement with CM, driven by client preference and demand for CM, alongside psychologist responsivity to this demand via psychology's own non-CM guidelines and EBPP principles.

9.3.2 Fear, disapproval, and professional risks when engaging with CM

Regardless of the target of their blame for the lack of CM relevant resources, the impact of psychologist's uncertainty on how to safely engage with CM appears to contribute to some of the psychologist's avoidance of engaging with CM in their clinical practice. This lack of clarity was projected as permeating through the ranks of professional psychologists, where senior and supervisory psychologists were recommending psychologists avoid CM. Thus, some of the interviewed psychologists described an inner conflict as they felt the client was interested in CM, the psychologist had discerned clinical benefit for engaging with CM, but they felt unclear if they were "allowed" (George and Charlotte p. 284) to incorporate CM into their clinical practice. Subsequently there appeared to be an interpretation by psychologists generally that CM is not allowed in clinical practice in Australia. The psychologists referred to a sense of disapproval of CM,

most likely emanating from a lack of clarity, lack of resources, thus a lack of engagement with CM by Australian psychology's professional associations.

Although the interviewed psychologists varied in what they consider to be the "rules" (Edith, p. 287), all of the psychologists had a sense that their engagement with CM had an element of risk and some of them also believe they may even be punished (e.g., lose their registration as a psychologist) should they engage with CM in their clinical practice. This sense of fear is consistent with previous research where psychologists in Australia felt fearful of punitive action from their psychology professional peers or psychology professional associations if they were found to be engaging with CM in their practice (Hamilton & Marietti, 2017; Ligorio & Lyons, 2018; Stapleton et al., 2015). One psychologist described this feeling, when other psychologists and health professionals were aware of her engagement with CM in her clinical practice, she felt like the "witch in town" (Helene, p. 262). One explanation for this sense of fear and disapproval may be the social phenomenon called "othering" (Goldney, 2018, p. 56), where individuals or groups are perceived and treated as fundamentally different based on certain characteristics (Akbulut et al., 2020). In the context of health professions, othering may be a form of discrimination based on characteristics such as preconceived discriminatory notions about status, skills and expertise of differing health professions (Keet, 2014). Essentially othering can be a form of exclusion. Goldney (2018) described othering within the profession of psychology in Australia, where anyone perceived as different or deviating from a prescriptive standard may find they become controlled or punished in subtle ways. This form of othering may

also explain the interviewed psychologists' inner conflict and sense of fear of being punished by their psychology peers or psychology's professional associations. The responses of the interviewed psychologists in the current study were indeed aligned with the psychologists in Goldney's research. This was particularly relevant in relation to the sense of fear and inner conflict around what is perceived as the expected standard of practice (by the psychology profession in Australia) versus how much the psychologist should utilise their clinical expertise and discernment (e.g., knowledge of CM) to inform their practice. If we are to use "othering" as a means of explaining the above challenges experienced by the psychologists in the current study, it is possible that there is no specific or scientific justification as to why psychologists should exclude CM from their clinical practice, rather the exclusion of CM may well be perpetuated by Australian psychology's professional associations, regulatory bodies and elite who disapprove of CM either generally or in the context of psychology.

9.3.3 Is psychology in Australia exclusive

One of the most interesting findings from the talk of the interviewed psychologists was their reflection that the discipline of psychology in Australia has become narrow, and thus excludes other potentially relevant approaches, including CM. In a previous chapter we heard justifications from psychologists that invoke inclusion, acknowledgement, and innovation in the context of their engagement with CM. Here, in the context of challenges, the interviewed psychologists describe a narrowing of psychology in Australia, where there

is exclusion, and a sense of being stifled in their clinical practice, particularly where they perceive they are unable to, or not allowed to, include other diverse practices (e.g., CM approaches) into their clinical practice. What is fascinating is that the psychologists described a sense of loss and grief, that something has been lost and the profession has been reduced to a manualised and prescriptive approach to psychology (e.g., over emphasis on CBT). This narrowing and exclusiveness of the psychology profession has been echoed in the literature (Settles et al., 2021). Some of the interviewed psychologists described this narrowing as feeling that they are less able to be flexible and creative in their clinical practice. Indeed, Goldney (2019) also described a stultification of creativity within professions where "othering" occurs. This form of constriction may have negative implications for psychologists, their clients, and the profession of psychology in Australia. The negative implications for psychologists may include feeling increasingly constrained in their ability to be responsive and innovative to the diverse and evolving needs of their clients. As the psychologists face these limitations and constrictions, this may impede not only their professional growth but more critically it may hinder the quality of care they provide to their clients. Indeed, some of the psychologists in the current study expressed they had abandoned psychology professional association membership (e.g., membership to the APS) and would consider relinquishing their required psychology general registration given this narrowing and restriction on their capacity to engage with CM in their clinical practice.

As noted above, some of the interviewed psychologists projected a perception that Australian psychology professional and regulatory associations deliberately exclude CM. In reviewing the data from the current study, and previous relevant literature, it is unclear if Australian psychology professional and regulatory associations intentionally exclude CM. It would seem counterintuitive for Australian psychology professional associations to exclude certain traditional and cultural systems of health care, given their mandates on psychologist cultural responsivity and encouraging psychologists to have capacity to engage in multidisciplinary collaboration and communication (Australian Psychology Accreditation Council, 2019). However, the exclusion of CM from psychology has been noted in other Western countries. In the context of the cultural relevance of some CM for some clients, literature from both Australia and international studies have acknowledged the cultural and epistemic exclusion enacted by the psychology profession broadly (Canham et al., 2021; Ciofalo et al., 2022; Reddy et al., 2021; Smith, 2021). Of note, the American Psychological Association (APA) has recently taken steps to address this historical exclusion by explicitly recommending psychologists engage with their client's cultural beliefs (Mattar & Frewen, 2020) and engage with culturally-oriented practices and ideologies (e.g., traditional Chinese medicine) to inform their clinical practice (American Psychological Association, 2019). Further, the APA have introduced guidelines that encourage psychologists to "actively educate themselves about diverse Indigenous/ethnocultural healing modalities" and suggest "training programs could incorporate Indigenous healing theories and practices throughout the curriculum"

(American Psychological Association, 2019, p. 25). Perhaps psychology in Australia could follow America's lead and address the complaints above, as projected by the interviewed psychologists. Of note, at present the APS guidelines for the provision of psychological services for Aboriginal and Torres Strait Islander Peoples (Australian Psychological Society, 2015) does not refer to Aboriginal and Torres Strait Islander healing modalities (see Chapter 4). While it would seem counterintuitive for Australian psychology professional associations to exclude certain traditional and cultural systems of health care, findings presented here reveal a complex landscape. There may well be gaps in how psychology in Australia responds to client and psychologist demand for resources related to CM in clinical practice, particularly those that have cultural/spiritual relevance. Perhaps psychology in Australia has an agnostic stance toward CM, which would be paradoxical given their mandates emphasising psychologist cultural responsivity. This current disconnect, observed in this thesis, suggests an opportunity for psychology in Australia to enhance its cultural competency by adopting a more expanded and inclusive approach, that acknowledges the role and relevance of CM to psychology, psychologists in clinical practice, and their clients.

9.4 Chapter summary

The psychologists in the current thesis projected a range of important arguments. One key finding from the qualitative analysis is that psychologist engagement with CM in their clinical practice appears to be driven by the psychologists attempts to be responsive to

client preference and demand for CM to be incorporated into their mental health care. The psychologists also justified their engagement with CM as being driven by the ethnocultural relevance of some CM for some clients. The psychologists also qualify these justifications by explaining they are not wedded to CM and that they critically evaluate the utility and efficacy of CM when discussing CM with a client. What is particularly interesting is that the psychologists appear to align with Australian psychology's own mandates on EBPP and inclusivity, and thus leveraging these efforts as their justification for their engagement with CM. Further, psychologists describe the value of a sense of flexibility to draw on CM in their clinical practice, and that CM as an additional tool allows them to be creative and innovative in their clinical practice. This creativity and innovation are juxtaposed against a perception that psychology has become bland and narrow. The psychologists believe this innovation, the inclusion of CM, is critical for psychology to remain a relevant and an inclusive health care discipline.

The justifications provided above by psychologists in the current study also align with those presented by medical professionals, including psychiatrists and GPs, in previous research relating to their engagement with CM (Kooreman & Baars, 2012; Liu et al., 2021; Wemrell et al., 2020). Importantly, both are helping professions in high demand and vulnerable to burnout and reduced job satisfaction (Lenoir et al., 2021; McCormack et al., 2018; Northwood et al., 2021). Exploring and utilising strategies to mitigate burnout in the health professions, such as increased flexibility and diversification of skills (Clough et al., 2020), is worthy of consideration. The arguments presented above, suggests the

psychologists view the inclusion of CM as enriching, both their clinical toolkit and aiding their work role satisfaction. While health care disciplines generally face challenges to the integration of CM, the fields of medicine and psychiatry continue to actively work toward the incorporation CM; it has not diminished over time (Ee et al., 2021; Malhi et al., 2021; Mwaka et al., 2018). Further there has also been the establishment of professional groups and colleges, such as the Australasian Integrative Medicine Association (AIMA), Australasian College of Nutritional and Environmental Medicine (ACNEM), and Australasian Society of Lifestyle Medicine (ASLM) which reflects the growing emphasis of CM within medicine and health care professions broadly. The findings from the current study may well predict a similar trajectory, to that of CM within medicine, and signal increasing engagement with CM by psychologists in Australia. Consequently, psychology in Australia may need to grapple with CM within psychology as an emerging phenomenon among grass-roots psychologists in clinical practice, that is potentially justified via psychology's own mandates of psychologists being responsive and culturally sensitive to client needs and preferences.

Future research may expand upon the psychologist's perception that the inclusion of CM – the flexibility to draw on CM as an additional tool – in their clinical practice improves career satisfaction. Exploring ways to improve psychologists work role satisfaction is important for role retention in an environment where there is high demand for, and on, psychologists. Future research may also consider client experiences and perceptions of their psychologist engaging with CM in clinical practice. Understanding

client's experience of having their preference for CM included may further support the psychologist's argument for engaging with CM in their clinical practice. Understanding the dynamics of incorporating CM within psychologists' clinical practice may contribute to the much needed development of CM relevant education and resources for psychologists in Australia.

Chapter 10. DISCUSSION

10.1 Preface

This chapter provides an interpretation of the main research findings of the thesis drawing upon insights from across *all* the thesis phases, and considers their implications on a number of fronts and for a number of stakeholders. This discussion will also help contextualise the key and broad thesis findings within wider arguments, divisions, and contests around professional identify, territory and practice for Australian psychology. The chapter closes with a review of the limitations of this research, as well suggestions regarding future research to help move the investigation and understanding of this important area of health care forward.

Firstly, a review of the research questions.

1. To what extent and in what ways does the field of psychology, psychologists, their regulatory bodies, and associations consider CM relevant and/or appropriate to (their) clinical practice and the treatment of mental health problems?

This question was addressed by all three phases of the thesis. Phase One – document analysis included a critical evaluation of current formal policy and guidelines for psychologists (from Australian psychology professional associations and regulatory bodies) with regards to the relationship between psychology and CM. The document analysis revealed Australian psychology professional associations and regulatory bodies provide

very limited CM relevant resources for psychologists, suggesting psychology in Australia has limited engagement with CM. Phase Two – The statistical analysis of survey data collected from psychologists in Australia revealed high levels of psychologists discussing, recommending, and referring to CM – across a range of CM products, practices and approaches – suggesting widespread psychologist engagement with CM in clinical practice. Phase Three – The thematic analysis of interview data revealed psychologists in clinical practice justify engagement with CM in their clinical practice via client centred and culturally responsive practice, suggesting psychologists consider CM relevant to clinical practice through psychology's own evidence-based practice principles. A discussion on how the thesis addresses this research question can be found in Sections 4.5, 5.5 and 6.5 and Chapter 9.

2. In what ways, and to what extent, are psychologists in Australia engaging with CM in their clinical practice (e.g., recommending CM products and practice and/or referring to CM practitioners)?

This question was addressed by Phase Two – The statistical analysis of survey data collected from Australian psychologists which revealed high rates of recommending and referring to types of CM within their clinical practice. The findings suggest not only the prevalence of psychologist CM engagement in clinical practice, but also the multifaceted nature of this engagement, suggesting a rich and complex landscape of integration between

conventional psychology and CM in clinical practice. A discussion on how the thesis addresses these research questions can be found in Sections 5.5 and 6.5.

3. How do Australian psychologists describe their knowledge and the efficacy, risk, and relevance of CM to the practice of psychology in Australia?

Phase Two – The statistical analysis of survey data collected from Australian psychologists explored psychologist perceptions of their knowledge, and the risks and relevance, of CM within their clinical practice, suggesting psychologist engage with CM despite concerns regarding lack of knowledge or perceived limitations around CM's efficacy. A discussion on how the thesis addresses this research question can be found in Section 6.5.

4. What clinical and other challenges face psychologists who may (wish to) utilise CM within their clinical practice? And how do psychologists explain and justify their relationship and engagement with CM in (their) clinical practice?

These questions were addressed by Phase Three – The thematic analysis of interview data where Australian psychologists explained their perspectives and experiences of engaging (or not engaging) with CM in their clinical practice, suggesting psychologists

experience challenges related to psychology in Australia (professional associations, regulatory bodies, and academia) not engaging with CM in the same way that psychologists at the grass-roots are engaging with CM in their clinical practice. Further, the interviewed psychologists justified their engagement with CM via extrinsic factors, such as being responsive to client values and preferences, as well perceiving CM to be an additional therapeutic tool that they can selectively and flexibly draw upon (or exclude) in their clinical practice. A discussion on how the thesis addresses this research question can be found in Chapters 7, 8, and 9.

5. What important issues will require consideration with regards to navigating the future relationship between CM and psychology?

This question is addressed in the current chapter (Chapter 10) which presents the discussion and integration of the results of the three phases of the thesis.

The overall findings from the thesis highlight a number of insights. First, the thesis shows that psychologist engagement with CM in Australia is not a fringe activity restricted to a particular subgroup of psychologists. Neither are those psychologists who are engaging with CM necessarily uncritical devotees of CM products, practices, and practitioners. The thesis findings also show psychologists in Australia are not superficially engaging with

CM, rather they appear to be actively engaging with, and discerning about their selection, and use of different types of CM in their clinical practice. Further, psychologists positioned their engagement with CM in their clinical practice in terms of extrinsic factors, in part as a response to client preference and demand for CM, and specifically with regards to providing client centred, and culturally sensitive health care. The psychologists in the third (qualitative) phase also framed these justifications around using their scientist-practitioner skills to be selective and discerning about safety, risks, and evidence for CM. The pattern that emerges from the thesis, particularly from psychologists' justifications, is one that aligns with the psychology professions' own mandates and frameworks, including evidence-based practice in psychology (EBPP) principles. This alignment includes the psychologist selecting the best available evidence, using their clinical expertise, and responding to client preferences, values, and characteristics (Melchert et al., 2023; Ward et al., 2022). In the context of this research the psychologists described selecting evidence-based CM, and/or using their clinical expertise to assist the client to navigate CM, and/or respond to client's preference for CM including the ethnocultural relevance of some CM for some clients. A discussion of psychologist engagement with CM, and the alignment between this engagement with CM in their clinical practice with psychology's own mandates, is presented below.

The high level of psychologist engagement with CM identified in this thesis (Chapter 5 and 6) appears to be enacted in clinical practice through a rationale based on psychology's own mandates, which will in turn have implications for psychology (as a

professional health care discipline in Australia) regarding how the profession responds to widespread psychologist and client engagement with CM. Particularly given psychology in Australia has a history of excluding other healing epistemologies, consciously or unconsciously, by omitting them from education, policy, research and relevant publications (Section 1.6) (Breen & Darlaston-Jones, 2010; Held, 2019; Phillips, 2023). This was also clarified in the document analysis (Chapter 4), which revealed that there is no reference to CM (nor any other traditional or complementary healing approach) in any of psychology's current clinical practice guidelines, thus psychology in Australia does not provide explicit guidance on how to integrate CM into clinical practice. Also importantly, as revealed in this thesis' document analysis, psychology in Australia (professional associations and regulatory bodies) does not acknowledge the ethnocultural relevance of some CM for some clients, including Aboriginal and Torres Strait Islander healing approaches (Chapter 4).

The document analysis addressed one of the research aims by clarifying the extent to which Australian psychology regulatory bodies and associations consider CM relevant to clinical practice, thus the absence of reference to CM suggests that psychology in Australia may not consider CM relevant to psychologists, and their clients, in clinical practice. The thesis findings suggest psychology in Australia (professional associations, regulatory bodies, and academia) may need to reflect and consider how to authentically engage with other health care approaches, such as CM, to foster inclusivity and pluralism, to consider the role of other healing epistemologies, professions, and approaches. Furthermore, the psychologists in clinical practice in the third phase of the thesis (interviews and qualitative

analysis) appear to call on psychology in Australia (professional associations, regulatory bodies, and academia) to acknowledge the diverse contributions these approaches could offer when safely integrated into psychologists' clinical practice. Acknowledging grass-roots psychologist engagement with CM, may need to be prioritised by the psychology profession in Australia, as there is urgent need to provide psychologists with relevant education, policy and research to help inform them on how the integration of CM in their clinical practice can be undertaken safely and appropriately. The following discussion presents key findings, through a wider historical and integrative lens, providing a broader cross-cutting discussion taking in all data and analyses undertaken across all phases of the thesis.

10.2 Discussion

There are a number of key findings from this thesis that will potentially help inform all psychologists working with clients, whether providing conventional psychological approaches, or engaging with CM in some form as part of their clinical practice. In brief, the original contributions of this research are; 1) The first quantitative study to identify the modes, frequency, and types of CM that psychologists in Australia engage with; 2) The first qualitative research to explore in depth how psychologists justify their engagement with CM, and how they explain the challenges to psychologist engagement with CM, focussed solely on psychologists in clinical practice in Australia; and 3) The first research to examine psychologist engagement with CM which also incorporates the policy and

regulatory environment for psychologists in Australia. The key findings related to the above contributions will be discussed below.

Of note, while the integrative review (Chapter 2) identified modes of CM engagement (Chapter 2), the survey data was able to quantify psychologist engagement with CM at these different modes of engagement. The modes of engagement a psychologist might have with CM in their clinical practice include discussion (e.g., being responsive to client disclosure of CM use), recommendation (recommending CM to a client such as massage therapy), referral (referring clients to CM practitioners such as naturopaths), and the direct application of CM within their clinical practice (such as instructing the client in yoga poses) (Chapter 2). It is also important to acknowledge here that psychologist engagement with each mode in the framework (discuss, recommend, refer, apply) would require progressively more specialised CM training to support the safe integration of CM within the psychologist's clinical practice. While this framework of modes itself does not form part of the thesis results, it is a useful tool to discuss and compare the rates and modes of psychologist engagement with CM in their clinical practice. The review (Chapter 2) also addressed one of the research aims by providing an understanding of the historical and current landscape of the wider discipline of psychology that informs psychology's, and psychologist's, relationship with CM.

To give context to this discussion, previous qualitative studies, as identified in the integrative review (Chapter 2) have described the perspectives of Australian psychologists

who wish to engage with CM (Hamilton & Marietti, 2017; Wilson & White, 2011), however these studies included other health professions (Baxter & Lovell, 2021; McKenzie et al., 2012), students of psychology tertiary courses (Wilson & White, 2007, 2011), and psychologists who have not yet completed their internships nor attained general registration as a psychologist (Hamilton & Marietti, 2017). One previous qualitative study used only Australian psychologists who identified as having additional training in at least one CM modality (e.g., certified yoga instructor) (Kassis & Papps, 2020). Prior to this thesis there were no qualitative studies that focused on the perspectives and experiences of Australian psychologists with general registration in clinical practice, regardless of their opinions of CM (including negative perceptions of CM) or any formal or informal training the psychologist may have in CM. It was important to the third (qualitative) phase of this thesis to include only psychologists in clinical practice who are client facing, as previous literature, including research specifically related to psychologist engagement with CM, reports psychologists in different roles, such as academia, respond differently to CM than do psychologists in clinical practice (Crosina & Bartunek, 2017; Ligorio & Lyons, 2018). The third (qualitative) phase of this thesis focuses solely on Australian psychologists in clinical practice. In the following sections, key findings related to Australian psychologist engagement with CM in their clinical practice will be discussed.

