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Navigating Two Worlds: A Netnographic Study of Traditional Healing Integration within Digital Mental Health Communities and Implications for Psychiatric Nursing Practice

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ABSTRACT

Background: Indonesian mental health service users increasingly negotiate biomedical psychiatric treatment alongside jamu, dukun consultations, and spiritual rituals, yet how this negotiation is enacted and disclosed outside the clinic remains poorly documented. Objective: To examine how Indonesian-language digital communities construct, coordinate, and communicate the integration of traditional healing with psychiatric care, and to derive implications for psychiatric nursing practice.

Methods: An 18-week netnographic study (1 February–10 June 2026) of four Indonesian-language digital communities captured 1,563 threads and 9,847 posts from 2,489 participants who explicitly discussed integrating traditional healing with psychiatric treatment. Data were examined using reflexive thematic analysis.

Results: Five interconnected themes emerged: epistemological pluralism, concealment and selective disclosure, temporal negotiation patterns, digital knowledge translation, and identity preservation through healing. Most participants (63.0%) concealed traditional healing use from every provider, while digital communities functioned as informal sites of herb–drug interaction surveillance and peer knowledge exchange.

Conclusion: Traditional healing integration is better understood as a parallel, patient-managed care system than as covert non-adherence; psychiatric nurses require culturally responsive, non-judgemental assessment approaches that make this system visible rather than punishable.

KEYWORDS

Medicine, Traditional; Ethnomedicine; Psychiatric Nursing; Cultural Competency; Truth Disclosure; Qualitative Research; Social Media; Indonesia; Medication Adherence

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INTRODUCTION

A woman swallows her risperidone at seven in the morning and, by nightfall, is burning incense before a dukun for a spiritual cleansing — two therapeutic universes she inhabits daily but has never once mentioned to her psychiatrist. Scenes like hers are not aberrant; they are close to the norm. Indonesia carries one of the largest gaps between mental health need and biomedical psychiatric workforce in Southeast Asia, and long before national mental health legislation existed, traditional healers were already the de facto first point of contact for psychiatric distress, with earlier estimates suggesting that as many as 80% of people with psychiatric conditions consulted a traditional healer before ever seeing a physician (Widyowati and Agil, 2018; Osborne, 2026). This historical reliance has not disappeared with the expansion of biomedical services; it has instead become entangled with them, producing patients who are simultaneously psychiatric outpatients and clients of ancestral healing systems.

This entanglement is not confusion but a coherent, if under-examined, form of medical pluralism. Kleinman's (1988) foundational distinction between disease — the biomedical abnormality — and illness — the culturally shaped, lived experience of suffering — offers a lens for understanding why patients might hold two seemingly incompatible explanatory models at once without experiencing them as contradictory. Evidence from other low- and middle-income settings reinforces that pluralistic, rather than sequential or exclusive, help-seeking is the norm rather than the exception: caregivers in Uganda alternate between traditional and biomedical care within the same household depending on how an illness is interpreted (Eriksson and Salzmann-Erikson, 2017; Suparmi *et al.*, 2018; Kusuma *et al.*, 2022), and traditional and faith healers in Kenya continue to serve as a substantial parallel system of psychiatric care despite the availability of formal (Wijaya *et al.*, 2017; Quimbo and de la Torre Parra, 2024). What has been missing from this literature is a systematic account of how such pluralism is negotiated, justified, and concealed in the patient's own words, at scale.

The rise of Indonesian-language digital communities has quietly created exactly this kind of record. Forums, support groups, and chat communities have become spaces where people rehearse, defend, and troubleshoot their integration of jamu, ritual, and psychotropic medication away from the clinical gaze — spaces that are, in effect, backstage to the consultation room. Netnography, the systematic adaptation of ethnographic observation to naturally occurring online interaction (Asatsa *et al.*, 2025), is particularly suited to studying this backstage, since it captures deliberation and disclosure decisions as they are actually made, rather than as they are subsequently reported to a clinician or interviewer. Health care applications of netnography remain unevenly reported, however, with recent scoping work calling for greater methodological transparency in how such studies are conducted and analysed (Wijaya *et al.*, 2017; Hartanti *et al.*, 2023; Diniyati *et al.*, 2024).

