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Article

Breaking Boundaries: Complementary and Alternative Medicine Provider Framing of Preventive Care

Qualitative Health Research
1–12

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Vinita Agarwal[1]

Abstract

This textual examination extends understandings of *how* complementary and alternative medicine (CAM) providers constitute preventive care in their discourse by identifying the frame of *breaking boundaries* referencing relational, structural, and philosophical orientations in their practice with their clients. Analysis of semistructured, in-depth interviews with CAM providers (n = 17) reveals that the frame of *breaking boundaries* was comprised of three themes: finding one's own strength; I don't prescribe, so I'm exploring; and ground yourself, and have an escape route. The themes describe preventive care by identifying how CAM providers negotiate their relational positionality in connecting with clients, structural positionality within the field of health care, and philosophical positionality within the ontological understandings that guide how health is defined and conceptualized. The study contributes toward enhancing diverse understandings of constituting preventive care in practice and suggests pragmatic implications for addressing biomedical provider communication with their patients seeking CAM care alongside conventional treatments.

Keywords

complementary and alternative medicine (CAM), preventive care, CAM provider communication, theme analysis, frame analysis, patient–provider relationship, [AQ2] North America

The increasing use of complementary and alternative medicine (CAM) among patients in the United States has foregrounded the need for greater understanding of communication and collaboration between physicians and CAM providers (Ben-Arye, Scharf, & Frenkel, 2007). A lack of physician emphasis on idiopathic behaviors, patient-centered communication, and preventive medicine in the biomedical relationship accounts for CAM use nondisclosure among patients (Faith, Thorburn, & Tippens, 2015). Although preventive approaches have been successfully implemented in some areas of integrative medicine practice (e.g., in palliative and rehabilitative care), there is a need for furthering open communication between CAM and biomedical providers and shared decision making of CAM options between patients and biomedical providers. When combined with conventional medicine, a preventive care ethos and an empowering patient relationship emphasized by CAM offers the potential for improved patient outcomes (Katz & Ali, 2009). A substantive body of research has examined the challenges of integrating preventive care and CAM use from the biomedical provider perspective, yet *how* CAM providers present preventive care in their modalities is poorly understood. [AQ3]

Understanding CAM provider perceptions on preventive care can help illuminate communicative pathways in integrative medicine by supporting biomedical provider framing of CAM use in their patient communication and identifying elements of preventive medicine that support their patients' individual health needs. Integrative medicine incorporates the emphasis of holistic medicine on somatic, emotional, and spiritual health as integral to achieving overall health (Goldstein, Sutherland, Jaffe, & Wilson, 1988). The strengths of integrative medicine include diminishing the negative effects of conventional treatments (e.g., cancer; Frenkel & Cohen, 2014), helping cope with chronic care conditions (e.g., chronic pain; Rosenberg et al., 2008), and providing a more compassionate approach (e.g., palliative care; Kozak et al., 2008). Challenges facing integrative medicine have been noted as collaboration,

[1]Salisbury University, Salisbury, Maryland, USA

Corresponding Author: [AQ1]
Vinita Agarwal, Department of Communication Arts, Fulton School of Liberal Arts, 272 Fulton Hall, Salisbury University, Salisbury, MD 21801, USA.

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legitimacy, consistency, and unification (Geist-Martin, Bollinger, Wiechert, Plump, & Sharf, 2016). Integrative medicine has been critiqued for constructing an idealized biopsychosocial approach to provider–patient relationships (Smith, Fortin, Dwamena, & Frankel, 2013) further complicated by conflicting understandings of spiritual health in biomedicine (Scheurich, 2003). Assimilating different understandings and communicative pathways of health care culture, education, and delivery for conventional and CAM providers can help meaningfully achieve integration of diverse medical approaches in ways that benefit the patient and lead to enduring health outcomes (Dutta, 2007; Ramadurai, Sharf, & Ramasubramanian, 2016).

In this study, I examine CAM provider discourse on preventive care to contribute to understanding CAM provider–patient relationships and furthering communication of CAM utilization in biomedical settings. The findings illuminate how CAM providers describe preventive care in their practice through the overarching frame of *breaking boundaries* comprising themes referencing relational, systemic, and philosophical orientations and address communicative barriers in biomedical provider perception of their patients' CAM use.