10.2.1 Psychologists are engaging with CM in their clinical practice

The findings from this thesis suggest widespread levels of engagement with CM among psychologists in Australia. The survey data from the thesis demonstrated 95.5% of

participant psychologists are discussing CM with their clients, and 90.5% are recommending CM to their clients. The survey data from the second (quantitative) phase also indicated 57.9% of these psychologists are referring to CM practitioners. The second (quantitative) phase detailed that this widespread engagement with CM is multifaceted with many psychologists recommending four or more different types of CM products and practices (63%), and one third referring to four or more different types of CM practitioners (33%). The results from the second (quantitative) phase of this thesis suggest widespread psychologist engagement with CM in Australia, across multiple forms of CM products, practices and practitioners. The second (quantitative) phase of the thesis addressed one of the research aims, by explaining the ways, and the extent to which, Australian psychologists recommend CM products and/or practices, and/or initiate referrals to CM practitioners as part of their clinical practice.

The high rates of psychologist engagement with CM found in this thesis are similar or higher than those identified in earlier research. For example, previous Australian research, although solely focused on psychologists providing nutrition and dietary advice, reported 56.7% of respondents as likely to include dietary interventions into their clinical practice (Nayda et al., 2021). For international comparison, a recent study of Iranian psychologists found 83% of psychologists believe CM may have a role in health care, and 37% engage with CM in their clinical practice (Tehrani et al., 2021). A survey of Indonesian clinical psychologists indicated 83% had recommended CM to their clients and 52% had made a referral to a CM practitioner (Liem & Newcombe, 2019b). The

widespread levels of engagement with CM among psychologists in Australia found in the current study are also similar to those of other health professionals in a range of localities. For example, a recent study of social workers in the United States found comparable rates of engagement with CM (60%) (Vitolo et al., 2023) to the psychologists in this thesis. There are also similar rates of acceptance and prescribing CM among physicians in Italy (55%) (Berretta et al., 2020), engagement with CM by psychiatrists in Sweden (62%) (Wemrell et al., 2020), as well as rates of GP referral to CM in New Zealand (82%) (Liu et al., 2021). These trends and comparisons are interpreted cautiously, as previous research on health professional engagement with CM often focuses on health professionals' attitudes, knowledge, and intentions regarding their engagement with CM in their clinical practice, rather than mapping comparable modes of health professional engagement with CM. Nonetheless, within the context of this thesis, it appears that Australian psychologists are actively incorporating CM within their clinical practice, at rates comparable, or higher, than rates seen in other health professions in Australia and other regions.

Within the psychology profession, there is little comparable data available – and while prevalence rates of psychologist engagement with CM will no doubt vary across geographical and cultural contexts – this early enquiry does appear to suggest relatively high rates of psychologist engagement with CM in their clinical practice (and possibly high in other jurisdictions too). What is interesting is that these high rates of psychologist engagement with CM contrast with the absence of reference to CM in Australian psychology's (professional associations and regulatory bodies) clinical practice guidelines,

as found in the document analysis (Chapter 4). Thus, the absence of reference to CM in clinical practice guidelines, may lend further support to the above arguments (disconnect between psychology and psychologists at the grass-roots of clinical practice) that Australian psychology's official pronouncements (or lack of reference to CM in clinical practice guidelines) do not necessarily reflect what may be happening on the ground, in terms of psychologist engagement with CM in their clinical practice. The results from the second (quantitative) phase of the thesis underscore, not only the prevalence, but also the multifaceted nature of psychologist engagement with CM, suggesting a rich and complex landscape of integration between conventional psychology and CM in clinical practice. Each of which will be discussed in more detail below.

10.2.2 Psychologists are responding to client values and preferences

The results from this thesis build on, and add to, earlier literature (Ligorio & Lyons, 2018; Nayda et al., 2021; Stapleton et al., 2015) to provide granular data which establishes a complex landscape of Australian psychologist engagement with CM in their clinical practice. These results, albeit from a small self-selecting population, are cautiously interpreted as indicating there is indeed widespread grass-roots engagement with CM amongst psychologists in clinical practice in Australia, through recommending and referring to CM as part of their clinical practice. Importantly, the thesis identified the factors that drive this high level of psychologist engagement with CM, which appear mostly to be justifications grounded in the psychologists placing high value and worth (Boltanski & Thévenot, 2006) on being responsive to client needs. The high level of

psychologist engagement found in this thesis also aligns with high CM use among people with mental health problems (Avci & Sabanciogullari, 2021; Clossey et al., 2023; Thirthalli et al., 2016), including in Australia (McIntyre et al., 2021). Specific client-based justifications described by the psychologists include being responsive to client needs, acknowledging client preference for CM, responding to the cultural/spiritual relevance of some CM for some clients, offering a holistic approach to mental health care, and having a sense of obligation to inform clients of alternative treatment options, including CM. These client-based justifications, as extrinsic drivers of psychologist engagement with CM, will be discussed further below.

The findings from this thesis suggest psychologist engagement with CM is not superficial, and not restricted to a small niche group among Australian psychologists. Indeed, the second (quantitative) and third (qualitative) phase of this thesis indicate that even those psychologists who are not convinced of the utility and efficacy of CM, are still discussing, recommending, and referring to CM as part of their clinical practice. Thus, the thesis findings suggest psychologists, regardless of their stance on CM, are committed to client-based reasons for engaging with CM, such as responding to client preference for CM. The responsiveness to client preferences found among psychologists in this thesis echoes broader research findings from previous enquiry. Health professionals, including psychologists, recognise the value of engaging with client preferences as an integral part of the health care they provide (Liu et al., 2021; Ostermaier et al., 2020). This responsivity to client preferences and values persists even when the health professionals are unsure about

the clinical benefits of CM and/or they acknowledge gaps in their understanding of CM (Aizuddin et al., 2022; Bahall & Legall, 2017; Berretta et al., 2020; Jarvis et al., 2015). There are additional benefits when health professionals are responsive to their client's preferences, including enhancing the therapeutic alliance (Cooper et al., 2022; Dimmick et al., 2022; Norcross & Cooper, 2021; Sandage et al., 2022). Within the context of this thesis, it appears that Australian psychologists put aside any preconceived views they may have of CM, to prioritise and actively engage with client preference for CM. Importantly, the findings from this thesis suggest that psychologist engagement with CM is not restricted to a peripheral faction of CM invested psychologists in Australia, rather many psychologists consider their engagement with CM as part of enacting responsivity to client preferences and values.

In the context of responsiveness to client preferences, the psychologists in this thesis also described having a sense of obligation to inform clients of alternative mental health treatment options, including CM. It is noteworthy that this type of client-based justification, to inform clients regarding other treatment options, aligns with broader mental health policies in Australia (Australian Health Ministers' Advisory Council, 2013b; *Mental Health Act 2016*, Qld; *Mental Health and Wellbeing Act 2022*, Vic; *West Australian Mental Health Act 2014*, WA) that legislate health practitioners are to apprise clients of alternative treatment options. As such, psychologists in this thesis, either consciously or unconsciously, may be authenticating their engagement with CM in their clinical practice

via existing broader health policies, beyond psychology, that are not explicitly related to CM.

Responsiveness to client preferences and values is indeed part of the profession of psychology's own mandates, including evidence-based practice in psychology (EBPP) principles. EBPP emphasises the psychologist should acknowledge client preferences, values, and characteristics (Australian Psychology Accreditation Council, 2019; Bartlett et al., 2021; Blease et al., 2016; Busch & McCarthy, 2022). The client-based justifications for engaging with CM in clinical practice offered by psychologists in this thesis, indeed align with EBPP. Further, the psychologist's client-based justifications align with existing broader mental health care policy in Australia. Thus, psychologist engagement with CM in clinical practice can be viewed as contributing to being an effective psychologist, where they adapt to the clients' evolving needs while remaining attuned to psychology's general and core mandates, and state/territory based broader health policy. Importantly, these justifications from the psychologists in this thesis, for engaging with CM in their clinical practice, may do some work for these practitioners in their day-to-day interactions, helping to destabilise or counter the possible arguments from others that present psychologist engagement with CM as only enacted by psychologists who are uncritical devotees of CM (Vyse, 2016). Additional findings related to the psychologists responding to client preferences for CM, including the cultural relevance of some CM, will be discussed below.

10.2.3 Psychologists are enacting cultural sensitivity and responsivity

The psychologists in the current study justify their engagement with CM through placing high value on being responsive to client values and preferences, including being responsive to the cultural/spiritual needs of their clients, and the relevance of some CM for some clients. Psychologists participating in the third (qualitative) phase of this thesis describe the importance of acknowledging and valuing the ethnocultural relevance of some CM for some clients. The Australian Psychology Accreditation Council (APAC) recommends inclusion of cultural responsiveness as a core competency in psychology tertiary qualifications in Australia. Further, the Psychology Board of Australia (PsyBA) National Psychology Examination includes assessment tasks related to working in cross-cultural contexts, including issues impacting Aboriginal and Torres Strait Islander people (Psychology Board of Australia, 2019a). The findings from this thesis suggest psychologists' justification of their engagement with the ethnocultural relevance of some CM may be legitimised through psychology's own mandates on cultural responsivity.

Wider research has explored mental health professionals' desire to be culturally responsive. For example, previous research reports Australian mental health professionals make attempts to be culturally responsive and create a safe therapeutic setting, by devising strategies to support clients from different cultural backgrounds (Dune et al., 2021). Some mental health professionals adapt their approaches in clinical practice to be culturally responsive by using strategies, such as acknowledging they may have limited knowledge of the client's culture/spirituality, and requesting feedback from the client regarding the

mental health professionals sensitivity to their client's cultural/spiritual needs (Ayub et al., 2019; Culbong et al., 2022; Currier et al., 2023; Dune et al., 2021; Sargeant & Yoxall, 2023). Further, developing and evolving cultural competence requires the psychologist to engage with, and be open to, questioning existing cultural constructs within health care and psychology (e.g., dominant white Western constructs of health care) (Henrich et al., 2010), and to being open toward new inclusive cultural constructs, particularly those that align with the needs of clients (Dudgeon & Walker, 2015; Dune et al., 2021; Horevitz et al., 2013). Indeed, engaging with the cultural relevance of some CM for some clients would also align with psychology's mandates around psychologists having cultural sensitivity and competency (Australian Psychology Accreditation Council, 2022). The findings from the second (quantitative) and third (qualitative) phase of this thesis show psychologists may well be actively attempting to respond to client preference for CM, including in the context of cultural responsivity, and the ethnocultural relevance of some CM.

10.2.4 Psychologists use clinical expertise to review evidence for CM

Psychologists in the third (qualitative) phase of the thesis described utilising their scientist-practitioner training (Section 1.6.4) and their clinical expertise (as part of evidence-based practice) to be selective about CM engagement in their clinical practice. Further, the psychologists described feeling as though they are in a unique position to offer their clinical expertise to clients, to assist them to navigate the safety, risks, benefits, and efficacy of CM, as well as provide referrals to carefully selected CM practitioners. The psychologists also described utilising a number of formal and informal resources, external

to psychology, to develop expertise in specific or broad CM topics, and to critically evaluate the evidence for CM. There are indeed advances being made in research for a range of CM for mental health problems. For example, there is evolving research evidence for movement (Noetel et al., 2024; Pascoe et al., 2020; Sun et al., 2024), herbal (Haque et al., 2023; Ozsavci et al., 2019; Sarris, 2018), and dietary approaches to mental health care (Bayes et al., 2023; Firth et al., 2020). The psychologists in this thesis positioned the use of their clinical expertise, and the selection of evidence-based CM, as further justification for their engagement with CM in their clinical practice.

The psychologists' discernment around CM may be interpreted in a number of ways. They describe not accepting CM as a blanket approach to mental health care or as an alternative to psychology. Further, they are not wedded to CM, and they appear willing to disregard CM if they judge it to not be clinically relevant to their client's needs. This is an interesting argument suggesting these psychologists are not uncritical devotees of CM. In some ways it may reassure the profession of psychology in Australia that these psychologists do not advocate for their profession to embrace CM approaches indiscriminately. Rather, they claim to draw upon their scientific training and clinical expertise to help move beyond a rigid commitment to CM. To illustrate, some of the psychologists in this thesis perceive CM as tool that can be selectively employed, or set aside, in clinical practice. In this context, as an example, CM could be used as a tool where the psychologist discusses the connection between sound nutrition and sound mental health (Arshad et al., 2024; Bayes et al., 2023; Ribera et al., 2024; Vasiliu et al., 2024), or

recommending walks in nature (Houlden et al., 2018; Revell & McLeod, 2016), or referring to a massage therapist (Espi-Lopez et al., 2020; Hall et al., 2020; Rapaport et al., 2021; Zeliadt et al., 2020), or instructing the client how to complete yogic breathing exercises to reduce anxious arousal (Cartwright & Doronda, 2023; T. Chang et al., 2022; Noetel et al., 2024; O'Dea et al., 2022) – depending on the psychologist's knowledge, skills, and qualifications in CM. The psychologists in this thesis described feeling energised and enriched when they could flexibly and selectively draw upon CM in their clinical practice. However, they claim, to also be able to disregard CM – a point they contrast with the general approach of CM practitioners consulting beyond the boundaries of the psychology profession. Overall, the psychologists described utilising their scientific training and clinical expertise to assist clients to navigate CM in the context of mental health care.

The findings of this thesis, concerning psychologists utilising their clinical expertise to assess evidence for CM on behalf of their clients, mirror those of other health professions, including medicine (Adams, 2000; Berretta et al., 2020; Salamonsen, 2013). Research indicates some health professionals may act as gatekeepers of CM through actively informing their clients about the utility of relevant CM (Adams et al., 2018; Jarvis et al., 2015). Both psychologists participating in the second (quantitative) and third (qualitative) phases of this thesis perceived benefits for the client when consulting a psychologist who is CM-informed. Indeed, wider research has identified benefits when the client's health professional is CM-informed, such as improved health outcomes, improved interprofessional collaboration around their care, and lower health care costs (Ee et al.,

2020b; Golden et al., 2023; Kooreman & Baars, 2012; Papathanassoglou et al., 2024). Widespread health professional engagement with CM, including psychologists, also aligns with the WHO Traditional Medicine Strategy (World Health Organisation, 2013) which encourages member states to acknowledge the role of CM, and to work toward the integration of CM into health care settings (World Health Organisation, 2023; Zhang et al., 2019). Rates of health professional engagement with CM signify growing acceptance (Berretta et al., 2020; Masemola et al., 2023; Phutrakool & Pongpirul, 2022) and underscore CMs sustained relevance within contemporary health care paradigms, suggesting a trajectory toward CM integration, and acknowledgement of the potential contribution of CM within the health care landscape internationally.

In conjunction with responding to client preferences, utilising clinical expertise and selecting evidenced-based CM, may also be viewed through the lens of EBPP. EBPP is a tripartite EBPP model which emphasises psychologists should demonstrate clinical expertise/discernment, select approaches with the best available evidence, and acknowledge client preferences (Section 1.6.6). This thesis has identified ubiquitous psychologist engagement with CM, and justifications for this engagement via psychology's own mandates and frameworks, which suggests that CM use is not limited to a small group of psychologists who are uncritical devotees of CM, rather a number of psychologists consider CM relevant to their clinical practice. The psychologists' justifications and presentations in this thesis may provide alternative and effective arguments, that work to demonstrate the psychologists' credibility, and to influence those with power and influence in the field of

psychology, to present these psychologists as bona fide providers of CM within their clinical practice. These may be important considerations for psychology's policy makers to ensure that psychology's regulatory and policy environment reflects the contemporary clinical practice needs of psychologists and the people they serve.

10.2.5 The unacknowledged role of CM in psychology

The high rates of psychologist engagement with CM, as identified in this thesis, are interesting in the context of the challenges for psychologists in Australia who wish to engage with CM. For example, the integrative review (Chapter 2) indicated one of the major challenges to psychologists' engagement with CM in their clinical practice is a perception of a lack of relevant CM resources available for them. The psychologists from the third (qualitative) phase of this thesis viewed this lack of CM relevant resources (e.g., clinical practice guidelines, policy, education, research) as the responsibility of the Australian Psychological Society (APS), who indeed have historically produced the bulk of existing clinical practice guidelines for psychologists. The interviewed psychologists described a sense that the APS was not keeping pace with client and psychologist demand for CM. This was indeed the finding from the document analysis (Chapter 4) which confirmed that there are currently no explicit guidelines provided by any Australian psychology professional associations (e.g., APS, AAPI) or regulatory bodies (e.g., Psychology Board of Australia/AHPRA, APAC) regarding how psychologists might safely engage with CM in their clinical practice.

The challenge of no CM relevant resources means psychologists do not have profession appropriate clinical practice guidelines to assist them to navigate the safe integration of CM into their clinical practice (Hamilton & Marietti, 2017; Stapleton et al., 2015). Indeed, findings from the second (quantitative) phase of this thesis indicate psychologists engage with CM even when they are unfamiliar with CM. It is unclear how psychologists interpret risks and evidence in CM without relevant CM resources. Subsequently, psychologists may draw on broader health policy relating to the safe integration of CM into clinical practice (as described above). Unfortunately, this lack of CM relevant resources is not unique to psychologists in Australia. The literature reports health professionals engage with their clients request for information on CM, despite the health professionals conceding they have limited knowledge of CM. For example, GPs in New Zealand who recommend CM to their patients also felt they needed more training in CM, and that relevant CM should be included in their tertiary curricula (Liu et al., 2021). There have also been similar findings regarding medical professionals engagement with CM in Australia where they engage, or wish to engage, with CM in their primary care practice while also acknowledging limitations to their knowledge of CM (Templeman et al., 2015; Wardle et al., 2013). However, medicine and psychiatry do include some CM in their guidelines for mental health in Australia (Malhi et al., 2021) and internationally (Grover et al., 2024). The results from the second (quantitative) and third (qualitative) phases of the thesis indicate psychologists in Australia, like other health professionals, are engaging with

CM in their clinical practice, despite a lack of CM relevant resources, and despite concerns they lack familiarity with CM, its risks and efficacy.

While this thesis focussed on exploring perspectives and experiences of psychologists who may not have additional qualifications in CM, 17.3% of those psychologists who completed the survey in the second (quantitative) phase of the thesis did have additional formal qualifications in CM (e.g., naturopathy). Thus, the remainder of survey participants who are actively engaging with CM in their clinical practice may not have any formal or informal education or training in CM. The widespread psychologist engagement with CM necessitates at least satisfactory CM relevant guidelines and CM relevant knowledge, including efficacy and risks associated with the integration of CM into their evidence-based clinical practice. The findings from this thesis underscore the importance and urgency for relevant CM resources to be provided by Australian psychology professional bodies to support the safe integration of CM into psychologists' clinical practice.

In the third (qualitative) phase of this thesis, psychologists interpreted the absence of CM relevant resources, as psychology's disregard for the relevance of CM, and as indicative of a deliberate effort by psychology in Australia to exclude CM. This perception of intentional exclusion of CM left psychologists feeling disappointed in psychology (discussed further below). In the context of this thesis, the lack of CM resources provided by psychology in Australia may also be simply interpreted as psychology's underestimation

of the relevance of CM to psychologists in clinical practice, and their clients. Regardless of the reason behind Australian psychology's lack of guidance on CM, psychologists appear to be actively engaging with CM in their clinical practice, via non-CM specific psychology mandates (such as EBPP) and broader health polices (such as state/territory mental health acts and adjacent professions clinical practice guidelines), in the absence of any explicit CM relevant resources from psychology.