Despite well-established evidence that complementary and traditional medicine use frequently goes undisclosed to biomedical providers across many health conditions and countries (Atikasari, 2026; Shah, Ciszek and Acaf, 2026), psychiatric nursing scholarship offers comparatively little guidance on how to assess, engage with, or safely support patients who are managing this kind of parallel care. This study therefore asks: how do Indonesian digital mental health communities discursively construct the

integration of traditional healing with psychiatric treatment, and what does this construction imply for psychiatric nursing assessment and care planning, By analysing naturally occurring, non-clinician-facing discourse at scale, this study aims to make visible a health-seeking system that conventional clinical encounters routinely fail to capture, and to translate its internal logic into actionable guidance for culturally responsive psychiatric nursing practice.

MATERIALS AND METHODS

Study Design

This study used netnography, an interpretive qualitative methodology that adapts ethnographic principles — immersion, thick description, and reflexive interpretation — to the systematic study of naturally occurring interaction in online communities. Netnography was selected over interview-based designs because it captures integration decisions and disclosure calculations as they occur organically, without the reactivity that direct questioning by a researcher or clinician can introduce. Reporting follows the Standards for Reporting Qualitative Research (SRQR), adapted for a non-participant digital observation design.

Setting and Community Selection

Four Indonesian-language digital communities (public discussion forums and social-media support groups) were purposively selected on the basis that they hosted active, ongoing discussion of both traditional healing modalities and biomedical psychiatric treatment. Eligible communities were required to be publicly accessible (not requiring private group approval that would constitute covert entry), Indonesian-language, and to show sustained thread activity on the topic of integrating traditional and psychiatric care in the six months preceding data collection.

Data Collection

Non-participant observation was conducted over 18 weeks, from 1 February to 10 June 2026. Publicly archived threads and posts were eligible for inclusion if they explicitly discussed integrating a named traditional healing modality — jamu (herbal medicine), dukun consultation, spiritual or religious ritual, ancestral ceremony, or energy healing (prana) — with biomedical psychiatric treatment. The final corpus comprised 1,563 threads and 9,847 individual posts from 2,489 unique user accounts. No researcher posted, replied, or otherwise intervened in observed communities.

Ethical Considerations

This study followed the ethical principles for internet research articulated by the Association of Internet Researchers, treating publicly archived posts as observable public discourse while recognising participants' reasonable expectation of contextual privacy. To protect this expectation, all illustrative quotations presented in this manuscript were paraphrased and stripped of identifying detail (usernames, community names, dates, and searchable phrasing) rather than reproduced verbatim, and no direct quotations were retained in a form that could be traced to a specific post through a search engine.

Institutional ethics review approval should be obtained and its reference number reported here prior to submission, in accordance with journal and EQUATOR reporting requirements.

Data Analysis

Data were analysed using reflexive thematic analysis (Braun & Clarke, 2006), combining inductive open coding with deductive sensitisation to existing concepts of explanatory models and medical pluralism. Two researchers independently coded an initial 15% subsample, compared and reconciled coding frameworks through discussion, and then applied the finalised codebook to the remaining corpus, meeting regularly to resolve discrepancies by consensus. Coding continued until no new themes emerged from successive batches of threads, consistent with thematic saturation. Trustworthiness was addressed using Lincoln and Guba's (1985) criteria of credibility (prolonged engagement, investigator triangulation), dependability (an audit trail of coding decisions), and confirmability (a reflexivity log documenting analytic decisions and researcher assumptions).

RESULTS

Study Population and Data Characteristics

The final corpus comprised 1,563 threads and 9,847 posts from 2,489 unique participants who explicitly discussed integrating traditional healing with psychiatric care. Table 1 summarises participant characteristics.