CAM Provider Communication

CAM approaches conceptualize health as a state of balance of mind, body, and the environment and focus on disease prevention and health promotion. CAM approaches have a predominantly preventive ethos and maintain health in the human body by conceptualizing disease as the earliest stage of imbalance before the manifestation of symptoms. The discourse surrounding CAM seeks to articulate its identity and positionality with respect to conventional medicine as exemplified by discursive shifts, such as from CAM to complementary and integrative medicine (CIM; alternative to integrative)[AQ4]. Preventive approaches evoke a proactive individual; one who engages in active monitoring of his or her health and in maintaining balance in the body. Thus, it positions the patient as engaged, interested, and involved in their health care. Preventive medicine (encompassing primary, secondary, and tertiary prevention) seeks to protect, promote, and maintain health and well-being and to prevent disease and disability and is central to the CAM ethos. Communication scholars examining challenges faced by CAM providers have found authenticating and integrating as central practices in CAM provider communication (Geist-Martin & Bell, 2009) or have critiqued how integration is performed through talk and enactment of particular social personae (Ho, Lalancette, & Leung, 2015). Others have examined how CAM providers privilege a paternalistic or collaborative relationship with patients (Ho & Bylund, 2008).

Successful construction of integrative medicine is predicated on health care providers from diverse disciplines and medical systems working together to achieve positive outcomes. The trend toward integrative medicine is facilitated by an increasing utilization of CAM approaches alongside clinical care and a greater patient involvement in the integration of CAM use with their care (Cvengros, Christensen, Hillis, & Rosenthal, 2007). For example, patient satisfaction is rated higher than physician technical skills as an indicator of quality of care (Bartlett et al., 1984), an assessment that recognizes the centrality of relational communication skills beyond conventional medical training. The lack of clarity on the discursive strategies employed by CAM providers, particularly in the realm of preventive medicine, is reflected in the ambiguous and contradictory location of CAM providers in the health care continuum. This confusion serves to distract and impede the collaborative and partnership model envisaged for integrative care coordination for patients. Consequently, understanding CAM providers' framing of preventive care in their practice fills an important gap in supporting the responsiveness of integrative practices. Increasing control exerted by patients over their health care options and therapeutic decision-making process has supported the emphasis on the holistic ethos of CAM (Bondurant et al., 2005). This is particularly notable as patients seek to incorporate an active, wellness-oriented lifestyle that includes preventive care. Moreover, individuals who assume greater control of their health are more likely to spend time actively researching therapeutic options from scientific studies, professional input, and the lived experiences of self and others (Dutta-Bergman, 2004).[AQ5]

Effective provider communication with patients about their use of CAM treatments alongside biomedical care is important for the practice of integrative medicine. Findings report an increase in satisfaction and clinical outcomes with patients using a range of integrative medicine therapies (Scherwitz, McHenry, Wood, & Stewart, 2004). CAM use is associated with clients reflecting a diversity across criteria such as income (Alwhaibi & Sambamoorthi, 2016), age, gender, and health status (Cramer et al., 2016), multiple chronic conditions (Falci, Shi, & Greenlee, 2016), and cancer survivorship (John et al., 2016). In constructing patient-centered care, providers are called to respect individual patient preferences, reduce distress, and improve quality of life and clinical outcomes in a diverse patient body. Communicative elements such as establishing trust, gathering information, addressing patient emotions, and assisting patients in making informed decisions about care influence patient-centered care through perceptions that common ground was achieved with the physician

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(Frenkel & Cohen, 2014; Stewart et al., 2000). As CAM use increases, the need for effective provider communication in constructing a patient-centered model of care privileging open communication becomes more important.

Furthermore, conceptualizing effective patient-centered care foregrounds the need to address critiques of a health care system where delivery is perceived as hurried, uncoordinated, and impersonal (Ho & Bylund, 2008). Biomedical provider effort to address patient needs in the psychosocial and spiritual domains is increasingly recognized as an important component in the delivery of care (Frenkel & Cohen, 2014). CAM practitioners provide an example of patient-centered communication with their focus on the therapeutic relationship in the provision of care.[AQ6]

With increasing use of CAM in a range of pathological domains, there is a need for further research on provider communication with patients to promote egalitarian decision making when discussing the protocol of care. In the domain of cancer treatments, for example, cancer survivors who had unmet psychosocial needs are more likely to use CAM (Campo et al., 2016). Many cancer patients continue to experience pain, fatigue, and cognitive dysfunction after treatments (Mustian, Sprod, Janelsins, Peppone, & Mohile, 2012). Common emotional reactions including anxiety, depression, anger, and fear, alongside untreated mood disorders negatively affect the patient's quality of life, pain management, and response to chemotherapy (Barg et al., 2007). Thus, it is important for providers to be able to listen, provide encouragement and hope, and cultivate an ability to convey empathy and compassion in assisting patients make decisions with respect to integrating CAM with oncology care (Scherwitz et al., 2004). However, in emphasizing the need for greater research on patient–doctor communication about CAM use in the oncology domain, Oh et al. (2010) find that a substantial proportion of cancer patients do not discuss their use of CAM with their oncologists. Notably, patients who do discuss the use of biologic CAM with their oncologists report greater satisfaction with their consultation. A greater understanding of CAM provider perspectives on preventive medicine can enhance biomedical provider communication regarding their patients' CAM use and improve communication between providers from the biomedical and CAM systems of practice in coordination of patient care.

