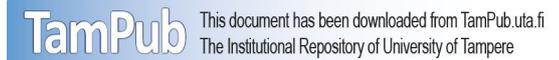


Patients' Interpersonal Communication Experiences in the Context of Type 2 Diabetes

Care



Short title: Patients' significant interpersonal communication experiences

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Abstract

The aim of our study is to determine the relational communication characteristics of professional-patient communication situations that have either facilitated or impeded patients' self-management. Conducted from the perspective of Finnish patients in the context of type 2 diabetes care, we used as our research method an open e-survey and semi-structured interviews. Data were analyzed using inductive qualitative content analysis. The critical incident technique was utilized throughout in all these methods. The results show that both positive and negative experiences described by patients were connected to four multidimensional relational communication characteristics: a) *building trust in the other party in the professional-patient relationship*, b) *willingness to communicate*, c) *emotional presence*, and d) *appropriateness*. Although the findings support the recommendations of earlier studies concerning individually tailored patient-centered care, acknowledging the characteristics in question can be used as a communication frame for constructing significant care relationships from the perspective of patients' self-management.

Keywords: doctor-patient communication, nurse-patient communication, health care, chronic illness and disease, diabetes, self-care, qualitative research, Finland

In the field of health communication research, one of the most problematic research questions in the treatment of chronic illness is how to improve patients' self-management through health care professional (HCP)-patient communication (e.g., Burke, Earley, Dixon, Wilke, & Puczynski, 2006; Linmans, van Rossem, Knottnerus, & Spigt, 2015). Earlier studies confirm the importance of this question by showing that patients with chronic illnesses – especially those with type 2 diabetes – have difficulty in achieving optimal glycemic control through a combination of healthy diet, physical activity, and medication (Mulder, Lokhorst, Rutten, & van Woerkum, 2015). It has been estimated that less than 20% of diabetic patients achieve optimal values in blood glucose, lipid levels, and blood pressure (Casagrande, Fradkin, Saydah, Rust, & Cowie, 2013) and that approximately 40% take less than 80% of the drugs prescribed (e.g., Cramer, Benedict, Muszbek, Keskinaslan, & Khan, 2008). Although diabetes care is known to entail patient-centered communication and thus good HCP-patient relationships to achieve optimal self-care discussions and treatment outcomes, the actual nature of such self-management related patient-centered communication remains unclear (e.g., Boström, Isaksson, Lundman, Lehuluante, & Hörnsten, 2014; Thorne, Harris, Mahoney, Con, & McGuinness, 2004).

This qualitative study aimed to ascertain the relational level of professional-patient communication within the framework of the interactional view (Watzlawick, Bavelas, & Jackson, 1967). We asked Finnish patients with type 2 diabetes to remember and describe positive and negative interpersonal communication experiences, with doctors and nurses, which either facilitated or impeded their self-management. The study offers concrete insights into the relational communication characteristics reported by patients in these situations and into how the behaviors of both participants are related to these characteristics.

Relational Communication Characteristics of HCP-Diabetic Patient Relationships

In addition to the medical care processes, interpersonal communication between HCPs and patients is known to contribute to patients' overall well-being (e.g., Duggan, 2006; Stewart et al., 1999). Interpersonal communication can be defined as communication where two participants create verbal and nonverbal communication messages in an effort to generate shared meanings and accomplish situation and relationship related goals (Burlison, 2010). Hence, interpersonal communication is not just communicating with someone, but entails addressing each other as unique human beings and acknowledging their personal and professional identities (Beebe, Beebe, & Redmond, 2008). The definition of interpersonal communication is in line with the patient-centered approach which has been held up as an ideal to improve medical practice (Swenson, Zettler, & Lo, 2006) and health outcomes (Charlton, Dearing, Berry, & Johnson, 2008; Robinson, Callister, Berry, & Dearing, 2008). The core of this approach is a functional HCP-patient relationship built through communication taking as its main goal mutual respect and patients' personal needs and values (Boström et al., 2014; Mead & Bower, 2000).

The crucial dimension in the patient-centered approach is relational communication rendering feasible psychosocial and emotional patient care (Cegala, 1997). According to the framework of Watzlawick's interactional view, in addition to purely informative content, people send relational messages through verbal and nonverbal communication (Watzlawick et al., 1967). Relational messages indicate how the content of the message should be interpreted, for example, if the message was intended to express concern or blame. Relational messages also give cues for constructing how participants actually perceive each other, themselves, and their communication – based relationship in specific communication situations. Thus these interpretations of the communication affect the relationship while the interpretation of the relationship affects the ongoing communication. This two-way effect of communication and

relationship creates a dynamic system between the interlocutors, who attempt to construct appropriate patterns of communication to achieve their respective goals in the ongoing process (Guerrero, Andersen, & Afifi, 2014). In the context of HCP–patient communication, this process contributes to a communication climate that can facilitate or inhibit various outcomes, such as patient satisfaction and patients’ participation in their care and medical conditions (Step, Rose, Albert, Chevuru, & Siminoff, 2009). In addition, it has been estimated that HCP–patient relational communication in particular is connected to the judgment patients and their families make regarding the perceived quality of care as a whole (Ruben, 2016).

The significance of relational communication features has also been identified in the treatment of chronic illnesses, where the need for care is usually lifelong and dependent on patients’ self-management (Dwarswaard, Bakker, van Staa, & Boeije, 2016). In diabetes care especially, it has been stated that patient-centered communication with HCPs is crucial to patients in learning self-management skills (e.g., Mulder et al., 2015; Schöpf, Martin, & Keating, 2017). Such cognitive, practical, and social skills include, for example, managing treatments, care discussions, emotional stress, and lifestyle changes concerning diet, exercise, and medication in daily life (Barlow, Wright, Sheasby, Turner, & Hainsworth, 2002; Moser, van der Bruggen, Widdershoven, & Spreuwenberg, 2008). Earlier diabetes-related studies have claimed, for example, that trust (Edwall, Hellström, Öhrn, & Danielson, 2008; Peek et al., 2013; Oftedal, Karlsen, & Bru, 2010), sympathy (Kokanovic & Manderson, 2007), nonjudgmental acceptance (Ritholz, Beverly, Brooks, Abrahamson, & Weinger, 2014) and frank communication (Beverly et al., 2012) are features of relational communication that facilitates self-management. In addition, showing interest in the patient and meeting the patient as a person instead of a sufferer of a certain illness have been found to be relational communication features conducive to self-management from the patients’ perspective (Burke et al., 2006). On the other hand, results have also shown that the neglect of self-management

may be due to relational communication features. For example, minimal emotional support from HCPs, lack of reassurance and cultural sensitivity (Sohal, Sohal, King-Shier, & Khan, 2015), lack of interest, unfriendliness (Abdulahadi, Al Shafae, Freudenthal, Östenson, & Wahlström, 2007; Thorne et al., 2004), lack of trust (Hornsten, Lundman, Selstam, & Sandstrom, 2005), and patients' fear of being judged (Ritholz et al., 2014) have been shown to impede self-management.