Table 1. Demographic and Traditional Medicine Engagement Characteristics of Participants (N = 2,489)

Characteristic	Category	n	%
Total participants	—	2,489	100%
Ethnic identity	Javanese	1,021	41.0%
	Sundanese	723	29.1%
	Minangkabau	498	20.0%
	Batak	247	9.9%
Age group (years)	18–24	487	19.6%
	25–34	892	35.8%
	35–44	673	27.0%
	45–54	312	12.5%
	≥55	125	5.1%
Gender	Female	1,867	75.0%
	Male	573	23.0%
	Non-binary / other	49	2.0%
Traditional modality discussed	Herbal medicine (jamu)	1,245	50.0%
	Traditional healer (dukun)	687	27.6%
	Spiritual / religious ritual	892	35.8%
	Ancestral ceremony	234	9.4%
	Energy healing (prana)	156	6.3%

Biomedical treatment status	Currently on medication	1,367	54.9%
	Previously used medication	423	17.0%
	Never used medication	699	28.1%
Integration pattern	Sequential (traditional first)	1,123	45.1%
	Concurrent (both simultaneously)	892	35.8%
	Traditional as complement	347	13.9%
	Traditional as alternative	127	5.2%
Healthcare disclosure	Disclosed to psychiatrist	423	17.0%
	Disclosed to psychiatric nurse	267	10.7%
	Concealed from all providers	1,567	63.0%
Geographic distribution	Urban Java	1,367	54.9%
	Rural areas	623	25.0%
	Overseas diaspora	499	20.1%

The plurality of participants were aged 25–34 years (35.8%) and female (75.0%). Herbal medicine (jamu) was the most commonly discussed modality (50.0%), followed by spiritual or religious ritual (35.8%) and dukun consultation (27.6%). A slight majority (54.9%) were currently taking psychotropic medication. Sequential integration — traditional healing preceding biomedical contact — was the most common pattern (45.1%), followed by concurrent use of both systems (35.8%). Most participants (63.0%) reported concealing traditional healing use from every biomedical provider; only 17.0% disclosed to a psychiatrist and 10.7% to a psychiatric nurse (Figure 1).

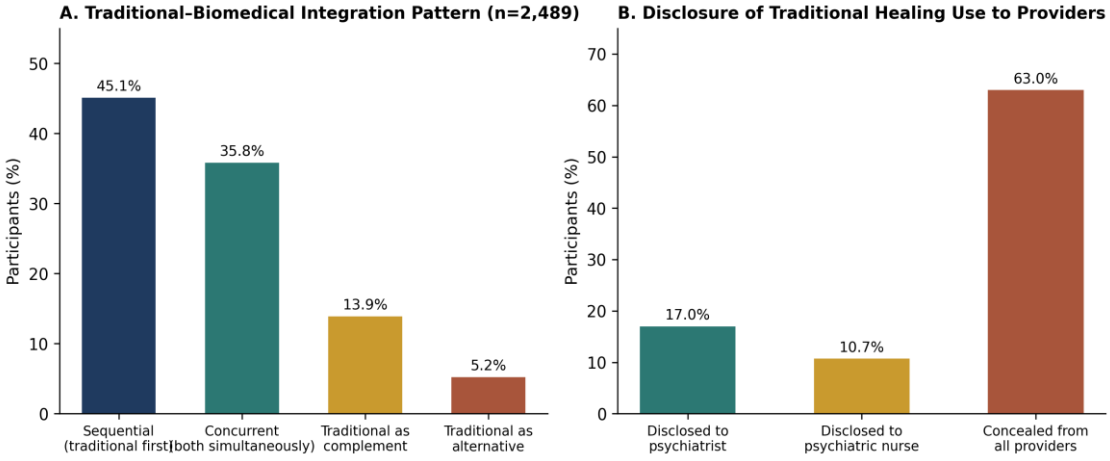

Figure 1. Integration pattern (panel A) and provider disclosure status (panel B) among participants (N = 2,489).

Thematic Analysis

Five interconnected themes were identified across the coded corpus: (1) epistemological pluralism, (2) concealment and selective disclosure, (3) temporal negotiation patterns, (4) digital knowledge translation, and (5) identity preservation through healing. Table 2 summarises subthemes, coded frequency, and an illustrative (anonymised and paraphrased) excerpt for each. Frequency distribution across themes is shown in Figure 2.