In chronic care conditions, challenges facing effective provider–patient communication on CAM use include provider reservations on the use of CAM, skepticism, lack of scientific rationale, and fear of CAM. Lack of physician knowledge of interactions with conventional drugs has also been noted as a significant concern (Bahrami, Hamedi, Salari, & Noras, 2016). Thus, research on the relative effectiveness or noneffectiveness of therapies such as bee sting therapy, reflexology, ginkgo biloba, fish oil, Cari Loder regimen, and magnetic therapy has been conducted in designing multiple sclerosis treatment regimens (Yadav et al., 2014). Others have investigated the appeal of CAM use in specific populations such as veterans with chronic noncancer pain (Denneson, Corson, & Dobscha, 2011). Greater perception of disease severity in patients has been found to be associated with greater CAM use, with comorbidities or disease burden being a limiting factor (Joubert et al., 2010). Effective integration of CAM use can be furthered by understanding how the biomedical provider–patient relationship can support communication of their patients' CAM use and of preventive medicine as practiced by CAM providers.

Provider–patient communication is central to the conceptualization and implementation of effective integrative care. For effective integration of CAM use, there is a need for aligning understandings of preventive medicine from the perspective of different professionals (CAM or allopathic) involved in patient care and in aligning provider construction of preventive medicine with their patients (Hollenberg, 2006). Although CAM approaches are seen as culturally acceptable, affordable, and sustainable in realms such as birthing practices, this acceptance is not without contradictions (Agarwal, 2017; Ho, Cady, & Robles, 2016; Hollenberg, Zakus, Cook, & Xu, 2008). A lack of acceptance and nuanced understanding of CAM approaches by conventional providers positions CAM and conventional medicine as parallel realms of practice, thus challenging the design of a coordinated continuum of care tailored to meeting individual patient needs (Bauer-Wu, Ruggie, & Russell, 2009).

A lack of provider interest, knowledge, scientific support, and skills are found to be the greatest barriers to engaging in meaningful conversations with patients about treatment options (Chao et al., 2008; McCall, Ward, & Heneghan, 2015). Physician indifference to or opposition of CAM and patient anticipation of negative physician responses toward CAM use have also been noted as a barrier (Barrett, 2004). Other barriers impeding the effective practice of integrative medicine include a lack of guidelines for integration processes, inadequate resources, and a lack of provider education about efficacy of CAM modalities (Neri, Beeson, Mead, Darbari, & Meier, 2016). Furthermore, the ability of physicians to make referrals to CAM practitioners (but not vice versa), an inability of CAM practitioners to directly document in the patients' medical records, restricted rights of CAM practitioners in access to biomedical testing, and dominance of conventional biomedical terminology in provider interactions continue to pose challenges (Bauer-Wu et al., 2009).[AQ7]

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Table 1. CAM Provider Characteristics (Self-Reported).

Provider Characteristics	No. of Participants
Gender	
Male	8
Female	10 (one recording discarded due to unusable audio)
Age (years old)	
20–30	1
31–40	2
41–50	4
51–60	6
61–70	4
Type of practice	
Self-employed (own practice, no. of years)	14 (total)
0–5	3
6–10	3
11–20	1
21–30	1
31–40	3
41–50	1
Did not provide	3
Employed for wages (no. of years)	3 (total)
0–10	2
30–40	1
Education	
High school graduate/diploma	2
Some college/bachelor's degree	7
Master's degree	3
Doctorate degree	5
Race/ethnicity	
White	16
Hispanic or Latino	1
Asian	1
Marital status	
Married/domestic partnership	11
Divorced/separated	2
Single/never married	4
Widowed	1
Religious affiliation	
Christian	5
Jewish	1
Buddhist	1
Spiritual	6
No affiliation	5

Note. CAM = complementary and alternative medicine.

Research findings address some of these barriers from the allopathic perspective. For example, Frenkel and Cohen (2014) recommend cross training allopathic and CAM practitioners and patients in philosophical principles, treatment approaches, and values to promote mutual understanding and effective communication. Others have proposed frameworks to bridge the CAM practitioner communication gap and improve communication between physicians and CAM practitioners (e.g., Schiff et al., 2011, from Israel). However, this literature is characterized by major gaps including limited research from a U.S.-based perspective and a reliance upon the biomedical provider perspective to understand the barriers and contribution of CAM patient–provider communication in biomedical care. Few studies have examined CAM provider perspectives on preventive care to identify implications for patient–provider relationships in the practice of integrative medicine. To examine CAM practitioner framing of preventive medicine in their practice, this study poses the following research question:

Research Question 1: How do CAM providers frame preventive care in their practice?[AQ8]

Method

Participants

Participants (N = 18, males = 8, females = 10) encompassed a range of modalities (yoga = 4, acupuncture = 4, chiropractic = 5, Reiki = 3, massage therapist = 2, hypnotherapist = 1; average age = 50 years; refer to Table 1 for details). Audio in one participant's interview did not record and had to be discarded (n = 17). Participants distinguished their practice in different ways (e.g., aerial yoga, integrative massage therapist) and reported obtaining a certification (e.g., Bikram Yoga Teacher Training Institute certification) or a degree (e.g., master's in oriental medicine).

