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Re-conceptualizing pain through patient-centred care in the complementary and alternative medicine therapeutic relationship

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Abstract

Aims: The study aim was to understand the patient description of the therapeutic relationship with their CAM provider in the context of pain self-management.

Background: Because pain is a subjective state, its assessment depends on patient perception of and response to pain. For nurses to provide empathetic and compassionate care, there is a need to explicate patient perceptions of the therapeutic relationship to (re)conceptualize models of patient-centred care.

Design: Inductive qualitative content analysis of patient interviews was conducted to identify how patients described therapeutic relationship themes and understand self-management of pain.

Methods: Participants were individuals working with a CAM practitioner and solicited through purposive and snowball sampling in collaboration with the practitioners from the mid-Atlantic region of the United States in 2016 ($N = 13$). Verbatim transcriptions of audio-recorded semi-structured in-depth interviews (430 single-spaced pages approximately) were content analysed.

Findings: Patients described the therapeutic relationship with the provider as a: (1) giver, who was "in-tune" with their sense of self to support self-affirmation through empathetic listening; and (2) guide, who connected the mind and body through their practice to support self-reflective learning.

Conclusion: This description of the CAM therapeutic relationship advances understandings of readjustment of patient relationship with pain through the provider's empathetic listening and connecting the mind and the body to support patient self-affirmation of pain experiences and self-reflective learning. The findings illuminate how a feminist standpoint contributes to understandings of the therapeutic relationship that centres patient subjectivity and co-construction of meaning-making processes to support self-management of pain.

KEYWORDS
complementary and alternative medicine, holistic care, nurses, pain acceptance, pain adjustment, pain self-management, patient-centred care, providers, therapeutic relationship

1 | INTRODUCTION

The experience of chronic pain is a subjective construct dependent on genetics, lifestyle and environmental factors. Patients with chronic pain self-manage their conditions in myriad ways and are increasingly recognized in biomedical approaches as their own principal caregivers with nurses playing a supportive role (Cuff, 2013). Wherein biomedical approaches hold the patient accountable for non-adherence or poor lifestyle choices, the patient-centred care (PCC) model holds that patients accept responsibility to manage their own conditions with support from integrative healthcare professional teams (Hsieh, Bruscella, Zannin, & Kramer, 2016). Holistic treatment effects arise from a supportive therapeutic relationship and patient empowerment seen as a key part of the philosophy of healing employed by complementary and alternative medicine (CAM) providers (Agarwal, 2018; Bann, Sirois, & Walsh, 2010).

Chronic pain, or pain that persists more than 6 months, negatively influences an individual's quality of life, having an impact on sleep, social functioning, family roles, sexual function and the activities of daily living (Jamison & Edwards, 2012). Because pain is a subjective state, its biomedical assessment depends on patient perception of and response to pain and pain-related disability. For nurses to provide empathetic and compassionate care (Maizes, Rakel, & Niemiec, 2009), there is a need to explicate CAM patient perceptions of the therapeutic relationship to (re)conceptualize patient empowerment and control in the healthcare relationship (Barr et al., 2015; Cyril, Smith, & Renzaho, 2016).

Feminist critiques of biomedical care see power as creating a sphere of regulated patient autonomy in structured healthcare relationships (Gastaldo, 1997; Lupton, 1995). The collaborative care paradigm in biomedical care credits patients with expertise equivalent to healthcare providers but limited within the bounds of normative self-management education programmes that promote medication adherence or compliance (Broom & Tovey, 2008; Ho & Bylund, 2008). The present study seeks to understand how patient discourse suggests empowering ways of restructuring pain and integrating the diversity of experiences that define the perception of pain. A myriad genetic, environmental, psychological and cognitive factors uniquely define the individual pain experience (Adams, White, & Beckett, 2010; Coghill, 2010; Jensen & Karoly, 1991); however, understandings of how providers can empower patients to productively self-manage their own pain experience outcomes remain unclear.

About 20% of adults suffer from pain globally and another 10% are newly diagnosed with chronic pain each year making the management of chronic pain a global health priority (Goldberg & McGee, 2011). There is a need for healthcare providers globally to construct an effective model of patient-centred care that provides an effective pathway for addressing the global burden and its comorbid conditions through empowering pain management programmes (Goldberg & McGee, 2011). Understanding how holistic CAM systems (e.g., Traditional Chinese Medicine, Ayurveda, Reiki) emphasize patient autonomy can benefit the clinical consultation (Foley & Steel, 2017; Owen et al., 2010) and patients alike.

