RUNNING HEAD: PSYCHOLOGISTS' PERCEPTIONS OF CAM USE

A Qualitative Investigation of Australian Psychologists' Perceptions about Complementary and Alternative Medicine for Use in Practice

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Highlights

- Psychologists have a role to play in the use of CAM in clinical practice.
- Psychologists, in general, are open toward using CAM with clients but are also sceptical.
- Adhering to the scientist-practitioner model and client-centred approach affected psychologists' beliefs about CAM use.
- The codes of conduct played a major role in informing psychologists' use of CAM in clinical practice.

Abstract

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

Key words: attitudes, complementary and alternative medicine, beliefs, mental health.

1. Introduction

The use of complementary and alternative medicine (CAM) has increased over the last two decades in places such as Europe and Australia (Australian Bureau of Statistics, 2005; Barnett & Shale, 2012; Fischer et al., 2014; Xue, Zhang, Lin, Da Costa, Story, 2007). While empirical evidence suggests the prevalence of CAM use is increasing (Harris, Cooper, Relton, & Thomas, 2012) and that many use CAM for the treatment of health and mental disorders (Barnett & Shale, 2012; Oh et al., 2010), little is known about how psychologists are dealing with this rising trend. Moreover, not only is the evidence behind CAM use for treating mental disorders equivocal (Fischer et al., 2014; Lyman, 2015), there is also a lack in standards and information among education and training institutions for safe CAM use in psychological practice (Lin et al., 2009). Given the prevalence of CAM use for mental wellbeing, such as yoga, meditation, pilate, massage, acupuncture, homeopathy, hypnotherapy, chiropractic, and herbal medicine (Clarke Black, Stussman, Barnes, & Nahin, 2015; Ernst, & Fugh-Berman, 2002), psychologists need to be prepared to discuss such therapies with clients and adhere to their ethical responsibility to provide accurate information to clients about treatment options. This is important given recent claims that psychologists provide such advice inadequately (Wilson & White, 2011). Even if psychologists have the appropriate training to implement a CAM technique on clients, the issues surrounding CAM make using such techniques complex both professionally and ethically. Accordingly, CAM use in psychological practice is a challenging issue, and it seems timely to explore psychologists' beliefs of CAM use for clinical purposes.

Previous research has focused on psychology students and registered psychologists' willingness to recommend or integrate CAM where it was shown that attitudes, beliefs of significant others, and risk factors influenced CAM behaviours (Liem & Newcombe, 2017;

Wilson, Hamilton, & White, 2012a,b; Wilson, White & Obst, 2011, Wilson & White, 2011).

Although current literature has provided some understanding of CAM and psychological treatment, there is a knowledge gap in understanding psychologists' use of CAM for clinical purposes. This knowledge will provide new insight into why psychologists think, feel, and act the way they do about CAM use, and potentially guide the development of best practice standards around CAM use and effective treatment outcomes. Regardless of how psychologists might choose to approach CAM, the increasing popularity of complementary and alternative approaches in mental health care around the world suggests that many individuals are combining or considering CAM strategies to treat their psychological symptoms, and are looking for knowledge and expertise regarding options for incorporating CAM techniques (Frenkel & Borkan, 2003). For this reason, a deeper understanding of CAM use for clinical purposes among psychologists is important to support best practice. The aim of the current study was to explore psychologists' knowledge about CAM, attitudes toward CAM, and experiences of using CAM in practice.

2. Method

2.1 Participants

A purposive sampling method (Patton, 2002) was used to recruit Australian psychologists who were either provisionally or fully registered. In Australia, undergraduate psychology programs are traditionally a three-year degree, with students competing for entry into an honours/four-year program of study. Students can then apply to the Australian Health Practitioner Regulation Authority (AHPRA) for registration as a provisional psychologist. To become a fully registered psychologist, students need to complete an additional two-year supervised work program, a combination of university coursework as a fifth year and one year

supervised work program, or a Masters or Professional Doctoral program (Littlefield, 2016). Students can then apply to AHPRA for registration as a general psychologist.