In earlier studies, there have been four major limitations in examining relational communication features in the patient-centered care of chronic illness. First, there has been less research on relational communication features chosen retrospectively by patients regarding what they deemed significant to their own self-management (e.g., Burke et al., 2006; Dwarswaard et al., 2016; Hornsten et al., 2005). One way to examine patients' perspectives is to focus on critical incidents. Depending on the research objectives and the methods used, nursing and medical studies have also referred to these experiences as meaningful encounters. Both concepts have been defined as affecting social situations in which a person has been personally involved and which he/she has thought to have had either positive or negative effect on change of his/her own ideas, attitudes, or behavior (Flanagan, 1954; Gustafsson, Snellma, & Gustafsson, 2013; Norman, Redfern, Tomalin, & Oliver, 1992; Schluter, Seaton, & Chaboyer, 2008). Such experiences have been studied especially when estimating the quality of nursing (Grant, Reimer, & Bannatyne, 1996; Kemppainen, 2000), exploring the outcomes of HCP-patient communication (Wong-Wylie & Jevne, 1997), and ascertaining what patients remember of their health care related encounters (Ruben, 1993). However, in the context of chronic illnesses the experiences in question have been only little studied.

Second, it remains unclear how patient-centered care is actually applied in actual health care practice (Koenig, Wingard, Sabee, Olsher, & Vandergriff, 2014). Although several studies have demonstrated the important communication features of the patient-centered approach

(e.g., matching treatment to patients' needs, encouraging, empowering, and giving patients the right to choose the best care for themselves), there have been inconsistencies across studies in the definition of patient-centeredness. Such conceptual inconsistency has made it more difficult to study associations between patient-centeredness and different health outcomes and to design replicable patient-centered interventions. (Michie, Miles, & Weinman, 2003; Smith, Dwamena, Grover, Coffey, & Frankel, 2011; Street 2017.) Patient-centeredness has been described as more of a philosophical orientation than a set of practical guidelines for patient-centered care, which may partly explain why patient centeredness has proven to be relatively challenging to implement in practical health care and its development projects. Most attention is still directed to solving patients' problems and managing symptoms, instead of building a reciprocal relationship through relational communication behaviors (Mulder et al., 2015; Roter & Hall, 2006; Ruben, 2016). More in-depth study of patient-centered communication from the perspective of relational communication is needed.

Third, although the efficiency of the HCP–patient relationship has been shown to depend on active participation by both the HCP and the patient (Cegala, Street, & Clinch, 2007), the patient-centered approach is usually defined through the relational communication behaviors of HCP. Through these, the HCP shows interest in the patient's feelings, concerns, and opinions and facilitates the patient's involvement in discussions and decision-making (Bensing, 2000; Mead, Bower, & Hann, 2002). This focus may result from the notion that building a functional care relationship is seen as more the responsibility of the professional than the patient due to the asymmetrical nature of HCP–patient communication (e.g., Bennett & Irwin, 1997; Cegala, McGee, & McNeilis, 1996; Roter & Hall, 2006). However, this does not mean that no attempts have been made to support the patient's communication behaviors. Quite a lot of research has, for example, addressed patient self-advocacy (e.g., Brashers, Haas, & Neidig, 1999), uncertainty management (Brashers et al., 2000), relational control patterns of

the HCP–patient relationship (e.g., von Friederichs-Fitzwater & Gilgun, 2001), and strengthening the patient’s participation in HCP-patient discussions (D’Agostino et al., 2017; Shue, O’Hara, Marini, McKenzie, & Schreiner, 2010; Cegala, Marinelli, & Post, 2000). These studies have concentrated primarily on the patient’s willingness and ability to challenge the HCP’s authority and to ask questions to gain information (Cegala, 2003). In this study, we seek to add to this body of research by paying attention to a less examined perspective on how patients view their own behavior as part of the work to build care relationships and functional self-management in the context of specific chronic illnesses (see e.g. Kettunen, Poskiparta, Liimatainen, Sjögren, & Karhila, 2001; Thorne et al., 2004). In addition, our study participates in the necessary discussion on whether these descriptions correspond to the principles of the patient-centered care recommended.

The fourth limitation is connected to the cultural dimension of HCP-patient relationships. Culture is suggested to have a significant but understudied and underestimated influence on HCP-patient discussions (e.g., Jain, 2014; Wachtler, Brorsson, & Troein, 2006). The cultural context shapes not only expectations regarding how certain things should be discussed, but also the communication behaviors concerning how messages are created and sensed as well as subsequent reactions in HCP-patient communication (e.g., Ruben, 2016; Young & Klinge, 1996). The cultural dimension is mostly addressed in studies comparing the communication styles of HCPs from different cultures or identifying barriers to intercultural communication (e.g., Schouten & Meeuwesen, 2006). Similarly, some studies have also assessed and improved the interlocutors’ cultural competence in certain areas, such as the use of the patient-centered approach (Schouten, Meeuwesen, & Harmsen, 2005; Teal & Street, 2009). Far less research has been devoted to specific communication cultures and their relational communication characteristics in HCP-patient discussions shaped by culturally acquired norms, expectations, and attitudes (e.g., Perloff, Bonder, Ray, Ray, & Siminoff, 2006).