Materials

After receiving institutional review board (IRB) approval for the study, data were gathered through in-depth, semistructured qualitative interviews (N = 17, total interview duration = 31 hours and 33 seconds) with CAM providers purposively sampled from practices located in the mid-Atlantic region of the United States. This study reports on a section of the data. Interviews ranged from 48 minutes, 53 seconds to 2 hours, 16 minutes, 23 seconds, with average interview duration of 2 hours and 12 minutes. Interviews were conducted on site at participant offices or practices. Participants were both provided and read a copy of informed consent and consent was recorded on tape. The semistructured interview protocol was guided by key discursive areas in CAM practitioner discourse (e.g., prevention, holistic, health, wellness). This study focuses on part of the data, with a focus on

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examining the prevention frames as utilized by CAM practitioners in their interviews. Interviews were transcribed by a professional transcriptionist agency resulting in a total interview data of 1,272 double-spaced pages. The researcher spot checked random sections of the completed transcripts against the audio recordings for accuracy and assigned participants pseudonyms to preserve anonymity.

Procedure

As an analytical framework, the framing paradigm is useful for the examination of health communication messages as these are constructed and presented for key audiences (Hallahan, 1999). The study is guided by Hallahan's (1999) model for framing of (a) situations (relationships among people as contextualized within the situation), (b) actions (framing the most desirable option among others), (c) issues (how to think about an issue, its concerns, and solutions), and (d) responsibilities (attributing responsibility).

Frames are patterns that guide perceptual recognition of events or issues (e.g., audience frames; Kline, 2006). As a pattern for making sense of the world (Gamson, Croteau, Hoynes, & Sasson, 1992), a frame can be defined as the "principles of organization that govern events [and] our subjective involvement in them" (Goffman, 1974, pp. 10–11). Frames can be embedded in text in the use or selection of specific words, images, facts, and presentation of sources of information or judgments, evaluations, and perspectives (Entman, 1993). Framing is based on the premise that the manner in which an issue is characterized and presented in discourse (stories, anecdotes, perspectives) plays an important role in how it is understood by its audiences (Scheufele & Tewksbury, 2007). Traditional message framing in health communication research has examined gain and loss frames (O'Keefe & Jensen, 2007), the present study extends this research to identify the frames utilized by CAM practitioner discourse on primary prevention.

Participant discourses examining prevention were read through and coded with memos being made on the margins. In subsequent passes through the data, the codes were collapsed into categories and examined for larger patterns. The categories were further synthesized into broader themes illuminating patterns and read through to eliminate redundancies. The researcher examined the key themes to identify the overarching frame employed in CAM practitioner discourse to present the issues, actions, behaviors, and challenges surrounding prevention.

Findings

The study sought to understand how CAM providers framed preventive care in their discourse. The frame of *breaking boundaries* was constituted of three themes in CAM provider discourse: (a) finding one's own strength, emphasizing the relational orientation; (b) I don't prescribe, so I'm exploring, emphasizing the structural orientation; and (c) ground yourself, and have an escape route, emphasizing the philosophical orientation.

Together, the themes illustrate the overarching frame of *breaking boundaries* in CAM provider discourse on preventive care, with implications for the relational, structural, and philosophical orientations for patient–provider communication in biomedical practice.

Finding One's Own Strength

The theme "finding one's own strength" references how CAM practitioners utilized practices enabling patients to prevent and resist disease on their own through emphasizing their relational orientation. This theme illustrates how practitioners sought to find ways of identifying practices that privileged prevention and resistance to disease. For example, Bob, an acupuncturist, described what he said to his clients: "no one is taught to think about prevention . . . [or to do] anything to resist disease." As Bob noted, "so what happens is, we go along and then when we get sick . . . [then] we seek someone for the remedy and remediation." His conversation framed *how*, in his practice, he sought to break from these boundaries in conventional health care relationships through cultivating relationships premised on building strength to help his clients resist disease and find their own strength in constituting healing.

Max, a hypnotist, described how he employed innovative approaches in his relationship with his clients that were distinct from the conventional health care relationship: "If someone walks through my door wearing a hat made of tin foil telling me that he's been abducted by aliens, I don't have to deal with diagnosing that." Instead, as a CAM provider, Max found he could help his patients find their own strength through constructing a relationship that empowered his clients: "I can deal with the stress of what this person's feeling. Come on, let's sit down, we'll talk about it." The frame of *breaking boundaries* was illustrated by Max as he noted his approach as a CAM provider gave him "a clear advantage of not being required to put people in these very standardized diagnoses, these boxes if you will." Thus, Max's discourse illustrated how he sought to constitute healing in his clients through cultivating relationships that were not constrained by the standard diagnoses and processes required of conventional providers.