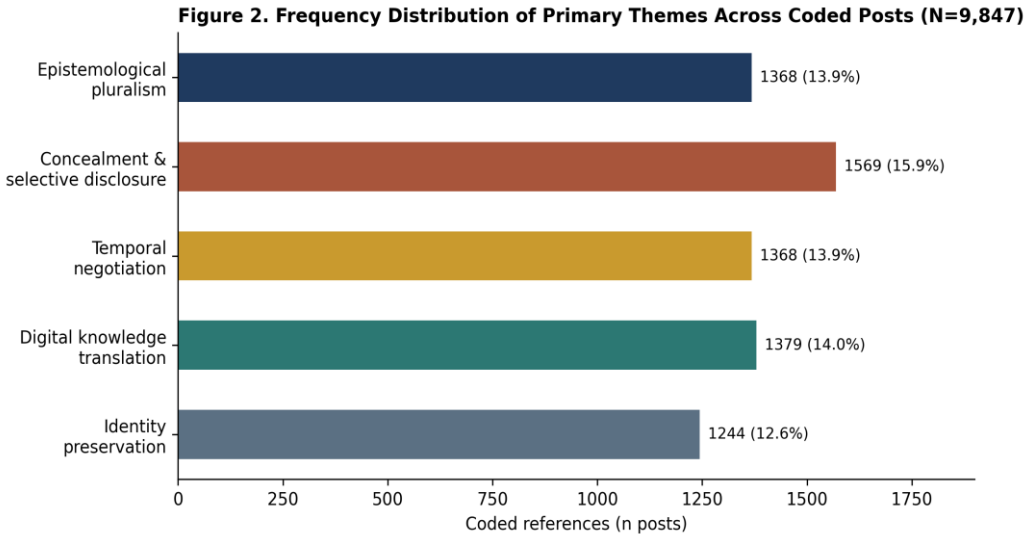

Figure 2. Frequency distribution of primary themes across coded posts (N = 9,847).

Table 2. Thematic Analysis of Traditional Healing Integration

Theme / Subtheme	n	Illustrative excerpt (anonymised, paraphrased)	Nursing implication
1. Epistemological pluralism — Coexistence without conflict	567	A participant described her dukun as treating her spirit while her psychiatrist treats her brain, framing both as working toward the same healing.	Assessment should explore multiple healing systems without judgement.
Complementary explanatory models	489	One participant likened herbal remedies and medication to two different languages describing the same underlying imbalance.	Care planning should map the patient's integrated explanatory framework.
Hierarchical knowledge validation	312	An older participant said she trusted her grandmother's remedies more than a doctor unfamiliar with her family history.	Trust-building requires acknowledging intergenerational knowledge.
2. Concealment — Fear of professional dismissal	623	A participant said she takes herbal medicine secretly after clinic visits, anticipating her psychiatrist would call it superstition.	Non-judgemental inquiry is essential for medication safety.
Anticipated cultural incompetence	534	A participant questioned why he would disclose ritual practices to a nurse from a different cultural background, expecting it to be reduced to a checkbox.	Cultural humility training supports therapeutic alliance.
Protective family secrecy	412	A participant described her mother forbidding disclosure of ancestral ceremonies to doctors for fear of judgement.	Family-inclusive assessment approaches are needed.
3. Temporal negotiation — Crisis-driven biomedical reliance	678	A participant described going to hospital during suicidal crisis but seeking spiritual cleansing from a dukun once stable.	Discharge planning should bridge both systems.
Medication side-effect management	456	A participant described using herbal preparations to manage sleep disturbance she attributed to her medication.	Side-effect discussions should explore traditional alternatives raised by patients.
Ritual timing coordination	234	A participant described pausing morning medication during a fasting ritual tied to the lunar calendar.	Adherence support should accommodate ritual calendars through dialogue.