Why is this research needed?

- The collaborative care paradigm in biomedicine positions patients within limiting normative self-management education programmes that promote medication adherence and compliance.
- Nurses can serve as a guide in empowering their patients dealing with chronic care symptoms through re-conceptualizing the therapeutic relationship.
- The philosophy of healing employed by CAM providers emphasizes holistic treatment effects centred in the therapeutic relationship and can provide a model of care.

What are the key findings?

- The therapeutic relationship emphasized the providers' being "in-tune" with the patient and connecting the mind with body to facilitate patient self-management of pain.
- Patients described listening in the therapeutic relationship as the providers' being "in-tune" with the sense of self and reintegrating life experiences to facilitate self-management of pain.
- Patients described the self-reflective learning space in the therapeutic relationship as supporting agency by connecting the mind and body to facilitate self-management of pain.

How should the findings be used to influence policy/practice/research/education?

- Healthcare providers should relate with the patient's sense of self and support the mind-body connection to achieve reintegration and self-reflective learning for pain self-management.
- Healthcare education should include communicative strategies to co-construct pain meanings in a self-affirming and learning therapeutic relationship to support patient agency/autonomy.
- Healthcare research should examine the therapeutic relational praxis as a site for facilitating self-management of pain through supporting patient awareness/self-reflective engagement.

2 | BACKGROUND

Health and healing of patients is intertwined inexplicably with subjectivities and discourses of knowledge, power and social relations.

Feminist approaches recognize that dominant medical discourse structures individuals as patients in particular realms even as they are allowed freedom in determining certain choices in their care (Hooks, 2000). Feminist theorizing delves into the rich experiences of the patients to reveal how the individuals themselves suggest ways of constituting health in empowered ways. By foregrounding the patient, feminist theorizing breaks down the boundaries between the provider and the patient and reveals ways these contribute to dependence, domination and disempowerment (Lupton, 1995).

Feminist perspectives attend to autonomy, paternalism and the regulation of the body to focus on questions of equity. The feminist perspective is well-positioned to further a critical dialogue contributing to the integrative healthcare emphasis on empowerment, egalitarian relationships and medical knowledge based on one's bodily experiences (Willard, 2005). Furthering a re-examination of alternative perspectives through a patient lens constitutes an empowering epistemological tool for shaping patient consciousness. This research gives voice to the situated experiences of patients to "reveal the illuminating knowledge claims not only about themselves, but also the. . .nature and social relations" (Harding, 2004, p. 4) in the medical realm of pain outcomes.

By foregrounding patient voices, the poststructuralist feminist approach foregrounds the role of under-recognized voices that are traditionally mediated through the providers' expert position (Dutta, 2007; Willard, 2005). Acknowledging the patients' positionality allows for a constructive critique of how knowledge and control are enacted in the domain of therapeutic health and alternative medicine to constitute healing. Poststructuralist feminist scholarship foregrounds the authenticity of the individual experience and argues for an epistemology of "location, positioning and situating, where partiality and not universality, is the condition of being heard to make rational knowledge claims" (Harraway, 1998, p. 589). By employing a feminist lens, a critique of patient voices in the management of their pain can foreground analytic healthcare spaces as complex and contradictory and imbue the patient–provider relationship with a concern with autonomy and lived experiences. Medical discourse exercises a hegemonic authority by operating within the normative legitimacy of healthcare constructed to articulate "problems" and provide solutions (Foucault, 1972). By foregrounding discourses of the body and the self in the context of power/knowledge in the therapeutic relationship, the study critiques notions of autonomy and authenticity of the individual pain experience in patient empowerment.

3 | THE STUDY

3.1 | Aim

The study aim was to understand the patient description of the therapeutic relationship with their CAM provider in the context of pain self-management.

3.2 | Sample/participants

Individuals currently receiving CAM care and above 21 years of age were solicited through purposive and snowball sampling ($N = 13$) by the researcher in collaboration with therapeutic practitioners. Participants were clients of the CAM practitioners/providers; however as they were being treated for particular health conditions (vis-à-vis for wellness only), they are referenced as patients of the CAM providers in this study. Thus, the sampling criteria emphasized representativeness and first-hand experience with the research focus. Participant recruitment was concluded based on diversity of modalities and data saturation (e.g., repetition of themes and experiences, see Table 1 for participant characteristics). Exclusion criteria included patients who were certified in a CAM modality during treatment.