There are a number of risks associated with Australian psychology's underestimation of the relevance of CM, and lack of provision of CM specific resources, for psychologists in clinical practice. In the context of psychology as a health care discipline in Australia, there are risks if psychology does not adapt and evolve to meet psychologist and client demand for CM. These risks to psychology in Australia include becoming stagnant and being seen as unresponsive and out of step with contemporary health care. These risks also include ongoing cultural and epistemic exclusion if psychology is unable to assist psychologists to adapt their practices and approaches to be culturally responsive, including the ethnocultural relevance of some CM (Ayub et al., 2019; Blackwell & Heidenreich, 2021; Phiri et al., 2023; Salamonsen & Ahlzen, 2018). For example, psychology may need to provide training to psychologists on how to adapt cognitive behavioural therapy (CBT) to suit the ethnocultural needs of their clients (Huey et al., 2023). The profession of psychology in Australia may need to act on the findings from this thesis to provide CM relevant resources, to enhance psychologists' capacity to be culturally responsive.

Psychology as a profession in other Western countries make efforts to redress issues related to the lack of acknowledgement of the relevance of other healing and health care approaches. The American Psychological Association (APA) has recently been working toward addressing issues of epistemic exclusion and sought to remediate psychology's previous exclusion and omission of the cultural and spiritual relevance of CM for some clients (American Psychological Association, 2019; Mattar & Frewen, 2020). The APA has encouraged psychologists to engage with their clients' cultural beliefs including Indigenous and ethnocultural sources of healing. This kind of promotion of the relevance of ethnocultural health modalities by the APA likely fosters reparation and empowers psychologists to consider and/or safely integrate diverse healing modalities into their clinical practice. The psychology profession in Australia may do well to duly observe the guidance offered by other Western psychology professional associations (such as the APA) on how to engage with diverse ethnocultural health modalities. As noted earlier in the thesis, previous literature has identified a number of tensions inherent within the discipline, and profession, of psychology including contestations about its identity and what is authentic and effective clinical practice. The thesis findings suggest that grass-roots psychologists adhere to psychology's mandates and frameworks with the goal of being effective psychologists. They also acknowledge the need to push their clinical practice and the profession forward by engaging with client demand (including CM) and with approaches that may not have explicit approval, thus demonstrating there are different ways of being an effective psychologist in clinical practice.

Indeed, the wider exclusion of CM from psychology in Australia as evidenced by the document analysis (Chapter 4) and previous literature (Hamilton & Marietti, 2017; Kassis & Papps, 2020; Wilson et al., 2012b; Wilson & White, 2011) gives a sense that this thesis is potentially a test case for psychology's identity, particularly in relation to the profession's selective engagement with other health care approaches, CM or otherwise. Beyond Australian borders, psychology's divisions and lack of unity, its lack of flexibility, and difficulty acknowledging and accepting diverse health care approaches has been noted in the wider literature (Ciofalo, 2019; Green, 2015; Koch, 1995). As seen in the qualitative analysis (Chapters 7,8 and 9), the interviewed psychologists drew on these divisions, whether consciously or unconsciously, to make new arguments about the inclusion of CM within the psychology profession. These arguments (e.g., engaging with CM promotes inclusion, diversity, and innovation) may well be authenticated in the context of contemporary debates about historical tensions and the importance and significance of innovation in psychology, and the need to acknowledge the rise of diverse specialities that fall under the umbrella of psychology (Hibberd & Petocz, 2022; Pickren & Teo, 2020). The findings of this thesis may signal the need for a paradigm shift within psychology, regarding how psychology views and engages with other healing epistemologies, including CM. Such a paradigm shift would require psychology to re-evaluate historical epistemic exclusions, and thus psychologists' engagement with CM may be a transformative opportunity for psychology to embrace innovation, diversity, and collaboration. The implications for these findings are discussed below.

10.2.6 Implications and insights

There are a number of implications arising from the contrast of psychologists in clinical practice having high levels of engagement with CM and the lack of engagement with CM from Australian psychology (professional associations, regulatory bodies, and academia). There are potentially negative implications if psychology, as a health care profession in Australia, does not engage with CM, in the same way that Australian psychologists are engaging with CM in their clinical practice. Psychology's lack of engagement with CM, and lack of provision of CM relevant resources, may be interpreted as a form of control over knowledge, and this type of control has historically been found in number of other health care disciplines – sometimes described as epistemic exclusion (Foucault, 2008; Keet, 2014; Zaidi et al., 2021). Historical epistemic exclusion was noted earlier in the thesis in the context of attempts to decolonise psychology, given that psychology (and other health care professions) may have overlooked the potential contributions of other health care approaches (see Section 1.6.3). However, many health care disciplines have recently taken action to resolve historical epistemic exclusion and marginalisation, including psychology in America and the UK (American Psychological Association, 2019; Bhakuni & Abimbola, 2021; Hashmi et al., 2024; Settles et al., 2021). In the context of this thesis, psychology in Australia seems to exert significant influence over psychologists' clinical practice behaviours by both prescribing (e.g., recommending psychologists select, and adhere to, a narrow range of psychotherapy approaches) and withholding resources (e.g., not referring to, or not including certain health care approaches

such as CM, in education and clinical practice guidelines). Withholding resources that could facilitate the safe integration of other healing modalities, such as CM, into psychologists' clinical practice, likely limit the extent of psychologists' engagement with CM. Unfortunately, the ongoing exclusion of CM may suggest Australian psychology is not keeping pace with contemporary mental health care internationally (Dandona, 2019; de Jonge et al., 2018; Firth, Siddiqi, et al., 2019; Grover et al., 2024; Gureje et al., 2015; Kennedy et al., 2016; Sarris et al., 2022; Thirthalli et al., 2016). For example, previous international literature highlights gaps in mental health professionals' understanding of the association between physical health and mental health, and underscores that investment in intervention and research is "urgently required" (Firth, Siddiqi, et al., 2019, p. 700) to foster more integrated care (Dandona, 2019) that includes CM to address the needs of individuals with mental health problems (Gureje et al., 2015; Thirthalli et al., 2016). The ongoing exclusion of CM may also limit psychology's capacity to evolve and innovate, and psychology may continue to fall behind in the context of global advancement in mental health care practices, thus failing to meet the diverse needs of the people it serves.

In the context of its pursuit of evidence-based practice, psychology may also need to acknowledge that CM is not one thing. Rather CM is a health care approach that includes a range of products and practices that the clients of psychologists may engage with as part of their self-care, self-selected or prescribed, to address a range of problems in the context of their general wellbeing and mental health care. Further, psychology may need to acknowledge that some CM approaches for mental health do have evidence (L. Chang et

al., 2022; Malhi et al., 2021; Park & Slattery, 2021; Sarris, 2018, 2019). Some CM approaches, such as sound nutrition, meditation and green space are considered frontline approaches to mental health care (Malhi et al., 2021; Marx et al., 2023; Ribera et al., 2024; Sarris et al., 2022). In addition, some CM practitioners are regulated under Ahpra, including osteopathy and traditional Chinese medicine (Carè et al., 2021). Further, in line with some of psychology's own philosophical and clinical practice underpinnings, CM also considers the importance of an integrated, holistic, client centred, evidence-based approach to health care (Foley et al., 2020; Leach & Veziari, 2023; Steel et al., 2023). Despite challenges (perceived conflict with Western dominance, costs, reliance on sound interprofessional communication), there is increasing acceptance and interest for the integration of CM approaches within conventional health care broadly, with the goal of improving health outcomes (Ee et al., 2020a; Ee et al., 2021; Papathanassoglou et al., 2024; Rooney et al., 2022; Royal Australian College of General Practitioners, 2024; Valentini et al., 2021). Like other health care professions in Australia, it may be important that psychology acknowledge the potential role of some CM within conventional health care.

Given a number of important factors – the high use of CM by people with mental health problems, the widespread psychologist engagement with CM at the grass-roots level, the justification of psychologist engagement with CM via psychology's own evidence-based practice in psychology (EBPP) mandates, and via broader health policy – it is interesting that psychology has not acknowledged the relevance of CM. The lack of acknowledgement of CM, raises questions about whether Australian psychology's current

clinical practice guidelines actually align with contemporary evidence-based practice in psychology, and broader health care policy, related to diversity and inclusion in mental health care (American Psychological Association, 2019; Australian Psychology Accreditation Council, 2022; Mattar & Frewen, 2020; Ward et al., 2022; World Health Organisation, 2013, 2023). Psychology's neglect of the ethnocultural relevance of some CM could be seen as somewhat discriminatory, particularly given that there is a mandate for psychologists in Australia to undergo training and demonstrate cultural competence. It is also noteworthy that none of Australian psychology's mandates refer to the cultural/spiritual relevance of any form of CM, including traditional healing approaches for Aboriginal and Torres Strait Islander people (Chapter 4). Indeed, the findings from the second (quantitative) phase of the thesis indicate that the lowest level of psychologist engagement with CM was with Aboriginal and Torres Strait Islander traditional healing practices and practitioners (Chapter 5). The literature relating to clinical practice mandates on cultural competence suggest these mandates should be inclusive of *all* relevant ethnocultural healing approaches and provide guidance on how to refer to relevant traditional healers (e.g., Ngangkari) (Asamoah et al., 2023; Blignault et al., 2018; Dudgeon & Bray, 2018; Dudgeon et al., 2023; Hewlett et al., 2023). Recent publications have underscored the culpability of psychology perpetuating cultural and epistemic exclusion, in Australia (Dudgeon & Walker, 2015; Keast, 2020; Smith, 2021) and internationally (Ciofalo et al., 2022; Reddy et al., 2021; Settles et al., 2021). It appears the literature, and psychologists in the third (qualitative) phase of the thesis, consider psychology's neglect of

the cultural relevance of traditional healing approaches, including some CM, may alienate some clients and have a negative impact on psychologists' capacity to build sound therapeutic relationships with clients who have a preference for CM. The omission of CM by psychology in Australia may reflect negatively on the profession, potentially leading to perceptions of discrimination and exclusion. Failure to acknowledge the relevance of some CM, and thus potential perpetuation of exclusion of other healing epistemologies, may result in psychology being perceived as discriminatory, exclusive, and out of step within a contemporary health care landscape.

Another important implication of Australian psychology's lack of acknowledgement of CM (e.g., CMs absence from clinical practice guidelines and from tertiary curricula in Australia), is to potentially perpetuate a perception that psychology is a narrow (recommending psychologists adhere to specific psychotherapy approaches) and exclusive (omitting other health care approaches from its clinical practice guidelines and tertiary curricula) health care profession. Thus, psychology controls and regulates the knowledge that psychologists in clinical practice can draw upon, through mechanisms like clinical practice guidelines (Breen & Darlaston-Jones, 2010; King, 2013; Stiles & Fox, 2019). The psychologists, who participated in the third (qualitative) phase of the thesis, positioned psychology's omission of CM as deliberate exclusion from formal policy, ethical and clinical practice guidelines. In the absence of comprehensive CM relevant clinical practice guidelines, psychologists in this study seem to justify their engagement with CM via extrinsic client-based factors. They validated this engagement through broader policy and

consumer demand, and without explicit approval of the established ranks of the Australian psychology profession, such as the elite and those holding leadership roles.

The participants in the third (qualitative) phase expressed a perception that psychology in Australia had been narrowed down to a limited set of clinical practices prescribed by psychology (key figures and the elite in psychology who have influence over the profession in Australia), overly focused on CBT, particularly under the influence of the Medicare subsidised rebates. This narrowing of Australian psychology has been identified and described by wider research, as psychology being overly focused on experiments/scientific evidence/evidence hierarchies and Western biomedicine as the dominant methodology (Breen & Darlaston-Jones, 2010; Henrich et al., 2010; King, 2013; Stiles & Fox, 2019). Australian psychology's focus on CBT is also an illustration of psychology not keeping pace with contemporary mental health care. For example, recent literature highlights global proponents of CBT are reflecting on "changes in the world, our societies, and therapeutic priorities" (Blackwell & Heidenreich, 2021, p. 2), particularly given the literature reports that CBT does not consistently demonstrate efficacy across diverse populations (Huey et al., 2023; Leichsenring & Steinert, 2017). Thus, psychologists would require guidance, not only in developing cultural competence, but also how to actively adapt psychotherapies, such as CBT, to suit individual needs of clients (e.g., ethnocultural needs) (Ayub et al., 2019; Huey et al., 2023; Phiri et al., 2023). One of the psychologists interviewed in the third (qualitative) phase described this narrowness in Australian psychology as reducing their clinical practice reduced to a formulaic approach

characterised by a room with two chairs (one for the psychologist and one for their client), a tissue box, and "sticking very, very closely to your standard CBT model". The psychologists described this narrowing as endorsing a feeling of being restricted in their clinical practice, suggesting that psychology in Australia is paternalistic. Paternalistic in this context refers to psychology (professional associations, regulatory bodies, and academia) adopting authoritative and directive roles, rather than guiding and supporting, toward psychologists' clinical decision making and clinical practice behaviours. Beyond the omission of CM, psychologists who participated in this study echoed broader concerns that psychology in Australia has become paternalistic. Consequently, there is a reduction in diversity, inclusion, and creativity in how psychologists make choices in their clinical practice, such as being able to select from a broad range of evidence-based psychotherapy types and diverse healing approaches (Berg & Slaattelid, 2017; Duckett, 2021; Goldney, 2018; Grzanka & Cole, 2021; King, 2013).

Psychology in Australia should carefully consider the potential adverse consequences of insisting psychologists conform to a narrow set of practices, as suggested by some of the data analysis in this thesis. A paternalistic approach to psychologists' clinical practice, directing psychologists to adopt specified orientations and practices under the belief they are the only valid (one size fits all) approach(es), may lead to psychology being perceived as unresponsive and out of step with the diverse health care needs of the people it serves. Such an approach would be misaligned with broader health care policy (Consoli & Myers, 2021). Broader research suggests there are negative implications when

health professionals, such as psychologists, have reduced flexibility and autonomy in their clinical practice, both for the individual (Clough et al., 2020; Harvey et al., 2021; Lee & Chang, 2022) and also the profession (Dias Neto et al., 2020; Goldney, 2018; McKnight & Morgan, 2020). The negative implications for health professionals encompass a sense of diminished control over their clinical practice decisions (loss of autonomy), the decline in skills related to synthesising a broad range of health care information, the erosion of artistry and autonomy in clinical decision making, the exclusion of various potentially beneficial healing approaches, and an increased risk of burnout (Bergqvist, 2020; Harvey et al., 2021; McKnight & Morgan, 2020). Specifically, negative implications for psychologists, as outlined in previous literature, encompass experiences of moral distress and contemplation of leaving the profession (Morgan et al., 2019; Sprigings, 2021). The findings from the third (qualitative) phase of this thesis align with previous research, as the psychologists expressed strong emotions associated with a sense of restriction and loss when they perceive their clinical practice decisions are excessively governed by psychology (Section 8.2.3). Indeed, loss of creativity (emphasising specific psychotherapy approaches rather than the therapist's individuality) and lack of professional autonomy have been identified as a significant contributors to burnout among psychologists and mental health professionals in previous literature (O'Connor et al., 2018; Turnbull & Rhodes, 2021). Similarly, there are adverse effects for clients when this paternalistic approach to health care extends to client care, including reinforcing inequity, exclusion, and disempowerment among clients, which leads to a loss of autonomy in their health care

choices (Fleisje, 2023; Juliá-Sanchis et al., 2019; Markwick et al., 2019; Schubert et al., 2024). Beyond the omission of CM, psychology may need to seriously consider the adverse effects of a paternalistic approach to psychologist's clinical decision making and clinical practice behaviours.

Psychology broadly has often rationalised its paternalistic approach by asserting that effective psychologists adhere to specific evidence-based practices, thereby safeguarding the scientific integrity of the discipline (Berg & Slaattelid, 2017; Harnett & Myers, 2018; Sackett et al., 1996). Within psychology there are, and have often been, identifiable tensions around what constitutes an effective psychologist, with science/evidence-based camps disagreeing with those who advocate for other common factors in therapy (see Section 1.6), such as the therapeutic alliance (Baker & McFall, 2014; Diaz et al., 2023; Laska et al., 2014; Norcross & Wampold, 2018; Pereira et al., 2023). Ultimately these tensions and debates within the Australian psychology profession (and broadly) leave Australian psychologists in clinical practice at a crossroads: they must choose between adhering strictly to the prescribed mandates out of fear of punitive consequences (from Australian psychology professional associations and regulatory bodies) or determine for themselves what embodies authentic and effective psychological practice. Indeed, this is the situation described by all the psychologists in the third (qualitative) phase of this thesis, they described having to choose between either disconnecting from engagement with CM or embracing such engagement in their clinical practice. Psychology in Australia may need to consider these tensions, and this crossroads, as an opportunity to become more inclusive

and to work toward addressing historical tensions. The psychologists who participated in this thesis, who are at the grass-roots level of the profession, made suggestions to psychology, advocating for diverse health care approaches, such as CM. They suggested to psychology that such approaches could foster a more inclusive and innovative landscape within the psychology profession in Australia. Indeed, the wider literature encourages psychology to overcome barriers, to unify as field, as we all as embrace a more inclusive and diverse range of methodologies and epistemologies within the discipline of psychology (Breen & Darlaston-Jones, 2010; Dweck, 2017).

As suggested by the third (qualitative) phase of this thesis (Chapter 9), grass-roots psychologists drew on the debates surrounding evidence-based practices and distinctions between what is scientific versus what is not, to emphasise and reinforce arguments justifying CM in their clinical practice. One such arguments is that simply evaluating the evidence (or lack of evidence) for CM does not provide the whole picture. The psychologists advocated for the inclusion of CM, emphasising its importance in remaining modern and innovative, and in being responsive to client demand and preferences. They justified their engagement with CM as one mechanism through which they bring this innovation (responsive and inclusive of other diverse approaches to mental health care), to psychology, their contribution to developing, evolving and advancing the psychology profession. Otherwise, it appears from the findings of the third (qualitative) phase of this thesis, that the profession may remain static, bland, manualised, narrow and irrelevant. As noted above, these arguments and themes align with contemporary debate in psychology

regarding historical divisions and highlight the importance of taking the opportunity to "re-think, re-envision, and re-calibrate" psychology (Pickren & Teo, 2020, p. 4), to be a flexible, responsive and contemporary profession (Hibberd & Petocz, 2022; Pickren & Teo, 2020). Indeed, previous literature highlights concern regarding how psychology will navigate and reconcile its internal value conflicts, balancing the imperatives of inclusivity and unity against the risk of losing its identity and professional territory, all while acknowledging the importance of diversity (Bhatia et al., 2024; Chaudhary et al., 2022). Perhaps these concerns reflect the debates in this thesis, suggesting that psychology simply does not know how to include diverse health care approaches without also perceiving that such accommodations or inclusions may lead to the profession losing its professional territory or identity. Perhaps psychology should consider the inclusion of diverse health care approaches, such as CM, as an opportunity to be inclusive, to expand its territory as a pluralistic health care approach and address historical tensions. By doing so, psychology can innovate and re-envision psychology's position in health care, its professional territory, and its identity.

The findings from this thesis raise questions about Australian psychology broadly and its inclusivity (of other mental health care approaches), breadth (beyond manualised CBT) – whether it is broad enough for contemporary clinical practice, regardless of CM. In terms of being broad enough, some argue that psychology generally has focused on a Western hegemonic view for too long, and that psychology will need to broaden to become inclusive of diverse epistemologies and ideologies in order to remain a contemporary and

responsive health care profession and discipline (Botanov et al., 2024; Chaudhary et al., 2022). The findings from this thesis, paired with the tribunal outcome discussed above (Section 1.7.5), suggest that Australian psychology (professional associations, regulatory bodies, and academia) indeed has a "narrow interpretation" of its own policy and guidelines. Moreover, these questions raised by the findings of this thesis should prompt psychology to re-evaluate its fundamental underpinnings (such as the influence of Western biomedicine) by "calling into question the ontological and epistemological bases of psychology" (Pickren & Teo, 2020, p. 3) that have led to historical divisions and exclusions. As noted above, psychology may perceive the inclusion of diverse healing approaches and epistemologies as potentially risking its scientific standing and distinct territory/identity. However, there may be more significant risks to psychology in Australia by not engaging with CM – by continuing with the broad exclusion of other healing approaches and overlooking the relevance of CM to psychologists and their clients – than psychology has previously considered. What is fascinating about the findings from this thesis is that the psychologists in the third (qualitative) phase positioned exclusions, historical tensions, and divisions in psychology as justification for their engagement with CM in their clinical practice. They highlighted these historical challenges by drawing attention to how practitioners, such as themselves, adhere to psychology's mandates while also managing to be inclusive and collaborative, thereby driving innovation within the field of psychology. Indeed, the third (qualitative) phase of the thesis identified how some psychologists likened their engagement with CM in clinical practice to pioneering and

trailblazing efforts. By doing so, they positioned themselves to stakeholders (their clients, psychologist peers, Australian psychology elite) as championing the psychology profession, driving it towards a more inclusive, responsive, and contemporary health care profession in Australia.