Carly's discourse revealed how she took inspiration from the Japanese way of life in her practice. Describing her time in Japan, she recounted how "they had a loud speaker that comes along, you know. You are at work and

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it says, 'okay time, time to exercise,' . . . so you put everything down and you do Y exercises." As Carly specialized in acupuncture, her challenge was to help her clients get to a point where they could continue their healing journey on their own. With her clients, Carly found that the "pattern is to expect to see someone about nine visits; Chinese love nine . . . and then drop back to once a month." She had "plenty of experience where someone will come in one time, and they won't come back." In her relationship with her clients, she sought to reinforce the importance of continuing their sessions without dropping out. Because change in health and healing was often intangible and required her clients to keep up their commitment with the appointments and practices, Carly drew on the strength of her relationship with her clients to achieve results by empowering her clients to take control of their own health outcomes. In the theme "finding one's own strength," CAM providers identified practices that empowered clients to resist and seek to remedy their condition and illustrated the frame of *breaking boundaries* by emphasizing distinctions in their relational orientation.

I Don't Prescribe, So I'm Exploring

CAM providers identified practices that promoted prevention through unconventional methods of restoring health and wellness without resorting to medications to illustrate the frame of *breaking boundaries* by emphasizing the distinctions in their structural orientation. Phillip, a chiropractor, sought to "find a way to restore health wellness without resorting to medications or pharmaceuticals." In doing so, he explored through conducting "quite a bit of laboratory testing . . . I routinely send patients for vitamin D testing and I find vitamin D deficiencies epidemic in this area." As a chiropractor, Phillip was concerned that even though he would himself check in with the patients' laboratory to see "what the patients had been routinely sent for in terms of laboratory and I almost never see B12 testing, vitamin D testing." He gave an example of a test for cardiovascular disease called a high sensitivity c-reactive protein and found "problems routinely on those tests that certainly could be run by the patient's primary care physician or specialist, but they are just not." Similarly, he noted that vitamin D levels should be checked "for optimal immune system function, which is like we know, is critical for fighting infectious disease, for general health, for your body eliminating cancer cells."

For Phillip, "the fact that my medical colleagues don't as much [as] I do emphasize the importance of looking at those sorts of things as opposed to just doing a complete blood count" differentiated him from his colleagues. His creative approach would help him "occasionally find a problem." Phillip's creative approach helped him with "problems that again can be dealt with in a nondrug treatment fashion." Ultimately, his approach illustrated the frame of *breaking boundaries* as he described how he didn't "really feel too handicapped by not being able to prescribe." In fact, for Phillip, his professional credibility was enhanced as "because I don't prescribe, I am exploring [a]reas of health that unfortunately may be through . . . lack of felt need [or] the patient's doctor or MD is not looking in the direction that I tend to routinely look." Thus, "they are missing a lot of things that I may be finding as result."

The challenge of not prescribing referenced structural constraints. Karl, a chiropractor, said, "our main focus is preventing the problems, so [when] people come to me when they are in pain, [t]he problem is too late to prevent at that point." As prevention was his main goal, "so we fix them and then tell them it's up to them, you know, my goal is to keep them from coming back and that's why I tell them, as you know, it's up to you." He tells his clients that "you can schedule an appointment and not show, or you can just not schedule an appointment. Either way, my goal is to keep you out of pain." Karl's discourse illustrated the frame of *breaking boundaries* as he felt a challenge of prevention was the awareness that: "it's up to you [the patient], you know, I can't make them make keep their appointments once they are out of pain." He provided his own strengths and limitations to his clients to increase awareness: "I worked with a lot of people with hip flexor issues and it comes across as lower back. They can't stand up straight." Karl noted, "when they sit for a period of time and they get to stand up they can't stand up straight . . . [and] they have to walk around [all bent] that's a muscular problem. I treat that." Advocating preventive practices, Karl asks his clients to "get comfortable and go to sleep with your arm up the pillow . . . [rather] than on your stomach [where they're] tearing the discs up in their neck." Although he can treat some issues, he encourages his clients to recognize the importance of preventive care by presenting his limits: "if you tear your discs up from sleeping on your stomach, I can't really—there's only so much more I can do with that."

Coordination of care and definition of boundaries was ambiguous even within CAM modalities. Sometimes, Karl's clients would consult a CAM provider not appropriate for their structural problems: "I get a lot of athletes who are either . . . adults who run competitively or kids who play lacrosse and they . . . may get hit in a certain way that knocks their rib cage out." He tells his clients, "if it's an alignment problem . . . you're going to feel better, but you're not going to get back to where you want to be," whereas massage might benefit others who have a structural and muscular problem. Karl emphasized, "I'm not saying; don't go to a physical therapist, don't go to massage therapy, go; knock yourself out, but if it only gets you so much better . . . that's when you need to look for something more." He felt he was "just empowering people to know that they can prevent things. You know, that it is, you know, it isn't fate."