3.3 | Data collection

Data were collected over summer and fall 2016 from the mid-Atlantic region of the United States in accordance with a semi-structured interview protocol and observation guide (Appendix 1). This method of data collection was selected because of its close alignment with the focus of the study and enhance trustworthiness (Elo et al., 2014). The researcher coordinated a mutually convenient time and location for the interview with the participants. Verbatim transcriptions of the audio recordings of the interview by a professional agency resulted in approximately 430 single-spaced pages of data.

3.4 | Ethical considerations

The study received IRB approval from the author's university (Salisbury University Institutional Review Board). Informed consent was obtained orally and recorded on tape. Patient confidentiality was maintained by assigning a pseudonym. Selected client–practitioner interaction and observation sessions were recorded by the researcher through journaling notes. Documents from selected modalities (e.g., Reiki, essential oil), in-person session observations (approximately 15 hr—e.g., chiropractic, Reiki), artefacts (e.g., flyers, observation notes, patient intake form) and visual documentation (e.g., individual lifestyles artefacts and office spaces) were compiled. The researcher sought to maintain self-reflexivity through careful explication of the researcher's positionality during the interview and in being reflective during the data analysis process (Elo et al., 2014). This study reports findings from a section of the interview transcriptions of the data.

3.5 | Inductive qualitative content analysis

Inductive qualitative content analysis was employed for data analysis (Elo & Kyngas, 2008). The data analysis process was conducted as follows. First, the textual data were synthesized by the author by attending to how patient voices engaged the therapeutic relationship. Further, multiple readings through the data were conducted alongside the compilation of preliminary memos. The line-by-line process of open coding highlighted key concepts (e.g., control,

TABLE 1 Participant summary (total verbatim transcription pages=850, double-spaced pages[b])

	Name/Gender[a]	Age/education/race/marital status/annual family income/health insurance/religion/health condition	CAM modality experienced/no. of years/practitioner name/gender
1	Gabe (F)	44 years/Masters/White/Married/$90,000 a year/has health insurance/Methodist, non-practising/her son has Chiari malformation. She has AMPS (kind of fibromyalgia)—goal is to manage the condition	Acupuncture, 7 years/N (F) (orthobionomy)
2	Tim (M)	78 years/Ph.D./White/Married/>100,000, retired/has health insurance/Methodist, agnostic/musculoskeletal disorders	/40 years, Every 3–4 weeks/B (F) (Chiropractic)
3	John (M)	50 years/White/Married/<50,000/has health insurance/Spiritual, raised Catholic/ADHD, depression	4–5 years/R (F) (Reiki)
4	Sue (F)	69 years/White/Married/$60,000/spiritual seeker/Lyme disease	30 years/Yoga therapy
5	Pam (F)	75 years/Ph.D./White/Widowed/retirement/income/has health insurance/in a religious reading group/surgery for atrial fibrillation	Does all, primarily meditation when started 20 years ago (F)
6	Alex (F)	62 years/Bachelors/White/Married, 40 years/on disability for 9 years/has health insurance/religion—assorted/Lyme disease	Essential oils/D (F)
7	Jane (F)	73 years/some college/White/retired/has health insurance/Methodist/ heart surgery, low back pain	25 years, Chiropractor and acupuncturist/B (F)
8	Mark (M)	65 years/Ph.D./White/Married/$110,000 a year/has health insurance/ Catholic/chronic pain	About 3 years, every 2–3 weeks. Orthobionomy/N (F)
9	Kate (F)	57 years/College/White/Married/$100–150,000 a year/has health insurance/Christian/breast cancer survivor for past 10 years/ daughter had craniosynostosis	Daily, 3 years/her chiropractor/T (F)
10	Brie (F)	41/3 years college/white/pending divorce/>$100,000/has health insurance/ Methodist/musculoskeletal disorders	About 8 months, every 6 weeks. Orthobionomy/N (F)
11	Kim (F)	56 years/married/$200,000/has health insurance (self-insured)/orthodox Christian/chronic pain	15 months, every 2–3 weeks/chiropractic/B (F)
12	Mel (F)	68 years/white/single/retired (income wise)/has health insurance/raised Methodist, not attending church/frozen shoulder	Massage 5–10 years, monthly, off and on/massage therapist/A (F)
13	Tom (M)	57 years/B.S. engineering/White/Married/$125,000 a year/has health insurance/Christian, not practising/musculoskeletal disorders	Homeopathy & chiropractic/R (F)