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

2.2 Measures

A brief demographic survey collected general background information of the participants while a semi-structured interview guide was used to explore the research aims. The interview protocol comprised open-ended questions that were based on the research questions, extant literature, and experience of the researchers; however, the questions were flexible to allow a variety of perceptions and experiences to emerge. The semi-structured interview guide was piloted with two participants and feedback was used to revise questions to improve participant understanding. The interview guide consisted of three main discussion sections. The first section explored psychologists' knowledge about CAM (e.g., "What do you currently know about

CAM?") including knowledge about any potential risks, benefits, and scientific implications. After this discussion, copies of the various CAM classifications and examples of the various CAM techniques were provided. These classifications were based on the four CAM categories outlined by the National Centre for Complementary and Alternative Medicine (NCCIH, 2014): 1) "Mind-Body" CAM, which includes meditation, yoga, relaxation techniques, healing touch, and hypnosis; 2) "Body-Based" CAM, which consists of acupuncture, massage therapy, movement therapies, and chiropractic; 3) "Biological" CAM, which involves vitamins and minerals taken to maintain health; and, 4) "Other Biological" CAM, which constitutes herbal therapies, homeopathy, naturopathy, and traditional Chinese herbal therapies. The second section examined participants' attitudes toward the different CAM categories for use in practice (e.g., "What is your attitude towards CAM for psychological purpose?"). The third section investigated psychologists' experience with CAM in practice (e.g., "What is your experience with CAM in your psychological practice?").

2.3 Design and Procedure

A qualitative research design using interview methods and adopting an inductive thematic analysis approach (Braun & Clarke, 2013) was employed to understand psychologists' views and experiences of CAM use for clinical purposes. The University Human Research Ethics Committee granted ethical clearance for this study. Participants were approached via email or face-to-face and given an information sheet explaining the study. Interviews took place at a location convenient to the participant. Participants signed a consent form and completed a brief demographic survey before beginning the interview. The interviewer briefly explained the purpose of the interview and reminded participants of their rights detailed on the information sheet.

Author VM conducted all interviews, which averaged 1-hour in length. The interview was guided by semi-structured open-ended questions, allowing the interviewer to be flexible to probe for clarification and elaborate on responses. This process was guided by several criteria of good practice in qualitative research (Tracy, 2010), including worthiness of the topic, sincerity (the interviewer practicing being self-reflective), as well as the research having rich rigour, credibility, and relational ethics. Upon completion, the interviewer summarized the discussion to ensure the qualitative validation of collected information (Braun & Clarke, 2013) and invited each participant to modify or elaborate on this summary. Furthermore, a reflexive journal was kept by the interviewer to record key ideas expressed throughout the interviews and to note comparisons and contrasts between the interviews; this journal was used to assist with the data analysis and as a guide to indicate a point at which theoretical saturation had been reached. (Braun & Clarke, 2006, 2013). Interviews were audio-recorded and author VM transcribed all data verbatim (removing any identifying data and assigning pseudonyms). At the time of the interviews, author VM was a provisionally registered psychologist and KH was a senior lecture with research interests in health psychology. Both authors have used some form of CAM for their health and wellbeing including mindfulness and nutrient supplements (VM) and yoga, pilate, massage, and chiropractic (KH). As recommended by Hill, Knox, Thompson, Williams, and Hess (2005), authors' discussed their biases and expectations with each other prior to, and throughout, the research process to ensure that these did not unduly influence the data collection and analysis process.

2.4 Analytic Strategy

Inductive thematic analysis of the data followed the six phases described by Braun and Clarke (2006, 2013). The first step consisted of repeated reading of the data to gain familiarity of the content. From this step, initial codes were generated. This process led to the third step where

codes with related ideas were grouped together to be refined into themes. Next, themes were grouped according to the four main interview topics and a thematic map was generated for each participant. The fourth step consisted of defining and naming themes while using quotes to capture the essence of each theme with reference to raw data. At this stage, the second author reviewed the data and with the first author discussed, refined, and came to consensus on emerging codes and themes. The fifth step focused on producing the outcome results where themes were developed to an in-depth level. The definition of each theme was written and re-written for each participant to ensure that sufficient evidence was given to support each theme by referring to codes and quotes (Crowe, Inder, & Porter, 2015). Themes were then examined for differences and commonalities both within and across participants. In this way, major themes could be made apparent.

3. Results

The descriptions about CAM among psychologists have been organized around the three main topic areas that framed the discussion guide. The categories that emerged across the individual interviews were similar; thus, the most salient emerging themes within the category expressed across all participants are presented. Extracts are classified by participant number (e.g., *P1*).

3.1 Knowledge about CAM

3.1.1 Mainstream vs. non-western science. CAM was often thought about in terms of mainstream, western science vs. non-western, non-traditional approaches to medicine.