Overall, the thesis findings, which show a high rate of psychologist engagement with CM, along with justifications for this engagement in clinical practice, suggest a movement among Australian psychologists toward holistic and integrative mental health care that includes CM. Despite the dominance of a Western biomedical model in psychology (Fennig & Denov, 2019; Hyland, 2023), and the lack of CM relevant resources from psychology, psychologists appear to be actively incorporating CM, in a variety of ways, into their clinical practice. While Australian psychologists, overall, appear to be inclusive of CM in their clinical practice, the broader psychology profession in Australia appears to be out of step with these grass-roots clinical practice behaviours and approaches. It may be imperative for the psychology profession in Australia to reference contemporary literature advocating reforms in health care (Bhatia et al., 2024; Ciofalo et al., 2022; Dudgeon & Bray, 2023; Hashmi et al., 2024; Schubert et al., 2024) to ensure that future research and clinical practice standards align with an inclusive, up-to-date, and evolving psychology profession. This alignment is essential to meet the needs and expectations of psychologists in clinical practice and their clients.

Psychology, including professional associations, regulatory bodies, and academia, may need to carefully consider the implications of psychologist engagement with CM for the future of the psychology profession. This may include leveraging psychologists existing interest and engagement with CM in their clinical practice to develop CM relevant clinical practice guidelines. Additionally, psychology may need to integrate relevant CM into tertiary curricula, possibly through existing mandatory psychologist competencies in responding to client preferences, acknowledging the cultural relevance of some CM, and fostering interprofessional collaboration that includes CM practitioners.

While this thesis does not aim to resolve historical divisions and tensions within the psychology profession broadly, it may alert psychology in Australia to an opportunity to understand the wider implications, that have been highlighted by the challenges and justifications for psychologist engagement with CM. This thesis has highlighted broader challenges to the psychology profession in Australia, beyond CM, in the context of psychology's relationship with psychologists (disconnects between psychology's elite and psychologists at the grass-roots in clinical practice) and psychology's position in the contemporary health care landscape.

10.3 Limitations

As with all research projects, the study presented in this thesis has a number of limitations which must be considered when appraising the contribution and implications of the thesis contribution to understanding this topic. These limitations are outlined below.

10.3.1 Limitations of the literature review

A limitation of the literature review/critical integrative review is the restriction to English language papers. This limitation could introduce language and culture bias, as relevant research published in other languages might have been excluded. Consequently, the included literature many not fully capture the global landscape of psychologist engagement with CM, and thus limiting generalisability. It is inherent in the research topic that there may be a response bias in the empirical studies included in the integrative review. Various tools have been used to reduce the impact of bias on the outcomes of the literature review, such as a critical appraisal tool, and triangulation of each author's interpretation of the bias and quality of included papers.

10.3.2 Limitations of the second (quantitative) phase

Research relating to CM has at times been controversial including criticisms around poor methodology, lack of standardisation/quality of some constituents (e.g., herbal medicine), and regulatory issues (Gray et al., 2019; Veziari et al., 2021; Veziari et al., 2022; Wardle, 2017). Commentary relating to CM within psychology is no different and has attracted criticism (Vyse, 2016). At the commencement of recruitment for the second (quantitative) phase of the thesis, when the research was placed on Australian psychology professional association websites, I received a complaint and several negative responses about the research. The complaints expressed concern that I must be an "uncritical devotee" of CM and the research would be biased. While these complaints were unsettling as a

student researcher, they also served to underscore the importance of minimising bias where possible throughout the thesis. An example of extra care taken to minimise bias was the construction of survey items. Survey items were reviewed, tested on several PhD students, and reworded in an attempt to minimise potential bias toward favourable responses.

Another potential source of bias relating to the second (quantitative) phase arises from the method of participant selection. Since participation was voluntary there is a risk of self-selection bias, where those with a particular interest or experience in CM might be overrepresented in the study. The diversity of perspectives from participants is an important consideration when interpreting the findings, as it may reflect a range of attitudes, and levels of engagement, toward CM within the study sample. Thus, it is also important to acknowledge that individuals who hold negative views or oppose CM may have also chosen to participate.

There are also cautions in interpreting quantitative data from a small sample size, as the findings may not represent the perspectives of all psychologists in Australia. Nevertheless, the sample is representative of the Australian psychology workforce demographics (Psychology Board of Australia, 2022).

10.3.3 Limitations of the third (qualitative) phase

As noted above, any form of bias is a concern in research. The very nature of reflexive thematic analysis is what the researcher themselves brings to the interpretation of the qualitative data. In this case myself, as the primary researcher, an insider to psychology

as an academic and historical volunteer within the APS, a holder of qualifications in naturopathy and nutrition, as well as a clinical psychologist in clinical practice in Australia. My own personal beliefs, experiences and perspectives may have unduly influenced the identification and interpretation of themes, potentially leading to bias in the results. Measures were regularly taken to minimise potential sources of bias such as, reviewing resources related to minimising bias in qualitative research (Braun & Clarke, 2022; Creswell & Creswell, 2018), personal and shared (with supervisors and fellow PhD researchers) reflections, formal triangulation where appropriate (as discussed above), supervisor attendance at some of the interviews, and validation of methodological steps through comparison with prior research utilising similar methodologies, and with similar health care professions (e.g., Byrne & Sharman, 2022; Byrne, 2022; Sprigings, 2021)

As the interviews were only a small sample size (*N* = 19) the results may not be generalisable to psychologists in Australia broadly, however generalisability was not the intention of the third (qualitative) phase. The third (qualitative) phase aimed to identify rich and deep information from the interviewed psychologists to gain insights that quantitative methods cannot provide (Braun & Clarke, 2022; Creswell & Creswell, 2018). This may limit the extent to which the thesis findings can inform the development of relevant resources and policy broadly.

10.3.4 Reflection on personal bias as a limitation

During the PhD experience, I encountered a metacognitive experience, in which I became aware of the evolving landscape of psychologist engagement with CM, and its potential influence on the resources (professional development activities) I was contemporaneous developing, and my own interest in the research topic. This awareness prompted careful consideration and decision making regarding whether to include the content I personally developed (professional development activities advertised on the APS website), driven by concerns about introducing bias. I grappled with the dilemma of whether to include or exclude this content recognising the possibility of bias either way. As an example, while the integrative review (Chapter 2) was completed at the beginning of the research, it was not published until the end of 2023. At the direction of the editor of the journal publishing the review, I had to incorporate my own publications into the review, this prospective bias, whether through inclusion or exclusion, is significant as it could affect the research's ability to fully capture the impact of primary research on psychology in Australia, thus shaping our understanding of CM within psychology as a discipline.

In the context of personal bias, I am indeed very interested in the potential role of CM within psychology – which is reflected in the desire to complete a PhD thesis on the topic. My intention was to utilise the platform of the PhD thesis to rigorously investigate the barriers to psychologists' engagement with CM within their clinical practice. I had a genuine curiosity as to whether CM was indeed relevant to psychologists in clinical practice, and if so, what would need to be included in clinical practice guidelines and tertiary education to support the safe integration of CM into their clinical practice. It is

important to acknowledge that during the PhD experience I was a committee member of the Australian Psychological Society's Psychology and Integrative Mental Health Interest Group. Thus, it is important to disclose two additional and important drivers that sustained me on the PhD journey, 1) to undertake rigorous research that informs the development of CM relevant guidelines and education for psychologists in Australia, and 2) if appropriate, submit my findings to psychology in Australia (APS and PsyBA). For example, I wanted to share the thesis findings, if relevant, with the PsyBA before they publish the new Code of Conduct, so that the findings may be considered, and perhaps have some impact, regarding the role of diverse mental health care approaches, such as CM, within the clinical practice of psychologists. As noted above (Section 10.3.3), throughout the PhD experience I reflected, and sought supervisory guidance, where there was potential for personal bias to influence interpretation and findings. It was also useful to gain perspectives from supervisors who are not psychologists in clinical practice.

10.4 Impact of COVID-19

Some phases of the thesis, and thus research outputs included in the final thesis, were significantly impacted by the SARS-CoV-2 (COVID-19) pandemic. The COVID-19 pandemic had significant negative physical and mental health impacts on people around the world (Dawel et al., 2020; Rossell et al., 2021). During the COVID-19 pandemic there was high public demand for mental health services, including service from psychologists (Marshall et al., 2020; Rahman et al., 2020). For my thesis, the primary impact related to the availability of psychologists who were the sole source of participants, and thus data, for

the second (quantitative) and third (qualitative) phases of the research. Frontline workers, such as psychologists, were also considered at higher risk of psychological distress due to these high workload demands (Braquehais & Vargas-Cáceres, 2023; Hooper et al., 2021). To accommodate demand on psychologists, and the impacts of COVID-19, several changes were made to the original research protocol. This primarily involved extending the length of time the survey was available online. It is possible that, even with a longer period of data collection, COVID-19 may have had a negative impact on the number of psychologists able to be recruited to the second (quantitative) and third (qualitative) phases of the thesis. I also allowed more flexibility when scheduling third (qualitative) phase interviews to accommodate psychologists' busy schedules. For example, I accommodated one psychologist's request for their interview to be held over shorter sessions. Of note the high utilisation of virtual/telehealth technologies during the pandemic (Marshall et al., 2020; Young et al., 2022) may have assisted the interview process, as many psychologists who had to adapt their practices to telehealth were comfortable with the use of Zoom for the interviews.

10.5 Future directions in research

Although the thesis has provided some interesting and novel findings, there are a number of ways in which further research can provide insights into the relationship between psychology, psychologists and CM. For example, future studies could explore the efficacy and safety of CM for various mental health problems in the context of

collaboration between CM practitioners and psychologists. Some potential areas of research are discussed below.

10.5.1 Future research directions regarding CM and psychology – the client

The psychologists in the current study describe their motivation for engaging with CM as being, in part, driven by an attempt to be responsive to client preference for CM. While there is a small amount of research on client non-disclosure of CM use to their health professionals (Foley et al., 2019; Golden et al., 2023; Halpin et al., 2019), there is very limited research related to the client's experience of disclosing their CM use to their psychologist, and in the Australian context. Given such widespread psychologist engagement with CM it would be interesting to identify specific rates of their client's use of CM. Although not specifically related to CM, a recent article identified high levels of acceptability toward lifestyle medicine approaches (an approach that includes, sound nutrition, movement and exercise, meditation, positive psychology) in mental health care, however participants were not clients of mental health services (Richardson et al., 2024). It would then be interesting to consider the client's perspective of the acceptability of having their psychologist CM informed. For example, what is the client's experience when their psychologist does, or does not, engage with their preference for CM? Future research might use survey or interview data to examine client perspectives and experiences of psychologist engagement with CM, or specifically whether they value their psychologist's engagement with CM. This research may help to understand whether clients perceive benefit when their psychologist has, at the least, some knowledge of relevant CM and is able to discuss CM

with their client. In addition, this type of research would also help to discern whether the perspectives of psychologists in this study, relating to responding to client-based factors, are borne out. Further, how the experience and perspectives of clients relates (compares and contrasts) to that of psychologists who engage with CM in their clinical practice.

It may also be of value to explore client's perspectives and experiences on the responsiveness of their psychologist to client disclosures of CM use. Particularly in light of previous research that reports client hesitation to disclose their CM use to their conventional health professionals (Foley et al., 2019; Halpin et al., 2019). In contrast it may also be helpful to understand the experiences of clients who may not have a preference for CM, and to explore their experience of receiving a service from a CM engaged psychologist. Understanding client preferences and experiences, in the context of a CM engaged psychologist, may complement the findings from this thesis to inform the development of resources for integrative mental health care more broadly within the Australian health care system.

10.5.2 Future research directions regarding CM and psychology – the psychologist

Future research may also replicate the second (quantitative) and third (qualitative) phases to explore changes, if any, across time in relation to the themes and topics discussed in the current thesis findings. For example, a longitudinal study may provide a host of other insights regarding clinical practice behaviours, perspectives, and experiences of

psychologists, in the context of their CM engagement, that may change and evolve over time. This type of research may also indicate changes in psychology's/psychologist engagement with CM, and other issues raised by this research, such as whether psychology acknowledges the role and relevance of CM to clients, including the ethnocultural relevance of some CM for some clients.

Another important area for possible further research is to explore psychologists' work role satisfaction when they incorporate CM into their clinical practice. In the current study some of the psychologists reported benefits to their sense of satisfaction in their work role when they engage with CM as part of their clinical practice. Future research may explore psychologists' job satisfaction, job retention, burnout, and the quality of the therapeutic relationship with their clients, when they engage with CM in their clinical practice. The outcomes of such research may address retention challenges facing the psychology workforce to meet the demand for mental health services (Australian Psychological Society, 2023; Chhabra & Dhingra, 2023; Department of Health and Aged Care, 2023; Macleod et al., 2023; McCade et al., 2021; Melville, 2023; Turnbull & Rhodes, 2021). As noted above, flexibility and professional autonomy are associated with job satisfaction, and the inclusion of diverse healing approaches, such relevant CM, may provide increased satisfaction for psychologists who are interested in including CM in their clinical practice.

Some health professions in Australia support specialisation in CM, including personalised medicine and health care (Deisenhofer et al., 2024; Haller et al., 2019; Zanardi et al., 2021). Specialisation in psychology is a nuanced topic, with its complexities grounded in the divisions and debates outlined above, such as division around the merits of clinical psychology versus general psychology, and debates such as monism versus pluralism in how psychology includes/excludes treatment approaches. As indicated by the second (quantitative) and third (qualitative) phases of this thesis, psychologists in Australia seek out independent training and qualifications in some form of CM. Future research might explore the types of CM training psychologists are engaging with (e.g., short courses or formal qualifications) and how they incorporate their new CM knowledge and skills into their clinical practice. Further research may also explore the potential benefits and drawbacks of such specialisations in psychology, including specialisation in complementary and integrative mental health care.

While the thesis focuses on psychologists discussing, recommending, and referring to CM in their clinical practice – the direct application of CM by psychologists may be an important avenue of research, including the potential to improve mental health outcomes. Future research may explore benefits (to client, psychologist, psychology profession) when psychologists with formal qualifications in CM (e.g., naturopathy) integrate CM through the direct application of CM into their clinical practice. For example, are there perceived benefits (for the client such as convenience, reduced costs) when a psychologist is able to provide both evidence-based psychological therapies as well as dispense evidence-based

herbal interventions (e.g., Kava – Piper methysticum). In this setting the client would see one practitioner, the psychologist, who had at least one other specialty (e.g., naturopathy). As discussed above (Section 4.5 and 5.5), at present clinical practice guidelines appear prohibitive of psychologists working with clients from dual qualifications. However, the Psychology Board of Australia's Code of Conduct (yet to be released) may be less restrictive, thus providing opportunity for dual qualified psychologists/researchers to explore the direct application of CM in clinical practice. In addition, employing single case design studies (N of 1) could serve as a valuable method to investigate the therapeutic potential of psychologist/naturopaths directly applying psychology/CM interventions (Bradbury et al., 2020; McDonald et al., 2020). These studies could offer a personalised and nuanced understanding of how such interventions impact individual clients, allowing for more tailored treatment plans that integrate CM with psychological interventions. The single case design studies would also allow research to explore the effectiveness of this type of CM/integrative intervention in real world clinical practice settings, providing insights into the logistics of the direct application of CM in psychologists' clinical practice and the potential benefits for clients.

10.5.3 Future research directions regarding CM and psychology – clinical practice

Although part of the thesis surveyed psychologists regarding how they recommend and refer to CM, future research might aim to explore naturalistic observations of how psychologists engage with CM in their clinical practice (as opposed to relying upon

reflections and recall that is removed from naturally occurring practice). Amongst other issues and topics, this work could include focus upon the process and decisions undertaken by psychologists regarding referral to CM, and/or the direct application of CM in their clinical practice. These observations may further inform gaps in psychologist education, clinical practice guidelines, and policy for those psychologists wishing to integrate CM into their practice. This type of research may also highlight strengths and limitations in terms of issues relating to psychologist's scope of practice and the type of education and training required for psychologists to develop competency in CM.

Important future research may also explore the role of psychologists as part of an integrative health care hub, where psychologists are co-located with a range of health/mental health care professionals including CM practitioners. Further, this type of research may build on previous smaller research projects in Australia that have demonstrated meaningful progress toward integrative mental health services (Beere et al., 2019). This type of research would be in contrast to a psychologist having a specialisation in CM, as described above. In this collaborative health care setting the client would have access to a number of practitioners situated in the same location/service, each of which had a health/mental health specialty (e.g., medical doctor, psychiatrist, yoga instructor). In a collaborative/integrative health care setting the psychologist would need skills that assist them to work within a team environment, and to use these skills (such as interprofessional collaboration – communication skills) to understand different/overlapping health care roles and scope of practice. Throughout the phases of this thesis, the psychologists emphasise the

significance of being able to refer to, and collaborate with, CM practitioners when appropriate, incorporating the client's preferred CM practitioner into collaborative efforts surrounding the client's care, and identifying the professional advantages gained through collaboration with CM practitioners. Some of the benefits of collaboration described by the psychologists in this thesis include being seen to be responsive to client demand, developing mutually beneficial collaborative relationships, and a sense of teamwork and shared responsibility in working toward the client's health care goals. Future research might delve into the feasibility of establishing an integrative and collaborative health care team environment, focussing on the viability and strategies (e.g., deliberate efforts to work collaboratively) to enhance the successful integration of psychologists within this framework and work environment. Future research might also explore the barriers and benefits (to clients, psychologists, and stakeholders) when psychologists participate in these collaborative integrative health care hubs.

Future research may further investigate a nuanced and personalised approach to mental health care within the context of integrated health hubs outlined above. For example, future research could explore how psychologists in clinical practice might implement and deliver a personalised approach to their client's care, integrating centralised case management, with the psychologist acting as the primary facilitator and coordinator of services. Personalised and integrative health care has been identified as an important development in health care (Ee et al., 2020b; Leach et al., 2018; Seetharaman et al., 2021; Sibbritt et al., 2021). During the third (qualitative) phase of this thesis, psychologists

emphasised the significance of adopting a client centred and holistic approach and how the psychologist may be viewed as a gatekeeper, or case manager, that assists the client to navigate CM. This type of research could explore this concept, how the psychologist utilises clinical expertise, to act as a gatekeeper of CM, actively informing their clients about the utility of relevant CM (Adams et al., 2018; Jarvis et al., 2015). This type of research would also align with the WHO Traditional Medicine Strategy (World Health Organization, 2013) which encourages member states to acknowledge the role of CM, and to work toward the integration of CM into health care settings (World Health Organization, 2023; Zhang et al., 2019).

10.5.4 Future directions of CM and psychology – psychology

The current study focussed on the grass-roots perspectives of psychologists and the current policy environment in relation to CM within psychology practice in Australia. This thesis found *different* rates of engagement with CM among psychologists and psychologists with an Area of Practice Endorsement (AoPE)/specialty area. In particular, this thesis identified psychologists with an AoPE in clinical psychology were less likely to refer to CM, thus there may be something unique to clinical psychology training that results in clinical psychologists having less engagement with CM than other types of psychologists. Future research could explore why there are differences in CM engagement among psychologist AoPE/specialty types. It is possible, in the Master of Clinical Psychology tertiary programs, that there is overemphasis on specific forms of evidence, such as metanalyses and randomised control trials of manualised psychotherapy interventions,

rather than evidence as the *best available evidence* integrated with clinical decision making and client preferences, values and culture – as evidence-based practice in psychology (EBPP) recommends (De Vincenzo et al., 2024). It may be that clinical psychologists, during the course of their education and supervised practice, are advised that the evidence hierarchy (favouring meta-analyses and randomised controlled trials) is a fundamental principle of EBPP, without giving due attention to the two other important components of EBPP; clinical decision making around what is clinically relevant, and the client's preferences, values and characteristics. Thus, it is possible that a larger proportion of psychologists with an AoPE in Clinical Psychology, than other AoPEs, (e.g., Educational and Developmental Psychology) may value high level scientific evidence for the psychotherapies they are taught (e.g., cognitive behavioural therapy – CBT) over other elements of EBPP, potentially devaluing the role of the clients' preferences, social/cultural factors and other relevant health care approaches. Future research might explore why there are differences in psychologist engagement with CM among different psychologist types.