It has been claimed that the population of Finland is highly homogenous, with distinctive cultural ways of communicating, and therefore, an interesting people to study (see e.g., Wilkins & Isotalus, 2009). The Finns have been observed to appreciate certain communication characteristics and behaviors, such as silence, message centeredness, a direct listener-oriented communication style, long turns at speaking (with low tolerance of interruptions), and a need for autonomy (e.g., Carbaugh, Berry, & Nurmikari-Berry, 2006; Sallinen-Kuparinen, 1986; Wilkins & Isotalus, 2009). In addition, Finnish people have been reported to be reserved, shy, and less willing to communicate than members of other speech cultures (Sallinen-Kuparinen 1986; Sallinen-Kuparinen, McCroskey, & Richmond, 1991). Similar results have been reported in a few studies on Finnish care culture. It has been claimed that Finnish people are inclined to shift the decision-making to the HCP (Kim et al., 1993). In addition, studies have found that patients are reluctant to burden their HCPs with their concerns, and certain issues, especially those of a psychological nature, are handled on a more superficial level (Suominen, 1994). However, it has also been claimed that Finnish patients can participate in HCP-patient discussions in several ways, by asking questions and expressing opinions and feelings (Häggman-Laitila & Åstedt-Kurki, 1994; Kettunen, Poskiparta, & Liimatainen, 2000). In this study we seek to add to this body of research by presenting new information on how Finnish speech-cultural elements of communication appear in authentic situations in the context of the prevailing health care culture, especially regarding how they are resolved, by describing the relational communication nature of HCP-patient relationships.

This study concentrated on addressing the limitations of earlier studies on the relational communication of both participants in individual care situations as described retrospectively by Finnish patients with diabetes in the framework of the patient-centered approach and interpersonal communication research. The main purpose was to identify the core relational communication characteristics of critical doctor-patient and nurse-patient incidents that

facilitated or impeded self-management by patients with diabetes. Critical incidents were defined in this study as HCP–patient discussions described by patients as somehow connected to patients’ self-management. To emphasize that patients’ ability for self-management invariably emerges in the context of HCP–patient relationships, in this study, we regard critical incidents as significant interpersonal communication experiences.

Because our study is specifically concerned with learning about the relational communication features connected to positive care experiences from the perspective of the self-management, the first research question is:

RQ1. What are the relational communication characteristics in positive interpersonal communication experiences from the patient’s perspective?

To ascertain if the relational communication characteristics present in both positive and negative situations can indeed be identified, it was deemed appropriate also to examine the negative experiences described by patients. The second research question, therefore, was:

RQ2. What are the relational communication characteristics in negative interpersonal communication experiences from the patient’s perspective?

The study objective was to produce new information to help HCPs, patients, and others in care networks to become more aware of the significance of the relational communication characteristics of HCP–patient relationships in the context of type 2 diabetes care. From the perspective of patient self-management, therefore, the study findings could be used to develop more effective and appropriate communication in care relationships.

Method

This study uses a descriptive qualitative design with an open e-survey and semi-structured interviews. The critical incident technique was utilized in both methods because it focuses on avoiding generalizations in order to find solutions to real practical problems and it has helped patients be as specific as possible when describing significant interpersonal

communication experiences (Flanagan, 1954; Kemppainen, 2000). In this study, the technique was used as a form of research where the patients provided, from memory, descriptions of HCP-patient discussions that facilitated or impeded their self-management. The participants also had the opportunity to report both positive and negative experiences with their HCPs and they were allowed to choose whether they would first talk about a positive or a negative experience.

The selection criterion for the participants included being aged 18 or over, voluntarily participating, having a diagnosis of type 2 diabetes, being resident in the province of Finland where the study was conducted, and having experiences of discussions with doctors or nurses concerning type 2 diabetes. Discussions with doctors and nurses were chosen for this study because in Finland doctors and nurses are generally the main professionals in the field of diabetes care. Instead no criterion was set as to whether the HCPs were employed in the public, private or occupational health care sector; diabetes care practices vary significantly in Finland (e.g. Tuomola, Idänpään-Heikkilä, Halkoaho, & Virkamäki, 2011).

Research data were collected during the years 2014 and 2015. Information on the e-survey and the semi-structured interviews was sent to all the diabetes associations in one Finnish province, to social media, and to the discussion forum of the Finnish Diabetes Association. Thirteen females and three males, with an age range of 30 to 93 years, participated in an e-survey. Three of the female participants' answers had to be excluded from the research data because their response forms had been left nearly empty. The semi-structured interviews included 18 female and 7 male participants, with an age range of 30 to 89 years. Time since diagnosis ranged from 3 to 28 years among the participants. In addition to dietary measures, all participants took insulin or oral medication to maintain glycemic control.

In both research methods the participants were asked to describe the situation and progress of the chosen HCP-patient discussion, how both parties to the interaction behaved,

the nature of the atmosphere, and the significance of the chosen discussion for their self-management. These questions are in line with the information requirements of effective and useful critical incident reports (Anderson & Wilson, 1997). The length of the e-survey responses varied from five lines to a whole page. The interviews lasted from 30 to 90 minutes; they were conducted by the first author in places chosen by the interviewees, for example, at the university, in a cafeteria, and at the interviewees' homes. All interviews were audio-taped and transcribed verbatim.

The first author started the analysis after collecting e-survey data and conducting ten interviews. In the analysis process the recommendations of the original critical incident technique were taken into consideration. Incidents were used as the unit of analysis, and the classification system was created in keeping with the main aims of the study. Categories were formed inductively and reported at the most appropriate level of specificity-generality. (Butterfield, Borgen, Amundson, & Maglio, 2005; Flanagan, 1954.) The unit of analysis in our study was a critical incident constituting a logical entity for several sentences relating to one HCP–patient discussion. Applying the principles of Flanagan (1954), the critical incident had to contain information on situational factors (the topic of discussion, the discussants) and a description of at least one factor contributing to both positive and negative experiences. Additionally, in the research field of this study, the critical incident had to include a description of at least one HCP–patient communication factor (what the communication between the HCP and the patients was like) and the self-management related outcomes of the incident. In this phase, 67 critical incidents were found in the data.

These 67 critical incidents were analyzed using inductive qualitative content analysis as recommended by Flanagan (1954) to achieve a concise but broad description of the relational communication characteristics (Elo & Kyngäs, 2008). This analysis method was chosen because it has been used to identify critical processes (Lederman, 1991) and to develop an

understanding of the meaning of communication in the health care context by generating detailed, practical, meaningful information on communication phenomena and their applicability in different care situations (e.g. Cavanagh, 1997).