Participants described it as something that “*does not come from mainstream or western model*” (*P4*) or as something “*not really thought of as traditional scientific approaches*” (*P 6*). CAM

was also thought of as anything that was *“not prescribed by a general practitioner or distributed through the pharmacist”* (P3).

3.1.2 Lacking an evidence base. Most participants described CAM as lacking a foundation of scientific evidence to support its use. One participant explained: *“Certainly there is a message from the science that CAM is lacking evidence, but a lot of people are drawn into it”* (P5). A few psychologists reported reviewing meta-analytic studies and systematic reviews about CAM efficacy, and described the research as being *“inconclusive and that it is not any better than a placebo”* (P 9).

3.1.3 Mismatch between perceived and actual knowledge. Psychologists, in general, were hesitant when describing CAM, which may in part have been due to their unfamiliarity with the word CAM in itself: *“CAM is more a term that you hear in the research but not in day to day use”* (P3). Although psychologists’ perceived their knowledge about CAM as limited, once the CAM classification was provided most realised their actual knowledge about CAM was greater than they had initially thought, and also recognized they were actually using CAM either for personal or professional purposes. Thus, a mismatch between psychologists’ perceived and their actual knowledge about CAM emerged: *“I didn’t realize that it was so broad so I guess that when you classify it in this way I know a lot and I use a lot”* (P13).

3.2 Attitude toward CAM

3.2.1 Pro or open toward CAM. Half of the psychologists reported being “Pro” CAM, meaning that they perceived there to be great value in its use for general as well as psychological purposes: *“Definitely positive, I am pro CAM”* (P2). Although not admitting to being pro CAM, many also reported being “Open” toward CAM, meaning they were interested, curious, and wanting to know more about it. In comparison to psychologists who were pro CAM,

psychologists who were open toward CAM did not hold a strong positive attitude toward it, but rather held a more neutral opinion about its advantages: *“I don't have strong opinions, I am pretty open minded to it” (P12).*

3.2.2 Sceptical about CAM. While psychologists reported a general positive attitude toward CAM, it became apparent that most psychologists also held contradictory beliefs. This attitudinal ambivalence was evident in the description of psychologists reporting they were also sceptical and had uncertain views about CAM, with their attitude toward CAM depending on the CAM modality: *“The Mind-Body CAM is essential, important, fundamental in my own practice and I think Biological CAMs would be an important part of this...To a lesser extent Body-Base” (P5).* Distinctive attitudes were also noted within each CAM modality, as illustrated: *“Ok. Pilates I would go for, but chiropractic, I would ask the client to explore this further” (P11).*

3.2.3 Knowledge and research shapes attitudes. Psychologists' knowledge of and scientific evidence for a CAM technique shaped their attitude toward CAM use. A more favourable attitude toward CAM was held when psychologists' believed there to be a greater amount of research supporting a technique, and they had a higher level of knowledge about specific CAM. In contrast, a more negative or sceptical attitude was held when it was perceived there to be a lack of research or equivocal evidence supporting CAM. As explained, *“...some other ones I am a bit more iffy about it, you know I could believe that they do work if you give me the research behind it” (P7).* In addition, having evidenced either personal or professional benefits of using CAM often shaped ones' attitude: *“... I have seen the benefit of mindfulness in myself and in my clients when I've done mindfulness with them, so I had the evidence not only research but within myself and clients” (P7).* In line with these discussions about research shaping attitudes, some psychologists perceived CAM as having a “magical” or “spiritual”

connotation which they reported does not fit with research and psychology: *“Psychology doesn't like anything to do with spirituality and there is some spiritual connotation around these CAM”* (P11).

3.2.4 Fearful of ‘quacks’. Some psychologists reported being sceptical toward CAM as they perceived some alternative therapists as being “quacks” and that it *“could potentially attract people who are not as qualified and could potentially rip people off”* (P17). Other psychologists expressed their concern about unprofessional or unqualified CAM therapists being able to practice and who could potentially cause harm to clients: *“I sometimes hear things about massage that if you are not massaged by someone who knows what they are doing it can cause injuries ...”* (P1).

3.2.5 It is up to the client. Many of the psychologists reported that they will not actively use or talk about CAM unless clients are showing an interest toward a technique. Psychologists will respect clients’ interest and be open to a conversation about CAM, and will not discourage such a conversation or clients engaging in a technique, even if they themselves hold a sceptical or negative attitude toward CAM. Clients’ interest toward CAM thus guides the therapy session and may negate psychologists’ attitude toward CAM: *“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...”* (P16).

