2018

Self-Disclosure, Gender, and Patient Satisfaction in the Doctor-Patient Relationship

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Recommended Citation

Self-Disclosure, Gender, and Patient Satisfaction in the Doctor-Patient Relationship

By

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A Thesis Submitted in Partial Fulfillment of the

Requirements for the Degree of

Master of Arts

In

Communication Studies

Minnesota State University, Mankato

Mankato, MN

August 2018

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This thesis has been examined and approved by the following members of the student's committee.

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Abstract

Self-Disclosure, Gender, and Patient Satisfaction in the Doctor-Patient Relationship

It has been well established that the doctor-patient relationship is integral for providing quality health care and sustaining patient satisfaction. Additionally, research has indicated that doctors' self-disclosure is considered as an essential interpersonal component of relational development. In terms of the doctor-patient interaction, previous research has produced numerous studies investigating the relationship between doctors' communication behaviors and patient satisfaction. Scholars have also explored how communication styles are associated with doctors' gender, and patient satisfaction. However, there is still a gap in the existing research concerning the connections between doctors' self-disclosure, gender, and patient satisfaction in doctor-patient interactions. My qualitative study sought to examine how doctors' self-disclosure impacts patient satisfaction and how doctors' gendered performances of self-disclosure were perceived by patients. I conducted an in-depth focus group interview with a total of eight volunteer participants (five females, three males). My findings indicated that doctors' self-disclosure positively impacts the patient satisfaction regardless of their gender. Additionally, participants indicated that self-disclosure from both male and female doctors was viewed as helpful when it was relevant and not excessive.

Acknowledgements

I would like to acknowledge the people whose support have been incredibly valuable to me during the process of completing this project. First and foremost, I would like to thank Dr. Anne Kerber who chaired and advised this thesis. I could not have done this without your advice and support. It wasn't easy, but you helped me get through it and pushed me to become a better writer and a better scholar. I appreciated your patience, all the feedback, and guidance throughout the whole process that helped me to complete this project.

I would also like to thank Dr. Leah White and Dr. Laura Harrison for being on my committee. I truly appreciated your patience and support. Throughout this whole process, you both have given me great feedback to improve my thesis. Dr. White, when the thought of writing a thesis was daunting to me and at that time you helped me a lot to figure out my interests, I appreciated your time and guidance. Dr. Harrison, you helped me broaden my knowledge on gender dynamics, I appreciated your all clarifications.

Finally, thanks to my family and my beloved friend Basit, for all the love, support and encouragement you have given me. Basit, thank you for allowing me to talk about my research constantly that helped me to put my mind at ease. Whenever I needed you, you were always there for me. Thank you very much for everything.

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Chapter One: Introduction

Growing up, I have always struggled with my health conditions, such as having constant dust allergies, fever, fatigue, and other issues. Unfortunately, falling ill and fighting with diseases have been regular segments of my life. For example, I remember as a child questioning why I am not as healthy as others. I even used to ask God, why am I the only person who often falls sick? Deep down, I knew that there were others who also suffered from many diseases. However, these sorts of questions have never stopped wandering in my mind.

One outcome of my health history is that it has given me extensive experience with medical encounters, as I have met and worked with a diverse range of male and female physicians. In my experience, building a good rapport with a doctor has been important for making me feel comfortable discussing my health and feel satisfied with the care I receive. Yet, finding doctors who meet these needs can be challenging. For instance, I remember visiting one "top" doctor when I was suffering from severe health issues where I also needed mental support. While he listened and wrote prescriptions, he handled the interaction with my mother and I like a robot – there was no emotional expression and appeared to be no interest in building a relationship with us. Dissatisfied, we stopped seeing him after only a few days. On the contrary, my current family doctor (a male) is very interpersonally skilled and we have been seeing him for almost 10 years. He takes time for consultations and always makes connection to patients' conversations, which shows care about his patients. A few years back, I had a breakdown in my life. I was mentally broken and became sick. My medication was not working, and I did not feel as if I could share anything with my family. I was fighting all alone. I remember that

day, I went to visit this doctor with my father. After some time, he requested my father to let him to talk to me alone. He asked about my situation and shared a similar story from his own life that gave me the mental support I needed to survive. Mostly, he builds rapport with patients through self-disclosing about both medical and non-medical topics. He also tries to make his patients feel happy, even making jokes. A case in point: My mother told him once that she was feeling good because she actually did not want to take medicine. In replying, the doctor said that if you are already feeling good, then how come I am seeing you again? This gentle teasing and question made my mother smile. We are comfortable discussing our health issues with him. He does not seem like a stranger to us because we at least know something about him.

When doctors share a little bit about their personal experiences, it makes a connection with patients, creating an atmosphere that is favorable for them to disclose as well. As a patient, I have found these personal connections to doctors to be beneficial because they give me peace of mind about receiving good care. Yet, doctors' gender differences might act as an obstacle to a smooth disclosure due to early gender-role socialization. Additionally, patients may have different communication expectations for male and female doctors based on gender roles.

Sex is the biological categorization of male/female based primarily on reproductive organs. Gender, on the other hand, is the social elaboration of biological sex (Eckert & McConnell- Ginet, 2013). Even though sex and gender are often considered as different from each other, this distinction is often intertwined. Gender builds on biological sex. However, it can also exaggerate the perceived biological differences between the sexes. Sex assignment is constructed particularly in light of cultural beliefs

about what actually makes someone a male or female. Although the terms associated with sex (male/female) and gender (masculine/feminine) are understood as part of this difference, they are often used interchangeably in the health communication literature. I follow this disciplinary convention in my use of the terms in this study.

We learn who we are and how our culture perceives our gender identity by communicating with others. People's understanding of themselves and others as male or female, is ultimately social. Gender differences begin in the earliest stages of our lives. Tannen (1990) asserts that girls and boys grow up in different worlds, even if they grow up in the same neighborhood, on the same block, or in the same house. For example, as children learn to play with toys, they receive messages from family, other role models, and the media that influence their perceptions of specific gender roles in various social contexts. Similarly, Wood (1997) states:

> What gender means depends heavily on cultural values and practices; a culture's definition of masculinity and femininity shapes expectations about how individual women and men should communicate; and how individuals communicate, establish the meanings of gender that, in turn, influences cultural views. (p. 20)

Not only is gender socially constructed, we learn how to perform gender identities through social norms that assign characteristics as masculine and feminine (Ivy & Blacklund, 2004; Kulik & Olekalns, 2012). For instance, being feminine is most often associated with being affectionate, emotional, friendly, sympathetic, sensitive, and sentimental. In contrast, masculinity is frequently associated with being dominant, forceful, aggressive, self-confident, rational, and unemotional (Ivy & Blacklund, 2004; Schneider, 2005). Most of the traits associated with specific genders are stereotypes.

However, early socialization into gender roles do foster these traits for how individuals build relationships.

Health care is one social context where the performance of gender roles can be particularly important. Doctors' gender differences may be reflected in how they communicate with patients, such as their willingness to self-disclose. At the same time, perceived gender differences may also influence whether such disclosures are expected and how they are received. Patients may assume or even expect that male doctors will not self-disclose or appear unemotional due to masculine norms. They may also feel uncomfortable discussing sensitive health issues when they visit doctors of the opposite sex. For instance, Yanikkerem, Ozdemir, Bingol, Tatar and Karadeniz (2009) reported that women patients prefer female doctors when they go through gynecological examinations because of feeling embarrassment, anxiety, and discomfort. Likewise, in my case, I do not feel comfortable disclosing sensitive health issues to doctors of the opposite sex. In particular, as a woman, I always try to visit a female gynecologist.

During medical consultations, the ways doctors communicate is fundamental to the care that patients receive, particularly as it relates to important outcomes such as: patient satisfaction; recall; treatment adherence; understanding of information, and health outcomes (Jefferson, Bloor, Birks, Hewitt, & Bland, 2013; Ong, Haes, Hoos, & Lammes, 1995; Street, 2002). An extensive body of research has observed variations in how gender roles are performed during patient-provider interactions and demonstrated how these differences impact patient outcomes. For instance, Cartwright (1972) found that female doctors and medical students were more highly interpersonal relationship-oriented and affective in medical practice, while men were more reserved and science-oriented.

Meeuwesen and Schaap (1991) noted that male doctors behaved in a more controlling and imposing manner than their female coworkers.