At the start of the analysis, all the descriptions connected to the patients' critical incidents were abstracted from the research data. Each incident had its own subcoding sheet to ensure an overview of the incidents. After abstracting the descriptions of critical incidents from the research data, each incident was read several times to obtain an overall understanding and to classify incidents as positive and negative according to the research questions. The classification was based on the patients' opinions on whether the experience was more positive or negative from the perspective of self-management. The division into positive and negative incidents proceeded smoothly, except for four experiences on which the patients could not decide whether they were positive or negative from a self-management perspective. Hence it was reasonable to exclude these experiences from the analysis to avoid the risk of excessive interpretation by the researcher. In total, the 13 participants in the open e-survey reported 23 incidents, and the 25 participants in the semi-structured interviews mentioned 40 incidents related to self-management.

After classification of the 63 incidents as positive and negative, all the patients' expressions concerning relational communication features were coded for each critical incident because they were the focal point of this study. Expressions were coded when they included descriptions of the HCP-patient relationship, the interlocutors in the relationship, the interlocutors' communication behaviors, and the patients' interpretations of the meanings of the communication behaviors of both discussants. These expressions were listed on the coding sheets and grouped according to on commonality (Krippendorff, 1980) into 26 tentative subcategories of positive experiences and 21 tentative subcategories of negative experiences.

The categories were formed to answer the question: *What kind of relational communication characteristics are found in the critical incidents?*

In the first round of analysis the incidents were coded in a highly specific manner, and the headings of the subcategories consisted of brief statements. In order to ensure the credibility of these subcategories, they were recoded and discussed with the second and third authors as well as with researchers from communication, nursing, and medical sciences. As a result of these discussions, significant parts of the specifically named subcategories were combined, and the number of subcategories was reduced in relation to both positive and negative experiences, resulting in 10 subcategories. For example, the subcategories “calming the patient down,” “expressing acceptance of the patient,” and “making the patient take things serious” were seen to be related to emotional support, which was needed to accommodate each patient.

Next, new coding sheets were created, and the relational communication characteristics of positive and negative experiences were compared in light of the duration of the care relationships and the precise profession of the HCP, which have been shown in earlier studies to be significant factors in patients’ evaluations of care relationships (e.g., Burke et al., 2006). No significant differences in these factors were perceived, so the categories of positive and negative experiences remained the only distinguishing characteristic.

In the final stage of the analysis the generic categories of the relational communication characteristics of the positive and negative experiences were merged to arrive at the most appropriate level of specificity-generality (Butterfield et al., 2005; Flanagan, 1954). In practice, this meant deciding on which level of precision would be appropriate for reporting the results given the potential applications of the results. According to Flanagan (1954), the headings of generic categories should be practical, easily applied, and neutral so that the critical features can be stated in positive terms. The headings should also cover all incidents and have the same level of importance. In deciding on the appropriate level of specificity-generality concerning

generic categories, the main questions were: should the relational communication characteristics of positive and negative experiences have separate generic categories, and should HCPs' and patients' relational communication behaviors be kept separate when naming the categories? In order to resolve these questions, we compared the relational communication characteristics of the positive and negative experiences to each other. We found that the patients' descriptions of the interpersonal communication in positive and negative experiences were associated with the same relational communication characteristics. Moreover, comparison of positive and negative experiences showed that the communication behaviors of both interlocutors seemed to be associated with the same relational communication phenomena in the positive and negative experiences. For example, feeling and demonstrating trust/mistrust in HCP–patient communication was seen to relate to the phenomenon of building trust. Thus it was decided that the relational communication characteristics concerning the experiences and both interlocutors would be combined into four generic categories. The names of the generic categories were: *building trust in the other party in the HCP–patient relationship*, *willingness to communicate*, *emotional presence*, and *appropriateness*. These categories are neutral, they cover all the incidents, and they have the same level of importance, as suggested by Flanagan (1954). In addition, they give a concise yet broad description of the relational communication characteristics, congruent with the aim of this study. Table 1 presents an example of the category formation process.

Good scientific practice was followed during every phase of the study. Accordingly, ethical approval by the Regional Ethics Committee of Tampere University Hospital was obtained prior to data collection (R14098). All the participants were informed about the purpose of the study and its voluntary nature. They were assured of confidentiality and anonymity before giving their written consent to participate. In the analysis of the research data, reliability was ensured by recoding during the preparation, organization, and reporting

phases (Elo et al., 2014). Thus the research methods and units of analysis were chosen carefully, the categorization of the research data was discussed with several researchers, and the findings are reported in a clear, easily comprehensible way. Throughout the research process the research material and the research results were treated in confidence as required by the law regarding personal data.

Table 1
Example of the Content Analysis Process (Positive Experiences).

Textual units	Brief statements	Subcategory	Generic category	Main category
I felt that the HCP accepted me as I am, even though this kind of serious illness has just been diagnosed.	The HCP accepted the patient as he is despite the illness	Accommodating emotional support	Emotional presence	Relational characteristics of positive interpersonal communication experiences.
I was shocked, but the HCP was able to calm me with his words.	The HCP calmed the patient down with his words.			
Even though the HCP had a strict tone of voice, it was rather a good thing at that point, because it made me realize that perhaps I should take this seriously.	The HCP made the patient take him seriously by using a strict tone of voice.			
After hearing that I felt relieved.	The patient felt relieved.	Handling emotions appropriately		
I told the HCP, for example, that I really had to discuss with myself why I had this kind of illness.	The patient told the HCP about his negative feelings about the diagnosis.			

Results

In the research data, 42 communication experiences were positive in nature: 32 concerned doctor-patient communication and 10 concerned nurse-patient communication. With the exception of one experience with a doctor involving a telephone discussion, all experiences described were face-to-face situations. According to the research data, 18 of the positive experiences occurred with a familiar HCP and 16 with an unknown HCP. Eight participants could not recall the duration of the care relationship or did not mention it in their responses to the open e-survey.