Note. Gender: M, male; F, Female.
[a]All names are pseudonyms.
[b]Study reports part of data.

feeling free, quality of life, supporting others, goal-setting, disappointment, experience of pain). Subsequent passes through the data helped identify axial codes (e.g., descriptive themes: being friends, how does the pain feel?–to establish interconnections between open codes). In parsing second level analytical, axial codes, the relationships among data were identified (e.g., control and power, healing and care) as themes to conceptualize and interpret relationships among the data. The themes were further collapsed through the process of abstraction and constant comparison (i.e., comparing codes and their underlying concepts, Strauss & Corbin, 1997) to illuminate the inductively refined study goal in consistent and distinctive ways. Thus, the themes integrate the core conceptual categories reflected in the data so as to represent the data, enable verification that the interpretation is true to the data and confirm that the themes are corroborated by the interviews (Elo et al., 2014).

3.6 | Rigour

To maintain validity, care was taken to balance the analytic narrative and extracts of participant voices to explicate each theme in the context of its construction and clearly illustrate the assumptions guiding the analysis. Second, to address for potential bias arising from selective perception of data and enhance trustworthiness, the conformability of the data analysis was enhanced through verifying and integrating congruence with a nursing faculty member (Elo et al., 2014). The researcher and the nursing faculty member individually conducted a close, line-by-line reading of the data presented in the manuscript, made notes and interrogated the themes to deepen the interpretation and discussed their interpretation. Feedback from the dialogue resulted in the re-interpretation of some codes in the findings section (e.g., the concepts of compassion, empathy, intuition, affirmation and openness in the relationship). This process helped establish the credibility and authenticity of the findings (Elo et al., 2014). Third, to address the potential for researcher bias and enhance trustworthiness, multiple perspectives including the content (e.g., patient voice) and the context of the interview and the therapeutic relationship were presented in the findings. These help "confirm the connection between the results and data and the richness of the data" (Elo et al., 2014, p. 7).

4 | FINDINGS

Participants ranged in age from 41-78 years and were recruited from the mid-Atlantic region of the United States (Table 1). Patients described the therapeutic relationship with the provider being a: (1) giver, "in-tune" with the body; and (2) guide, connecting the mind to the body through their practice to support self-management of pain (Table 2).

4.1 | Being "In-Tune" with the body

CAM patients described their relationship with their provider as being "in-tune" with their body in a way that helped them feel valued and allowed them to embrace the full range of the body's experiences. Providers created a space of empathy and trust by listening and affirming their experiences to empower them to self-manage the pain.

The therapeutic relationship was grounded in listening, such as by privileging patient experiences more than objective data in helping patients' interpret their experiences. For example, Gabe and her son had a connective tissue disorder (amplified musculoskeletal pain syndrome). Gabe sought CAM for 7 years to manage her pain that she had since she was 15-years-old, yet did not feel her experience was recognized by her biomedical providers: "I haven't been officially diagnosed with [a]nything. . .No actual doctor has ever said, 'you hurt because of this. . .I've had x-rays, I've had MRI's, they're always like, 'you're fine.'"

Through their listening, CAM providers gave their patients' permission to accept and take care of their body. Gabe described how she was "almost like crippled. . .in severe pain, where. . .I can't even walk." Her provider was fully "in-tune" with her body: "if I'm standing next to her, she'll say, 'you have a headache, don't you? I'll say, 'yes, I do!' she's like, 'I can tell.'" The compassionate openness of her provider, in turn, helped Gabe connect with her provider: "when she's practicing on you, you can feel her hands are very, very warm. . .it's like this energy. . .and I believe in that." In her biomedical treatments she was told: "it's all in your head." Gabe described her practitioner, N, as: "listening to your body and understanding what the body needs. And knows [it's] about. . .being mindful of what the body needs and relaxing it."