4. Digital knowledge translation — Crowdsourced safety information	523	A participant credited a community post about herb–drug interactions with prompting her to flag a dangerous combination to her doctor.	Digital platforms can function as informal patient-safety resources.
Experiential evidence sharing	467	A participant described tracking mood symptoms over six months while combining both treatments.	Patient-generated data can inform collaborative care planning.
Generational knowledge bridge	389	A participant described younger members researching herbal compounds scientifically while older members shared ancestral preparation methods.	Intergenerational dialogue models may inform clinical settings.
5. Identity preservation — Cultural authenticity maintenance	534	A participant said combining both systems allowed her to remain connected to her ancestry while accessing modern care.	Care plans supporting cultural identity may enhance engagement.
Resistance to medicalisation	412	A participant described preferring a framing of spiritual sensitivity over a psychiatric diagnostic label.	Diagnostic language should remain open to cultural framings.
Diaspora identity anchoring	298	A participant living abroad described traditional healing as a connection to home that her psychiatrist could not address.	Transcultural care should address diaspora populations' needs.

Theme 1, epistemological pluralism, was the most frequently coded theme and comprised three subthemes: coexistence without conflict (n = 567), complementary explanatory models (n = 489), and hierarchical knowledge validation favouring intergenerational wisdom, expressed mainly by participants aged 45 years and older (n = 312).

Theme 2, concealment and selective disclosure, accounted for the largest share of coded posts overall and comprised fear of professional dismissal (n = 623), anticipated cultural incompetence from providers of a different ethnic background (n = 534), and protective family secrecy (n = 412).

Theme 3, temporal negotiation, described deliberate sequencing of traditional and biomedical care by illness phase: crisis-driven biomedical reliance (n = 678), use of traditional modalities to manage medication side effects (n = 456), and ritual-calendar coordination of medication timing (n = 234).

Theme 4, digital knowledge translation, captured the community's function as an informal safety and evidence-sharing infrastructure: crowdsourced herb–drug interaction information (n = 523), participant-generated outcome tracking (n = 467), and intergenerational bridging of scientific and ancestral knowledge (n = 389).

Theme 5, identity preservation, comprised cultural authenticity maintenance (n = 534), resistance to exclusively biomedical framings of distress (n = 412), and diaspora participants' use of traditional healing to maintain connection to their country of origin (n = 298).

DISCUSSION

The predominance of epistemological pluralism in this corpus is consistent with, rather than a departure from, existing accounts of medical pluralism in low- and middle-income settings. Kleinman's (1988) distinction between disease and illness offers one plausible explanation for why participants did not experience holding two explanatory frameworks as contradictory: each framework addressed a different dimension of suffering rather than competing to explain the same one. This pattern echoes findings from Indonesia itself, where a substantial minority of people continue to view spiritual or religious

intervention as an appropriate response to psychological distress alongside biomedical treatment (Perceived causes of mental illness and views on appropriate care pathways among Indonesians, 2021), and mirrors household-level evidence from Uganda showing that care-seeking itineraries are routinely pluralistic rather than sequential-and-exclusive (Babatunde, 2018; Ortiz and Smeltzer, 2024). These parallels should be read cautiously: this study cannot establish whether digital discourse reflects private belief accurately or is itself shaped by the performative norms of the communities observed.

The high rate of concealment from providers (63.0%) sits within, though toward the upper end of, the range reported in the broader complementary and alternative medicine (CAM) disclosure literature, where non-disclosure has been estimated at 23–72% across settings and conditions (Sood, 2016; Zhang and Shen, 2025). The specific drivers identified here — anticipated dismissal, perceived provider unfamiliarity with traditional practice, and family-protective secrecy — closely resemble those reported in a phenomenological study of traditional and complementary medicine disclosure decisions among Malaysian primary care attendees (Salzmann-Erikson and Eriksson, 2023; Ting *et al.*, 2025), and align with survey evidence that trust in the treating clinician is one of the strongest correlates of disclosure (Asatsa *et al.*, 2025; Cors-Cepeda *et al.*, 2025; McCaffrey, 2025). Taken together, these findings suggest concealment is best understood as a rational response to an anticipated relational cost rather than as a marker of poor insight or deliberate deception, though this study cannot determine how accurately participants' anticipations reflected the actual attitudes of the providers they were avoiding.