According to the research data, 21 experiences were negative in nature: 14 concerned doctor-patient communication and seven concerned nurse-patient communication. Except for one experience involving a telephone discussion with a doctor, all experiences involved face-to-face situations. According to the data, 11 of the discussions took place with a familiar HCP and five with an unknown HCP. Five participants could not recall the duration of the care relationship, or did not mention it in their responses.

Regardless of whether the professional was a doctor or a nurse, or whether the care relationships were new or continuing, the findings indicated that both positive and negative experiences were connected by the four main relational communication characteristics. These characteristics were building trust in the other party in the HCP-patient relationship, willingness to communicate, emotional presence, and appropriateness.

Building trust in another party in the HCP-patient relationship

Building the patients' trust in their professionals was connected to the patients' evaluations of the HCPs' style of providing care and especially their ability to manage the patients' care. In positive experiences, this trust seemed to increase when the professionals showed interest in the patients' overall state of health and shared understandable, many-sided

information that seemed to be processed many times with the help of the patients' own experiences and new research results. One of the patients described the information as follows:

The information was of such a nature—well, I cannot say that it was personal information because I don't think that the HCP had diabetes. But it was information that she had developed through work experience. It seemed to be somehow more profound than information stated in a brochure.

In contrast, in negative experiences, the patients' trust in the HCPs' ability to manage their care decreased when the patients felt that the HCPs were not interested in the patients' state of health and when they gave contradictory information concerning diabetes care. In addition, the patients' trust in their HCPs decreased when the HCPs seemed to be incapable of coping with their patients' needs. One example of this is seen in the following citation:

I told the HCP that my eating had something in common with symptoms of eating disorders, and I asked her what could be done for this kind of problem. She said that I could, for example, keep a candy day once in a while. I thought, 'You've got to be kidding me'. It was horribly difficult to admit this to myself and still more difficult to an outsider, and then the reaction was this! I wondered whether we were talking about the same matter. She was a wonderful human being and surely wanted to do good for me, but I realized that she had no ability to help in that kind of a situation.

The patients' feelings of trust were also connected to their evaluations of the care provided by the HCPs. These evaluations were based on the patients' perceptions developed in the situations described, in previous encounters, and, in some cases, the experiences of other patients. The evaluations included notions of what kinds of people the HCPs seemed to be and what kind of work motivation they seemed to have. The patients with positive experiences described their HCPs' personalities with positive adjectives: pleasing, humane, nurturing, and consistent in different situations involving different patients. The HCPs' work motivation was

evaluated positively when they seemed to put effort into designing the best possible care to facilitate the patients' lives and told the patients that they continuously develop their expertise. One example of a positive description of the type of care provided by the HCP is seen in the following citation:

For me, it seemed that the HCP gave every patient help. I had a safe feeling because he really tried to put effort into patient care... I knew right away that I was in safe hands.

In the negative experiences, some patients described their HCPs with adjectives such as non-empathetic, weird, and incapable of communicating with patients. The HCPs' lack of work motivation was described as concentrating on doing routine medical care activities without giving patients individual attention. However, after expressing negative opinions, the patients often softened their statements by offering possible explanations for the HCPs' negative behaviors, such as haste and problems in their personal lives. One patient described the HCP's lack of motivation as follows:

The HCP did not bother to treat me as a patient. ... I think that she did not actually think of me in that situation. She thought of what she had to do, and perhaps some other matter was also troubling her at that moment.

In the research data, the patients perceived trust building as the HCPs demonstrated trust in their patients' self-management abilities. In the positive experiences, the HCPs believed the patients' descriptions of their health situations, introduced them to the possibility of surviving without medication, and gave useful, flexible instructions—not strict orders. That behavior empowered the patients to decide what medications they would take and what care plan they would follow. Such autonomy in decision making was reportedly important to the patients:

It was really important that I was allowed to carefully think about beginning the insulin care before we started the treatment. ... There was no feeling of being forced or such in that situation. The HCP only gave options.

In the negative experiences, some patients felt that the HCPs questioned their self-care motivation. Some patients said that their professionals did not seem to believe their descriptions of their health situation or their ability to manage dietary treatment. This distrust also seemed to affect matters related to diabetes. One description of this is seen in the following:

When type 2 diabetes was diagnosed, ... the HCP insisted that a mere change of diet would not suffice. ... I was merely handed a prescription with no explanation of the nature of the illness or the overall care.

In summary, the patients' and the HCPs' trust building manifested as different kinds of processes in the patients' significant interpersonal communication experiences. According to the patients' positive and negative experiences, the patients felt trust, while the HCPs were described as demonstrating trust in their patients. In addition, the patients' trust was more closely associated with the HCPs' communication behaviors, but the HCPs' trust was associated with evaluations concerning patients' self-management abilities. However, in this research data, the manner in which the HCPs appeared to make evaluations concerning the patients' self-management abilities seemed unclear.

Willingness to communicate

In the patients' experiences willingness to communicate was connected to evaluations of communication activity, suitable use of time, and being unreserved. In the positive experiences it was crucial that the patients experienced these elements as behaviors involving both parties. Regarding communication activity, reciprocity was especially significant in nonverbal communication behaviors. Both the patients and the HCPs made eye contact, sat down face to face, and showed that they were listening to each other. Although the patients

described all the HCPs as engaged in high levels of verbal activity, the patients' level of activity in verbal communication varied. Some patients described themselves as listeners, and others as very active communicators. The common factor was that the patients described themselves as communicators capable of asking questions and participating in the discussion when they found it appropriate. In positive experiences, the suitable use of time was seen as proceeding flexibly in the discussion according to the situation, not acting in hurried manner, and reserving enough time for the discussion. One example concerning reciprocal communication activity and suitable use of time is seen in the following citation:

The length of the visit was set appropriately, and it was also good that the HCP talked with me a lot during the same visit. ... My own communication behavior was important in the sense that I was forthcoming myself and I wanted to know things. However, I was also good at listening. The illness itself interested me, and the diagnosis interested me. I was not in a hurry to leave.