Future research may also explore psychology's position (e.g., agnostic, unintentional/intentional exclusion of CM), regarding CM within psychologists' clinical practice – the position of the elite in psychology in Australia (executives, board members and chairs of professional, regulatory and academic bodies) and clarify what is their opinion on the relevance of CM to both psychologists in clinical practice and the broader profession. For example, qualitative interviews and/or a Delphi study may provide insight on Australian psychology's position, and justification for this position, in relation to CM in

psychology, and within psychologists' clinical practice. Further research may provide more detailed information regarding the psychology elite's position to help better understand their motivations, perspectives, expectations and desires around CM, and beyond CM. This type of research may also highlight how key personnel, the elite in psychology, and their formal and personal positions on CM influence the psychology profession in Australia. Further research may explore how psychology, as a profession in Australia, responds to shifts and trends, toward the inclusion of CM and integrative health care, and how psychology's elite inform tertiary education and clinical practice. A Delphi study, of the elite in psychology in Australia, as well as experts in ethics, clinical practice and relevant CM, may also be of benefit to inform the development of CM relevant policy and clinical practice guidelines. There may be similar avenues for this type of research, as well as opportunities for interprofessional research and collaboration where the input of the psychology elite and experts in psychology/CM ethics/policy for mental health may identify what steps need to be taken to progress the safe integration of CM within psychology, and assist psychologists in clinical practice to maintain safety for clients when recommending, referring, or directly applying CM as part of their treatment approach with clients.

10.5.5 Future research directions regarding CM and psychology – Public health

From a public health perspective, future research may also explore the clinical outcomes experienced by clients whose treating psychologist is engaged with CM. For instance, conducting studies comparing the mood symptom improvement of a client

undergoing CBT alone, versus those clients receiving CBT in combination with referral and services from a CM practitioner, such as culturally relevant traditional healing approaches. Investigating how the integration of psychological interventions with CM modalities may enhance mental health outcomes represents a promising avenue for research. Improved mental health outcomes is a public health priority in Australia and globally (GBD 2019 Mental Disorders Collaborators, 2022; Moitra et al., 2022). The increase in demand for CM, integrative medicine, and lifestyle medicine as prevention and treatment approaches for mental health will be an important consideration for Australian psychology. Aligning with Australian and global policy and goals for improved mental health outcomes (Australian Health Ministers' Advisory Council, 2013b; Department of Health and Aged Care, 2021; World Health Organisation, 2013) underscores the potential significance and opportunity for innovation through the integration of CM in psychology, and clinical practice, to address the complex and diverse needs of people experiencing mental health problems.

Future research could employ the framework provided above (discuss, recommend, refer, apply) to map the extent of health professional engagement with CM at each mode, to establish explicit rates of engagement, and to monitor trends in CM engagement allowing for easier and rigorous comparison across time. The compilation of data that reflects trends in health professional engagement with CM may assist health care planning, relevant policy development, education and training needs, as well as resources to inform integrative mental health care models.

10.6 Chapter summary

This overall discussion chapter has explored the significant broad findings of the thesis and their implications. The results from the thesis suggest there is widespread psychologist engagement with CM in Australia, across multiple forms of CM products, practices, and practitioners. Despite psychologists having limited CM relevant clinical practice resources (from Australian psychology professional and regulatory bodies) the psychologists justify their engagement with CM via extrinsic client-based reasons. These client-based reasons include responding to client preference for CM and the ethnocultural relevance of some CM for some clients. Importantly, the psychologists in the third (qualitative) phase of the study qualify their engagement with CM as not uncritical, are keen to posit their position as selective and discerning regarding the efficacy and utility of CM, and are willing to dismiss CM if, in their judgement, it is not clinically useful. The justifications put forward by the psychologists in this thesis align with psychology's own mandates around evidence-based practice in psychology (the integration of the best available research, clinical expertise of the psychologist, and client characteristics, culture, and preferences). Further the psychologists justify their engagement with CM as being inclusive, collaborative, and fitting with their role as culturally responsive health care practitioners. Unfortunately, the wider profession of psychology in Australia has not engaged with CM in the same way as grass-roots psychologists in clinical practice appear to engage with CM. Thus, there are opportunities for Australian psychology to engage with psychologist and client demand for CM, leveraging insights gleaned from psychologists

already engaged with CM in their clinical practice, to enhance inclusivity, collaboration, and cultural responsiveness within the psychology profession and mental health care more broadly.

Chapter 11. CONCLUSION

The overall findings of the thesis have a number of possible implications for the psychology profession in Australia. The results from the thesis suggest there is widespread psychologist engagement with CM in Australia, spanning various modalities, practices, and practitioners across the spectrum of the CM field. Despite facing challenges stemming from limited CM relevant resources (not provided by the Australian psychology professional and regulatory bodies) psychologists justified their engagement with CM as primarily driven by extrinsic client-based reasons. The client-based reasons put forward by the psychologists in the third (qualitative) phase of this thesis may be powerful arguments (perhaps toward their psychologist peers and/or the Australian psychology elite) to justify their engagement with CM in their clinical practice, including being responsive to the ethnocultural relevance of some CM for some clients. Moreover, the psychologists were keen to qualify their engagement with CM as via a critical lens, demonstrating they are selective and discerning toward the efficacy and utility of CM. Further, they are willing to dismiss CM if it is not clinically useful.

Importantly, the justifications articulated by the psychologists in this thesis mirror core mandates of evidence-based practice in psychology (EBPP) which emphasises the integration of the best available research, clinical expertise, and acknowledging client preferences, values, characteristics, and culture. Consciously or unconsciously, the justifications put forward by the psychologists in this thesis align with psychology's own mandates and broader mental health care policy in Australia and internationally.

Despite the widespread grass-roots integration of CM by Australian psychologists in their clinical practice, the psychology profession in Australia (psychology's professional and regulatory bodies) is yet to respond to psychologist and client demand for CM. Currently there is no explicit reference to CM in Australian psychology's clinical practice guidelines, including no reference to Aboriginal and Torres Strait Islander traditional healing practices. There may be a number of risks for psychologists, their clients, and the profession if psychology is not able to keep pace with demand for CM in a contemporary health care landscape. These risks include the challenge of psychologists not having access to CM relevant resources to safely integrate CM within their clinical practice. There are also risks to the psychology profession in Australia if it is not perceived as responsive to demand for CM, including perceptions that the profession is exclusive, narrow, and lagging behind psychology in other Western locations and not keeping pace with inclusive health care more broadly.

The extensive engagement of Australian psychologists with CM in their clinical practice highlights the need for Australian psychology to address both psychologist and client demand for CM integration. The findings from this thesis highlight that there may be an opportunity for psychology in Australia to reflect on its own mandates on inclusivity, interprofessional collaboration, and cultural responsiveness, to progress psychology forward as a responsive and contemporary health care approach. Future research should explore opportunities to enhance mental health outcomes through the safe integration of CM within psychology.

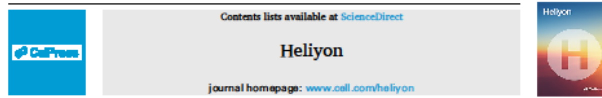
As noted above, in some ways this thesis gives a sense that it is a test case. A test case is a scenario that assesses hypotheses or concepts within a field through empirical observation and analysis. In the context of this thesis, it may be a test case that explores psychology's identity in Australia, particularly in relation to how the profession engages with other health care approaches, CM or otherwise. Psychology may need to consider the issues outlined in this thesis and how it will navigate and engage with CM, in the context of high levels of psychologist and client engagement with CM. These issues around how psychology in Australia engages with CM are unlikely to go away (Fernandes-Nascimento & Wang, 2022; Mwaka et al., 2018). There are many possibilities and opportunities for psychology, rich ground for future research – all with a view to helping understand, clarify, and ultimately guide the safe and effective mental health care of the community that psychology and psychologists serve.

APPENDIX

Appendix A

Critical Integrative Review

Heliyon 9 (2023) e21201



Review article

The engagement of psychology with complementary medicine: A critical integrative review

Carrie Thomson-Casey [a,*], Jon Adams [a], Erica McIntyre [a,b]

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A R T I C L E I N F O

Keywords:
Psychology
Complementary medicine
Policy and guidelines
Integrative health care

A B S T R A C T

Amidst the global rise in complementary medicine (CM) use for mental health, a substantial number of clients consulting a psychologist also utilise at least one form of CM. Yet, how psychologists *should* engage with CM in their clinical practice (e.g., how to respond to a client disclosing CM use or enquiries regarding CM products or services for mental health) remains contested and unclear. In response, a systematic integrative review was conducted to examine empirical literature reporting on one or more aspects of the relationship between psychology (incorporating clinical practice, professional associations and academia) and CM, and how that relationship may relate to or inform psychologists' engagement with CM in their clinical practice. Twenty-seven peer-reviewed articles met the specific inclusion criteria and quality appraisal was employed. Analysis shows a substantial number of psychologists are engaging with, or are interested in engaging with, CM in their clinical practice. Analysis identified a dissonance between psychologists' engagement with CM in clinical practice and the limited engagement of the broader discipline of psychology with CM. Further research is required to understand these differing types of engagement with a view to helping inform relevant policy and practice guidelines, and ultimately assist psychologists in navigating CM in their clinical practice.

Globally, psychologists are likely to encounter clients who are using at least one form of complementary medicine (CM), including over the counter vitamin and mineral supplements, herbal medicines, traditional medicines, yoga, aromatherapy, meditation and massage [1–5]. For the purpose of this review, CM (also referred to as complementary and alternative medicine [CAM]) includes a broad range of health care products, services and practices, that are "not part of a country's own traditions or conventional medicine and are not fully integrated into the dominant health care system" [[6], 2019, p. 1]. Products, services and practices included within definitions of CM vary, as they are dependent on how CM is culturally, socially and politically positioned [7–9]. In addition, some CM practices such as meditation and mindfulness are now more widely accepted by psychologists and integrated into their practice, yet they have not traditionally been considered a component of psychology [10–12].

CM use for mental health is substantial. Reported utilisation of CM amongst those with mental health problems (e.g., participants self-reporting a mental health diagnosis in last 12 months) ranges from 0.7 to 89 % [2,9,13–15]. Although there is large variation in these prevalence rates (due to CM definitions and inclusion criteria adopted and the population studied in each study), a preference for CM amongst people living with mental health problems is consistent across regions, such as Ireland, Netherlands, Saudi Arabia and the US [16–19]. A study at various Saudi Arabian hospitals found 82.2 % of inpatients with mental health problems reported using at least

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2405-8440/© 2023 The Authors. Published by Elsevier Ltd. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).

Appendix B

Search terms used in the integrative review

Search term categories	Search terms
Psychology in title AND abstract	(Psycholog*) Psychology, Psychologist, Psychological
Complementary Medicine in title OR abstract	Complementary Therapies (MeSH term): Complementary and Alternative Medicine, OR Complementary and Alternative Therapy, OR Complementary and Alternative Therapies, OR Complementary Medicine, OR Complementary Therapy, OR Complementary Therapies, OR Alternative Medicine, OR Alternative Therapy, OR Alternative Therapies, OR Natural Medicine, OR Natural Therapy, OR Natural Therapies, OR Traditional Medicine, OR Integrative Medicine, OR Functional Medicine, OR Holistic medicine
CM modalities in title OR abstract	Naturopathy (Naturopath*), OR Nutrition (Nutrition*), OR Herbalism (Herbal*), OR Chiropractic (Chiropract*), OR Osteopathy (Osteopath*), OR Massage, OR Traditional Chinese Medicine, OR Homeopathy (Homeopath*), OR Ayurvedic medicine

Appendix C

Inclusion and exclusion criteria for integrative review

Inclusion Criteria	Exclusion Criteria
Articles that discuss interdisciplinary relationship between psychology and CM	Articles that focus on Therapist, Therapy, Counsellor, Counselling, Psychotherapist, Psychiatry, Psychiatrist without discussion on psychology as a discipline
Articles that discuss psychologists' attitudes to CM	Articles that focus on CM as an adjunct to Therapist, Therapy, Counsellor, Counselling, Psychotherapist, Psychotherapy, Psychiatry, Psychiatrist without discussion on psychology as a discipline
Articles that discuss psychologists' experiences of CM (including personally, education, professionally)	Articles that do not discuss issues related to clinical decision making in psychology practice (such as treatment selection, clinical decision making, ethics).
Articles that discuss psychologists' (individuals and groups) philosophical, ethical, political, and clinical stance regarding CM	Efficacy and effectiveness studies of CM modality/treatments applied to mental health conditions. Comparison studies of CM modality/treatment vs psychological approach/treatment
	Studies not available in full text or in English

Appendix D

Outcome of quality appraisal

Author (date)	Screening		Qualitative					Quantitative (descriptive)					Mixed Methods					Bias	
Bassman & Uellendahl (2003) *	✓	✓						✓	✓	✓	✓	X						No	No
Crowe-Salazar (2007)	✓	✓	✓	✓	✓	✓	✓											Yes	No
Wilson & White (2007) *	✓	✓						✓	✓	✓	X	✓						No	No
Ditte et al (2011)	✓	✓						✓	✓	✓	✓	✓						Yes	No
Wilson & White (2011)	✓	✓	✓	✓	✓	✓	✓											No	No
Wilson et al (2011)	✓	✓						✓	✓	✓	-	✓						Yes	Yes
McKenzie et al (2012)	✓	✓											✓	✓	-	✓	X	No	Yes
Wilson et al (2012a)	✓	✓						✓	✓	✓	-	✓						Yes	No
Wilson et al (2012b)	✓	✓						✓	✓	✓	-	✓						Yes	Yes
Wilson et al (2013)	✓	✓						✓	✓	✓	✓	✓						Yes	Yes
Stapleton et al (2015)	✓	✓						✓	✓	✓	-	✓						Yes	No
Fay et al (2016)	✓	✓						✓	✓	✓	✓	✓						Yes	Yes
Hamilton & Marietti (2017)	✓	✓						✓	✓	✓	✓	✓						Yes	Yes
Liem & Newcombe (2017)	✓	✓						✓	✓	✓	-	✓						Yes	No
Liem & Rahmawati (2017)	✓	✓						✓	✓	✓	✓	✓						Yes	No
Ligorio & Lyons (2018)	✓	✓						✓	✓	✓	X	✓						Yes	Yes
Liem (2018)	✓	✓											✓	✓	✓	✓	✓	Yes	No
Liem (2019a)	✓	✓						✓	✓	✓	-	✓						Yes	No
Liem (2019b)	✓	✓	✓	✓	✓	✓	✓											Yes	Yes
Liem (2019c)	✓	✓	✓	-	✓	✓	✓											Yes	Yes
Liem (2019d)	✓	✓	✓	✓	✓	✓	✓											Yes	Yes
Liem & Newcombe (2019a)	✓	✓						✓	✓	✓	✓	✓						Yes	Yes
Liem & Newcombe (2019b)	✓	✓						✓	✓	✓	✓	✓						Yes	No
Medeiros et al (2019)	✓	✓						✓	✓	✓	✓	✓						Yes	No
Kassis & Papps (2020)	✓	✓						✓	✓	✓	✓	-						Yes	No
Kralj & Kardum (2020) *	✓	✓						✓	✓	✓	X	✓						No	No
Liem (2020)	✓	✓						✓	✓	✓	✓	✓						Yes	No
Morkl et al (2021)	✓	✓						✓	✓	✓	✓	✓						Yes	Yes
Nayda et al (2021)	✓	✓						✓	X	✓	✓	✓						No	Yes
Thomson-Casey et al (2023)	✓	✓						✓	✓	✓	✓	✓						Yes	Yes

* = excluded

Appendix E

Summary of the types of CM integration used by psychologists and examples

Types	Type of integration	Example
Discuss	Interactions/side effects/potential benefits	St John's wort contraindicated with some antidepressants
Recommend	Recommend a CM service/product	Recommending a client attend a yoga class for relaxation and social connection
Refer	Referral to licensed/registered CM practitioner	Referring a client to a Naturopath for evidence-based herbal approaches fo
Apply	Acceptable/assimilated CM	Guiding a client through meditation
	With informal/additional certification	Guiding a client through hypnosis
	With dual qualifications (separate lic registration)	Providing evidence-based nutrition/d improvement recommendations to in mood/behavioural activation

Appendix F

Document Analysis

Thomson-Casey *et al.*
BMC Complementary Medicine and Therapies (2022) 22:171
https://doi.org/10.1186/s12906-022-03620-2

BMC Complementary
Medicine and Therapies

RESEARCH Open Access

Complementary medicine in psychology practice: an analysis of Australian psychology guidelines and a comparison with other psychology associations from English speaking countries

Carrie Thomson-Casey[1*], Jon Adams[1] and Erica McIntyre[1,2]

Abstract

Background: Psychologists, and their clients, are engaging with complementary medicine (CM). Increasing evidence for CM approaches, such as improved nutrition and St John's wort, has led to their inclusion in the Royal Australian New Zealand College of Psychiatrists clinical practice guidelines for mood disorders. This research aims to determine in what ways, and to what extent, Australian psychology regulatory bodies and associations consider CM relevant to psychology practice. Specifically, how these regulatory bodies and professional association's ethical and practice guidelines engage with CM.

Methods: Documents from Australian regulatory bodies and professional associations, that relate to the governance or guidance of psychologists' clinical practice, were systematically searched for key terms relating to CM.

Results: There were no direct references to CM in the 58 ethical and practice guidelines reviewed. There was also no reference to the relevance of CM to ethnocultural groups, such as Aboriginal and Torres Strait Islander traditional healing practices.

Conclusion: While other mental health care disciplines are working toward integrating CM, the discipline of psychology in Australia is not currently engaged in such developments. Given the exponential rise of CM use amongst those with mental health problems, psychology associations should consider developing resources and guidelines to assist psychologists in navigating CM in relation to clinical practice to help minimise risks, such as patient safety associated with concurrent CM use.

Keywords: Clinical practice, Complementary medicine, Ethics, Policy and guidelines, Integrative mental health

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Appendix G

Phase Two and Three Ethics Approval

Carrie Thomson-Casey

From: research.ethics@uts.edu.au
Sent: Monday, 2 November 2020 11:59 AM
To: Erica McIntyre; Carrie Thomson-Casey
Subject: Your ethics application has been approved as low risk - ETH20-5138
Attachments: Ethics Application.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Dear Applicant,

Re: ETH20-5138 - "An Exploration of the Integration of Complementary Therapies In Psychology Practice"

Your local research office has reviewed your application and agreed that it now meets the requirements of the National Statement on Ethical Conduct in Human Research (2007) and has been approved on that basis. You are therefore authorised to commence activities as outlined in your application, subject to any conditions detailed in this document.
You are reminded that this letter constitutes ethics approval only. This research project must also be undertaken in accordance with all UTS policies and guidelines including the Research Management Policy.
Your approval number is UTS HREC REF NO. ETH20-5138
Approval will be for a period of five (5) years from the date of this correspondence subject to the submission of annual progress reports.
The following standard conditions apply to your approval:

- Your approval number must be included in all participant material and advertisements.
- Any advertisements on Staff Connect without an approval number will be removed.
- The Principal Investigator will immediately report anything that might warrant review of ethical approval of the project to the Ethics Secretariat (Research.Ethics@uts.edu.au).
- The Principal Investigator will notify the UTS HREC of any event that requires a modification to the protocol or other project documents, and submit any required amendments prior to implementation. Instructions on how to submit an amendment application can be found here.
- The Principal Investigator will promptly report adverse events to the Ethics Secretariat. An adverse event is any event (anticipated or otherwise) that has a negative impact on participants, researchers or the reputation of the University. Adverse events can also include privacy breaches, loss of data and damage to property.
- The Principal Investigator will report to the UTS HREC annually and notify the HREC when the project is completed at all sites.
- The Principal Investigator will notify the UTS HREC of any plan to extend the duration of the project past the approval period listed above through the progress report.
- The Principal Investigator will obtain any additional approvals or authorisations as required (e.g. from other ethics committees, collaborating institutions, supporting organisations).
- The Principal Investigator will notify the UTS HREC of his or her inability to continue as Principal Investigator including the name of and contact information for a replacement.