As a powerful indicator of health care quality, doctor-patient interaction plays a crucial role in determining patients' self-management behavior and health outcomes (Matusitz & Spear, 2015). Through interpersonal communication, physicians and patients mostly exchange information which eventually builds an effective relationship between them. Likewise, Ha, Anat, and Longnecker (2010) stated, "Medicine is an art whose magic and creative ability have long been recognized as residing in the interpersonal aspects of patient-physician relationship" (p. 38). Therefore, if male and female doctors differ in their communication styles during health care interactions, patient outcomes, and particularly patient satisfaction, may vary as a result. According to Kane, Maciejewski and Finch (1997), patient satisfaction is considered as an attitudinal response to value judgments that patients make about their medical experiences. Patient satisfaction has long been thought of as an outcome of doctors' verbal and nonverbal communication while interacting with patients (Daly & Hulka, 1975; Korsch, Gozzi, & Francis 1968; Spiro and Heidrich, 1983). However, it is increasingly viewed as a significant determinant of compliance in order to improve the effectiveness and quality of health care (Korscher et al., 1968; Korsch & Negrete, 1981; Lane, 1983; Woolley, Kane, Hughes, & Wright, 1978). Moreover, physicians have financial incentive to attend to patient satisfaction. Gesell (2003) noted that patient dissatisfaction is linked to doctor switching and patient retention issues. Likewise, Rundle-Thiele and Russell-Bennett (2010) reported that even a "5% patient dissatisfaction rate can cost a doctor $150,000 in lost revenue" (p. 196).

Problem Statement. Patient satisfaction has been a central concentration in the health communication research to date. Boquiren, Hack, Beaver, and Williamson (2015) stated that doctor-related factors during medical interactions, especially concerning communication ability, interpersonal and technical skill, and accessibility, are significantly associated with the evaluation of healthcare providers in anticipating patient satisfaction. For example, they explained that a perception of a 'good doctor' refers to being friendly and empathetic, honest, polite, approachable, and treating patients with respect. Additionally, a doctor who is willing to spend time with them and address all their concerns; who is accessible, skilled, and can communicate information in an understandable manner is valued by patients (Boquiren et al. 2015). On the other hand, there are several ways in which doctor-patient interactions can create patient dissatisfaction. In particular, some communication barriers that have been observed as decreasing patient satisfaction include: a doctor's perceived lack of warmth and friendliness toward patients, failure to consider patients' concerns and expectations, lack of a clear-cut explanation concerning diagnosis and causation of illness, and excessive use of medical jargon (Korsch et al. 1968; Roter, Stewart, Putnam, Lipkin, Stiles & Inui, 1997).

There is evidence that gendered communication styles may contribute to perceptions of patient satisfaction. Existing literature suggests that patient satisfaction is positively associated with affiliative communication styles (Anderson & Zimmerman, 1993, 2000; Buller & Buller, 1987; Cousin & Schmid Mast, 2013; Hausman, 2004; Ong et al. 2000; Pieterse, Street & Buller, 1987; Van Dulmen, Beemer, Bensing, & Ausems, 2007) that exhibit more patient-centered behaviors such as, showing concerns,

agreeableness, empathy, friendliness (Boer, Delnoij, & Rademakers, 2013; Carrard, Schmid Mast, Jaunin-Stalder, Perron, & Sommer, 2018). The use of controlling behaviors by doctors has similarly been found to have negative impacts on patient satisfaction (Anderson & Zimmerman, 1993; Bradley, Sparks & Nesdale, 2001; Buller & Buller, 1987). Moreover, research suggests that male doctors commonly use the controlling style to communicate, where the affiliative style is more common among female doctors (Aruguete & Roberts, 2000; Buller & Buller, 1987; Buller & Street, 1992). Additionally, Leserman (1981) reported that female medical students have been found to value more egalitarian doctor-patient relationship which involved greater information exchange and questioning by patients.

One area of doctor-patient interaction that has shown promise for deepening therapeutic relationships is self-disclosure because it engages patients actively in interactions. According to Jourard (1971), self-disclosure is defined as sharing personal information to others characterized by the honesty, intent, and willingness. Jourard (1958) related self-disclosure to the 'healthy interpersonal relationship' in which people willingly reveal their real self while interacting with others. Self-disclosure has been extensively studied in interpersonal communication and is seen as integral for building significant interpersonal relationships. Regarding interpersonal relationship outcomes, patients are mostly satisfied with doctors who self-disclose more (Beach, Roter, Rubin, Frankel, Levinson, & Ford, 2004; Holmes, Harrington, & Parrish, 2010; Lussier & Richard, 2007). The act of disclosure creates intimacy between people, enabling individuals to resolve fear, shame, or crippling social inhibitions in terms of compulsive needs for privacy (Corey & Corey, 1992; Robison, Stockton, & Morran 1990; Yalom,

1985). On the other hand, Jourard (1958) stated that non-disclosure creates communication patterns with negligible interpersonal feedback, increases the likelihood of maladjusted social behaviors, and makes relationships difficult.

Usually, self-disclosure is not expected by people in professional relationships because it may violate the boundaries between personal and occupational spheres. Additionally, doctors may be concerned that the potentially positive effects of self-disclosure will be outweighed by possible risks (e.g., embarrassment, lower self-esteem, and relationship deterioration or termination). However, physicians are increasingly encouraged in their training to disclose their personal experiences in medical interactions because it projects friendliness and builds a therapeutic doctor-patient relationship.

Because disclosure and emotional expressiveness are closely associated with feminine styles of communication, it is often believed that women self-disclose more than men. Jourard (1971) ascribed these differences to culturally driven sex roles, particularly for men:

> The male role requires men to appear tough, objective, striving, achieving, unsentimental, and emotionally unexpressive … The male role, and the male's self-structure will not allow man to acknowledge or to disclose the entire breadth and depth of his inner experience to himself or to others. Man seems obliged, rather, to hide much of his real self—the ongoing flow of his spontaneous inner experience—from himself and from others. (p. 35; see related arguments by Jourard & Lasakow, 1958; Jourard & Richman, 1963; Schneider, 2005)

Therefore, male and female doctors have been socialized to enact traditional gender roles. Overall, female doctors tend to be more sensitive, expressive, and

empathetic than male doctors in medical encounters (Meeuwesen & Schaap, 1991; Bylunda & Makoul, 2002; Kilminster, Downes, Gough, Murdoch-Eaton, & Roberts, 2007; Howick, Steinkopf, Ulyte, Roberts, & Meissner, 2017; Linzer & Harwood, 2018). Likewise, Mendez, Shymansky, & Wolraich (1986) found female doctors' use more 'emotional probing' and 'reflection of feelings' than male doctors when consultations contain distressing information. Additionally, Day, Norcini, Shea, and Benson (1989) reported female doctors as being less egotistical and more humanistic, sensitive, and altruistic than their male counterparts. These observed gender differences may be attributed to socialization, which deters men from expressing emotions and appearing weak to other males (Dolgin, Meyer, & Schwartz, 1991; Schneider, 2005).

Similarly, patients may bring traditional gender role expectations or stereotypes to the medical encounters and respond to doctors based on these expectations. For instance, Shapiro, McGrath, and Anderson (1983) found that female patients tended to view female doctors having both instrumental (technical) and expressive (interpersonal) qualities/behaviors. Yet, male and female patients alike tended to view male doctors as either low on both dimensions or as only instrumental. Mast, Hall, Klockner & Choi (2008) found that male and female physicians who accordingly showed their traditional masculine and feminine gendered behaviors indicated greater patient satisfaction. Historically, research on gendered communication differences has found that women's interpersonal styles are generally perceived as more engaging, warm, and immediate (Goman, 2016; Hall et al. 1984, 1987). For example, the research illustrated how women's non-verbal communication (e.g., facial expressiveness, gazing, interpersonal distance, body posture, touch, and bodily gestures) tends to suggest more accessibility

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and friendliness (Aries, 1987; Goman, 2016). During conversation, women are socialized to find it easier to disclose information about themselves and facilitate others to talk to them more freely.

Additionally, patients' gendered perceptions and expectations toward doctors may influence them to react differently to disclosures (or the lack thereof) by male and female doctors. Derlega and Chaikin (1976) found that women who did self-disclose were perceived as better adjusted and more likable than women who did not, and the reverse was perceived for men. Research also noted that women have been socialized to be submissive in their interactions with men, while men have culturally primed to withhold disclosure to maintain relational power (Dolgin et al. 1991; Mulac, Bradac & Gibbons, 2001). Moreover, women are more likely to be socialized to expect comfort, personal growth, and relief through disclosing feelings as compared to men.

Therefore, historically the research suggests that gender socialization may have a significant impact on doctors' willingness to self-disclose during interactions with patients. Additionally, gendered expectations may influence how patients perceive and whether they are satisfied with disclosure from their health providers. However, there is a lack of studies that specifically focuses on the relationships between doctors' self-disclosure, gender, and patient satisfaction.

Purpose of the Study

Quality health care and patient outcomes depend on the doctor-patient relationship, which makes effective health communication imperative. Doctors often disclose their personal experiences during clinical consultations in order to enhance communication with patients and increase patients' satisfaction with these interactions.