Empathetic listening facilitated being "in-tune" with patients, providing self-affirmation to the patients and allowing them to value their own experiences. Gabe felt empowered to learn to be "mindful of how I'm sitting, or how my feet are placed" and later became a mindfulness ambassador. Gabe described the process of how she has "literally walked into [N's] office, like crooked, all bent over and hunched over and in pain and I've walked out much better." N would lay her down on the table and:

> She'll just ask. . .'Where's your pain?' 'How does the pain feel?'. . .'Does it feel better when I push it in?' 'Or, does it feel better when I pull out? And then, you explain to her 'It feels better when you pull out.' And then, she'll pull, like, pull out, a little bit. [Then she'll ask:]. . .'Where else does it hurt?'. . .And if you still feel it, she'll lay you back down and continue to work on that area.

For Gabe, N is "more in-tune and she's listening to the body more and giving you more what you need." Patients saw their providers as givers, so much "in-tune" with their body's pain that patients' opened up in a way that their providers were able to physically draw it out of them. This intimate empathetic listening allowed patients to also listen to their bodies, to be "in-tune" with their body and its pain in a way that empowered patients like Kate, who: "started. . .interacting with other people who were using [CAM]. . .[now] I've read. . .50–70 books. . .And, it just led me to essential oils, [to]. . .chiropractic care. . .and now Reiki" (Kate, a 57-year-old breast cancer survivor).

Patients saw their providers as givers, who saw them as being more than a body with pain and valued their provider's affirmation of their sense of self almost as a gift. Kate described how "some people have a gift that" goes beyond learning, "and I believe T has that." When T (Kate's provider): "lays hands on you, I believe she feels more than just that joint out of whack." Another of Kate's practitioners, "A, with her massage. . .I can feel her drawing out the tension. . .and the negative energy." In fact: "when we're done and I look at her, I feel like she looks like a dish rag. . .she really has spent herself cleaning all that out of me." For Kate, A was, "just tuning-in to you. And, A is one of those [that] tunes in to you and finds out what you need. And then, she releases it." Patients felt their providers accepted them as more than just the body with the pain, related to them in a way that felt their body's need and helped them recover, sometimes by relating with own body's experiences (e.g., through touch).

Patients noted their practitioners' ability to be "in-tune" with their physical body encompassed reintegrating and being "in-tune" with the experiences of their *whole* body. Mark had severe disc

TABLE 2 Summary of patient empowerment themes in the therapeutic relationship

Theme label	Theme definition	Reframing the chronic pain experience
Being "In-Tune" with the Body	Therapeutic relationship whereby the provider related as an empathetic listener, who sought to create openness to and acceptance of the patient experience	Co-creation of a web of therapeutic interdependence; interdependence of care as healing in an iterative process
Connecting the Mind with the Body	The therapeutic relationship empowered clients by connecting the mind to the body to encourage self-reflective learning through an awareness of their mind-body connection to (re)contextualize their experience of pain	Co-creating practices that contribute to a relational praxis by engaging the realm of chronic pain as a space of meaning construction rather than symptom or patient management

degeneration in level 4 and level 5 and was "in intense pain. . .my pain. . .was 7 or 8. . .I could barely sleep. . .Meds wouldn't help. Wine wouldn't help. Nothing will help me sleep." He found that, his provider, N, "had significantly reduced the back pain to roughly 2 or 3 on my scale of 0 to 10. . .[T]rying the pills, Tagamet®. . .They didn't manage." N was a "very, very good listener," with whom Mark could reflect on the recent death of his father and recognize how "that contributed. . .to some choices I made that aggravated my back." N was: "open to listening and talking it through. . .[doing] things that are pushing and pressing and pulling and stretching and twisting," in a way that was "changing the way my body is responding to the deterioration and reducing the pain." By empathetic listening, providers used their treatment to help patients' recognize how their emotional and psychological needs were related with their physiological experiences and enabled them to move towards response and recovery.

Mark described N as being "in-tune" with him through listening to his pain experiences in a way that gave him time and permission validate his experiences: "N starts every session: 'Where are you? What's going on?'" Her listening approach helped him "feel you can change a condition that is very unsettling, in a way that you can manage it and cope with it and live with it." Mark described N's attentiveness: "She's not: 'I've got 3 minutes. She goes 90 minutes. . .instead of 60. And she listens carefully.'" Mark's description illustrates how N empowered him by affirming his body: "I [Mark] have more agency and she's supporting that, affirming that, by exploring what. . .I'm experiencing in my body." By exploring patients' experiences as an empathetic, accepting partner, practitioners opened them to an awareness of their whole body and thereby reintegrate and (re)contextualize their pain.