3.2.6 Beneficence principle is fundamental. Most psychologists discussed that their practice aims to best assist clients’ needs and presenting problems. Accordingly, most psychologists, regardless of their own attitude toward CAM, will use or encourage CAM if it was thought to increase client benefits, as long as it does not cause harm: *“I guess that if*

something isn't harmful and if they [clients] find it really helpful to improve their lives, then you know who am I to say that they should not do it, if it is not hurting them" (P13).

3.2.7 CAM better as an 'add on' vs. in isolation. Almost half of the psychologists reported that CAM was better adopted as an "add on" to therapy rather than using it in isolation to treat a condition. Psychologists emphasised that, in the first instance, it is important to use an evidence base treatment and then to complement this with CAM, thus not replacing evidence-based treatments with CAM or advocating CAM as the first line of treatment: *"... I believe CAM would be an add-on to other treatments, so you can't do CAM in isolation you need to do it with other treatments ... I think you have to give the evidence-based guideline a go... and if those things are not working and the person has done a really good job at giving those things a go, I will think about CAM" (P1).* Some of the psychologists also discussed the danger of using CAM in isolation to treat a condition: *"It would be very hard to work with these techniques alone... if you have cancer or schizophrenia you know homeopathy is not going to help you and if you keep using it thinking that it would help and if it prevents you from accessing the care that you need then it can be risky" (P6).* One psychologist went on to explain that using CAM in isolation to treat mental health meant that clients *"don't take responsibility and ownership for their behaviours... It is not going to challenge their thoughts..." (P14).*

3.3 Experience with CAM

3.3.1 Scientific-practitioner model guides use. The majority of psychologists reported that they would not feel comfortable using CAM with their clients if there was no evidence supporting it for psychological purpose: *"If it is not evidence-based I would not feel comfortable to do it" (P12).* Psychologists explained that research was important as psychology is regarded

as a science and psychologists are guided by the scientist-practitioner model: *“Psychologists are research focused and they need to be scientific practitioners and none of us want to work with clients with techniques that don’t work, we want things that work”* (P9).

3.3.2 If I don’t know I don’t do. Almost all of the psychologists reported level of training and expert knowledge as essential before using CAM with clients: *“That’s the thing, if I don’t know I don’t do, I try to talk to my colleague and see what is the most appropriate way to help the client”* (P2). The majority of psychologists reported that if they had no training in a particular CAM technique they would not use it with clients but rather might recommend it or refer a client to another specialised professional: *“If a client is coming and wanting to try some CAM that I am unsure about, I would recommend them to speak to someone else about it: GP, pharmacist, and maybe naturopath”* (P3). Psychologists also emphasised they will not try to be an expert in something that they have not been trained in: *“I would feel uncomfortable being the expert in something we have not been trained in”* (P12), with some psychologists reporting that they would like to have more direction on how to use CAM: *“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”* (P1).

3.3.3 Acceptance of CAM validates CAM. Some of the psychologists discussed how knowing that a specific CAM technique was well accepted among psychologists would increase their likelihood to use that same technique with their clients. This belief was based on the premise that acceptance validates the technique as being appropriate to adopt: *“I suppose it is more validation and recognition... Validating that CAM is an appropriate technique to use, not as a psychologist, but the therapy in itself”* (P8). Psychologists identified meditation and relaxation as being the main techniques approved and used by other psychologists. They

explained that *“knowing it is something well-accepted, especially in the clinical training and psychology area, knowing why we are using it makes me comfortable to use it ...”* (P9). Some of the psychologists also discussed that other psychologists using a technique can influence their use of CAM as *“you assume that if a psychologist is using it, then they have researched it and that it is reliable and that the evidence base is there”* (P7). For others, a sense of approval from other psychologists as well as the work environment was needed for them to use CAM. This was especially the case for provisionally registered psychologists. They explained that their supervisors’ view and use of CAM was crucial to them to be able to use CAM: *“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’”* (P12). For some provisionally registered psychologists it was evident that they felt limited in their capacity to use CAM as they referred to themselves as being *“students who are just learning basic skills”* (P12).

3.3.4 Sharing information is paramount. Some psychologists believed that sharing their own experience about CAM could help clients to see the benefit of a technique and to guide them toward CAM: *“I think sharing your own experience... I think that it is part of sharing your own experience so it gives people permission to think about it for themselves”* (P16). Some other psychologists discussed that sharing the evidence base behind a technique can make clients more open to CAM and improve treatment outcome: *“Clients who have more information about how the techniques work and their effectiveness and their level of support, clients who understand the rationale into why CAM is beneficial and why it can be utilised might work better”* (P3).