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CAM providers sought to empower through awareness that there was not "some genetic fate that's going to determine that they get heart disease, all this major cancer." For Karl himself, that meant working on "preventing like future issues, because I did have a tumor." As a cancer survivor, he changed his diet, "to prevent the formation of any other like cancers," which also helps Karl with "heart disease prevention and weight management." Others enabled the patient to be in control of his or her own wellness destiny through providing him or her a mechanism to be healthy. Catherine, a Reiki practitioner, said "yes there are definitely chemical imbalances in people that need medicine. That is very true . . . but not something that you want to do for the long term." For Catherine, the primary preventive care ethos must be privileged in constituting health. Health "has to come from, you know, your family, your faith, you know it's, it takes a village" such that "preventive is providing a method for a person to allow their body to be as healthy as possible" through community, faith, or lifestyle structures. In the theme "I don't prescribe, so I'm exploring," CAM practitioners focused on healing by exploring innovative practices and illustrated the frame of *breaking boundaries* by addressing challenges through emphasizing their structural orientation.

Ground Yourself, and Have an Escape Route

The theme "ground yourself, and have an escape route," references how CAM providers focused on the invisible (the breath, spirituality) and the visible (physicality) to achieve balance and how CAM providers worked to establish their philosophical identity. This theme illustrates how providers sought to emphasize practices connecting the invisible with the visible through their philosophical orientation. Catherine, a Reiki practitioner, emphasized to her clients that the invisibility of the energy in the breath offered perceptible health benefits through empowerment: "understanding that you have control . . . through the breath. The breath is a very important thing about Reiki." Thus, for Catherine, prevention meant "learning to be aware of what is the right the way to breathe, what is the right way to eat." Besides maintaining one's health, Catherine described prevention as "an alternative way of being able to ground yourself. And to have an escape route." By grounding themselves through a philosophical awareness of how controlling the breath allowed clients to constitute health and wellness, Catherine sought to break boundaries with the mind–body dichotomies followed by conventional medicine.

Halen, a Bikram yoga instructor, sought to ground his patients through the practice of yoga. His clients try physical therapy (PT) and then they "come in here and they take a class and it feels ten times better than the physical therapy thing." For Halen, "Western medicine is not so good . . . like the diabetes, the overweight, like heart disease and I think they just kind of prescribe you medicine and you chew away." Halen's discourse illustrated the frame of *breaking boundaries* through taking ownership of one's own health: "there's way more things you can do physically to help yourself out" in preventing health conditions through breaking from the traditional approach and taking ownership of one's own health. Carly's discourse illustrated the frame of *breaking boundaries* differently: "an interesting woman, who came in with very serious symptoms, and she was 45 or so . . . had been on one medicine since she was 13 for preventing asthma." In her hour-and-a-half-long intake interview, Carly, an acupuncturist, noted, "she had taken this medicine prophylactically over all these years . . . after we talked and I got her relaxed on the table I came back out." Carly researched the prescription, finding that "every symptom she had . . . was exactly right, as a side effect, was of that drug." Instead of dissuading her patient from trying conventional treatments and risk her message being rejected, Carly handed her "the book, [and said] 'Please read this.' And she was horrified and furious. So . . . I just delivered a message, I was able to show her that problems were being caused by this medicine."

For CAM providers, grounding themselves in their practice drew upon evidence in their field: "the musculoskeletal part, mechanical part, a lot of work has been done on that and . . . they've determined there is some benefit there to a lot of that part of it." Phillip felt his job of adjusting the spine: "the PTs don't do that. We are doing more of it. And especially now that they are seeing doctorate PTs coming out," Phillip felt that would "widen their scope to do more, and that was always a political issue—trying to save the spinal manipulation part or they are not allowed to do it." As Phillip described, "they are rotating people now where they never used to," this also provided him an opportunity: "that has kind of made it easier for me to say, hey, this person can't do a whole lot of this, but they can do this. So can you send him over there." Phillip felt conventional providers "are constrained . . . [although] there are some that are very good and really do take the time to be more holistic with the patients and not just target the main complaint." Thus, Phillip's discourse illustrated the theme of *breaking boundaries* in working through the constraints of his discipline and in empowering his clients to take control of their health. The theme of "ground yourself, and have an escape route" highlights how CAM providers focused on connecting the invisible (spirituality) and the visible (physicality) to achieve balance and

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…."prevent the formation of any other, like, cancers,"

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…"Catherine, a Reiki practitioner, said 'yes, there are definitely…"

negotiated challenges to their professional ethos to illustrate the frame of *breaking boundaries* through emphasizing the distinction in their philosophical orientation.