The patients' impression of being unreserved in positive experiences was based on reciprocal open self-disclosure and an absence of emphasis on difference in status. In addition, the patients' perceptions of themselves as somehow similar to their professionals—especially having common or compatible communication styles—strengthened the impression of there being no reservations. The de-emphasized difference in status was seen in the HCPs' behaviors as avoiding medical language, warming up to the situation by discussing matters unconnected with the illness, and using humor when talking about health issues. For the patients, de-emphasizing the difference in status meant accommodating their behavior, particularly the absence of reserve on the part of the HCPs and overall readiness for communication, which was said to be easier if the patients had visited the HCPs before. However, according to some patients, this was also possible in a first meeting:

To me, it felt as if we had known each other for ages, even though it was the first time we had ever met. First, the HCP's attention was caught by my surname. Right away, he asked where I was from. ... The first appointment is absolutely essential. It should not start with the question, 'What is the matter'? We discussed all sorts of other matters first. The interaction should be initiated with a little small talk free of jargon to make it spontaneous and not too formal.

Reciprocal self-disclosure was seen in discussing hobbies, families, places of residence, and ways of spending vacations. Given the health-related topics, in all the cases the patients revealed more about themselves than did the HCP. Nevertheless, the patients appreciated the HCPs' willingness to share personal information about themselves and thus not strictly separate the work self and personal self in care situations. One example concerning this finding is seen in the following description:

I remember that the HCP at one time mentioned that she would not be there the next time because she would be on maternity leave. In addition, she told me how many children she had. In my opinion, it was not too personal information. ... Many keep their work self and personal life strictly separate. She obviously felt no need to do so, and I at least felt it was positive.

In the negative experiences, the patients' evaluations of willingness to communicate were connected especially to the HCPs' behaviors. The patients described their HCPs as engaging in minimal communication activity, including giving short answers, avoiding eye contact, and asking few questions. The use of time was also seen as inappropriate because the HCPs usually expressed haste nonverbally and verbally, for example, moving restlessly and telling the patients that they had many things to do. In addition, giving the patients no space to process matters in a limited time was part of the inappropriate use of time. Moreover, a lack of immediacy was perceived in the patients' experiences as the HCPs' did not self-disclose and

emphasized the difference in status, particularly by using medical language and a lack of humor. One description of an HCP's minimal communication activity and emphasized status difference is seen in the following citation:

There was a chair, the HCP, and the computer. It was as if there should have been a perspex screen between us. He didn't let the patient respond in normal language; all the time it had to be this Latin or something about the comprehension of comprehension.

All the patients with negative experiences said that the HCPs' behavior, especially minimal communication activity and standoffishness, diminished their willingness to communicate. They described minimal communication activity as giving short answers, asking few questions, and not expressing differing opinions. One patient described the effects of the HCP's communication behavior as follows:

When with a smile I tried something, no, a got nothing back. No humor, but I tried to ask something nicely about the subject, he didn't change at all. That he would turn as express an opinion. That didn't happen so it was quite dull. I expected that, interaction. That it would be comfortable for me to talk... for that reasons much about health was left unsaid. I just got the medication, the prescriptions and then I left.

The standoffishness emerged in the patients' descriptions as minimal self-disclosure and recalling negative attitudes toward the communication situation. This was seen, for example, in focusing on and waiting for the end of the discussion. A few patients said they had a negative attitude toward the communication situation beforehand because they had negative experiences with the particular HCP. In addition, the patients' notions of themselves as somehow different from their professionals—especially having different personalities or communication styles—exacerbated the lack of unreservedness in the patients' behaviors. Some of the patients reported that the dissimilarity also prevented the patients from being themselves in HCP-patient discussions:

For some reason, communication is important to me. That I could be me. I do not mean that I would laugh and giggle for a half an hour in the consultation pace. I mean that I have multiple words in my vocabulary that I can use to explain my own situation. But it was not possible with the HCP because he was so stiff.

In summary, the initiative of the HPCs in expressing willingness to communicate was a significant factor in both the positive and negative experiences described by the patients. However, regarding the positive experiences, the patients also emphasized the meaning of reciprocity and appreciated the different opportunities to participate in the discussions. In contrast, regarding the negative experiences, the HCPs' lack of willingness to communicate was so chilling that the patients experienced a sense of powerlessness to change the relational communication behaviors in question.

Emotional presence

In both positive and negative experiences, emotional presence was especially connected to the patients' evaluations of their HCPs' ability to give accommodating emotional support. In positive experiences, the patients described their HCPs' accommodating emotional support as giving approval to their patients, calming them down, or helping them to take things seriously. The HCPs showed approval by giving positive feedback on self-care and showing understanding of the patients' feelings, disagreements, and problems in self-management. Calming the patients down meant focusing on the positive aspects of their health, giving up-to-date information on their health, and assuring them that everything was going to be all right. A few patients found it calming when the HCPs spoke in a peaceful manner and patted them on the shoulder. In a few experiences reported by the patients, the HCPs attempted to make the patients serious by expressing their anxiety and urging them not to underrate the situation. Even though these situations made the patients feel confused and ashamed, the experiences became

positive in their minds because it was possible to perceive caring in the HCPs' communication behaviors:

Even though the HCP had a strict tone of voice, it was a good thing at that point as it caused me to think that perhaps I should take this seriously, that perhaps this illness was not to be trifled with. ... In fact, I was a little surprised that this person actually cared about what I did.

In the negative experiences, the HCPs' lack of accommodating emotional support was seen in showing frustration to the patients, threatening them with the risk of additional illnesses, and softening information so that the patients did not realize the seriousness of their condition. One example of this is seen in the following citation:

The HCP was extremely emphatic when diabetes was diagnosed. ... She talked really approvingly and maybe too gently when I think about it afterwards. She did not put all the cards on the table immediately. For this reason, I did not perhaps understand the seriousness of the illness at first.

While the HCPs' emotional presence was highlighted in both positive and negative experiences, the patients' descriptions also reflected their own emotional presence. In positive experiences, it was seen in experiencing positive internal emotions and handling difficult emotions with HCPs, such as feeling guilty about getting diabetes. Despite the patients' emotional presence, not all of them felt the need to discuss emotional matters with their professionals but, nonetheless, appreciated feeling that it was easy to discuss all kinds of things with their HCP. An example of an HCP's accommodating emotional support and a patient's handling of difficult emotions with the HCP is seen in the following statement:

The HCP's ability to accommodate the patient's emotional arousal was impressive. I said, for example, that I really have had to discuss with myself why I had to have this kind of illness. She replied that getting diabetes is always a challenging situation, and

some people have to process it for a long time, but usually, it gets easier with time and achieving a good care balance.