3.3.5 Providing a safe and secure therapeutic alliance. For the majority of psychologists, the therapeutic alliance role was believed to have the most influence over

decisions to use CAM with clients. The therapeutic alliance was commonly thought of as “...an emotional connection” (P 6) that aims to provide a “secure therapeutic environment regardless of strategies used” (P16). Psychologists will use any strategy that can provide a secure environment to clients, whether or not it includes CAM. Thus, psychologists believed that the therapeutic alliance “would neither way strongly influence CAM use” (P14). On the other hand, some psychologists described CAM as helping them to create a stronger therapeutic alliance with their clients: “In my experience using CAMs in general I think it has helped me in making an emotional connection with some clients...” (P6). The therapeutic alliance was also viewed as a way to become open, inclusive, and non-judgmental toward CAM: “Well if they come to me and they say oh I’m seeing a hypnotherapist, to maintain rapport with that person I won’t shut them down and I won’t say that it is crap” (P7).

4. Discussion

Previous literature suggests beliefs about CAM play an important role in the decision making among psychologists to refer or recommend CAM to clients (Wilson & White, 2011; Wilson, White, & Obst, 2011). These accounts, however, only focus on recommending or referring CAM to clients and ignore psychologists’ current attitudes and experience of using CAM with clients. Gaining this knowledge is important and timely given many individuals seek CAM to treat their mental conditions (Australian Bureau of Statistics, 2005). In the current study, knowledge of CAM, attitude toward CAM, and experience with CAM use in practice were explored.

4.1 Knowledge about CAM

The findings from the current study show that psychologists have come to understand CAM as not belonging to mainstream medicine and as lacking of an evidence base, which align

to the current CAM literature (Fischer et al., 2014; Lyman, 2015). Although psychologists were hesitant about what constitutes CAM, once provided with a definition, psychologists realised they knew about and used significantly more CAM than what they initially thought. This is consistent with previous research that found there to be a discrepancy between what psychologists understand and what they practice in regards to CAM, in that psychologists were practicing CAM without being aware of it (Barnett & Shale, 2012). Some participants explained that the mismatch between their perceived and actual knowledge of CAM was due to their unfamiliarity with the word CAM as well as not associating it with clinical practice, a finding supported by previous research (Stapleton et al., 2015). Indeed, the majority of CAM research is published in discipline-specific journals, rather than psychology journals, and that these may be considered less credible (Bassman & Uellendahl, 2003).

4.2 Attitude toward CAM

In support of the previous literature (Liem & Newcombe, 2017; Wilson & White, 2011), psychologists described a generally positive attitude toward CAM; however, ambivalence, and in some cases opposition, to CAM use emerged when a technique was perceived as lacking scientific support. Previous research has shown significant correlations between attitudes to science and scepticism about CAM (Furnham, 2007). In the current study, it emerged that knowledge and science did indeed shape CAM attitudes, which aligns with suggestions that research plays an important role in determining psychologists' attitude toward any psychological intervention, including CAM (Barnett & Shale, 2012).

The way in which CAM was used and by whom also influenced psychologists' attitude. Psychologists were suspicious about alternative therapists' legitimacy in their training in CAM. For example, some CAM modalities require many years of study (e.g., chiropractic), while other

modalities can be practiced by unlicensed individuals after attending brief workshops (Bassman & Uellendahl, 2003). In addition, CAM was not perceived well when it was used in isolation and as the only treatment option justified. Psychologists believed that ‘mainstream’ science options should be the first line of treatment as they are often empirically supported.

Further, a client-centred approach consistently emerged as overriding psychologists' attitude toward CAM. For instance, participants explained that following clients' preferences and upholding client beneficence is much more important than their own attitude toward CAM. This supports previous research where it was found that clients' preferences are greatly valued and guide treatment plans (Luebbe, Radcliffe, Callands, Green, & Thorn, 2007). CAM in general encourages patients to be active contributors in their treatment plan (Hughes, 2008), which could also explain why psychologists valued a client-centred approach when discussing CAM.