Several studies have found that communication preferences related to the openness and closedness of privacy boundaries vary due to gender differences. Accordingly, doctors' gender may affect the structure and contents of self-disclosure while interacting with patients. Moreover, how the disclosure is perceived by patients may be influenced by expectations of gendered role performances. In my thesis, I intend to explore the following research questions:

(RQ.1) How does the physician's self-disclosure impact patient satisfaction?

(RQ.2) How is patient perception of physician self-disclosure influenced by the physician's gender?

(RQ.3) How is patient expectation for physician self-disclosure in medical interactions influenced by the physician's gender?

Preview of Thesis Chapters

Chapter 2: The second chapter delved into the existing literature on this topic. The literature review started out by reviewing overall communication behaviors of doctors connecting to patient satisfaction in order to examine how doctors' self-disclosure may connect to patient satisfaction in terms of the doctor-patient interaction. Accordingly, the literature review explored the communication styles concerning the difference between male and female doctors to examine how doctors' gender difference may cause variations in the use of self-disclosure as well as how gender may shape patients' perceptions/expectations of physicians' disclosure.

Chapter 3: The third chapter focused on the methods used in this study. For this study, I used the qualitative in-depth focus group interview. In this section, I touched on the justification of using qualitative research for this study, described my participants and procedures, and explained my data analysis.

Chapter 4: In the fourth chapter, I addressed my results of the study. Specifically, I identified the common themes of my data. I also used quotations from my interview and previous research on this topic to support the common themes within my research. Through these components, I was able to establish what my results are.

Chapter 5: In the final chapter, I revisited my research questions by looking at how findings relate to the issues guiding my inquiry. Then I discussed the implications, limitations, and future research areas suggested by my study.

Chapter Two: Literature Review

This chapter explores overall communication behaviors of doctors connecting to patient satisfaction and how doctors' self-disclosure may connect to patient satisfaction in terms of the doctor-patient interaction. Specifically, it investigates how communication styles have historically been associated with doctors' gender influencing patient satisfaction in order to examine how doctors' gender performances of self-disclosure are perceived by patients.

Doctor-Patient Interaction

During medical encounters, the way doctors communicate with their patients is seen as instrumental in both shaping interactions and influencing health outcomes. Scholars have long recognized that interpersonal communication is an essential component of medicine and plays an important role in directing health care practices (Roter & Hall, 2011; Street, 2002). To be effective in their practice, doctors must establish their credibility; accurately assess patients' needs and identify diseases; provide emotional support and regulate emotions; and, facilitate the patient's understanding of medical information (Ha et al., 2010; Jenerette and Mayer, 2016). A doctor's communicative competence is consequential for developing relationships with their patients (Ong et al., 1995). Specifically, Roter and Hall (1992) noted that in medical care, talk is the main component and fundamental instrument which crafts the doctor-patient relationship to achieve therapeutic goals.

The quality of doctor-patient relationships has implications for patient health outcomes as well. For example, research indicates that a provider's ability to demonstrate care and concern influences whether and how patients will reveal symptoms to them in

the future (Gallagher et al., 2005). Neumann et al. (2010) similarly reported that the effectiveness of medical treatment does increase through patient-provider interaction. For instance, they noted interactions between doctors and patients may trigger specific physiological mechanisms (e.g., a reduction in pain, nausea, heart rate, and blood pressure) simply by meeting patients' treatment related expectations. Moreover, the level of a doctors' interpersonal skills has been connected to other important metrics for health care organizations, including: understanding and recall of information, adherence to recommended therapy, health care utilization, quality of care and health outcomes (Ha et al., 2010; Gallagher et al., 2005).

Patient satisfaction. One increasingly important measure for both doctors and health care organizations is patient satisfaction. Conlee and Olvera (1993) defined patient satisfaction as ''the response patients have toward their physicians based on perceptions of affective, cognitive, and behavioral elements of the physician's behavior'' (p. 25). Roberts and Aruguette (2000) categorized affective behaviors as including social conversation, showing empathy, being friendly, asking questions, listening attentively, and talking in a warm tone. Cognitive elements emphasize perceptions of a physician competency, and behavioral elements focus on task behaviors, such as explaining a disease, asking about symptoms, recording items in charts, and prescribing medication. Although all three elements of physician communication are important, Conlee et al. (1993) and Van Dulmen (2002) found affective behaviors are the strongest predictors of patient satisfaction. Similarly, other research has linked patient satisfaction to affective forms of communication, including building rapport and trust; engaging in psychosocial discussion to demonstrate concern, courtesy, and attentiveness; and lower physician

dominance (Hausman, 2004; Ong et al., 2000; Pieterse, Van Dulmen, Beemer, Bensing, & Ausems, 2007). Therefore, patient satisfaction is often dependent on positive emotional responses to and interpretations of the health care interaction, particularly interpersonal elements related to the bond between doctors and patients (Hausman, 2004).

At the same time, poor communication from physicians frequently leaves patients feeling dissatisfied with their care. According to Butow (2001), lower patient satisfaction is associated with unclear communication about treatment benefits, side effects, and symptom control. Moreover, patients report higher levels of dissatisfaction when doctors are perceived to exhibit little warmth and friendliness (Korsch, Gozzi, and Francis, 1968). In short, doctors must not only have good technical skills to be successful, but they also must enact communication behaviors that influence patient satisfaction. In terms of building interpersonal relationships between doctors and patients, and anticipating patient satisfaction, doctors' self-disclosure may act as a significant factor.

Self-disclosure and the doctor-patient relationship. Self-disclosure is frequently used as an interpersonal communication strategy to enrich and foster relationships, such as those between doctors and patients. According to Greene, Derlega, and Mathews (2006), self-disclosure is an ''interaction between at least two individuals where one intends to deliberately divulge something personal to another'' (p. 411). The types of information revealed in self-disclosure might include thoughts, feelings, or information about one's self (Derlega, Winstead, & Greene, 2008).

The reasons why people choose to self-disclose vary based on an individuals' relational goals, as well as the potential costs and benefits of disclosure. For instance,

self-disclosure is one important way to reduce uncertainty about new social situations or relationships. For patients, medical consultations are already fraught with uncertainty regarding their health status. This uncertainty is increased when working with a new or unfamiliar care provider. If a patient is already uncomfortable discussing health information (due to perceived stigma or fear of judgement), relational dynamics within the health encounter may further impede their willingness to share salient concerns with their provider. Uncertainty Reduction Theory asserts that people have a need to reduce uncertainty about others by gaining information about them, which can be used to predict the other's behavior (Berger & Calabrese, 1975). Self-disclosure offers physicians with a method for providing information to patients that can not only reduce patients' uncertainty, it can also be used as a technique for fostering others' disclosure (Berger & Bradac, 1982). Vrchota (2011) explained that "relationships are built through the negotiated progression of increased and reciprocated disclosures by the participants" (p. 221). To build rapport and put the patient at ease, doctors commonly talk informally about their interests. Thus, self-disclosure is often viewed as a critical component of relational development.

Relational quality has also been a part of most disclosure and privacy theorizing. A case in point: Communication Privacy Management (CPM) theory (Petronio, 2002) emphasizes how people generally disclose to those with whom they feel close, believe they can trust with personal information, and are confident they will receive positive responses from. Therefore, "better relational quality and more positive anticipated responses are related to increased disclosure intentions or willingness to disclose" (Greene, Magsamen-Conrad, Venetis, Checton, Bagdasarov, & Banerjee, 2012, p. 358).

In doctor-patient interaction, better relational quality is a keystone of care because it is integral to accomplish an accurate diagnosis, build trust with patients, and improve compliance to treatment, overall patient satisfaction, therapeutic outcomes, and avoid litigation.

In professional relationships, it is less common for individuals to disclose personal experiences due to concerns surrounding the boundaries between work-life spheres. Scholars have noted a number of concerns for health providers who consider disclosing personal information to patients, specifically regarding when disclosure is appropriate, what the extent and content of self-disclosure should be, and what the clinical and ethical consequences are (Reamer, 2012). For example, Gutheil and Gabbard (1995) noted that therapists who self-disclose "must be sure that their reasons for doing so are not related to their own unfulfilled needs in their private lives" (p. 222) to ensure such disclosure is not exploitative and/or unethical. In addition to these concerns, there are a variety of factors that may influence when self-disclosure is viewed as appropriate and/or potentially beneficial in health care encounters. According to Kunkle and Gerrity (1997), "appropriate self-disclosure depends on the target, timing, quantity, and quality" (p. 214). Guthrie (2006) further noted that disclosure requires health providers to carefully consider how the meaning of an issue may be interpreted by a patient at a particular moment. As Frommer (1999) put it, "if [disclosures] are to be meaningful, [they] require that we grapple with them in the context of specific treatment situations" (p.57).