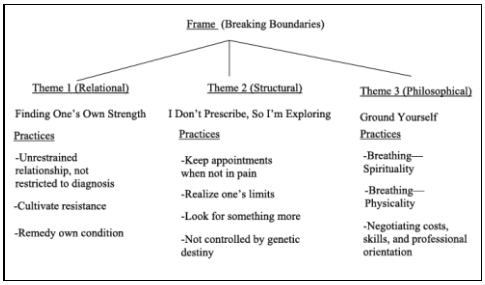

Figure 1. CAM provider framing of alternative medicine in preventive medicine.

Note. CAM = complementary and alternative medicine.

Discussion

The study findings extend understanding of *how* CAM providers constitute preventive care in their discourse. In their discourse, CAM providers employ the frame of *breaking boundaries* referencing relational, structural, and philosophical orientations to describe preventive care in their practice (Figure 1). The frame of *breaking boundaries* comprises the themes of finding one's own strength; I don't prescribe, so I'm exploring; and, ground yourself, and have an escape route. Understood together, CAM providers' discourse emphasizes how the frame of *breaking boundaries* is illuminated through the relational orientation, structural orientation, and philosophical orientation comprising their preventive care practices. CAM provider discourse suggests providers construct their relationship with their clients through finding their own strength, work through the structural constraints of their practice in innovative ways to support healing in their clients, and address the philosophical orientation of their clients through constructing preventive care as a bridge between mind and body for their clients.

The first theme describes preventive care as finding your own strength. CAM providers employ the frame of *breaking boundaries* to emphasize the relational orientation of their practice in empowering their clients to find their own strength. To do so, CAM providers identify practices that assist clients in resisting and looking to remedy their condition through their own actions. Building resistance was constituted as healing in the different practices described by CAM providers. CAM provider discourse constructs a relationship where clients were supported in conceptualizing resistance to disease through thoughts and actions that the clients could take on their own through the CAM providers' relational support.

In the second theme describing preventive care, CAM providers employ the frame of *breaking boundaries* to reference their own innovative actions toward addressing the structural aspects of their practice. The theme "I don't prescribe, so I'm exploring" focuses on constituting healing through CAM providers' exploration of innovative practices. As CAM providers did not diagnose or treat conditions through prescription medication and biomedical interventions in their practice, they build upon their strengths to innovate through creative ways in addressing their clients' concerns. This theme demonstrates CAM providers' willingness to be open to new ideas and approaches and, thus, their ability to identify and set up processes in their practice that were not constrained by predetermined structures and protocols.

The third theme, "ground yourself, and have an escape route," highlights the philosophical orientation of CAM providers' approach in their practice. It describes how CAM providers sought to connect the invisible (the breath) and the visible (physicality) to achieve balance from within. This theme illustrates the frame of *breaking boundaries* as CAM providers describe healing as not dichotomous but a continuum encompassing a philosophical orientation that connects the energy (e.g., of the breath) to the physical manifestation of symptoms in the body. This theme describes CAM providers' distinctive belief systems as it was exemplified in the materiality of their practice to constitute preventive care.

The frame of *breaking boundaries* to describe preventive medicine fundamentally emphasizes connecting relationally with clients, the structural processes characterizing the field of health care, and the ontological philosophies that guide how health is defined and conceptualized across diverse knowledge traditions and historical periods. Moreover, the frame of *breaking boundaries* exemplifies the potential of connecting across the differences identified in the three themes to address the challenges facing preventive medicine within the dominant biomedical system of medicine. The challenges facing integrative medicine include conventional provider reservations for the use of CAM because of skepticism, a lack of scientific rationale, and fear of CAM. By illustrating *how* the CAM provider discourse on preventive medicine employs the frame of *breaking boundaries* to describe their approach and how CAM providers address the challenges to their practice through the three themes, the study findings make a significant contribution to how care is conceptualized in integrative medicine.

The skepticism faced by patients seeking CAM utilization alongside their biomedical care is a major deterrent in open communication between biomedical providers and their patients. The findings of this study indicate CAM providers construct the therapeutic relationship in fundamentally distinct relational,

structural, and philosophical ways. A major critique of chronic care patients with the biomedical system has been a hurried and rushed physician encounter that ignores patient concerns and lifestyle in codetermining their treatment protocol. In addition, the physician-dominated model has been critiqued for its inattention to patient nonadherence to treatment protocols or poor quality of life outcomes. The present research finds CAM providers' discourse enlarges this relationship to envisage how building resistance from within the individual is an important aspect in the primary preventive stages. Encouraging patients to conceptualize resistance through dialogue and role modeling to identify stressful factors in their life empowers and builds strength in the individuals through CAM provider support and emphasizes patient quality of life outcomes.