4.3 Experience with CAM

In discussions about their experience of CAM, the influence of adhering to the Australian Psychological Board code of conduct and acceptance by the profession emerged as guiding psychologists' CAM use with clients. Similar to shaping their attitudes, the scientific-practitioner model strongly guided CAM use. This strong conviction could be explained by the fact that the practice of psychology has been grounded historically in the scientist-practitioner model, which is taught and emphasised in psychological training (Luebbe et al., 2007) and is the foundation of the Australian ethical code of conduct (Navab, Koegel, Dowdy, & Vernon, 2016). Previous research has suggested that this model could be detrimental to psychological practice as it can increase clinicians' rigidity and reduce any opportunity to use different treatment options (Hughes, 2008). Indeed, it is suggested that the scientist-practitioner model should adapt to the

modern demands on psychology to make new alternative ways accessible to professionals (Chang, Lee, & Hargreaves, 2008).

Similarly, psychologists reported the need to feel competent before using CAM with clients, an ethical principle that aligns with propriety and competence; as well as the importance to share information about CAM with their clients, an ethical principle that aligns with informed consent (Australian Psychological Society, 2007). In the current study, psychologists denied using any psychological intervention unless they were trained, while previous research has shown that it is possible for psychologists to still provide information about CAM without adequate training in CAM or resources about CAM (Wilson & White, 2011). Some psychologists reported disappointment about the lack of CAM training or guidance on integrating CAM in psychological practice, which may be due to the predominant lack in standards and information available among education and training institutions (Bensoussan et al., 2005). It further suggests that educational experiences have a strong contribution to preferences for therapeutic orientation and interventions for psychologists (Carless, Robertson, Willy, Hart, & Chea, 2012).

In addition to the code of ethics guiding CAM use, acceptance of CAM among the psychology profession was also important. For example, the context of the psychology practice as well as colleagues or supervisors' approval of CAM were mentioned as potential barriers or facilitators for CAM use. It is not uncommon for psychologists to look for support or guidance about a psychological intervention via their supervisors or peers (Luebbe et al., 2007). Moreover, supervisors' orientation exerts an influence on trainees' preferred orientation, even years after qualifying (Carless et al., 2012). Findings are also consistent with social information processing

theory, which claims that social cues from supervisors play a key role in influencing students' professional development and attitudes (Carless et al., 2012).

Providing a safe and secure therapeutic alliance was also valued by psychologists and influenced CAM decisions. In one sense, psychologists will prioritise and value the therapeutic alliance over and above psychological interventions, including CAM. Therefore, psychologists would remain flexible and respectful about including CAM in treatment, which are characteristics that contribute to a positive therapeutic alliance (Ackerman & Hilsenroth, 2003). Furthermore, some psychologists viewed CAM as helping them to create a stronger alliance by being able to connect with clients via CAM. Given CAM is usually described and associated with a holistic model to treatment (Kayne, 2008), it might explain why CAM can enhance this therapeutic alliance.

4.4 Study Limitations, Future Research, and Applied Implications

The current study explored psychologists' perceptions of CAM use for clinical purposes and, thus, has the major strengths of investigating an under researched yet rapidly growing practice in a sample of registered psychologists and psychologists in training. Limitations to the study should also be noted. The sample comprised more females than males, although the gender split is comparative to the profession. Since sex differences for CAM have been found, in that females are more likely to use CAM than males (MacLennan, Myers, & Taylor, 2006), it would be useful for future research to explore CAM perceptions among more male psychologists. In addition, the current research did not focus on a specific CAM technique but rather focused on all the different CAM modalities. Even though participants talked about specific techniques they viewed more positively or negatively, the data can only be generalized to CAM use in general.

Future research may benefit from conducting research that focuses on unpacking the beliefs for specific CAM techniques.

4.5 Conclusion

Findings from the current study demonstrate an important need to investigate CAM use for clinical purposes. First, from a legal consideration, clear ethical guidelines for CAM use should be developed given that psychologists not only strongly identified with the code of conduct, but also expressed an interest in having more guidance on how to integrate CAM in their practice. Additionally, it was found that some psychologists were using CAM without being aware of it. Training and knowledge about CAM, including the empirical evidence base behind CAM, should be integrated into psychologists' training and as professional development opportunities, to better equip psychologists about CAM use with clients. Finally, to ensure an appropriate evidence base, the research field must respond by improving the quality of CAM research so psychologists have a better understanding of the effective uses for and limitations of using CAM in psychological practice. Overall, it seems beneficial to have discussions about CAM use for clinical purposes, and elicit psychologists' beliefs about this uncertain therapeutic treatment. Such discussions could help to maximize the benefit and minimize the harm to clients and achieve better treatment outcomes via encouraging practitioners and educators to effectively address the issues in course work, research, and practice.

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