Even when a physician carefully assesses whether to disclose personal information, different patients may have different reactions (Goldstein, 1997; Gutheil &

Brodsky, 2011). There are considerable complications when anticipating patients'

responses to health professionals' self-disclosures (Peterson, 2002). For example,

excessive disclosure may make patients feel uncomfortable or misunderstood, create role

confusion, be perceived as self-preoccupation, or encourage them to believe the same

high levels of self-disclosure are expected in return (Audet & Everall, 2010; Nadelson &

Notman, 2002; Strassberg, Roback, D'Antonio, & Gabel, 1977). Disclosure can also

lessen patients' feelings of trust and safety if it is not helpful, and in the worst-case

scenarios, can harm the therapeutic relationship (Hanson, 2005).

Despite these potential risks, research indicates there may be a relationship

between self-disclosure and increased patient satisfaction. For example, doctors who

usually disclose something about themselves with patients create a greater sense of

closeness, greater sympathy, and a climate of trust (Lussier & Richard, 2007). As a result,

patients may feel more welcome to share their own stories. Hearing a provider's story

may also enhance perceptions of their credibility, which has also been shown to influence

patient compliance and satisfaction (Beach et al., 2004; Lussier & Richard, 2007).

Moreover, there is evidence to suggest self-disclosure may be important in

specific types of medical practices. For instance, Beach et al. (2004) found surgical

patients, especially those with high levels of anxiety before procedures, were highly

satisfied with those surgeons who self-disclosed because they felt warmth/friendliness

and reassurance/comfort. In addition, Holmes, Harrington, and Parrish (2010) found that

parents were more satisfied with pediatricians who self-disclosed than those who did not

in the context of a 'sick child' office visit. Their study indicated self-disclosure played a

significant role for relationship-building in the pediatric setting and recommended that

pediatricians should feel comfortable sharing information about themselves with parents where it might include "the sharing of physician emotions, attitudes, and opinions, as well as personal and professional experiences" (Holmes et al., 2010, p. 368).

Regarding the development of the doctor-patient relationship, Jourard (1971) defined self-disclosure as a characteristic of the healthy personality. Yet, different personalities have unique ways of communicating. Gender socialization and expected role performances may also influence doctors' communicative practices in healthcare encounters. Therefore, it is essential to examine the relationship between gender differences and doctors' willingness to disclose to patients.

Gender, Disclosure, and Satisfaction in the Doctor-Patient Relationship

The quality of health care interactions is determined through the attitudes and role expectations of both doctors and patients. In health care, there are many ways where gender-linked communication differences are parallel to gender differences in other contexts. Historically, due to gender socialization, men stereotypically are perceived as talking in terms of establishing status and independence, whereas women are viewed as talking more to build community and rapport (Mulac, Bradac & Gibbons, 2001; Tannen, 1990). Regarding interpersonal domains, women are socialized to be more expressive and more accurate in perceiving the emotions of others compared to men because in gender socialization, expressing emotions and appearing weak to others are against masculinity (Dolgin et al. 1991; Jourard & Lasakow, 1958; Jourard & Richman, 1963). Accordingly, Merchant (2012) stated that men and women view the purpose of conversations differently in terms of the difference between men's and women's communication styles. According to Basow and Rubenfield (2003), overall women are seen more expressive,

tentative, and polite in conversation, while men are seen more assertive, and power-hungry. With regard to psychological gender differences, women tend to use communication as a tool to enhance social connections and create relationships, while men tend to use language to exert dominance and achieve tangible outcomes (Leaper, 1991; Maltz & Borker, 1982; Mulac, Bradac & Gibbons, 2001; Wood, 1997; Mason, 1995). However, it is important to note that not all men and women follow the gender roles they are socialized to perform. Neither all women are interpersonal relationship-oriented, nor all men are dominant by nature. Both men and women can adopt either masculine or feminine styles. Although this is how research has historically viewed gender differences, gender role socialization remains a salient, contemporary issue for doctor-patient interaction. Therefore, it is essential to explore the prevalence of gendered communication styles among doctors in order to examine the variation of interpersonal aspects between male and female doctors connecting to patient satisfaction.

Gendered communication styles among doctors. Street (2002) stated that the interpersonal domain is the primary context within which provider-patient interaction occurs. Yet, he also noted these interactions may be fundamentally shaped by gendered socialization, and beliefs about identity and values (Street, 2002). During interactions, gender differences connect the interactants' goals, skills, perceptions, emotions, and the way the participants adapt to their partners' communication. There is an extensive body of research on differences in communication styles used by doctors in medical encounters, and the results have largely been consistent with gendered stereotypes. For example, female doctors are viewed as more patient-centered in their behaviors, conducting longer consultations, giving more information, engaging in more partnership-

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building, exhibiting less directive behaviors, demonstrating more concern about

psychosocial aspects of health (e.g. emotions, lifestyle, family), and providing more

explicit reassurance and encouragement than men (Bensing, Van den Brink-Muinen, &

de Bakker, 1993; Roter & Hall, 1997; Street, 2002). Other researchers have found that

male and female doctors adopt different communication styles (Buller & Buller, 1987;

Buller & Street, 1992; Stewart & Roter, 1989). For instance, West (1993) reported that

male doctors were more likely to speak in an authoritative manner, using explicit

commands while giving instructions to patients whereas, female physicians were more

likely to give their instructions and directives as proposals, engaging patients in a more

balanced partnership. Similarly, Meeuwesen et al. (1991) stated that male general

practitioners were more directive and informative than female general practitioners.

Research has also found that female doctors are more likely involved in the expression of

feelings and empathy in terms of affiliative communication styles (Scully, 1980;

Wasserman, Inui, Bamatura, Carter, & Lippincott, 1984). Although there are clears link

between affiliative communication practices and patient satisfaction (Aruguete &

Roberts, 2000; Bradley, Sparks & Nesdale, 2001; Buller & Buller 1987; Cousin &

Schmid Mast, 2013; Hausman, 2004; Ong et al. 1995; Pieterse, Van Dulmen, Beemer,

Bensing, & Ausems, 2007) and the use of affiliative styles among female patients, it is

less clear how patients react to male doctors who use this approach.

     Patient-centeredness. Patient-centered communication positively affects

patients' satisfaction, adherence, and health (Mead & Bower, 2002). Stewart (2001)

stated that the notion of patient-centeredness highlights the significance of giving voice to

patients' needs, emphasizes the importance of including patients' perspectives, and

establishes shared understanding, power, and responsibility between doctors and patients (Epstein et al. 2005). Hall and Dornan (1988) stated that communication behaviors related to patient satisfaction include empathy, courtesy, respect and attention to patient requests derived somewhat from affiliative communication style (DiMatteo et al. 1979; Friedman et al. 1980; Ong et al. 1995; Pantell et al. 1982).

Patients often tend to evaluate their experience in terms of communication skills of healthcare professionals (Gremigni, Sommaruga, & Peltenburg, 2008). During the whole medical consultation, how a doctor responds to a patient influences how much information he or she will obtain and helps to build a stronger relationship with patients. According to Epstein et al. (2005), doctors who exhibit more patient-centeredness communication generate higher levels of trust. Doctors' self-disclosure has positive effects on doctor-patient relationship to enhance trust and decrease role distancing (Ashmore & Banks, 2002) because how the patient views his or her doctor or how that doctor communicates, may determine the patient's willingness to disclose and the likelihood of following advice. For example, Frank et al. (2000) stated that doctors can motivate patients to adopt healthy habits through conveying their own personal healthy habits which improves doctors' credibility. Self-disclosure encompasses the process of one person affecting the actions, attitudes, or feelings of another. Therefore, as an interpersonal influence, doctors' self-disclosure plays a vital role in patient-centeredness.

Gender has been recognized as the source of variation in perceptions of patient-centeredness. Existing studies have found female doctors to be more patient-centered in their communication with patients than male doctors (Bertakis, Franks, & Epstein, 2009; Krupat et al., 2000; Roter & Hall, 2004). Specifically, this area of research has found that

female doctors, in general, engage in longer consultations, use more emotionally focused talk, and engage more active partnership behaviors (e.g., encouragement, reassurance, lowered dominance, positive talk, concern, empathy and sympathy) than male doctors (Jefferson et al., 2013; Roter & Hall, 1997, 2004; Shin et al., 2015; Wissow, 2004). Additionally, there is evidence these gendered perceptions of communication affect patients' choices of physicians. For example, Janssen and Largo-Janssen (2012) found that patients preferred female gynecologist-obstetricians because they used a more patient-centered communication style. This suggests that male gynecologist-obstetricians could adopt more patient-centered communication behaviors to enhance patient satisfaction and trust. Self-disclosure is one possible method for physicians to demonstrate their ability to relate to patient experiences as well as the kind of care suggested by patient-centeredness.