The temporal negotiation patterns identified — crisis-driven reliance on biomedical care paired with traditional healing during stable periods — resemble the pluralistic, phase-dependent help-seeking documented in a Cambodian case report in which a family moved between a pagoda, a traditional healer, and a psychiatric hospital before arriving at a stable care arrangement (Atikasari, 2026; Shah, Ciszek and Acaf, 2026), and with the parallel systems described among Kenyan patients using both traditional and faith healers alongside, rather than instead of, formal care (Ortiz and Smeltzer, 2024). Collaborative work between Indonesian mental health workers and traditional healers has similarly found that both groups can come to see their roles as complementary rather than competing once communication is established (Babatunde, 2018). These findings should not be read as evidence that ritual-linked medication interruption is clinically safe; they instead point to a coherent patient logic that discharge planning and adherence counselling would need to engage with directly rather than override.

The digital community's role in circulating herb–drug interaction information carries genuine clinical weight, since interactions between herbal preparations and psychotropic medication are pharmacologically well documented rather than speculative. St John's wort, one of the most widely used herbal preparations for mood symptoms, induces cytochrome P450 3A4 and P-glycoprotein activity and carries a recognised risk of serotonin syndrome when combined with SSRIs, SNRIs, or monoamine oxidase inhibitors (Sood, 2016), a risk corroborated by pharmacokinetic reviews describing altered plasma concentrations of numerous co-administered drugs (Ortiz and Smeltzer, 2024; Zhang and Shen, 2025) and by broader reviews of clinically significant herb–drug interactions in other therapeutic contexts (Sood, 2016). This lends credibility to the participants' narrative that peer-shared interaction information prevented harm; at the same time, crowdsourced safety information of this kind is not

professionally vetted, and its accuracy relative to formal pharmacological guidance was not independently verified in this study.

The community's broader function as a peer-support infrastructure is consistent with a growing evidence base on digital peer support in mental health, which has generally reported improvements in engagement, self-management, and personal recovery outcomes (Asatsa *et al.*, 2025; Atikasari, 2026; Shah, Ciszek and Acaf, 2026). This evidence is nonetheless mixed rather than uniformly positive: a recent systematic scoping review found that while clinical and personal recovery outcomes were generally favourable, user experiences varied considerably depending on platform safety, anonymity, and interaction quality (Suparmi *et al.*, 2018). Calls for greater methodological transparency in netnographic health research apply with equal force to this study's own claims about community function, which describe discourse rather than verified clinical outcomes.

The concealment theme, and specifically participants' fear that disclosure would be reduced to a documentation checkbox, speaks directly to a long-standing distinction in the nursing and medical education literature between cultural competence and cultural humility. Tervalon and Murray-García (1998) argued that cultural humility — a lifelong process of self-reflection and redress of power imbalance — addresses a gap that static, checklist-based cultural competence training leaves open, a distinction subsequently elaborated as a call to treat the two as complementary rather than as rival frameworks (Salzmann-Erikson and Eriksson, 2023) and extended into community-based practice contexts (Greene-Moton & Minkler, 2020). The present findings suggest that psychiatric nursing assessments framed around eliciting a checklist of "cultural beliefs" may inadvertently reproduce the very dynamic participants said they were avoiding.

Resistance to exclusively biomedical framings of distress, and the description of traditional healing as protecting rather than threatening identity, resonates with collaborative accounts from Indonesian mental health services in which healers and clinicians came to describe their work as harmonising rather than merging two knowledge systems (Setiyawati et al., 2025), and with the national policy shift acknowledging traditional healers as a legitimate part of the Indonesian care landscape following earlier epidemiological work on help-seeking (Diniyati *et al.*, 2024). Broader transcultural psychiatry scholarship has likewise called for greater attention to indigenous explanatory frameworks and healer perspectives in shaping culturally valid diagnostic language (Wijaya *et al.*, 2017). These parallels support treating identity-protective healing choices as a therapeutic resource to be engaged rather than as a barrier to be corrected, while recognising that this study cannot determine whether such engagement changes clinical outcomes.