This research must be undertaken in compliance with the Australian Code for the Responsible Conduct of Research and National Statement on Ethical Conduct in Human Research.

You should consider this your official letter of approval.

1

Appendix H

Phase Two Participant Consent Form and Survey

Contemporary psychology practice: Is there a role for secondary qualifications?

An Exploration of the Integration of Complementary Therapies in Psychology Practice

UTS ETHICS APPROVAL NUMBER ETH20-5138

What is the research study about? The purpose of this research/online survey is aims to explore the perspectives and experiences of psychologists regarding complementary medicine (CM). Over 70% of people diagnosed with mental health disorders, in Australia, are reported to use CM. Psychologists are likely to encounter a substantial number of clients using at least one form of CM. Yet, the role of CM in psychology, and how the field of psychology (incorporating academia, clinical practice and wider professional associations) should engage with CM, remains contested and unclear.

You have been invited to participate in this study because you are a registered psychologist in Australia. Your contact details were obtained by/from publicly available information such as websites or via a psychology professional association. We are asking

Australian psychologists to help us understand how they approach working with clients who use CM as part of their mental health treatment planning. The survey aims to address the research question: How do psychologists in Australia explain and justify their support (or lack of support) for CM in clinical practice? Your participation survey will help us to gauge opinion, relevance, and acceptability of CM within psychology.

Who is conducting this research? My name is Carrie Thomson-Casey and I am a PhD student at UTS. My supervisor is Dr Erica McIntyre (Erica.McIntyre@uts.edu.au).

Inclusion/Exclusion Criteria Before you decide to participate in this research study, we need to ensure that it is ok for you to take part. The survey is for students of psychology or registered psychologists in Australia.

Do I have to take part in this research study? Participation in this study is voluntary. It is completely up to you whether or not you decide to take part. If you decide to participate, I will invite you to complete the online survey which takes about 15 minutes to complete. We are asking Australian psychologists (including non-practising) to help us understand how they approach working with clients who use CM as part of their mental health treatment planning. The survey aims to address the research question: How do psychologists in Australia explain and justify their support (or lack of support) for CM in clinical practice? Your participation in this 15-minute survey will help us to gauge opinion, relevance and acceptability of CM within psychology. Participation is voluntary,

confidential and de-identified where required. Participants who complete the survey can choose to go into the draw to receive a $250 EFTPOS voucher. To enter the prize draw you will be asked to click a link at the end of the survey that opens a new window. Contact details entered will only be used for the prize draw and will not be linked to your answers in the survey.

- Read the information carefully (ask questions if necessary);
- Complete an online questionnaire.

You can change your mind at any time and stop completing the survey without consequences.

Are there any risks/inconvenience? We don't expect this questionnaire to cause any harm or discomfort, however if you experience feelings of distress as a result of participation in this study you can let the researcher know and they will provide you with assistance.

What will happen to information about me? Access to the online questionnaire is via weblink. Submission of the online questionnaire/s is an indication of your consent. By clicking the weblink you consent to the research team collecting and using personal information about you for the research project. All this information will be treated confidentially. By proceeding to the survey you are confirming your consent to the research

team collecting and using your answers to the questions for the research project. All this information will be treated confidentially. However, you are not required to provide any identifying information. Participants who complete the survey can choose to go into the draw to receive a $250 EFTPOS voucher. To enter the prize draw you will be asked to click a link at the end of the survey that opens a new window. Contact details entered will only be used for the prize draw and will not be linked to your answers in the survey. Your information will only be used for the purpose of this research project, except as required by law.

Your information will only be used for the purpose of this research project and it will only be disclosed with your permission, except as required by law.

We plan to discuss/publish the results in a relevant journal and/or present findings at a relevant conference.

What if I have concerns or a complaint? If you have concerns about the research that you

think I or my supervisor can help you with, please feel free to contact me on Carrie.S.Thomson-Casey@student.uts.edu.au.

If you would like to talk to someone who is not connected with the research, you may contact the Research Ethics Officer on 02 9514 9772 or Research.ethics@uts.edu.au and quote this number ETH20-5138

Are you a psychologist (including intern/registrar/provisional psychologists) who undertakes work as a psychologist (including in clinical practice, academic, research, policy, governance)? (This survey is not designed to be completed by students of psychology)

- ○ Yes
- ○ No

Skip To: End of Survey If Are you a psychologist (including intern/registrar/provisional psychologists) who undertakes work... = No

End of Block: Screening

Start of Block: Section 1: About you

Section 1: About you

What is your main area of practice/registration as a psychologist?

- ○ General psychology
- ○ Clinical psychology
- ○ Clinical neuropsychology
- ○ Community psychology
- ○ Counselling psychology
- ○ Education and developmental psychology
- ○ Forensic psychology
- ○ Health psychology
- ○ Organisational psychology
- ○ Sport and exercise psychology
- ○ Intern/registrar/provisional psychologist

Which of the following best describes your primary work setting?

- ◯ Solo Private practice
- ◯ Group private practice
- ◯ Private health service/inpatient facility/outpatient facility
- ◯ Public health service/inpatient facility/outpatient facility
- ◯ Research/academia (not working in clinical practice)
- ◯ Private health service (not working in clinical practice)
- ◯ Public health service (not working in clinical practice)
- ◯ Other ____

How long have you worked in a psychology role (including non-clinical practice)?

- ◯ Less than 5 years
- ◯ 5 – 10 years
- ◯ 11 – 20 years
- ◯ 21 – 30 years
- ◯ 31 – 40 years
- ◯ 40+ years

What is your gender identity?

◯ Male

◯ Female

◯ Non-binary

◯ Other ____

What state/territory do you mainly work in?

◯ ACT

◯ NSW

◯ NT

◯ QLD

◯ SA

◯ TAS

◯ VIC

◯ WA

What is your year of birth?

____

End of Block: Section 1: About you

Start of Block: Section 2: Additional/dual health-related qualification

Section 2: Additional/dual qualifications

For the purpose of this survey *additional health qualification* refers to qualifications, approaches or treatments that would not be considered as part of a psychologist's standard tertiary training or scope of practice.

Do you have a qualification/s in any of the following professions in addition to your psychology qualification? (Tick all that apply)

- ☐ No (if you select no you will skip to the end of this section)
- ☐ Business
- ☐ Criminal Justice/Criminology
- ☐ Dietetics
- ☐ Education
- ☐ Exercise physiology
- ☐ Law
- ☐ Medical degree
- ☐ Naturopathy
- ☐ Nursing/Midwifery
- ☐ Nutrition
- ☐ Physiotherapy
- ☐ Traditional Chinese Medicine
- ☐ Western herbal Medicine

☐ Yoga Instructor

☐ Other ____

Skip To: End of Block If Do you have a qualification/s in any of the following professions in addition to your psychology... = No (if you select no you will skip to the end of this section)

What is the highest level of education you have completed in the profession/s listed?

○ Certificate IV

○ Diploma

○ Advanced Diploma

○ Bachelor

○ Postgraduate

○ Masters

○ PhD

○ Other ____

Do you hold separate professional indemnity insurance (separate from any insurance you may hold as a psychologist) for any other profession?

○ Yes (If yes which profession)
____

○ No

○ Not applicable

Do you hold professional registration (separate from registration you may hold to practice as a psychologist) for any other profession (e.g. Australian Health Practitioner Regulation Agency)?

○ Yes (which agency do you hold professional registration with)

____

○ No, I do not practice any other health profession (psychologist only)

○ No, my second health profession/s is/are not regulated

Do you hold professional association membership (separate from membership you may hold with a professional psychology association) (e.g. Australian Medical Association)?

○ Yes (which professional association/s do you hold membership with?)
____

○ Yes, but I do not use my additional health-related qualification/s with clients/patients (which professional association/s do you hold membership with?)
____

○ No I don't have professional association membership for my additional health related qualification/s

○ No, I do not practice any other health profession (psychologist only)

Do you integrate or incorporate (in some form) your additional qualification/s into your psychology practice?

○ Yes, I provide services related to additional qualification/s to my psychology clients WITHIN psychology sessions

○ Yes, I provide services related to additional qualification/s to my psychology clients in sessions SEPARATE to their psychology sessions

○ No I provide services related to my additional qualification/s to my psychology clients with a separate (non-psychology) client group

○ I don't work in clinical practice with clients

End of Block: Section 2: Additional/dual health-related qualification

---

Start of Block: Section 3: Psychologists and scope of practice

Section 3: Psychologists and scope of practice

Following are definitions for the terms used within the survey. Before continuing, please read these definitions as they may differ from your understanding of these terms.

Evidence-based: Throughout this survey the term *evidence-based* is used. The use of evidence-based for some questions allows participants to quantify their agreement if the approach/treatments were evidence-based – as opposed to the approach generally speaking. For the purpose of this survey the definition of evidence-based (including evidence-based practice) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences.

Health-related profession: A health-related profession refers to any non-psychological health-related approach and not complementary medicine specifically.

Complementary medicine: The World Health Organisation defines complementary medicine as **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. Complementary medicine includes a range of treatments not considered part of mainstream health care, such as biological medicines (e.g., herbal, vitamin, mineral and nutritional supplements), and mind-body therapies (e.g., yoga, mindfulness). Complementary medicine **treatments** are often prescribed within complementary medicine **systems**, such as Western herbal medicine, chiropractic, osteopathy, naturopathy, traditional Chinese medicine, and homeopathy. Reference to complementary medicine in this study is in complement to conventional psychology treatments and not an alternative to the work of psychologists.

Do you think psychologists should be allowed (formally approved by psychology's regulatory agencies) to use practices/treatments from an additional **health-related**

qualification with their psychology clients (e.g., treat a client from two separate qualifications such as a psychologist and a dietitian)?

- ◯ No
- ◯ Yes, within the same sessions
- ◯ Yes, in separate sessions
- ◯ Unsure

To what extent do you agree with the following statements:

Applying adjunctive non-psychological mental health interventions may benefit my client.

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

Mental health outcomes may improve if psychological interventions are combined with other mental health-related interventions.

- Strongly agree
- Agree
- Somewhat agree
- Somewhat disagree
- Disagree
- Strongly disagree

Having an additional health-related qualification improves communication about mental health care with clients.

- Strongly agree
- Agree
- Somewhat agree
- Somewhat disagree
- Disagree
- Strongly disagree

There is a benefit to clients when incorporating evidence-based treatments from a non-psychology health-related qualification into my clinical practice

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

To what extent do you agree with the following statements:

Having an additional health-related qualification would allow psychologists to apply novel evidence-based treatments

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

Any issues around scope of practice and role confusion can be resolved with informed consent.

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

There is risk to the purity of psychology practice when incorporating an additional health-related qualification into clinical practice.

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

There is risk to psychology's scientific standing when incorporating an additional health-related qualification into clinical practice.

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

To what extent do you agree with the following statements:

There is risk to psychology's reputation when incorporating an additional health-related qualification into clinical practice.

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

There is risk to client safety when incorporating an additional health-related qualification into clinical practice.

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

There is risk of role confusion when incorporating an additional health-related qualification into clinical practice.

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

There is no suitable health-related profession that would assist mental health outcomes when used as an adjunct within psychology practice.

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

In your own words, please describe any reasons why you believe psychologists should or should not incorporate an additional health-related qualification into clinical practice.

____

____

____

____

____

To what extent do you agree with the following statements:

Psychologists should be allowed to use an additional health-related qualification/dual qualification within their psychology practice with their psychology clients (e.g., working as both a psychologist and exercise physiologist) with the **same** client in the **same** sessions, with informed consent.

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

Psychologists should be allowed to use an additional health-related qualification/dual qualification within their psychology practice with their psychology

clients (e.g., working as both a psychologist and exercise physiologist) with the **same** client in **separate** sessions, with informed consent.

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

Applying skills from an additional health-related qualification within psychology practice may improve mental health outcomes for psychology clients.

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

End of Block: Section 3: Psychologists and scope of practice

Start of Block: Section 4: Psychology and Complementary Medicine

Section 4: Psychology and Complementary Medicine

The following questions are designed to understand how psychologists engage with complementary medicine. This could involve discussing the client’s use of complementary medicine (e.g., potential interaction with medications), recommending complementary medicine (e.g., attend a yoga class), referring to a complementary medicine practitioner (e.g., Traditional Chinese medicine practitioner), or the direct application of complementary medicine.

Section 4a: Knowledge of complementary medicine

To what extent do you agree with the following statements?

Psychologists should have knowledge of complementary medicine.

- Strongly agree
- Agree
- Somewhat agree
- Somewhat disagree
- Disagree
- Strongly disagree

Psychologists should learn about complementary medicine as part of their tertiary training.

- Strongly agree
- Agree
- Somewhat agree
- Somewhat disagree
- Disagree
- Strongly disagree

How often do you engage in the following activities?

Participate in education related to complementary medicine and mental health (e.g., webinars, workshops, formal training).

- ◯ Daily
- ◯ Weekly
- ◯ Monthly
- ◯ Twice a year
- ◯ Once a year
- ◯ Never

Read a peer-reviewed journal articles related to complementary medicine and mental health.

- ◯ Daily
- ◯ Weekly
- ◯ Monthly
- ◯ Twice a year
- ◯ Once a year
- ◯ Never

Use information resources (e.g., databases that look for drug-herb interactions) to understand complementary medicine risks/benefits/safety/drug interactions.

- ◯ Daily
- ◯ Weekly
- ◯ Monthly
- ◯ Twice a year
- ◯ Once a year
- ◯ Never

How do you **rate your level of knowledge** for each of the following complementary medicine treatments for mental health (e.g. how they work, any potential

interactions with medications, and how they may be part of your psychology client's mental health care choices)?

Aboriginal and Torres Strait Islander Traditional Medicine/Healing Practices

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

Acupuncture

○ Excellent

○ Good

○ Fair

○ Poor

Exercise/movement interventions

○ Excellent

○ Good

○ Fair

○ Poor

Herbal Medicines

○ Excellent

○ Good

○ Fair

○ Poor

Hypnotherapy

- ◯ Excellent
- ◯ Good
- ◯ Fair
- ◯ Poor

Massage

- ◯ Excellent
- ◯ Good
- ◯ Fair
- ◯ Poor

How do you rate your level of knowledge for each of the following complementary medicine treatments for mental health (e.g. how they work, any potential interactions with

medications, and how they may be part of your psychology client's mental health care choices)?

Meditation

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

Dietary interventions

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

Nutritional supplements (vitamins and minerals)

- Excellent
- Good
- Fair
- Poor

Probiotic "Psychobiotic" supplements

- Excellent
- Good
- Fair
- Poor

Yoga

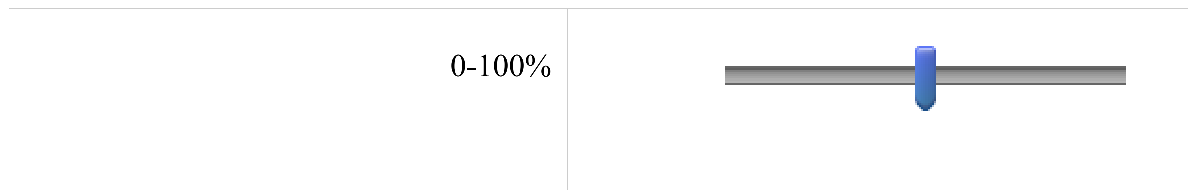
- Excellent
- Good
- Fair
- Poor

Section 4b: Perspectives on client's complementary medicine use

What percent (roughly) of clients who use psychology services do you think are using complementary medicine of some kind?

1 2 3 4 5 6 7 8 9 1

0 0 0 0 0 0 0 0 0 00



How often should psychologists in clinical practice ask their clients if they use complementary medicine treatments (e.g., herbal medicines or mind-body therapies) as part of initial assessment?

- ◯ Always
- ◯ Most of the time
- ◯ About half of the time
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

To what extent do you agree with the following statement?

Complementary medicine treatments (e.g., herbal medicines or mind-body therapies such as yoga) are unlikely to benefit those who use them as part of their mental health treatment plan.

- ○ Strongly agree
- ○ Agree
- ○ Somewhat agree
- ○ Somewhat disagree
- ○ Disagree
- ○ Strongly disagree

Section 4c: Perspectives on policy and guidelines on psychology and complementary medicine

To what extent do you agree with the following statements?

Current psychology ethical practice guidelines (e.g. Australian Psychological Society guidelines) are adequate in guiding psychologists on how they can engage with their client's complementary medicine use.

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

It would be helpful if there were specific guidelines/policy related to psychology and complementary medicine from professional associations (e.g. from the Australian Psychological Society) for recommending complementary medicine treatments and services, referring to complementary medicine practitioners or applying complementary medicine in clinical practice.

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

Psychiatry and general medicine include some evidence based complementary medicines (CM) in their treatment guidelines.

Considering this, to what extent do you agree with the following:

Psychology as a field (including professional associations, academia, research) should provide more training on complementary medicines.

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

Psychology as a field (including professional associations, academia, research) should provide more research on complementary medicines.

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

Psychology as a field (including professional associations, academia, research) should provide more guidelines on complementary medicines.

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

Section 4d: Perspectives on complementary medicine. To what extent do you agree with the following statements?

Complementary medicine is not scientifically valid.

- ○ Strongly agree
- ○ Agree
- ○ Somewhat agree
- ○ Somewhat disagree
- ○ Disagree
- ○ Strongly disagree

Complementary medicine is not a good match with psychology.

- ○ Strongly agree
- ○ Agree
- ○ Somewhat agree
- ○ Somewhat disagree
- ○ Disagree
- ○ Strongly disagree

It is important for psychologists to understand and engage with their client's preference for complementary medicine as part of their mental health treatment.

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

Psychology integrating with complementary medicine (through either recommending complementary medicine treatments and services, referring to complementary medicine practitioners or applying complementary medicine in clinical practice) puts psychology's reputation at risk.

- ○ Strongly agree
- ○ Agree
- ○ Somewhat agree
- ○ Somewhat disagree
- ○ Disagree
- ○ Strongly disagree

To what extent do you agree with the following statements?

Referring clients to complementary medicine practitioners or services puts client safety at risk.

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

There is potential to improve mental health outcomes with the integration of evidence-based complementary medicine (CM) within psychology practice (through either recommending complementary medicine treatments and services, referring to

complementary medicine practitioners or applying complementary medicine in clinical practice).

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

Complementary medicine practitioners (e.g., naturopaths) can play a valuable role in assisting clients with their mental health problems.

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

4e Complementary medicine use by psychologists as part of treatment planning

Which of the following complementary medicine treatments or services have you ever **recommended** to your psychology clients for additional support for their mental health? Tick all that apply.

- ☐ I have not/do not see psychology clients in clinical practice (skip to Section 6)
- ☐ Aboriginal and Torres Strait Islander traditional medicine/healing practices
- ☐ Acupuncture
- ☐ Exercise/movement interventions
- ☐ Herbal medicines
- ☐ Hypnotherapy
- ☐ Massage
- ☐ Meditation
- ☐ Nutrition/dietary interventions
- ☐ Probiotic supplements
- ☐ Vitamins and nutritional supplements

- [ ] Yoga
- [ ] Other ____
- [ ] None

Skip To: End of Survey If Which of the following complementary medicine treatments or services have you ever recommended to... = I have not/do not see psychology clients in clinical practice (skip to Section 6)

Which of the following complementary medicine practitioners have you ever referred your psychology clients to for additional support for their mental health? Tick all that apply.

- [ ] Aboriginal and Torres Strait Islander traditional medicine/healing practitioner
- [ ] Acupuncturist
- [ ] Exercise/movement trainer/coach
- [ ] Hypnotherapist
- [ ] Massage therapist
- [ ] Naturopath
- [ ] Nutritionist
- [ ] Western herbalist
- [ ] Other (please specify)

____

- [ ] None

Which of the following health professionals have you ever **referred** your psychology clients to for additional support for their mental health? Tick all that apply.