Gender and self-disclosure. Overall, research suggests that female doctors tend to be more expressive and self-disclosing than male doctors. Wissow (2004), for example, noted that female doctors are, notably more involved in active partnership talk, positive talk, offering empathy, counselling, and asking questions about emotions where their patients reciprocate providing more information about their emotions. Additionally, Mazzi et al. (2014) stated that doctors' gender differences may be reflected in what topics male and female doctors choose to disclose with patients, even what they express about their likings or disliking to patients. For example, people feel more comfortable and honest with others of the same gender when they talk about intimate, taboo or otherwise sensitive topics (Betts, Wilmot & Taylor, 2008). Likewise, Martin (1997) indicated that women tend to be more self-disclosing about their thoughts, concerns, fears, and

emotions in their same-sex relationships where men prefer to disclose when they engage in some activity (Dindia & Allen, 1992). On the other hand, homogeneous gender groups explore topics that are seen "as appropriate by some but not all groups – what may be of relevance or concern to female participants may not necessarily be so to male participants" (Betts et al., 2008, p. 287). These all may work in the same way for both doctors and patients. For instance, female doctors may feel more comfortable self-disclosing about certain topics with female patients. The same may be true for patients. In that case, gender congruence may lead to more productive doctor-patient interaction for some types of health care, such as sexual health (Yanikkerem et al., 2009). As male and female doctors hold somewhat different attitudes toward medical practice and women's issues and patients hold different expectations of male and female doctors, Weisman & Teitelbaum (1985) have suggested that same-sex doctor-patient interactions may be considered as more effective communication and stronger rapport than opposite-sex dyads.

Gendered expectations and patient satisfaction. Given the research on gender differences in self-disclosure in general, it stands to reason that a physician's gender may influence their willingness to disclose in a health care interaction. Support, empathy, compassion, and the desire to reduce uncertainty and improve understanding are powerful motivations for self-disclosure to develop intimacy in interpersonal relationship (Pekkar, 2012). Moreover, early gender-role socialization is extremely resilient to change. Therefore, female doctors might have been socialized to the traditional feminine gender-role like more nurturant, expressive and stronger interpersonal-orientated than male doctors. Similarly, male doctors might have been socialized to be more reserved and less

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empathetic than female doctors regarding traditional masculine gender-roles (Weisman & Teitelbaum, 1985). For example, doctors' gender might function through numerous mechanisms such as, differences in personality, attitudes or interpersonal skills that might affect interactions with patients (Scanzoni, 1975).

Accordingly, patients may have different expectations for male and female doctors. Differences in gender-role expectations may influence patients' perceptions of the appropriateness of doctors' communication behaviors, and patients' own affective responses to those behaviors as well. Specifically, these kinds of gender perceptions may influence patients' expectations for whether and how much doctors may self-disclose, and how doctors' self-disclosure will be received, and what the impact of disclosure will be on the patients' feelings of reciprocation (Conlee, Olvera & Vagim, 1993). For instance, Mast, Hall, Klockner and Choi (2008) found greater patient satisfaction for those physicians who showed behaviors that aligned with traditionally gendered roles. Therefore, it is important for doctors to understand the role gendered expectations and satisfaction play in order to determine when and how self-disclosure should be included in a therapeutic relationship.

In general, several studies on doctor-patient interactions have been done with respect to patient outcomes and relational development. The existing body of research suggests that doctors' self-disclosure is positively connected to patient satisfaction and perceptions of patient-centeredness. Several studies have also found that male and female doctors, in general, adopt different communication styles which may also influence on doctors' self-disclosure as well as how disclosures are received by patients. Moreover, gender differences in self-disclosure and how it is perceived may be connected to early

gender-role socialization. As patient satisfaction has become undoubtedly significant in health care, it is essential to more deeply examine the connections between self-disclosure and gender.

Chapter Three: Research Methods

The doctor-patient relationship is integral to many health care outcomes, including patient satisfaction. In terms of interpersonal relationship development, doctors often self-disclose thoughts, feelings, or information in order to foster an environment where patients also feel comfortable with disclosing. However, whether and how much a doctor chooses to self-disclose may vary due to their preferred and potentially gendered communication styles. Additionally, expectations for gendered performance may influence how patients perceive a doctor's self-disclosure. The purpose of my research was to further explore the connections between self-disclosure, gender, and patient satisfaction in healthcare interactions through qualitative inquiry.

My research questions included:

(RQ.1) How does the physician's self-disclosure impact patient satisfaction?

(RQ.2) How is patient perception of physician self-disclosure influenced by the physician's gender?

(RQ.3) How is patient expectation for physician self-disclosure in medical interactions influenced by the physician's gender?

In the following chapter, I will explain my method, describe my participants and procedures, and explain my data analysis.

Justification for Method

When we become sick, we feel vulnerable. The reason I chose to use qualitative research methods for my study is because they

enable us to explore concepts that we experience in our everyday lives, such as empathy, hope, suffering, caring, fear; to explore these concepts as they are

perceived and defined by real people; and to allow people to speak for themselves, thereby emphasizing the human capacity to know. (Hoskins & Carla, 2004. p. 4)

Medical consultations, which consist of interactions regarding doctors' objectives and patients' expectations, drive health care practices and patient outcomes. Qualitative research provides deep insights into interpersonal interactions, such as these health encounters and the doctor-patient relationships that are formed during consultations (Real, Bramson, & Poole, 2009). Specifically, qualitative research approaches enable researchers to deeply examine "why people engage in such relationships, the way their interactions emerge and change, and how they evidence their feelings for each other" (Tracy, 2013, p. 6). By definition, qualitative research is designed to "investigate the quality of relationships, activities, situations or materials" (Fraenkel & Wallen, 2003, p. 380). It does this by empowering researchers to deeply probe a phenomena or topic of interest by privileging the lived experiences of participants, rather than foregrounding existing theory. As a result, the use of qualitative approaches to guide my study enabled me to focus on patients' perceptions on what happens in interactions with doctors and what they expect regarding their satisfaction. More specifically, I used a focus group interview to collect data for my study. Focus groups are a beneficial approach for getting a rich and detailed set of data about individuals' perceptions, understanding, thoughts, feelings, impressions, and experiences in their own words (Kitzinger, 1995; Stewart and Shamdasani, 1990).

Data Collection

　　Processes. I conducted a semi-structured, in-depth focus group interview for this study. According to Denscombe (2007), "A focus group consists of a small group of people, usually between six and nine in number, who are brought together by a trained moderator (the researcher) to explore attitudes and perceptions, feelings and ideas about a topic" (p. 115). Conducting a focus group was ideal for my study for multiple reasons. First, it enabled me to hear participants' first-hand experiences while minimizing institutional challenges for gaining access to healthcare encounters. Morgan (1997) noted that one comparative weakness of participant observation is "the difficulty in locating and gaining access to settings in which a substantial set of observations can be collected on the topic of interest" (p. 9). For instance, it would likely be challenging for a researcher to accompany participants to their health care appointments and directly observe their interactions with their doctors. On the other hand, conducting a focus group by interviewing participants about their experiences enabled me to "gather information about things or processes that cannot be observed effectively by other means" (Lindlof & Taylor, 2011, p. 175).

　　A second advantage of using focus groups is that they often "produce insightful self-disclosure that may remain hidden in one-on-one interviews" (Tracy, 2013, p. 167). For instance, people may feel shy or uncomfortable or insecure discussing sensitive health issues in individual interviews. Yet, it is sometimes easier to discuss these issues in a group setting because participants' dialogue about memories, experiences, and ideas may spark others to share their feelings about particular topics. Morgan (1997) elaborated, noting that "group discussions provide direct evidence about similarities and

differences in the participants' opinions and experiences as opposed to reaching such conclusions from post hoc analyses of separate statements from each interviewee" (p. 10). For the purposes of my study, the comparative advantage of using the focus group interview was my ability to observe the group's interactions regarding doctor-patient relationships overall, and more specifically on doctors' self-disclosure and gender differences. This information provided insights into participants' opinions and experiences to anticipate patient satisfaction.

For the purposes of this study, I conducted one focus group interview. The focus group was conducted as a face-to-face conversation, and my goal was to foster a dialogic setting where participants felt comfortable sharing lived experiences and negotiating talk and topic shifts to identify issues important to them. The interview protocol I used included open-ended questions, and participants were given equal opportunities to respond to prompts in their own words. For instance, participants were asked to discuss what patient satisfaction means to them, what they view as important qualities of doctors and doctor-patient relationships, how they perceive gender and communication differences between doctors, and how they interpret and respond to doctors' self-disclosure (for the complete focus group protocol, see the appendices). Participants' responses demonstrated how they found similarities and dissimilarities among their experiences, which fostered free-flowing discussions. Additionally, the participants' comments identified some possible strategies for further research to improve doctor-patient relationships.