Pam found A, her provider, has "a gentle and loving approach. . .she's especially nurturing." Pam described how "her calmness," how "she's not hurried, or she doesn't communicate anxiety," and how A "would always talk about the movement and what part of the body it was intended to be a healing practice." A's being "in-tune" with her body in his listening and communication empowered Pam to open up to her pain experience "by telling myself to relax and let go and enjoy it, to feel and experience and to share. . .if I have an area of my body that carries tension or pain." A was a giver, who listened carefully: "She always asks how I'm feeling: how I'm feeling physically and probably emotionally. [It's] never, 'Come on in and get on the table.'. . .She would. . .even be prayerful."

CAM patients described their relationship with their provider as a giver who was "in-tune" with their sense of self. Patients described their providers' approach in the therapeutic relationship as employing empathetic listening in a way that affirmed their body's experiences and gave them permission to accept and reintegrate their pain to take care of their body.

4.2 | Connecting the mind with the body

Patients described their relationship with their provider as a self-reflective learning space that cultivated awareness of the connection between their mind and body. Self-reflective learning was a turning point in the patient's life as they became aware of their agency to heal the pain.

John's example illustrates this experience: "I felt my body opening up. My, my, what they call a crown *chakra*. . .completely opening up to—what my life purpose was. . .Reiki literally changed my life. That's what I mean by 'blown'" (John, a patient diagnosed with ADHD, describing his first Reiki session). Likewise, Sue's example illustrates how she found the agency through self-reflective learning to weed out toxic lifestyles and individuals. For Sue, "Western medicine didn't have much to offer" for her Lyme disease, so she chose instead yoga, *tai chi* and meditation, to get the inner "knowledge to be able to manage the symptoms." Sue's experience illustrates how the self-reflective nature of her learning helped her manage change in other areas of her life: "I've really changed, you know, where I put my energy and my time. . .I really evaluate whether something is, or a person is toxic." She moved her home: "on the water. It's out in the country. It's peaceful. . .I go out on the deck and do my *tai chi*. I sit in silence and meditate. And that [h]elps maintain my wellness." She changed her friends, who "in terms of the way they eat [their]. . .vibrational level is low. . .and that toxicity introduces. . .illness." Sue's self-reflective journey informed her learning and gave her permission to make life changes to manage her symptoms without medication.

Kate, a breast cancer survivor, described her treatment as: "it's because I have blocks there, that she opens those channels. And then the energy can flow. . .because she innately goes to where there is a tension." Kate's description connects the mind with the body's energy channels. Kate's practitioner, A: "trusts and uses her intuition." Earlier, Kate "was on heavy dose antibiotic, anti-fungal, anti-parasitic. . .the Tamoxifen® and all that." With A's help: "I've gotten rid of everything. . .and I feel better than I felt in forever." With her practitioner's help, Kate was able to achieve her wellness and healing goals without medication through addressing the energy channels connecting her mind with her body.

Pam, a 75-year-old retiree with a heart condition (atrial fibrillation), described her *Qi Gong* practitioner's work on the mind-body connection with her as: "the verbal guidance that the teachers give direct to me–[b]reathing techniques [to] connect the mind to the body and you can then do it yourself when you learn it." Pam explained how mantras work: "[Mantras work by] telling your body what you want to feel. . .sending your breath to some part of your body that hurts, or is in pain." Pam's condition "got out of control, [needing] surgery and electric shock to the heart to get back in rhythm and lots of medication, which was horrible." Due to poor medication tolerance, Pam was in and out of the emergency room. Pam's practitioner "helped Pam with "staying focused on relaxing and decreasing stress and increasing movement. . .by helping one direct one's thoughts." Connecting the dots between relaxation of the mind and body movement was a turning point that enabled clients learn to direct their thoughts and self-manage their healing.

Mark described how N will: "often remind me to breathe in deeply. . .in relationship to the movement she's making." Reinforcement

of the connections between the body and the mind created a turning point for the patients' relationship with pain: "We will talk usually in the beginning and eventually, I get so relaxed and more passive and just allowing her to do what she does." N reminded Mark of the connection between relaxing the mind and the perception of pain: "then I can experience from the beginning to the end… [a] noticeable change in the…pain in mind… [To] … get to the point where the pain is manageable and I'm feeling less hopeless" (Mark). His provider enabled him to engage in self-reflective learning: "about how my movements in day-to-day life are directly related to my problems with the back [such that] I feel a lot more upbeat. I feel more positive." He is "more conscious of my choices of movement … because I'm seeing more clearly the relationship between all those things and the… body, my muscles and my back pain." Mark overcame his feelings of helplessness to pain as the time: "when I broke down in the street and I would have to stop with such great pain because of the spasm. I didn't want the neighbours to see, they'd think I was dying or something."