- [ ] Dietician
- [ ] Exercise physiologist
- [ ] General Practitioner
- [ ] Nurse/Midwife
- [ ] Occupational therapist
- [ ] Psychiatrist
- [ ] Social Worker
- [ ] Other (please specify)

____

- [ ] None

To what extent do you agree with the following statements?

I feel confident to discuss complementary medicine use with my psychology clients.

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

I am interested in learning more about how to recommend complementary medicine products and services to my psychology clients

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

I am interested in learning more about how to refer my psychology clients to complementary medicine practitioners and services

- ○ Strongly agree
- ○ Agree
- ○ Somewhat agree
- ○ Somewhat disagree
- ○ Disagree
- ○ Strongly disagree

I am interested in learning more about applying complementary medicine treatments (e.g., herbal medicines or mind-body therapies) to my psychology clients.

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

I am interested in learning more about how to use my complementary medicine qualification within psychology practice with my psychology clients.

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

To what extent do you agree with the following statements?

I would refer or recommend evidence based complementary medicine products/practices/services if I had more knowledge of referral processes as guided by the APS (or other psychology professional association)

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

I avoid referring or recommending complementary medicine products/practices/services because it is unclear what is allowed/not allowed by the APS (or other psychology professional association)

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

I would refer to complementary medicine practitioners if I had more knowledge of complementary medicine practitioners' scope of practice in the context of mental health

- Strongly agree
- Agree
- Somewhat agree
- Somewhat disagree
- Disagree
- Strongly disagree

I would refer to complementary medicine practitioners if I had more knowledge of complementary medicine practitioners' training and experience in the context of mental health

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

How often do the following statements apply to your practice as a psychologist?

I have recommended that my psychology clients use essential oils in some form as part of their mental health treatment (e.g. lavender for relaxation)

- ◯ Always
- ◯ Most of the time
- ◯ About half the time
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

I have recommended that my psychology clients use herbal teas in some form as part of their mental health treatment (e.g. chamomile tea for relaxation)

- ◯ Always
- ◯ Most of the time
- ◯ About half the time
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

I have recommended that my psychology clients use minerals in some form as part of their mental health treatment (e.g. magnesium bath crystals for relaxation)

- ○ Always
- ○ Most of the time
- ○ About half the time
- ○ Sometimes
- ○ Rarely
- ○ Never

How often do the following statements apply to your practice as a psychologist?

I have recommended that my psychology clients use vitamins in some form as part of their mental health treatment (e.g. multivitamin for energy)

- ◯ Always
- ◯ Most of the time
- ◯ About half the time
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

I have recommended that my psychology clients improve their diet as part of their mental health treatment (e.g. Mediterranean diet for mental health)

- ◯ Always
- ◯ Most of the time
- ◯ About half the time
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

I have recommended that my psychology clients use exercise in some form as part of their mental health treatment (e.g. walking for mental health)

- ○ Always
- ○ Most of the time
- ○ About half the time
- ○ Sometimes
- ○ Rarely
- ○ Never

I have recommended that my psychology clients use mind/body therapies in some form as part of their mental health treatment (e.g. yoga for mental health)

- ○ Always
- ○ Most of the time
- ○ About half the time
- ○ Sometimes
- ○ Rarely
- ○ Never

Thank you for participating.

Click on the next button to complete the survey. Once you click the next button a new window will open and you will have the option to enter your email address if you wish to:

1. Participate in the next stage of the research

2. Receive a summary of the research

3. Enter the prize draw for $250 voucher.

End of Block: Section 4: Psychology and Complementary Medicine

---

Appendix I

Phase Three - Participate in the next stage of the research

Start of Block: Default Question Block

Q81 Yes I would like to be contacted to participate in the next stage of the research. Please contact me on the email below:

____

End of Block: Default Question Block

Appendix

Phase Two - Published article 1

PLOS ONE

RESEARCH ARTICLE

The relationship between psychology practice and complementary medicine in Australia: Psychologists' demographics and practice characteristics regarding type of engagement across a range of complementary medicine modalities

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OPEN ACCESS

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Data Availability Statement: All data files are available from the University of Technology Sydney repository (DOI: 10.26195/ecvr-vq16).

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Competing interests: Authors CT is currently, and EM was previously, a member of the Australian Psychological Society "Psychology and Integrative Mental Health Interest Group". The third (KR) and

Abstract

Introduction

Many people with mental health problems utilise a range of complementary medicine (CM) practitioners, products, and practices. Psychologists are likely to consult with clients who are seeking and using CM, in some form, as part of their wider mental health treatment. The aim of this research is to determine how much, and in what ways, Australian psychologists recommend CM products and/or practices, and/or initiate referrals to CM practitioners as part of their clinical practice and to explore if these behaviours have any association with the characteristics of the psychologist or their wider practice.

Methods

Survey data was collected from psychologists in clinical practice who self-selected to participate between February and April 2021. Participation in the study was via an online 79-item questionnaire exploring core aspects of CM engagement in psychology clinical practice.

Results

Amongst the 202 psychologists who completed the survey, mind/body approaches (90.5%) were the most recommended CM and cultural/spiritual approaches the least recommended CM (7.5%). Participants also reported referring to CM practitioners with naturopaths the most common focus of their referrals (57.9%) and cultural and spiritual practitioners the least common focus of their referrals (6.69%). Our analysis shows the demographic and practice characteristics of a psychologist are generally not predictors of a psychologist's engagement with CM in their clinical practice.

Appendix K

Phase Two - Published article 1 - Supplementary table - Rates of recommending CM

Rates of recommending. Percentage of psychologists who recommend CM products and practices according to demographic and practice characteristics of psychologists and their recommending CM products and/or practices

	Mind/body (n = 202)	Movement (n = 202)	Ingestibles (n = 202)	Dietary change (n = 201)	Manual (n = 202)	Cultural spiritual (n = 201)
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Total recommending	183 (90.5)	161 (79.7)	106 (52.4)	147 (73.1)	135 (66.8)	15 (7.4)
Gender						
Female	147 (88.0)	131 (78.4)	82 (49.1)	119 (71.2)	113 (67.6)	14 (8.3)
Male	35 (97.2)	29 (80.5)	23 (63.8)	27 (75.0)	21 (58.3)	1 (16.6)
Other	1 (100.0)	1 (100.0)	1 (100.0)	1 (100.0)	1 (100.0)	0 (0.0)
Age						
18 to 35	18 (90.0)	15 (75.0)	8 (40)	17 (85.0)	14 (70.0)	2 (10.0)
36 to 50	61 (92.4)	51 (77.2)	35 (53.0)	45 (68.1)	38 (57.5)	4 (6.0)
51 to 65	69 (90.7)	64 (84.2)	42 (55.2)	59 (77.6)	57 (75.0)	7 (13.7)
65 plus	35 (87.5)	31 (77.5)	21 (52.5)	26 (65.0)	26 (65.0)	2 (10.0)
State						
NSW	61 (93.8)	53 (81.5)	34 (52.3)	46 (70.7)	42 (64.6)	5 (7.6)
VIC	31	22	16	22	21	0

	Mind/body (n = 202)	Movement (n = 202)	Ingestibles (n = 202)	Dietary change (n = 201)	Manual (n = 202)	Cultural spiritual (n = 201)
	(87.0)	(70.9)	(51.6)	(70.9)	(67.7)	(0.0)
QLD	57 (89.0)	52 (81.25)	36 (56.2)	45 (70.3)	41 (64.0)	8 (12.5)
Other states	37 (90.2)	33 (80.4)	19 (46.3)	33 (80.4)	30 (73.1)	2 (4.8)
Practice setting						
Solo	123 (89.7)	111 (81.0)	69 (50.3)	102 (74.4)	92 (67.1)	13 (9.4)
Group	60 (92.3)	50 (76.9)	37 (56.9)	45 (69.2)	43 (66.1)	2 (3.0)
Years of practice						
Less than 10	48 (94.1)	37 (72.5)	19 (37.2)	35 (68.6)	30 (58.8)	0 (0.0)
11 to 20	65 (90.2)	62 (86.1)	44 (61.1)	53 (86.8)	51 (70.8)	8 (11.1)
21 to 30	42 (87.5)	36 (75.0)	26 (54.1)	37 (77.0)	32 (66.6)	5 (10.4)
31 plus	28 (90.3)	26 (83.8)	17 (54.8)	22 (70.9)	22 (70.9)	2 (6.4)
AoPE						
General	67 (88.1)	61 (80.2)	47 (61.8)	57 (75.0)	47 (61.8)	10 (13.1)
Clinical	75 (94.9)	63 (79.7)	36 (45.5)	53 (67.0)	52 (65.8)	3 (3.7)
Other	41 (87.2)	37 (78.7)	23 (48.9)	37 (78.7)	36 (76.5)	2 (4.2)
Additional qualifications						
None	87 (92.5)	75 (79.7)	44 (46.8)	68 (72.3)	63 (67.0)	5 (5.3)
Education	31 (79.4)	30 (76.9)	18 (46.1)	24 (61.5)	23 (58.9)	5 (12.8)
Complementary medicine	35 (100.0)	29 (82.8)	25 (71.4)	28 (80.0)	27 (77.1)	4 (11.4)

	Mind/body (n = 202)	Movement (n = 202)	Ingestibles (n = 202)	Dietary change (n = 201)	Manual (n = 202)	Cultural spiritual (n = 201)
Non-health	27 (90.0)	23 (76.7)	16 (53.3)	20 (69.0)	21 (70.0)	2 (6.7)

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Appendix J

Quantitative Paper 1 Supplementary Table 1 Rates of Recommending

Supplementary Table 1. Rates of recommending. Percentage of psychologists who recommend CM products and practices according to demographic and practice characteristics of psychologists and their recommending CM products and/or practices

	Mind/body (n = 202)	Movement (n = 202)	Ingestibles (n = 202)	Dietary change (n = 201)	Manual (n = 202)	Cultural spiritual (n = 201)
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Total recommending	183 (90.5)	161 (79.7)	106 (52.4)	147 (73.1)	135 (66.8)	15 (7.4)
Gender						
Female	147 (88.0)	131 (78.4)	82 (49.1)	119 (71.2)	113 (67.6)	14 (8.3)
Male	35 (97.2)	29 (80.5)	23 (63.8)	27 (75.0)	21 (58.3)	1 (16.6)
Other	1 (100.0)	1 (100.0)	1 (100.0)	1 (100.0)	1 (100.0)	0 (0.0)

	Mind/body (n = 202)	Movement (n = 202)	Ingestibles (n = 202)	Dietary change (n = 201)	Manual (n = 202)	Cultural spiritual (n = 201)
Age						
18 to 35	18 (90.0)	15 (75.0)	8 (40)	17 (85.0)	14 (70.0)	2 (10.0)
36 to 50	61 (92.4)	51 (77.2)	35 (53.0)	45 (68.1)	38 (57.5)	4 (6.0)
51 to 65	69 (90.7)	64 (84.2)	42 (55.2)	59 (77.6)	57 (75.0)	7 (13.7)
65 plus	35 (87.5)	31 (77.5)	21 (52.5)	26 (65.0)	26 (65.0)	2 (10.0)
State						
NSW	61 (93.8)	53 (81.5)	34 (52.3)	46 (70.7)	42 (64.6)	5 (7.6)
VIC	31 (87.0)	22 (70.9)	16 (51.6)	22 (70.9)	21 (67.7)	0 (0.0)
QLD	57 (89.0)	52 (81.25)	36 (56.2)	45 (70.3)	41 (64.0)	8 (12.5)
Other states	37 (90.2)	33 (80.4)	19 (46.3)	33 (80.4)	30 (73.1)	2 (4.8)
Practice setting						
Solo	123 (89.7)	111 (81.0)	69 (50.3)	102 (74.4)	92 (67.1)	13 (9.4)
Group	60 (92.3)	50 (76.9)	37 (56.9)	45 (69.2)	43 (66.1)	2 (3.0)
Years of practice						
Less than 10	48 (94.1)	37 (72.5)	19 (37.2)	35 (68.6)	30 (58.8)	0 (0.0)
11 to 20	65 (90.2)	62 (86.1)	44 (61.1)	53 (86.8)	51 (70.8)	8 (11.1)
21 to 30	42 (87.5)	36 (75.0)	26 (54.1)	37 (77.0)	32 (66.6)	5 (10.4)
31 plus	28 (90.3)	26 (83.8)	17 (54.8)	22 (70.9)	22 (70.9)	2 (6.4)
AoPE						

	Mind/body (n = 202)	Movement (n = 202)	Ingestibles (n = 202)	Dietary change (n = 201)	Manual (n = 202)	Cultural spiritual (n = 201)
General	67 (88.1)	61 (80.2)	47 (61.8)	57 (75.0)	47 (61.8)	10 (13.1)
Clinical	75 (94.9)	63 (79.7)	36 (45.5)	53 (67.0)	52 (65.8)	3 (3.7)
Other	41 (87.2)	37 (78.7)	23 (48.9)	37 (78.7)	36 (76.5)	2 (4.2)
Additional qualifications						
None	87 (92.5)	75 (79.7)	44 (46.8)	68 (72.3)	63 (67.0)	5 (5.3)
Education	31 (79.4)	30 (76.9)	18 (46.1)	24 (61.5)	23 (58.9)	5 (12.8)
Complementary medicine	35 (100.0)	29 (82.8)	25 (71.4)	28 (80.0)	27 (77.1)	4 (11.4)
Non-health	27 (90.0)	23 (76.7)	16 (53.3)	20 (69.0)	21 (70.0)	2 (6.7)

Appendix K

Survey Paper 1 Supplementary Table 1 Rates of recommending CM

Rates of recommending. Percentage of psychologists who recommend CM products and practices according to demographic and practice characteristics of psychologists and their recommending CM products and/or practices

	Mind/body (n = 202)	Movement (n = 202)	Ingestibles (n = 202)	Dietary change (n = 201)	Manual (n = 202)	Cultural spiritual (n = 201)
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Total recommending	183 (90.5)	161 (79.7)	106 (52.4)	147 (73.1)	135 (66.8)	15 (7.4)
Gender						
Female	147 (88.0)	131 (78.4)	82 (49.1)	119 (71.2)	113 (67.6)	14 (8.3)
Male	35 (97.2)	29 (80.5)	23 (63.8)	27 (75.0)	21 (58.3)	1 (16.6)
Other	1 (100.0)	1 (100.0)	1 (100.0)	1 (100.0)	1 (100.0)	0 (0.0)
Age						
18 to 35	18 (90.0)	15 (75.0)	8 (40)	17 (85.0)	14 (70.0)	2 (10.0)
36 to 50	61 (92.4)	51 (77.2)	35 (53.0)	45 (68.1)	38 (57.5)	4 (6.0)
51 to 65	69 (90.7)	64 (84.2)	42 (55.2)	59 (77.6)	57 (75.0)	7 (13.7)
65 plus	35 (87.5)	31 (77.5)	21 (52.5)	26 (65.0)	26 (65.0)	2 (10.0)
State						

	Mind/body (n = 202)	Movement (n = 202)	Ingestibles (n = 202)	Dietary change (n = 201)	Manual (n = 202)	Cultural spiritual (n = 201)
NSW	61 (93.8)	53 (81.5)	34 (52.3)	46 (70.7)	42 (64.6)	5 (7.6)
VIC	31 (87.0)	22 (70.9)	16 (51.6)	22 (70.9)	21 (67.7)	0 (0.0)
QLD	57 (89.0)	52 (81.25)	36 (56.2)	45 (70.3)	41 (64.0)	8 (12.5)
Other states	37 (90.2)	33 (80.4)	19 (46.3)	33 (80.4)	30 (73.1)	2 (4.8)
Practice setting						
Solo	123 (89.7)	111 (81.0)	69 (50.3)	102 (74.4)	92 (67.1)	13 (9.4)
Group	60 (92.3)	50 (76.9)	37 (56.9)	45 (69.2)	43 (66.1)	2 (3.0)
Years of practice						
Less than 10	48 (94.1)	37 (72.5)	19 (37.2)	35 (68.6)	30 (58.8)	0 (0.0)
11 to 20	65 (90.2)	62 (86.1)	44 (61.1)	53 (86.8)	51 (70.8)	8 (11.1)
21 to 30	42 (87.5)	36 (75.0)	26 (54.1)	37 (77.0)	32 (66.6)	5 (10.4)
31 plus	28 (90.3)	26 (83.8)	17 (54.8)	22 (70.9)	22 (70.9)	2 (6.4)
AoPE						
General	67 (88.1)	61 (80.2)	47 (61.8)	57 (75.0)	47 (61.8)	10 (13.1)
Clinical	75 (94.9)	63 (79.7)	36 (45.5)	53 (67.0)	52 (65.8)	3 (3.7)
Other	41 (87.2)	37 (78.7)	23 (48.9)	37 (78.7)	36 (76.5)	2 (4.2)
Additional qualifications						
None	87 (92.5)	75 (79.7)	44 (46.8)	68 (72.3)	63 (67.0)	5 (5.3)
Education	31	30	18	24	23	5

	Mind/body (n = 202)	Movement (n = 202)	Ingestibles (n = 202)	Dietary change (n = 201)	Manual (n = 202)	Cultural spiritual (n = 201)
	(79.4)	(76.9)	(46.1)	(61.5)	(58.9)	(12.8)
Complementary medicine	35 (100.0)	29 (82.8)	25 (71.4)	28 (80.0)	27 (77.1)	4 (11.4)
Non-health	27 (90.0)	23 (76.7)	16 (53.3)	20 (69.0)	21 (70.0)	2 (6.7)

Appendix L

Phase Two - Article 1 – Supplementary Table 2 – Rates of referring to CM

Rates of referring. Percentage of psychologists who refer to CM practitioners according to demographic and practice characteristics of psychologists and their recommending CM products and/or practices

	Mind/body (n = 202)	Movement (n = 202)	Prescribes ingestibles (n = 202)	Prescribes nutrition (n = 201)	Manual (n = 202)	Cultural spiritual (n = 201)
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Total referring	48 (23.7)	102 (50.4)	117 (57.9)	99 (49.2)	98 (48.5)	14 (6.9)
Gender						
Female	38 (23.1)	85 (51.8)	96 (58.5)	82 (50.0)	76 (46.3)	13 (7.9)
Male	10 (27.7)	17 (47.2)	21 (58.3)	17 (47.2)	22 (61.1)	1 (2.7)
Other	0 (0.0)	0 (0.0)	SM	0 (0.0)	0 (0.0)	0 (0.0)
Age						
18 to 35	1 (5.0)	8 (4.0)	9 (45.0)	9 (45.0)	4 (20.0)	2 (1.0)
36 to 50	11 (16.6)	31 (46.9)	38 (57.5)	32 (48.4)	30 (45.4)	4 (6.0)
51 to 65	23 (30.2)	48 (63.1)	47 (61.8)	39 (51.3)	44 (57.8)	6 (7.89)
65 plus	13 (32.5)	15 (37.5)	23 (57.5)	21 (52.5)	20 (50.0)	2 (5.0)
State						

	Mind/body (n = 202)	Movement (n = 202)	Prescribes ingestibles (n = 202)	Prescribes nutrition (n = 201)	Manual (n = 202)	Cultural spiritual (n = 201)
NSW	15 (23.0)	37 (56.9)	36 (55.38)	30 (46.1)	33 (50.7)	4 (6.1)
VIC	11 (35.4)	11 (35.4)	19 (61.2)	17 (54.8)	14 (45.1)	0 (0.0)
QLD	13 (20.3)	30 (46.8)	37 (57.8)	35 (54.6)	29 (45.3)	8 (12.5)
Other states	9 (21.9)	24 (58.5)	25 (60.9)	19 (46.3)	22 (53.6)	2 (4.8)
Practice setting						
Solo	33 (24.2)	72 (52.9)	82 (60.2)	73 (53.6)	69 (50.7)	10 (7.3)
Group	15 (23.0)	30 (46.1)	35 (53.8)	28 (43.0)	29 (44.6)	4 (6.1)
Years of practice						
Less than 10	7 (13.7)	21 (41.1)	24 (47.05)	22 (43.1)	20 (39.2)	0 (0.0)
11 to 20	18 (25.0)	40 (55.5)	45 (62.5)	38 (52.7)	39 (54.1)	7 (9.7)
21 to 30	11 (23.4)	23 (48.9)	28 (59.5)	22 (46.8)	18 (38.2)	4 (8.5)
31 plus	12 (38.7)	18 (58.0)	20 (64.5)	19 (61.2)	21 (67.7)	3 (9.6)
AoPE						
General	18 (23.6)	35 (46.0)	45 (59.2)	38 (50.0)	33 (43.4)	9 (11.8)
Clinical	13 (16.4)	33 (41.7)	41 (51.8)	34 (43.0)	35 (44.3)	2 (2.5)
Other	17 (36.9)	34 (73.9)	31 (67.3)	29 (63.0)	30 (65.2)	3 (6.5)
Additional qualifications						
None	18 (19.1)	43 (45.7)	53 (56.4)	45 (8.4)	39 (41.5)	3 (3.2)
Education	10	20	20	19	19	6

	Mind/body (n = 202)	Movement (n = 202)	Prescribes ingestibles (n = 202)	Prescribes nutrition (n = 201)	Manual (n = 202)	Cultural spiritual (n = 201)
	(25.6)	(51.3)	(51.3)	(50.0)	(48.7)	(51.4)
Complementary medicine	9 (25.7)	21 (60.0)	25 (71.4)	21 (61.8)	19 (54.3)	3 (8.6)
Non-health	11 (37.9)	12 (41.4)	18 (62.1)	13 (48.1)	14 (48.3)	2 (6.9)
Health	4 (22.2)	11 (31.1)	11 (61.1)	10 (62.5)	9 (50.0)	3 (16.7)

Appendix M

Phase Two – Published article 2

Thomson-Casey *et al.*
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BMC Complementary Medicine and Therapies

RESEARCH Open Access

Practice recommendations and referrals, perceptions of efficacy and risk, and self-rated knowledge regarding complementary medicine: a survey of Australian psychologists

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Abstract

Background Many people with mental health problems use a range of complementary medicine (CM), including over the counter products, practices, and utilise the services of CM practitioners. Psychologists are likely to consult with clients using CM, in some form, as part of their broader mental health care. The aim of this research was to determine the number of types of CM products, practices, and practitioners are recommended and/or referred by Australian psychologists as part of their clinical practice, as well as explore the relationship between psychologists' perspectives on the risk and relevance of engaging with CM in psychology.