Limitation

Diaspora participants' description of traditional healing as a means of maintaining connection to a cultural homeland is consistent with transcultural psychiatry literature linking cultural identity, acculturation stress, and mental health among migrant populations (Hartanti *et al.*, 2023), and with clinical guidance that cultural identity assessment should form part of routine transcultural psychiatric evaluation (Ortiz and Smeltzer, 2024). A recent scoping review of culturally adapted mental health education programmes for migrant populations similarly found that interventions incorporating

traditional and indigenous healing knowledge were viewed as more acceptable by participants than education delivered through a purely biomedical frame (Asatsa *et al.*, 2025). Several limitations qualify these findings: the netnographic design relies on self-reported, unverifiable demographic and clinical detail; the four communities studied likely over-represent digitally literate, predominantly female participants relative to the broader population negotiating traditional and psychiatric care; the cross-sectional observation window cannot establish how integration patterns change over an individual's illness course; and paraphrasing quotations to protect participant privacy, while ethically necessary, may have softened some of the original nuance. The findings are also drawn from Indonesian-language, largely Muslim-majority cultural contexts and should not be assumed to transfer directly to other traditional healing systems. None of this changes the central clinical implication: what looks, on a medication chart, like silent non-adherence is often a fully reasoned, actively managed second health system — and psychiatric nursing's task is not to dismantle it, but to finally be let in.

CONCLUSIONS

This study demonstrates that the integration of traditional healing with psychiatric treatment in Indonesia is not an incidental or peripheral behaviour but a structured, patient-managed system of parallel care embedded within cultural identity and everyday decision-making. Rather than reflecting poor adherence, the widespread concealment of traditional healing practices from clinicians underscores persistent relational and cultural barriers within psychiatric services. Digital mental health communities have simultaneously emerged as influential spaces where individuals negotiate therapeutic decisions, exchange experiential knowledge, and monitor perceived treatment safety beyond formal healthcare settings. These findings extend current understandings of medical pluralism by showing that traditional and biomedical care are actively coordinated rather than viewed as mutually exclusive alternatives. For psychiatric nursing, culturally responsive assessment should move beyond documenting complementary medicine use toward fostering psychologically safe conversations that legitimise patients' explanatory models and facilitate disclosure without fear of judgement. Recognising traditional healing as a visible component of the care pathway has the potential to strengthen therapeutic alliances, improve medication safety, and support person-centred psychiatric care in culturally diverse settings. Future research should evaluate whether integrating culturally humble disclosure frameworks into routine psychiatric nursing practice improves communication, treatment engagement, and clinical outcomes across pluralistic healthcare systems.

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Conflict of Interest

The author declares that there is no conflict of interest in the preparation and publication of this article.

REFERENCES

Asatsa, S. *et al.* (2025) "Regulating community well-being through traditional mourning rituals: Insights from the Luhya People of Kenya.," *Evolution, medicine, and public health*, 13(1), pp. 140–150. Available at: https://doi.org/10.1093/emph/eoaf012.

Atikasari, H. (2026) "Care-full negotiation of hospital discharge and end-of-life care in an Indonesian palliative care unit.," *Medical anthropology quarterly*, 40(2), p. e70049. Available at: https://doi.org/10.1111/maq.70049.

Babatunde, A. (2018) "The efficacy of traditional cultural practices in the rehabilitation of victims of torture in Nigeria's Niger Delta.," *Torture : quarterly journal on rehabilitation of torture victims and prevention of torture*, 28(3), pp. 46–62. Available at: https://doi.org/10.7146/torture.v28i3.111184.

Cors-Cepeda, X. *et al.* (2025) "Integrating traditional and modern Practices: Qualitative perspectives from mental health professionals in Mexico.," *Complementary therapies in clinical practice*, 60, p. 102003. Available at: https://doi.org/10.1016/j.ctcp.2025.102003.

Diniyati, D. *et al.* (2024) "Household resilience of women migrant worker sellers of Jamu Gendong.," *F1000Research*, 13, p. 25. Available at: https://doi.org/10.12688/f1000research.142709.3.

Eriksson, H. and Salzmann-Erikson, M. (2017) "The digital generation and nursing robotics: A netnographic study about nursing care robots posted on social media.," *Nursing inquiry*, 24(2). Available at: https://doi.org/10.1111/nin.12165.