The focus group took place in a reserved library room at Minnesota State University-Mankato and was scheduled based on participants' convenience. The

approximate length of the interview time was 55 minutes. When everyone arrived, I started the interview by asking some off-topic questions to break the ice. Then, I gave a concise overview of the project before going through the consent forms, guidelines for participation, and the interview questions. Additionally, a brief demographic survey was sent to participants prior to the interview. They were asked to complete the survey and return it to me prior to the focus group. The conversation was video- and audio-recorded with the participants' consent. I transcribed my data in full by using transcription software, and then verified the accuracy of it by listening to the audio recording thoroughly.

Participants. A total of eight participants (five females, three males) took part in the focus group. Participants were at least 18 years or older and varied in terms of race, religion, and ethnicity (See page 76: Table 1 for a summary of the demographic information of the participants). To recruit participants, I utilized snowball sampling, which is defined as "random sample of individuals [that] is drawn from a given finite population" (Goodman, 1961, p. 3). I used snowball sampling by posting the call for participants to Facebook. My friends then shared my posts on their pages. Additionally, another way I utilized snowball sampling was through my participants. If someone agreed to be a participant in the study, I asked the volunteer if they would share the details of the study with people they knew. After getting the initial response, I emailed them the formal consent form and the brief demographic survey to read through it prior to the focus group. I brought additional printed consent forms and demographic surveys with me and collected the completed forms and surveys from the participants prior to conducting the focus group.

Data Analysis

To analyze my data, I transcribed the focus group interview. Once my transcriptions were completed, I went through the transcriptions and made initial notes about my reactions about the transcriptions. After I made initial notes on the transcripts, I used thematic analysis to find emerging themes.

For qualitative researchers, thematic analysis can be beneficial because it allows individuals to be flexible with their research. This means it can be used within different theoretical frameworks to answering research questions connecting to individuals' experiences, views or perceptions, understanding and representation, such as, 'What do patients think of female doctors who do not play traditionally feminine gender-role?' or, 'How do patients understand doctors' gender differences in self-disclosure?' Braun and Clark (2006) stated that qualitative researchers get to "make active choices about the particular form of analysis they engaged in" (p. 78). This was beneficial for my project because I got to be flexible in the themes that I choose. I based my approach to thematic analysis on Tracy's (2013) iterative thematic analysis where iteration is "a reflexive process in which the researcher visits and revisits the data, connects them to emerging insights, and progressively refines his/her focus and understandings" (p. 184). Through an ongoing back and forth movement between the data and my initial themes, I was able to come up with several potential interpretations and links to theory, and then gradually became more specific about the phenomena to determine insightful themes. I identified four themes exploring the connections between doctors' self-disclosure, gender, and patient satisfaction in the doctor-patient relationship. I elaborate more on the findings in the chapter four.

Chapter Four: Results

In this chapter, I articulate the findings of my study and draw upon existing scholarship to analyze my results. In this chapter, I discuss four themes. First, I explain aspects of doctors' communication behaviors that participants found to positively or negatively influence patient satisfaction. Second, I discuss participants' perceptions of doctors' gender in relationship to their communication behavior. Third, I address patients' overall perceptions of doctors' self-disclosure how it impacts patient satisfaction. Fourth, I scrutinize how participants' gendered expectations of their doctors influenced their reception of self-disclosures.

Positive and Negative Aspects of Doctors' Communication Behaviors

First, participants discussed doctors' communication behaviors that they believed positively and negatively influenced their satisfaction with healthcare interactions. Interestingly, while discussing doctors' several communication behaviors, almost all participants didn't really acknowledge the term 'self-disclosure' as a communication behavior until they realized how they were involved in doctors' self-disclosure during interactions. Besides, participants overall reported the doctors' gender was irrelevant to how satisfied they typically were with their care. Additionally, they didn't report any certain behaviors that they preferred or expected only male or female doctors to use.

Positive aspects. Similar to the existing literature, participants' comments indicated their satisfaction was closely linked to their physicians' communication ability, interpersonal and technical skills, and accessibility (Boquiren, Hack, Beaver, & Williamson, 2015). Specifically, their comments linked closely to doctors' affective and cognitive behaviors (Conlee & Olvera, 1993). Like the findings of Roberts and Aruguette

(2000), participants stated they felt most comfortable discussing their health issues when doctors used affective behaviors such as: being personable, engaging in social conversation, talking in a warm tone, being friendly, being honest, showing empathy, asking questions, and listening attentively. For instance, one of the female participants noted:

> One quality for sure for me would be personable. So, they have to be able to seem comfortable when they're interacting with me. If you have a doctor that seems awkward and uncomfortable with their interaction with you, then it's a turn-off right away.

Additionally, most participants indicated the importance of positive cognitive elements such as, giving attention, understanding patients' perspectives/problems to diagnose accurately and prescribe right medication to patients. For instance, one of the female participants mentioned:

> So, if I have a question they actually answer the question and not give five million things to do on top of that in terms of giving me the right prescription, giving me the right knowledge about what I need because I need a checklist of everything before I get out of that doctor's office.

Moreover, most participants' comments emphasized specific communicative preferences related to task-based communication, such as explaining a disease, asking about symptoms or medication (see Roberts & Arguette, 2000). Providing clear explanations was one important communication behavior for the participants. One female participant explained:

I want to know when they tell me, "You need to do this," why is it? And also, when I say, "Okay, this is my problem," they need to be able to explain to me what's going to be the cause and why I'm taking medicine or why I need to be cured of it.

The participant's comments underscore existing research on how a physician's lack of communicative clarity can decrease patient satisfaction (Butow, 2001). Participants also highlighted the importance of other task-based communication from physicians. For instance, one female participant commented on the importance of doctors' follow-up questions to ensure a correct diagnosis. She stated, "If I'm explaining something and I'm not doing a good job because I'm nervous, they'll ask, 'is it this kind of pain? Does it feel like . . .?' I find that helpful." Another female participant expressed a similar sentiment by saying "the way they answer my questions makes me feel comfortable that, Oh okay! I can explain as much as I can."

Participants' responses indicated that *how* a physician performs task-based communication was just as important *what is said* in the healthcare encounter. Specifically, participants' comments reinforced the existing literature by indicating doctors' affiliative verbal and nonverbal communication styles were linked to their perceptions of satisfaction (Hausman, 2004; Ong et al., 2000; Pieterse, Van Dulmen, Beemer, Bensing, & Ausems, 2007). For example, a female participant said, "I like it when they don't yell. And they explain everything in a calm manner. Like I'm already in pain, I'm already going through whatever. Don't make it worse for me." Another female participant stated she preferred, "a good listener too. So, then they're explaining the right thing." One of the male participants mentioned, "I think, the willingness to answer

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questions rather than just giving you information and just kind of saying: you do this now." Another male participant noted, "I believe the doctor should be trusted so patients can feel comfort to express him or herself very easily. Giving assurance like telling you 'you're going to be okay.' It's the positivity attitude." In each of these comments, patients seem to be expanding the notion of care provided by a physician beyond physiological ailments to encompass psychological needs. This makes given the intertwined emotional and physical experience of illness: Disease represents a state of physiological disturbance that is accompanied by a certain degree of anxiety (Cartwright, 1976; Duff & Hollingshead, 1968; Parsons, 1964). Illnesses create stress and uncertainty at multiple levels (e.g., what does a disease mean for the immediate present? Or for an individual's long-term plans?). When patients seek medical treatment, they are not only looking for relief from physical discomfort, they desire reassurance and certainty from their doctors as well. Thus, it is not surprising that affective communication behaviors are connected to reducing patients' anxiety (Ben-Sira, 1988; Kosa & Robertson, 1969).

Patient satisfaction with the assessment of the efficacy of the treatment relies on the mode of doctors' behaviors. Therefore, doctors' instrumental activities accompanied by affective communication behaviors, creates a favorable environment during interactions that makes patients discuss their health issues more comfortably. Above all, participants' comments demonstrated that doctors' communication behaviors to demonstrate care and concern may influence a patient's willingness to reveal/explain symptoms (Gallagher et al., 2005).

Negative aspects. Participants' comments also indicated several communication behaviors that increased their dissatisfaction with physicians. For instance, the majority

of the participants disliked doctors who either had what they perceived was a cold personality or lacked what they saw as warmth and friendliness (Korsch, Gozzi, & Francis, 1968). One of the participants stated:

> If they're not personable and not willing to maybe take a little bit of time to ask how you are, how's your day going…? That's very cold and a huge turn-off for someone who should be caring about your health.

Non-verbal communication was cited as an important element for how participants perceived a doctor's warmth. For instance, eye contact was mentioned as an integral component of helping patients feel engaged and comfortable in the healthcare encounter. A female participant mentioned, "If they show no eye contact that feels really cold." She continued, "If they're willing to make eye contact, like if they need to examine you as far as feeling you, but being comfortable with that, making you feel comfortable with those kinds of things especially." When a doctor maintains good eye contact while examining patients, it creates a positive atmosphere and let patients feel that the doctor cares about them. A male participant said, "for me, I would say don't be like a spooky face. Be like a happy face. Eager to help." He continued, "Be happy when I show up. I don't want a serious person meeting the first time." Here, the male participant preferred doctors who smile because they seemed more accessible and friendlier. This comment is consistent with research indicating that smiles are one of the most frequent facial expressions used to communicate positive emotional states and to serve social functions, such as greetings (Sidequersky et al., 2016). Therefore, the participant's comments illustrated that a doctor's positive facial expressions create a friendly atmosphere that

encourages patients to disclose information about themselves more easily and openly (Aries, 1987; Hall, 1984).