Methods Survey data was collected from psychologists in clinical practice who self-selected to participate in the study via an online 79-item questionnaire exploring core aspects of CM engagement in psychology clinical practice.

Results Amongst the 201 psychologists, 5% reported not recommending any type of CM, with 63% recommending four or more types of CM. Further, 25% had not referred to a CM practitioner, while 33% had referred to four or more types of CM practitioner. Psychologists are recommending and referring to CM even when they perceive their knowledge of CM to be poor, and that engaging with CM was a risk.

Conclusion This study provides insights into psychologist perceptions of CM within psychology practice and how these perceptions are associated with rates of recommending and referring to CM as part of their clinical practice. These findings may inform the development of CM relevant education and guidelines for psychologists.

Keywords Psychology practice, Clinical practice, Complementary medicine

Background

The use of complementary medicine (CM)—a range of practices, products and systems of care not traditionally associated with the conventional medical profession or curriculum [4]—has gained increasing acceptance alongside conventional medical treatments in a number of health settings [1, 10, 19, 23, 43, 46, 56]. Amongst these developments, some psychologists have reported positive views toward the use of CM as part of, or as an

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Appendix N

Survey Article 2 Supplementary Table 1 Rates of referring to CM

Psychologist demographic and practice characteristics and recommending or referring to CM

		Recommending CM products and practices			Referring to CM practitioners		
		Recommended none (*n*=201)	Recommended 1 to 3 types (*n*=200)	Recommended 4 plus types (*n*=200)	Referred to none (*n*=201)	Referred to 1 to 3 types (*n*=200)	Referred to 4 plus types (*n*=200)
		n (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)
Gender							
	Female	10 (90.9)	53 (81.5)	102 (81.0)	44 (88.0)	62 (73.8)	59 (86.8)
	Male	1 (9.1)	12 (18.5)	23 (18.3)	5 (10.0)	22 (26.2)	9 (13.2)
	Other	0 (0.0)	0 (0.0)	1 (0.8)	1 (2.0)	0 (0.0)	0 (0.0)
Age (years)							
	18 to 35	1 (9.1)	3 (4.6)	16 (12.7)	8 (16.0)	8 (9.5)	4 (5.9)
	36 to 50	3 (27.3)	26 (40.0)	37 (29.4)	18 (36.0)	29 (34.5)	19 (27.9)
	51 to 65	4 (36.4)	23 (35.4)	49 (38.9)	13 (26.0)	32 (38.1)	31 (45.6)
	65 plus	3 (27.3)	13 (20.0)	24 (19.0)	11 (22.0)	15 (17.9)	14 (20.6)
State and territories							
	New South Wales	3 (27.3)	22 (33.8)	40 (32.0)	14 (28.6)	30 (35.7)	21 (30.9)
	Victoria	4 (36.4)	9 (13.8)	18 (14.4)	9 (18.4)	11 (13.1)	11 (16.2)
	Queensland	2 (18.2)	22 (33.8)	40 (32.0)	18 (36.7)	22 (26.2)	24 (35.3)
	Other states	2 (18.2)	12 (18.5)	27 (21.6)	8 (16.3)	21 (25.0)	12 (17.6)
Practice Setting							
	Solo private practice	8 (72.7)	43 (66.2)	86 (68.3)	32 (64.0)	55 (65.5)	50 (73.5)
	Group practice	3 (27.3)	22 (33.8)	40 (31.7)	18 (36.0)	29 (34.5)	18 (26.5)
Years of practice							
	Less than 10 years	3 (27.3)	21 (32.3)	27 (21.4)	18 (36.0)	21 (25.0)	12 (17.6)
	11 to 20	2 (18.2)	22 (33.8)	48 (38.1)	14 (28.0)	32 (38.1)	26 (38.2)
	21 to 30	3 (27.3)	15 (23.1)	30 (23.8)	13 (26.0)	20 (23.8)	15 (22.1)
	31 plus	3 (27.3)	7 (10.8)	21 (16.7)	5 (10.0)	11 (13.1)	15 (22.1)

		Recommending CM products and practices			Referring to CM practitioners		
		Recommended none (*n*=201)	Recommended 1 to 3 types (*n*=200)	Recommended 4 plus types (*n*=200)	Referred to none (*n*=201)	Referred to 1 to 3 types (*n*=200)	Referred to 4 plus types (*n*=200)
		n (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)
AoPE[1]/Specialty							
	General	4 (63.4)	23 (35.4)	49 (38.9)	23 (46.0)	27 (32.1)	26 (38.2)
	Clinical	3 (27.3)	27 (41.5)	49 (38.9)	23 (46.0)	38 (45.2)	18 (26.5)
	Other	4 (36.4)	15 (23.1)	28 (22.2)	4 (8.0)	19 (22.6)	24 (35.3)

[1]Area of Practice Endorsement

Appendix O

Survey Article 2 Supplementary Table 2

Statements about engagement with CM and recommending or referring to CM

	Recommending CM products and practices			Referring to CM practitioners		
	Recommended none (*n*=201)	Recommended 1 to 3 types (*n*=200)	Recommended 4 plus types (*n*=200)	Referred to none (n=201)	Referred to 1 to 3 types (*n*=200)	Referred to 4 plus types (*n*=200)
	n (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)
Agreement with statements about CM efficacy						
CM is not scientifically valid	6 (66.7)	20 (30.8)	21 (16.7)	17 (35.4)	25 (29.8)	5 (7.4)
CM is not a good match with psychology	2 (22.2)	12 (18.5)	7 (5.6)	10 (20.8)	9 (10.7)	2 (2.9)
Agreement with perspectives about risk and relevance of CM to psychology						
CM treatments are unlikely to help those who use them as part of their mental health treatment	2 (20.0)	16 (25.0)	15 (11.9)	13 (26.5)	12 (14.5)	8 (11.8)
Current psychology ethical practice guidelines are adequate in guiding psychologists on how they can engage with their client's CM use	3 (30.0)	21 (32.3)	36 (28.6)	19 (38.8)	25 (29.8)	16 (23.5)
It would be helpful if there were specific guidelines/policy related to psychology	8 (88.9)	58 (89.2)	114 (90.5)	38 (79.2)	80 (95.2)	62 (91.2)
Psychology as a field (including professional associations, academia, research) should provide more training on CM	5 (50.0)	55 (84.6)	114 (90.5)	32 (65.3)	79 (94.0)	63 (92.6)
Psychology as a field (including professional associations, academia, research) should provide more research on CM	6 (60.0)	51 (78.5)	116 (92.1)	33 (67.3)	76 (90.5)	64 (94.1)
Psychology as a field (including professional associations, academia, research) should provide more guidelines on CM	7 (70.0)	49 (75.4)	118 (93.7)	35 (71.4)	76 (90.5)	63 (92.6)
It is important for psychologists to understand and engage with their client's preference for CM as part of their mental health treatment	9 (90.0)	57 (87.7)	122 (96.8)	40 (81.6)	80 (95.2)	68 (100.0)

	Recommending CM products and practices			Referring to CM practitioners		
	Recommended none (*n*=201)	Recommended 1 to 3 types (*n*=200)	Recommended 4 plus types (*n*=200)	Referred to none (n=201)	Referred to 1 to 3 types (*n*=200)	Referred to 4 plus types (*n*=200)
	n (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)
There is potential to improve mental health outcomes with the integration of evidence-based CM within psychology practice	7 (70.0)	58 (89.2)	120 (95.2)	39 (79.6)	79 (94.0)	67 (98.5)
CM practitioners (e.g., naturopaths) can play a valuable role in assisting clients with their mental health problems	6 (60.0)	46 (70.8)	116 (92.1)	31 (63.3)	70 (83.3)	67 (98.5)
Psychologists should have knowledge of CM	7 (70.0)	48 (73.8)	115 (91.3)	34 (69.4)	74 (88.1)	62 (91.2)
Psychologists should learn about CM as part of their tertiary training	7 (70.0)	48 (73.8)	115 (91.3)	34 (69.4)	74 (88.1)	62 (91.2)
Psychology integrating with CM puts psychology's reputation at risk	7 (70.0)	30 (46.2)	30 (23.8)	30 (61.2)	30 (35.7)	7 (10.3)
Referring clients to CM practitioners or services puts client safety at risk	5 (55.6)	23 (35.4)	20 (15.9)	24 (50.0)	19 (22.6)	5 (7.4)
Self-rated knowledge of CM types as excellent/good						
Aboriginal and Torres Strait Islander Traditional Medicine /Healing practices	0 (0.0)	0 (0.0)	12 (9.5)	0 (0.0)	4 (4.8)	8 (11.8)
Acupuncture	1 (10.0)	7 (10.8)	31 (24.6)	4 (8.2)	15 (17.9)	20 (29.4)
Dietary intervention	4 (40.0)	28 (43.1)	99 (78.6)	23 (46.9)	52 (61.9)	56 (82.4)
Exercise/movement interventions	4 (40.0)	27 (41.5)	79 (62.7)	18 (36.7)	51 (60.7)	41 (60.3)
Herbal medicine	1 (10.0)	8 (12.3)	35 (27.8)	6 (12.2)	14 (16.7)	24 (35.3)
Hypnotherapy	4 (40.0)	16 (24.6)	53 (42.1)	13 (26.5)	22 (26.2)	38 (55.9)
Massage	3 (30.0)	19 (29.2)	68 (54.0)	17 (34.7)	34 (40.5)	39 (57.4)
Meditation	7 (70.0)	53 (81.5)	118 (93.7)	40 (81.6)	74 (88.1)	64 (94.1)

	Recommending CM products and practices			Referring to CM practitioners		
	Recommended none (*n*=201)	Recommended 1 to 3 types (*n*=200)	Recommended 4 plus types (*n*=200)	Referred to none (n=201)	Referred to 1 to 3 types (*n*=200)	Referred to 4 plus types (*n*=200)
	n (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)
Nutrition supplements	3 (30.0)	16 (24.6)	62 (49.2)	14 (28.6)	33 (39.3)	34 (50.0)
Probiotic supplements	1 (10.0)	9 (13.8)	47 (37.3)	12 (24.5)	21 (25.0)	24 (35.3)
Yoga	5 (50.0)	33 (50.8)	91 (72.2)	28 (57.1)	51 (60.7)	50 (73.5)

Note. In the table *n* refers to the number of participants who recommended or referred as per the amount stated in the column heading. The % refers to the percentage of participants who recommended or referred as per the amount stated in the column heading.

Appendix P

Pre-Interview Demographics

Start of Block: Block 3

Q17

PARTICIPANT INFORMATION SHEET - INTERVIEWS

WHAT IS THE ROLE OF COMPLEMENTARY MEDICINE IN PSYCHOLOGY?

UTS HREC APPROVAL NUMBER ETH20-5138

WHO IS DOING THE RESEARCH?

My name is Carrie Thomson-Casey and I am a student at the University of Technology Sydney (UTS). My supervisors are Dr Erica McIntyre and Distinguished Professor Jon Adams.

WHAT IS THIS RESEARCH ABOUT?

This research aims to find out about the perspectives and experiences of psychologists regarding complementary medicine (CM). The research also aims to identify the ways in which psychologists educate themselves in CM, their perspectives on CM treatments for use by psychologists in clinical practice, their understanding of their clients' use of CM, and their perspectives and experiences of barriers and opportunities relating to CM integration.

WHY HAVE I BEEN ASKED?

You have been invited to participate in this study because you are a student of psychology or a registered psychologist in Australia. You provided your contact details when you responded to an invitation to participate in the study.

IF I SAY YES, WHAT WILL IT INVOLVE?

If you decide to participate, you will be invited to attend a one-on-one interview via phone or Zoom. Prior to the interview you will be asked to completed a short online survey (approximately 2 minutes to complete) covering basic demographic information and related information. The interview will explore your experience and perspective relating to complementary medicine and its relationship to the field of psychology and clinical practice. Interviews will be conducted either online or by phone at your convenience and will take approximately 45 minutes. Interviews will be audio recorded, transcribed, de-identified and analysed. All recorded material will be stored securely.

ARE THERE ANY RISKS/INCONVENIENCE?

There are minimal risks/inconvenience. There is a risk of inconvenience of the time taken to complete the survey, or interview if you choose to participate. If you participate in the interview, you will be sent an EFTPOS card to the value of $100 as a thank you for your time.

DO I HAVE TO SAY YES?

Participation in this study is voluntary. It is completely up to you whether or not you decide to take part.

WHAT WILL HAPPEN IF I SAY NO?

If you decide not to participate, it will not affect your relationship with the researchers or the UTS. If you wish to withdraw from the study once it has started, you can do so at any time without having to give a reason, by contacting Carrie.S.Thomson-Casey@student.uts.edu.au.

If you decide to leave the research project at any time, any recordings or transcripts will be destroyed.

CONFIDENTIALITY

By proceeding with the interview, you are confirming consent for the research team to collect and analyse the information you provide for the research project. All this information will be treated confidentially. However, you are not required to provide any identifying information. Participants who complete the interview will be provided with a $100 EFTPOS voucher. Your information will only be used for the purpose of this research project, except as required by law.

We plan to discuss/publish the results in a relevant journal and/or present findings at a relevant conference. In any publication, information will be provided in such a way that you cannot be identified.

WHAT IF I HAVE CONCERNS OR A COMPLAINT?

If you have concerns about the research that you think I or my supervisor can help you with, please feel free to contact me on Carrie.S.Thomson-Casey@student.uts.edu.au.

You will be given a copy of this form to keep.

NOTE:

This study has been approved in line with the University of Technology Sydney Human Research Ethics Committee [UTS HREC] guidelines. If you have any concerns or complaints about any aspect of the conduct of this research, please contact the Ethics

Secretariat on ph.: +61 2 9514 2478 or email: Research.Ethics@uts.edu.au] and quote the UTS HREC reference number. Any matter raised will be treated confidentially, investigated and you will be informed of the outcome.

CONSENT

I agree to participate in the research project Psychology and complementary medicine [UTS HREC APPROVAL NUMBER ETH20-5138] being conducted by Carrie Thomson-Casey, Carrie.S.Thomson-Casey@student.uts.edu.au.

I have read the Participant Information Sheet or someone has read it to me in a language that I understand.

I understand the purposes, procedures and risks of the research as described in the Participant Information Sheet.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time without affecting my relationship with the researchers or the University of Technology Sydney.

I understand that I will be given a signed copy of this document to keep.

I agree to be audio recorded.

I agree to the research data gathered from this work to be published in a form that does not identify me in any way.

I am aware that I can contact Carrie Thomson-Casey if I have any concerns about the research.

◯ I agree and give my consent to participate (1)

◯ I don't wish to proceed (4)

Skip To: End of Survey If PARTICIPANT INFORMATION SHEET - INTERVIEWSWHAT IS THE ROLE OF COMPLEMENTARY MEDICINE IN PSYCHOLOG... = I don't wish to proceed

End of Block: Block 3

Start of Block: Default Question Block

Q13 What is your first and last name? (To be linked with consent form - Your data will be de-identified and will not be linked to the interview content)

____

Q1 What is your main area of practice/registration as a psychologist?

○ General psychology (1)

○ Clinical psychology (2)

○ Clinical neuropsychology (3)

○ Community psychology (4)

○ Counselling psychology (5)

○ Education and developmental psychology (6)

○ Forensic psychology (7)

○ Health psychology (8)

○ Organisational psychology (9)

○ Sport and exercise psychology (10)

○ Intern/registrar (11)

Q2 Which of the following best describes your primary work setting?

○ Solo Private practice (1)

○ Group private practice (2)

○ Private health service/inpatient facility/outpatient facility (3)

○ Public health service/inpatient facility/outpatient facility (4)

○ Research/academia (not working in clinical practice) (5)

○ Private health service (not working in clinical practice) (6)

○ Public health service (not working in clinical practice) (7)

○ Other (8) ____

Q3 How long have you worked in a psychology role (including non-clinical practice)?

- ○ Less than 5 years (1)
- ○ 5 – 10 years (2)
- ○ 11 – 20 years (3)
- ○ 21 – 30 years (4)
- ○ 31 – 40 years (5)
- ○ 40+ years (6)

Q4 What is your gender identity?

- ○ Male (1)
- ○ Female (2)
- ○ Non-binary (3)
- ○ Prefer not to say (4)

Q5 What is your year of birth?

____

Q6 What state do you work from?

○ ACT (1)

○ NSW (2)

○ NT (3)

○ QLD (4)

○ SA (5)

○ TAS (6)

○ Vic (7)

○ WA (8)

End of Block: Default Question Block

Start of Block: Block 1

Page

Break

Q7 Do you have any formal qualifications in addition to your psychological qualification?

○ Yes (1)

○ No (2)

Skip To: End of Survey If Do you have any formal qualifications in addition to your psychological qualification? = No

Q8 What is your additional qualification (e.g., teaching degree, yoga instructor)?

____

Q9 What is your highest level of education for this additional qualification

○ Certificate IV (1)

○ Diploma (2)

○ Advanced Diploma (3)

○ Bachelor/degree (4)

○ Postgraduate diploma (5)

○ Masters (6)

○ PhD (7)

○ No formal qualification (8)

○ Other (9) ____

Q10 Do you hold separate professional indemnity insurance for the additional qualification/s?

- ◯ Yes (1)
- ◯ No (2)
- ◯ N/A (3)

Q11 Do you hold professional registration for the additional qualification/s?

- ◯ Yes (1)
- ◯ No (2)
- ◯ N/A (3)

Q12 Do you hold professional association membership for the additional qualification/s?

- Yes (1)
- No (2)
- N/A (3)

Q14 How many hours per week do you work with clients in your additional (non psychology) qualification?

○ Nil (1)

○ 1-10 hours (2)

○ 11-20 hours (3)

○ 20-40 hours (4)

○ 40 hours + (5)

End of Block: Block 1

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