Unification of the different orientations is a crucial challenge facing integrative medicine (Geist-Martin et al., 2016). This harks to the critique of a binary conceptualization of a patient-centered biopsychosocial approach incorporating CAM and conventional medicine (Smith et al., 2013). The second theme identifies the CAM provider discourse frame of breaking (structural) boundaries as comprising CAM providers' efforts to explore innovative ways of keeping their patients out of pain. CAM providers often achieve this by adopting creative approaches to identify factors that conventional medicine might ignore (e.g., laboratory testing for vitamin D deficiency) and that may offer naturalistic ways of treating chronic conditions. Alongside communicating their own limits, CAM providers' emphasis on empowering their clients to address their problems (e.g., as not predetermined by fate or a genetic destiny) is an important entry point for a collaborative and integrative relationship in establishing coordination of care.

The third theme revealed by CAM provider discourse comprising the frame of *breaking barriers* explicates the philosophical orientation of CAM care. What comprises spiritual health has been noted as a concern for physicians (Katz & Ali, 2009). CAM provider discourse emphasizes the invisible markers of health (e.g., the fundamental aspects of breathing) as enhancing both spiritual (e.g., Reiki providers' discourse) and physical (e.g., yoga instructors' discourse) well-being to bring about healing. The theme of grounding yourself philosophically (e.g., through spirituality and physicality) to address patient stress or in the providers' philosophical orientation toward their CAM practice (e.g., through negotiating costs, knowledge, and care territory with conventional medicine) breaks boundaries in two ways. It does so, first, in its definition and conceptualization of health (e.g., as intrinsic and invisible or spiritual), and second, in constructing integration as communicating an overarching philosophical orientation toward their patients and practice. The philosophical orientation offers a third entryway to overcome barriers to integrative medicine in the preventive care continuum.

As an in-depth, semistructured interview-based study of a purposive sample of CAM providers from the mid-Atlantic region, the study contributes toward furthering understandings of CAM provider discourses of preventive care in their practice. Future studies can explore the frame of *breaking boundaries* as constituted through the three themes referencing relational, structural, and philosophical orientations by conducting generalizable studies drawing upon large-scale data sets, by demonstrating the degree to which each theme contributes, and by identifying their constituent dimensions. Furthermore, because the findings draw upon CAM provider interviews, how the themes are constituted in practice could not be examined. Future studies can examine CAM provider interaction with their clients through ethnographic or participant observation to further explicate how preventive care is constituted in practice.

The findings suggest important pragmatic implications in understanding and communicating preventive care to patients for biomedical health care providers. First, biomedical providers can promote open disclosure of CAM use by openness in their relationship with their patients by envisaging health and healing as coming from within the patient. Although treatments and interventions are a central part of biomedical care, an understanding of patient empowerment can further health promotion and disease prevention as well as improve quality of life outcomes by envisaging the patient as a whole, empowered entity who is inherently healthful and in control of their health outcomes. Second, biomedical providers can open communication with their patients' CAM provider to understand how the preventive care approaches undertaken by the CAM provider can affect their patient's quality of life outcomes. Biomedical providers can encourage conversations with their patients on the findings obtained by them in their CAM providers' practice to assist with a more comprehensive and proactive approach to care. Third, biomedical providers can be open to envisaging alternative philosophical systems in their communication with their patients and to support their patients by investigating the efficacy of their integration with pharmacologically based treatments. In doing so, biomedical providers can construct a patient–provider relationship that promotes open communication, disclosure, and connections with their patient's health goals and encourage understandings of preventive care even for patients whose care protocol requires treatment and interventions. Such approaches could support a culture of prevention while achieving the goals of treatment through intervention and pharmacological methodologies when necessary to improve the patient's condition mentally, spiritually, and physically. These criteria

comprise an essential component of an individual's ultimate quality of life outcomes.

In illuminating the CAM provider perspective, the study identifies how the frame of *breaking boundaries* comprising the three themes of finding one's own strength; I don't prescribe, so I'm exploring; and ground yourself, and have an escape route presents preventive care and contributes to furthering communication of CAM utilization in biomedical contexts. The study explicates CAM provider understandings of preventive care to illuminate communicative pathways enhancing the biomedical provider–patient relationship in ways that support the goals of integrative medicine. It is the first to identify the material practices constituting the themes and provide a framework for conceptualizing them based upon the relational, structural, and philosophical orientations constituting CAM practice. The CAM provider discourse identifies how CAM providers shift between relational, structural, and the philosophical orientations in framing preventive care reflecting their positioning in their patients' health care landscape alongside biomedical providers. In doing so, this examination of CAM provider discourse contributes toward an enhanced understanding of alternative modalities by envisaging how preventive care is conceptualized and practiced in Western societies and provides pragmatic implications for addressing biomedical provider communication with their patients seeking CAM care in addition to conventional treatments.

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Author Biography

Vinita Agarwal, PhD is an associate professor in the Department of Communication Arts at Salisbury University.[AQ15]

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