CAM patients described their relationship with the provider as a guide who created a self-reflective learning space that helped them connect their body and the mind and open them to their body's own healing mechanisms. Patients described how the provider cultivated self-reflective learning of the mind's connection with the body's energy flow (e.g., *chakras*), blocks (e.g., emotional), breathing (e.g., *mantras*) and movements (e.g., massage) to facilitate self-management of their pain.

5 | DISCUSSION

Patient self-management of pain was facilitated through the therapeutic relationship that emphasized their provider as being "in-tune" with them and connecting their mind with the body (Table 3). The therapeutic relationship described the provider as a giver who affirmed their sense of self in an empathetic listening space and as a guide who cultivated self-reflective learning to (re)integrate with their body's experience of pain (Table 3). In a therapeutic relationship situated in this self-affirming space, the patient no longer felt the need to deny or struggle to control their body's pain experiences and could work with the provider to reframe their relationship with the pain. Previous literature finds correlations of acceptance of pain with decreased pain-related anxiety, intensity and avoidance and notes this association varies with the type of healthcare centres of treatment (Esteve & Ramirez-Maestre, 2013; McCracken, 1997). CAM patients' description of the therapeutic relationship extends understandings of pain beyond passive pain acceptance. The therapeutic relationship engaged patient agency and empowerment to allow patients to reframe their pain through self-affirmation and self-reflective learning supported by the provider's empathetic listening and connecting the mind and the body.

The study advances understandings of patient adjustment to pain through therapeutic interdependence based on provider validation of patient experiences by being "in-tune" with the patient and helping connect the mind with the body through self-reflective awareness. The therapeutic relationship focused patient learning as a turning point for patient agency in reintegrating their sense of self with their life experiences to support pain acceptance. The findings of the present study extend scholarship demonstrating that patient resilience is positively associated with pain acceptance (Ramirez-Maestre, Esteve, & Lopez-Martinez, 2014) to envisage the therapeutic relationship as a form of support for patient agency and empowerment to self-manage their pain. In doing so, the study centres traditionally under-recognized patient voices in the holistic nursing care relationship to envisage patient agency and empowerment in a healthcare relationship as distinct from the hierarchical knowledge/power axis.

Through a therapeutic relationship constituted by empathetic listening and self-reflectivity, the patients saw their provider as a giver and a guide who gave them permission to accept their pain experiences and explore their body's healing mechanisms. Through affirming their sense of self and supporting self-reflective learning, the provider served as a giver reframing the patient's context of pain by being "in-tune" with the patient's life experiences and as a guide connecting the mind with the body's agency to heal. Empathetic listening and self-reflective learning contributes to health communication praxis by engaging self-management of pain as a space of co-construction of meaning rather than symptom management. The study findings enhance understandings of and invite deeper examinations of the relationship between pain acceptance and mindfulness (McCracken & Keogh, 2009). The findings suggest directions for the provider-patient relationship that reframes the patient's relationship with pain to cultivate agency and empowerment within the unique lived contexts of patients.

The recent shift in integrative interdisciplinary teams in pain management clinics takes some steps in the holistic direction by including providers from a diversity of perspectives (Harding, 2004). However, in clinical encounters, the subjectivity of the individual patient remains unchanged and, in fact, is reinforced in their construction as a patient. The provider in the therapeutic relationship reorients the patient's relationship with pain through being "in-tune" with the patient's body as a giver who provides acceptance and affirmation of their sense of self and as a guide who cultivates self-reflective learning allowing patients to align with and reframe their relationship with pain. As this study drawing on patient discourse suggests, the patients describe how their provider's being "in-tune" with them and connecting the mind with the body constitutes a turning point in their ability to accept and release their pain, reintegrate with their sense of self and feel empowered to make changes in their lives. By suggesting an alternative positionality of patients as partners with equal agency in re-contextualizing their pain experience, this study envisions healthcare relationships that empower patients to own and reintegrate their meanings of pain in the context of their life.