In the case of negative experiences the patients' emotional presence was manifest in silence and becoming serious. This was felt to be a consequence of the HCPs' behavior. In addition, the patients experienced a significant amount of negative internal feelings, such as guilt, panic, and depression. In the patients' negative experiences there was one exception in which the patient showed her emotions to the HCPs. The patient said that she openly expressed her frustration to the HCP, asking her to stop talking about negative things. The HCP changed her behavior, and the patient recognized that she was able to defend herself in that kind of situation, so this action stayed in the patient's mind as positive.

In summary, the patients found it important that they could handle and express all kinds of emotions in ways that were suitable for them in the care situations. In this process, the emotional support from the HCPs was essential in both positive and negative experiences. According to the patients' descriptions', the main communication process related to giving emotional support was accommodation. For example, in this study, some of the patients appreciated very gentle emotional support, but some of them appreciated a firmer communication style when giving emotional support – especially when they analyzed the care situations afterwards.

Appropriateness

On the level of communication behavior, appropriateness comprised two factors: showing understanding of the purpose of the communication situation and demonstrating respect. In the positive experiences, it was crucial that the patients saw these as reciprocal communication behaviors by both parties. The first factor meant reciprocal understanding that a particular discussion was intended to benefit the particular patient. This was seen as concentrating on the main reason for the communication situation and as attempting to

determine the patients' other possible acute needs. The HCPs seemed to play a certain role in this task, listening to the patients and asking at the end of the discussion whether the patient still had acute needs. According to the data, mutual understanding also entailed a forward-looking orientation. In particular, the HCPs focused on the future by finding solutions, did not blame the patients for having diabetes and unhealthy lifestyles, and instead tried to motivate them to improve their self-management. In negative experiences, the HCPs typically engaged in blaming behaviors and concentrated on irrelevant issues. One patient described these communication behaviors as follows:

I went to the HCP because of having flu. Luckily, I haven't had to visit the HCP often for that purpose. And she wanted to inform me more about diabetes and its dangers, instead of concentrating on the fact that I needed an antibiotic. That visit made me feel very guilty. However, she did take care of what I wanted. The flu matter was taken care of, but at the same time, we addressed diabetes care issues I could not have managed at that moment.

In the patients' positive experiences, mutual respect was seen as mutual politeness, appreciation for each other's expertise in the field of type 2 diabetes care, and honesty. In practice, mutual politeness meant being friendly and neutral to each other and avoiding disagreements. Appreciating each other's expertise was seen as mutual willingness to benefit from the other's knowledge. The patients gave their HCPs space to conduct the necessary medical examinations, give information, and present the possible care guidelines. The HCPs asked about and listened to the patients' experiences of their health situation and the outcomes of various treatments. In mutual honesty, all matters were talked through appropriately so that the patients had a realistic idea of the dimensions of treating a chronic illness:

I left there with a positive mentality even though the HCP's answers were not mind encouraging. He talked very clearly about those matters and did not make the illness sound nice, but he did not make it any worse either. That was a very appropriate visit.

In the patients' negative experiences, the descriptions related to respect were mainly connected to the HCPs' communication behaviors. Some patients described their HCPs as impolite, for example, snapping and underestimating the patients' concerns. Underestimating the patients' expertise emerged in not asking about and listening to the patients' descriptions of their state of health and indicating that the HCPs knew more about diabetes than the patients. The elements of honesty were not seen in negative experiences as they were in positive experiences.

In the patients' negative experiences, the patients' descriptions of their own communication did not noticeably demonstrate elements of appropriateness. Three patients mentioned that they had found it difficult to show respect for their HCPs, which may have caused some communication difficulties. One patient said that she formed a negative attitude towards the HCP at the first meeting. The other two reported that their negative attitudes toward their HCPs had developed during long-term care. One of these patients described her negative attitude as follows:

I usually feel it extremely distasteful to attend her consultation. Perhaps I am not appealing, I don't know, but I do not waste words. I talk about my issues with her, and if I do not get a response that I like I can't be bothered to beat around the bush. Because the situation is as it is, I see no point in persevering.

In summary, appropriateness was associated with appreciation of each other's expertise, humanity, and common objective in terms of facilitating a patient's well-being in a particular situation. For both positive and negative experiences the time orientation seemed to be connected to these elements. According to the patients' descriptions, several situations were

deemed meaningful, e.g., the kind of situation in which the diabetes care was discussed, where the discussions were past or future oriented, and how the earlier care history and knowledge about diabetes were used and seen in the care discussions.

Discussion

According to the results, the four core relational communication characteristics of the HCP–patient communication in the patients’ positive and negative care experiences were *building trust in the other party in the HCP–patient relationship, willingness to communicate, emotional presence, and appropriateness*. The occurrence of these characteristics in both experiences indicates that the characteristics in question may be central in achieving experiences of care conducive to self-management from the patients’ perspective. The main findings concerning relational communication characteristics could be crystallized into four main points.

First, the four relational communication characteristics of the patients’ experiences related to self-management related experiences appeared to support the idea of patient-centeredness. All the characteristics in question seem to be associated with the care recommendations, whereby supporting patients’ participation and overall wellbeing and building a confidential and respectful care relationship are placed at the center of a good care experience (see e.g. Epstein & Street 2007; Mead & Power 2000; Smith et al. 2011). In addition, the results lend support to the recommendation that patient-centeredness should not be understood simply as a result of the verbal and nonverbal behaviors of HCPs. Although the initiative of the HCPs was decisive in the patients’ experiences, both positive and negative, reciprocity in relational communication was also clearly emphasized. Thus patient-centeredness can be understood as a process and as a result of HCP–patient interpersonal communication in which both interlocutors’ relational communication behaviors are of

significance for the success of the care relationship and the patients' care (e.g., Street, 2017; see also Watzlawick et al., 1967).