Additionally, one of the female participants discussed the importance of both verbal and non-verbal communication during physical examinations. Based on an experience of having her nose pierced by a male doctor, she said she preferred when the doctor asked for and received her consent at each step rather than just using non-verbal signals. She explained:

> If you're doing physical examinations with non-verbal communication, if you're doing it in a very mild tone way, and very just going through the motions and doing that, that's not... I would just be very scared of what's going to happen next.

Her comment illustrates the importance of reducing patients' anxiety and uncertainty by thorough explanations that accompany physical examinations, rather than just conducting the exam silently. For example, during an orthopedic exam, a doctor explains that he/she will be holding the body part to be treated and will apply pressure to certain areas for diagnosis. Similarly, when the participant pierced her nose, she wanted her doctor to elaborate his procedure beforehand rather than just doing it non-verbally.

Moreover, participants' comments indicated they were not satisfied by doctors who were perceived as being distracted or uninterested during healthcare encounters. One of female participants explained, "Make sure that the doctor is focused on you and not having anything else in his head. He looks cold and having a negative attitude. That should be strongly avoided." Another male participant connected doctors being distracted to showing false sincerity. For instance, he said:

I'd rather have someone who is like, "All right. Let's get this in. Get you out and move on" rather than someone who's like . . . you can tell who's faking an interest. Because I've had that where the doctor's like, "Is there anything else I should know?" And I'm like, "Well..." and they're like, "All right. Thank you. We'll see you later." And I was like, "Okay, I guess we're done."

These comments illustrated that if doctors are not concentrating while interacting patients, they exhibited a lack of interest about patients' concerns. Patients try to explain their issues to doctors, assuming that the doctor is being mindful and paying attention to them. Therefore, when doctors somehow are not focused on patients due to personal or other issues, but pretending to listen, it shows false sincerity. In short, the patient feels the doctor is not caring enough to really focus. Moreover, one female participant reported doctors' false sincerity as condescending and disrespectful to patients because it made them feel as if they were not important.

A female participant added another point of view, noting that a doctors' way of explaining information can also be misperceived as condescending, "Obviously, doctors have a level of knowledge that most people don't. And so, to step down and explain things properly, but not where they're talking to you in a condescending way like you're a child and you're completely uneducated." Her comment reflects how doctors should explain information to patients in a respectful manner. Likewise, the female participant additionally mentioned, "so being able to use the right amount of language in order to make you understand stuff but also not make you feel like you're being looked down upon." In other words, physicians must be careful to reduce jargon and use words that engage patients in their care.

Overall, participants discussed numerous positive and negative aspects of doctors' communication behaviors from their experiences and opinions. The following theme explored whether participants differentiated these communication behaviors based on doctors' gender.

Patients' Perceptions of Doctors' Gender in Communication Behaviors

In general, participants didn't report any significant gender differences in terms of doctors' communication behaviors. Notably, the participants' preferences for visiting male or female doctors were linked more closely to specific communication behaviors and expertise, rather than sex or gendered communication traits.

All of the focus group participants reported that their top reason for choosing a physician was the doctors' expertise. There was only one difference noted between the male and female participants: Male participants did not report any preferences related to a doctor's gender. For example, one male participant mentioned, "I'm always looking for an expert who is good, in his or her individual field. This is important for me. He or she, it doesn't matter to me." However, two of the female participants acknowledged they preferred to visit a same-sex doctor or nurse, especially for potentially sensitive consultations related to gendered health issues (e.g., breast examinations, gynecological consultations, etc.). For example, a female participant noted, "I always say go to female nurses because they have the same body parts usually as me. That's why I feel like . . . I don't know. That's a personal preference." At the same time, female participants indicated that they did not view sex as being as important as doctors' expertise and communication behaviors. For instance, one female participant noted, "So, for a breast examination, they've asked me, 'Do you want a female doctor?' But I was like, 'I just

want someone who is educated in that area.' It doesn't matter to me. I've had good experiences with both."

With the exception of consultations for gendered heath issues, the female participants' comments revealed a number of tensions with same-sex providers. Surprisingly, most of the female participants stated they actually preferred visiting male doctors. One female participant stated "female doctors, I always had that feeling that they're just ... I don't know they're just kind of giving you attitude and they're a little bit arrogant. I don't know why, but I always get that vibe." Another female participant similarly stated:

> In my experience, most of the female doctors I've seen right away start talking about things that I think are extremely inappropriate and have nothing to do with what we're talking about. And they complain about my skin and my hair and say, "Oh, if you're a pale redhead, it's going to be so hard to get the IV in." I'm like, "Um okay."

Additionally, the same participant continued, "I've actually found that the female doctors I've had were more condescending to me as well. I don't know why. Maybe I'm doing something." In contrast, the majority of the female participants found male doctors to be kinder, and more personable towards them. One female participant noted, "In my experience, I always had more male doctors than female doctors and they were always nicer to me and more kind to me." The same participant continued, "and then male doctors, they're like always kind. And I don't know, treating me like I'm their daughter, not like . . . I mean, if they're very [much] older than me." Another female participant found in her experiences that male doctors were clearer, more concise, and made eye

contact properly. In her explanation, "I didn't feel like there were any games being played with my head. It was more of you're in for this problem, we're going to deal with this problem and then we're going to move on." In general, above all these positive and negative experiences of the female participants identified the connection to some specific communication behaviors of doctors. The reasons behind negative experiences from female doctors reported by female participants included perceiving these physicians as using arrogant, judgmental, and condescending behaviors. In contrast, the positive experiences they shared about male doctors included kind gestures, a non-judgmental attitude, good eye contact, and being more personable, which are considered as affiliative communication behaviors. However, it might not be the same ways for all male and female doctors.

Research suggests that the differences in gender-role expectations may influence patients' perceptions of the appropriateness of doctors' communication behaviors, and patients' own affective responses to those behaviors as well. For example, research has historically shown patient satisfaction increases when female physicians perform traditionally feminine behaviors (Mast, Hall, Klockner & Choi, 2008). Yet, these negative experiences reported by female participants about female doctors demonstrated that these physicians did not engage in expected feminine behaviors. In contrast, female participants appreciated male doctors' affiliative (feminine) communication behaviors rather judging the absence of their traditional masculine gendered behaviors. This finding aligns with Burgoon, Bark, and Hall's (1991) study, which found that whether male doctors' level of verbal aggressiveness didn't really affect patient compliance and

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satisfaction. However, the same study found the level of verbal aggressiveness did affect patient compliance and satisfaction for female doctors (Burgoon, Bark & Hall, 1991).

The existing literature links affiliative communication behaviors to female doctors because of traditionally feminine gender roles, such as being more nurturing, expressive, and more interpersonally oriented (Aruguete & Roberts, 2000; Buller & Buller, 1987; Buller & Street, 1992). However, my findings challenge the existing views on how female providers are perceived. Overall, participants' preferences were positively connected to affiliative communication styles of both male and female doctors.

Patients' Perceptions of Doctors' Self-disclosure

Regarding patient outcomes, the majority of the female participants found doctors' self-disclosure to be a positive and an effective strategy for fostering interpersonal relationships, a finding that supports existing research (Beach, et al., 2004; Holmes, Harrington, & Parrish, 2010; Lussier & Richard, 2007). In contrast, male participants didn't experience any self-disclosure from their doctors. One male participant stated, "I don't think I've ever had a doctor do that. It's always been pharmacists or someone who does additional stuff."

The majority of female participants reported that when doctors self-disclose, it makes them feel more comfortable discussing their health issues, which supports the existing research. For instance, one female participant noted, "You're telling them some of your personal health problems and so you want them to be able to share a little bit about themselves before you open up and share about yourself." Most of the female participants preferred their doctors get to know them as a person, not by their illness. As one female participant stated, "I think seeing me for me and not for what my illness or

what my thing is. For example, get to know me." Therefore, doctors' self-disclosure is a way to start the conversation and make patients engaged in interaction through sharing about themselves. Another female participant explained:

It's kind of hard for me to imagine talking about something and we don't share our personal stuff. Because I always feel that's how we communicate. It might not be directly, or it might not be the doctor telling a story that oh this happened to me. But I always feel like there's some part of the conversation that is always going to be personal.