Hartanti, D. *et al.* (2023) "The standardized Jamu pahitan, an Indonesian antidiabetic formulation, stimulating the glucose uptake and insulin secretion in the in-vitro models.," *Heliyon*, 9(3), p. e14018. Available at: https://doi.org/10.1016/j.heliyon.2023.e14018.

Kusuma, W.A. *et al.* (2022) "Bipartite graph search optimization for type II diabetes mellitus Jamu formulation using branch and bound algorithm.," *Frontiers in pharmacology*, 13, p. 978741. Available at: https://doi.org/10.3389/fphar.2022.978741.

McCaffrey, G. (2025) "Nursing and Pluralism: The Work of Michel Serres.," *Nursing philosophy : an international journal for healthcare professionals*, 26(2), p. e70017. Available at: https://doi.org/10.1111/nup.70017.

Ortiz, C.E. and Smeltzer, S.C. (2024) "Utilization of traditional healing practices from Mexico by U. S. women of Mexican origin: A systematic review.," *Explore (New York, N.Y.)*, 20(5), p. 102997. Available at: https://doi.org/10.1016/j.explore.2024.04.001.

Osborne, A. (2026) "Embracing Pluralism: Rethinking Western Psychiatric Models for Equitable Global Mental Health.," *Culture, medicine and psychiatry*, 50(1). Available at: https://doi.org/10.1007/s11013-025-09966-9.

Quimbo, S. and de la Torre Parra, L. (2024) "Ancestral healing rituals and the significance of Taky

Samy in andean spirituality.," *Explore (New York, N.Y.)*, 20(6), p. 103075. Available at: https://doi.org/10.1016/j.explore.2024.103075.

Salzmann-Erikson, M. and Eriksson, H. (2023) "A Mapping Review of Netnography in Nursing.," *Qualitative health research*, 33(8–9), pp. 701–714. Available at: https://doi.org/10.1177/10497323231173794.

Shah, M., Ciszek, E. and Acaf, Y. (2026) "Minority Stress in Digital Contexts: Emotional and Cognitive Patterns in Transgender Health Discourse on Reddit.," *Health communication*, pp. 1–12. Available at: https://doi.org/10.1080/10410236.2026.2625295.

Sood, A. (2016) "The Global Mental Health movement and its impact on traditional healing in India: A case study of the Balaji temple in Rajasthan.," *Transcultural psychiatry*, 53(6), pp. 766–782. Available at: https://doi.org/10.1177/1363461516679352.

Suparmi, S. *et al.* (2018) "Natural occurrence of genotoxic and carcinogenic alkenylbenzenes in Indonesian jamu and evaluation of consumer risks.," *Food and chemical toxicology : an international journal published for the British Industrial Biological Research Association*, 118, pp. 53–67. Available at: https://doi.org/10.1016/j.fct.2018.04.059.

Ting, R.S.-K. *et al.* (2025) "Decolonizing mental health practice through traditional healing frameworks: Insights from Canada, China, Singapore, and the United States.," *The American psychologist*, 80(4), pp. 630–642. Available at: https://doi.org/10.1037/amp0001386.

Widyowati, R. and Agil, M. (2018) "Chemical Constituents and Bioactivities of Several Indonesian Plants Typically Used in Jamu.," *Chemical & pharmaceutical bulletin*, 66(5), pp. 506–518. Available at: https://doi.org/10.1248/cpb.c17-00983.

Wijaya, S.H. *et al.* (2017) "Metabolomic Studies of Indonesian Jamu Medicines: Prediction of Jamu Efficacy and Identification of Important Metabolites.," *Molecular informatics*, 36(12). Available at: https://doi.org/10.1002/minf.201700050.

Zhang, L. and Shen, T. (2025) "Identity negotiation on the LIHKG platform: a grounded theory study of Mainland Chinese immigrants' adaptation to Hong Kong society.," *Frontiers in psychology*, 16, p. 1643942. Available at: https://doi.org/10.3389/fpsyg.2025.1643942.