Second, the relational communication characteristics were perceived to be more reciprocal in the positive experiences than in the negative experiences, which emphasized the relational communication of the HCPs. Interestingly, the descriptions of the patients' relational communication differed significantly in the positive and the negative experiences. In the positive experiences, the patients' ways of showing willingness to communicate varied from listening to active questioning and open disclosure in care situations, whereas in the negative experiences most patients described themselves as passive, quiet listeners due to the HCPs' behavior. Although these descriptions differed, a common feature was that the patients' relational communication was connected to the ability to communicate in ways natural to them. This finding partially questions the findings of earlier studies suggesting that in care situations and decision-making HCPs should encourage more verbal participation on the part of patients to make the communication more patient-centered (see e.g., D'Agostino et al. 2017; Shue et al., 2010). Although various types of verbal communication, such as asking questions, stating opinions, and expressing emotions have been associated with treatment adherence, psychological well-being and satisfaction in the HCP-patient relationship (e.g., Cegala, Marinelli, & Post, 2000; Venetis, Robinson, & Kearney, 2015), there also seems to be a need to strengthen patients' interpersonal communication skills to facilitate their chances of participating, especially in negative communication situations (e.g., D'Agostino et al. 2017; Kettunen et al., 2001). Despite the increasing attention directed towards improving patient skills in the 2000s (Duggan, 2006; Shue et al., 2010), strengthening patients' interpersonal communication skills to participate in the construction of appropriate HCP-patient relationships has not been sufficiently emphasized.

Third, according to the patients' views, patient-centered care could be carried out in individual care situations, as well as in continuous relations with doctors and nurses. In this study, in positive and negative experiences alike the continuity of the care relationship appeared to affect both patients' willingness to communicate and the trust the HCP invested in the care provided. However, the elements of trust and willingness to communicate were also seen in the descriptions of individual care situations. Interestingly, more than half of the patients' negative experiences (11/21) occurred with familiar HCPs. Although in earlier studies patients with diabetes have apparently appreciated continuity in care relationships (e.g., Burke et al., 2006; Naithani, Gulliford, & Morgan, 2006; Parchman & Burge, 2002), the continuity of the care relationship did not seem protect the patients in this study from negative care experiences. Earlier research has also questioned whether continuity is more important to interpersonal communication-related outcomes than to outcomes related to self-management (Mainous, Koopman, Gill, Baker, & Pearson, 2004). These findings afford another perspective on the development of health care services: how relational communication characteristics supported both objectives in relationships and objectives in care regardless of the duration of the care relationship.

Finally, although the relational communication characteristics seemed to be the same across professionals and the length of the HCP–patient relationship, the features of these multidimensional characteristics may have manifested differently in the positive and negative experiences depending on the speech culture (e.g., Jain, 2014). For example, the many-sided descriptions of the characteristic “willingness to communicate” support those old studies where Finns have been claimed to be less willing to communicate (Sallinen-Kuparinen, McCroskey, & Richmond, 1991) but also where Finnish patients have been claimed to participate in the HCP-patient discussions in numerous ways (Kettunen et al., 2000; Kim et al., 1993). The uniformity of the results of this and earlier studies may indicate that such multidimensional and

even contradictory tendencies in patients' relational communication behaviors may be typical – not only in Finnish speech culture – but also specifically in Finnish health communication culture, which is important to recognize when developing old and new health care practices.

In addition to different manifestations of relational communication characteristics, patients' care experiences in general may have included special relational communication characteristics depending on the speech culture. Appropriateness was the most interesting individual relational communication characteristic in this study because, unlike the other three characteristics, it has not been emphasized as a central relational communication characteristic in international health communication research. In earlier studies related to Finnish speech culture, the features of appropriateness were seen primarily as cultural norms manifest primarily in nonverbal communication, communication content, and personal characterizations produced by individuals (e.g., Wilkins, 2005; 2009) – and not in features of relational communication in relationships, as in this study. The same connection was also apparent in Finnish health care instructions and instruments concerning quality of care (e.g., Töyry, 2001). These findings suggest that appropriateness seems to be an appreciated relational communication characteristic, at least in the context of Finnish health care services. More research is needed to identify the ways in which appropriateness is connected to the relational communication behaviors of both participants in medical discussions, as well as in the context of different speech cultures.

The limitations of this study are connected particularly to the research methods. One limitation is that the research data may suffer from recall bias in patients' retrospective self-reports from several years before (e.g., Burleson & MacGeorge, 2002). Moreover, patients with continuing care relationships may have confused their perceptions of a single visit with those of other visits. However, studying retrospective self-reports gave the participants time to thoroughly process the main factors of the HCP-patient communication situations, which is

important in studying significant interpersonal communication experiences. The success of the research frame is additionally reflected in the fact that the patients described more positive (42) than negative (21) experiences. It has been stated that the meaning of the communication processes will usually be concrete to the parties in typically negative situations (Roter & Hall, 2006); however, in this study, both positive and negative experiences were well represented.

Although most of the participants could define the nature of the significant interpersonal communication experiences as clearly positive or negative, some participants had difficulties in distinguishing whether their experiences were predominantly positive or negative. In this study, this limitation was resolved by classifying the patients' experiences as positive and negative according to whether the patients themselves regarded the experiences a help or hindrance to their self-management. As regards distinguishing between the processes, the other challenge was the multi-dimensional nature of the relational communication characteristics meaning, that their characteristics could be equally well related to other relational communication characteristics. More research is needed on relational communication characteristics as separate phenomena and as combinations contributing to different outcomes in the HCP-patient relationships.

The final limitation was that most of the participants were women, and their perceptions of supportive communication may have differed from those of men (e.g., Hanasono et al., 2011). However, the same questions were gone through with all the participants and there were no significant differences between the responses of the women and the men.

Conclusions

Significant interpersonal communication experiences related to self-management are formed in a frame of relational communication, where the participants' manner of establishing a particular care relationship with a particular person is crucial. This is specifically communicated through verbal and nonverbal communication behaviors. The relational

communication characteristics of the patients' significant interpersonal communication experiences seem to be constructed simultaneously by the behaviors of both the patient and the HCP – especially in positive experiences. More research is needed on patients' relational communication behaviors in negative experiences and on ways to strengthen the use of interpersonal communication skills in such situations. Although individually tailored communication has always been thought to be important to patients, this research identified the relational communication characteristics that are common across situations involving patients. Clinicians can utilize these as characteristics as an important support for self-management and choose individual strategies to accommodate individual, contextual, and cultural differences.

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The Author(s) declare(s) that there is no conflict of interest.

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