5.1 | Limitations

The study findings draw on a subset of patient perspectives focusing on pain management among patients from a range of CAM

TABLE 3 Summary of patients' description of CAM providers' therapeutic relationship themes

Provider relationship themes/dimensions	Patient agency/empowerment for self-management of pain
Theme 1: Being "In-Tune" with the body	
I. Listening intuitively 1. Patient experiences more than objective diagnostic data 2. Without conditions II. Compassionate openness 1. Being open to the world 2. Connect with patient's pain III. Empathetic acceptance 1. Seeing patient as a whole body 2. Being givers 3. Valuing and accepting patients IV. Holistic nurturing 1. Prayerful 2. Communicate calmness and love	• Validation, self-affirmation • Permission to accept pain • Be "in-tune" with the provider, give them permission to heal their body • Learn to be aware of and heal own bodies • Encourage mindfulness of own feelings • Hearing and sharing about their own bodies • Gratitude at receiving the gift of self-care • Managing their own pain, change their own condition, cope with it, or live with it • Calm and loving approach towards patients • Talk to patients about their bodies and its relationship with the healing movements
Theme 2: Connecting the mind with the body	
I. Connecting to life purpose 1. Opening to patients' body through their mind 2. Enabling patients see themselves as a whole person beyond their pain II. Providing self-knowledge of whole body 1. Giving permission to make changes 2. Bringing an awareness of their agency 3. Reframing attention to positive strength and abilities in the patients' whole body III. Providing mind-body techniques 1. Communicating how to connect through the breath 2. Communicating how to relate to one's physiological perception of pain IV. Providing explanatory framework connecting 1. Healing Practices with Body 2. Creating a communicative space 3. Teach patients to relax and be mindful of the pain	• Identify goals, get self-confidence to achieve them • Feeling their own bodies opening up (e.g., *chakras*) • Identifying toxic relationships and environments, feeling permitted to let go of them • Understanding control of energy as flowing and able to address tension or pain • Verbal, individualized personal guidance to breathe (e.g., *mantras*) • Learn how to affect positive changes in one's own physiology (e.g., perception of pain) • Support learning through directing one's thoughts • Connecting the dots between physiological movement and relaxation • Enabling patients to be aware of and learn about their own movements in their own life

providers. Future studies can focus on specific modalities to find how therapeutic relationship models address the perception of pain.

6 | CONCLUSION

This research identifies how the relational praxis of care helps patients (re)conceptualize the pain experience through the providers' empathetic listening that affirms their sense of self and provider support of their self-reflexive learning engagement with their mind and body experiences. The findings situate pain discourses within the therapeutic encounter by foregrounding patient voices as collaborators in the therapeutic relationship to promote patient agency and empowerment in self-management of pain. Healing, like pain, is a subjective dimension of healthfulness constituted through feeling whole, connected and integrated within a values- and belief-system of care and well-being (Agarwal, 2017). Through being "in-tune" with their sense of self (i.e., subjectivity) and supporting self-reflective learning of their mind-body connection (i.e., empowerment), the patient description of the therapeutic relationship illuminates how it helped them reframe their relationship with pain. The therapeutic relationship emphasizes the patients' co-construction of meaning with the provider as distinct from the hierarchical knowledge/power relations (Willard, 2005) characterizing clinical meetings.

The study findings illuminate how a feminist standpoint contributes to understandings of the therapeutic relationship in the (re)-constitution of pain going beyond pain acceptance and adjustment. The therapeutic relationship provides support to patients in embracing their sense of self and guiding their learning of the mind and body connection. By centring relating (being "in-tune" with) and connecting (the mind and the body) to frame pain acceptance and management processes in the context of provider-patient interdependence, the therapeutic relationship empowers patient agency and autonomy in (re) shaping their relationship with pain. The therapeutic encounter is grounded in the subjectivity of the patient, suggesting that care pathways are unique, iterative, reflexive processes. Eschewing standardization of care, the therapeutic encounter is grounded in an interdependent context that centres the patients' sense of self and its relationship with pain and co-constructs meaning-making of pain through the mind and body's healing mechanisms.

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CONFLICT OF INTEREST

No conflict of interest has been declared by the author.

AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE http://www.icmje.org/recommendations/):

- substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;
- drafting the article or revising it critically for important intellectual content.

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