Another female participant concurred, "Yeah, I agree. And maybe that's why I can't think of a specific situation where there wasn't really a specific story mentioned like yours." These comments indicated that the doctor-patient interaction improves through a reciprocal sharing of information that influences on the doctor-patient relationship outcomes.

Accordingly, female participants' comments revealed a connection between doctors' self-disclosure and longevity of the doctor-patient relationship. Most female participants preferred doctors' self-disclosure when it happened as part of a long-term relationship. For instance, one female participant stated that "Yeah exactly! I would say for therapists, like for my dietitian. For all of those, those are very long-term stuff. But for my urgent care, strep throat…like oh okay! I'll see you some time, maybe soon." Another female participant expressed a similar sentiment:

Because I've seen them since I was born, most of them. They were just always my doctors. So, they really know me well because they used to see me a lot. So, it was like something that they would share about their personal life.

Emphasizing doctors' self-disclosure with regard to longevity in the doctor-patient relationship, female participants shared experiences mostly about primary care physicians. For instance, one female participant said:

Because that kind of doctor, they have been taking care of you since you were a kid. So, it really matters. Because when you take care of someone, it's like a family. And when they show that kind of feeling towards what they say, it's really nice. Because I don't think going to the doctor is usually a pleasant thing to do because we usually go when we are not feeling good. But that just makes it better.

The majority of the female participants' comments indicated that doctors' self-disclosure creates a greater sense of closeness, greater sympathy, and a climate of trust (Lussier & Richard, 2007) that helps doctors finding a way to know about their patients and the doctor-patient relationship improves through a reciprocal sharing of personal information. When doctors share a little bit about their personal experiences, it makes a connection with patients, creating an atmosphere that is favorable for them to disclose as well. For instance, one female participant noted:

I've had the same eye doctor since I was 14. And so, we're very comfortable sharing. He knows about my life. Like he'll ask, "Oh how was school at Mankato? What are you up to with work these days?" And I personally really enjoy that, even if it may not be incredibly important for my care. Especially at the eye doctor, you're there for a while if you're getting a new prescription. So, someone who is able to actually make interesting, not important, conversation while you're there makes it a lot better.

Patients feel comfortable and become more engaged in interactions when they find their doctors know or remember little things about them. They indicated these kinds of personal connections make them feel doctors are being caring, empathic, friendly, and personable, which gives them peace of mind about receiving good care. For example, the same participant shared another similar experience:

And even for me, I hate going to the dentist, but I really like my dentist and they're able to make conversation as much as they can. Obviously with having their hands in your mouth, it's a little difficult. But the conversation that they can make, it's interesting, and it's nice to know that they remember little things about me, like the school I go to, what major I'm in and stuff like that.

Regarding the contents of self-disclosure, over-disclosure and irrelevant self-disclosure from doctors was significantly discouraged by almost all participants. For instance, one of the male participants preferred doctors' self-disclosure that was "like relating it to the situation." Similarly, one female participant mentioned "over self-disclosure makes me crazy. When I walk in and a doctor starts talking about their divorce or their kids or their problems, I'm like, who is paying who here?" Another case in point from a female participant:

So, it was for a mental health check-up. And I honestly don't know where it came from, but the female doctor started talking about how when she was in high school, she was really stressed out and she was really scared, and it was because of a boyfriend and then an ex-boyfriend. And, 'I shouldn't have . . . I should have had a warning that he got drunk at her wedding. I'm telling you.' And I felt like

she was distracted. How can you help me in my mental health journey if you're

clearly not over things in your mental health journey?

These comments demonstrated that the purpose of the doctor's self-disclosure

went awry. The participants couldn't find any meaningful connection in the doctor's self-

disclosure, creating a situation that was uncomfortable and decreased the physician's

credibility. This is aligned with previous research suggesting that patients feel

uncomfortable, role confusion, a lack of trust and safety with doctors' self-disclosure

when it's excessive, irrelevant, not helpful and if it's more of a personal need to vent

(Audet & Everall, 2010; Gutheil & Gabbard, 1995; Hanson, 2005; Nadelson & Notman,

2002; Strassberg, Roback, D'Antonio, & Gabel, 1977). In addition, participants'

experiences indicated that doctors face the difficulty of trying to self-disclose

appropriately because not every patient is same. How a doctor's self-disclosure will vary

from patient to patient.

In contrast, the majority of the participants reported that patient satisfaction is

positively connected to doctors' self-disclosure when it's appropriate, meaningful and

helpful. For example, one female participant explained:

I was in the ER, I was very nervous and scared. And the male ER doctor started

talking about, "You know what, it's totally normal to be nervous and it's okay that

your mom is freaking out a little bit too. When I brought my daughter in here for

the first time I was really nervous, and she was really nervous. But I promise you

we're going to take good care of you." That I found really helpful because it made

me feel I wasn't alone and I shouldn't be embarrassed about my feelings. And it

made me feel as a person more than the problem I was being seen for.

Here, the doctor's self-disclosure created intimacy with the participant, enabling her to resolve fear or shame (Corey & Corey, 1992; Robison, Stockton, & Morran 1990; Yalom, 1985). Another female participant acknowledged a similar sentiment by sharing one of her family member's critical health situation when she was worried, confused and helpless about what to do:

> And I really appreciated that the doctor disclosed, "If this were my mother, this is what I would do." Or, in the ER when they'll say to your parents or something, "If this were my child, this is what I would do."

> Here, the doctor's self-disclosure made the participant feel warmth, and reassurance, and comfort in a crisis, influencing patient compliance and satisfaction. This finding is supported by the existing literature (Beach et al., 2004; Lussier & Richard, 2007). For instance, hearing doctors' personal stories enhance patients' perceptions of their credibility when the information disclosed is seen as meaningful in the context of specific treatment situations (Frommer, 1999; Guthrie, 2006; Kunkle & Gerrity; 1997).

Despite some possible risks, the majority of the participants appreciated doctors' self-disclosure when it was received as being appropriate and helpful. In terms of doctor-patient interaction, their experiences and opinions demonstrated that doctors' self-disclosure deepens the therapeutic relationship because it engages patients actively in interactions. The following theme examined whether participants' expectations of doctors' self-disclosure varied between male and female doctors.

Patients' Perceptions/Expectations of Doctors' Gender in Self-disclosure

Participants, in general, didn't find or expect any notable differences in self-disclosure between male and female doctors. Regardless of doctors' gender, the majority

of the participants viewed doctors' self-disclosure as important when it was received as being relevant and helpful. For instance, one male participant noted that "as long as it pertains to what's going on. Not just bringing in outside stuff about themselves." One female participant said, "like, it's related to the illness or a specific thing they went through." Almost all participants expressed the same. When asked what types of information patients expect their male and female doctors to self-disclose, the majority of the participants reported that they prefer doctors share information about their education, degrees, and expertise regardless of gender differences. Three of the female participants noted that patients may feel comfortable when that female doctors disclose personal information specific to women's health issues (Betts, Wilmot & Taylor, 2008; Mazzi et al., 2014). For example, one female participant stated:

> Like if you're seeing a doctor for breast cancer, let's say. You may want a female doctor. And for them to disclose, maybe they have a history with it in their family and so maybe that personal disclosure helps you feel more comfortable.

Another female participant gave a similar opinion, "for female-specific things or male-specific illnesses, like periods or anything male or just specific things like that. But that's the only thing I could think of when gender plays a role in it." These comments demonstrated that while discussing health problems related to sex, female patients prefer their female doctors who disclose some similar personal information if they have any. Interestingly, female participants' comments didn't report any male-specific health issues, just women's health issues. Similarly, male participants neither talked about male-specific health issues nor they did they mention any expectations for self-disclosure from male doctors related to gendered health concerns.

In contrast to the existing literature, participants didn't report any significant influences of traditional masculine and feminine gender-role socialization on doctors' self-disclosure. Research found female doctors tend to be more expressive and self-disclosing (Basow & Rubenfield, 2003; Weisman & Teitelbaum, 1985; Wissow, 2004) as disclosure and emotional expressiveness are closely associated with feminine styles of communication. However, participants' comments did not align with these threads of research. Rather, most of the experiences about doctors' self-disclosure that female participants revealed were from male doctors. On the other hand, male participants didn't reveal any experiences of doctors' self-disclosure, however, their preference/expectation encouraged relevant self-disclosure relating to patients' illness/situations regardless doctors' gender difference. These findings may also come as a future inquiry- does this mean that physicians (male or female) may feel the need to disclose more to female patients? And, why might this be? Besides, overall, both male and female participants overall didn't have any expectations/reactions to doctors' self-disclosure based on masculinity and femininity. More specifically, both male and female doctors had been found sharing personal information with patients in terms of positive patient outcomes.

In summary, I provided an analysis of four themes in this chapter, which explored participants' experiences and opinions of doctors' communication behaviors to anticipate patient satisfaction and found an understanding of the connections between self-disclosure, gender, and patient satisfaction in healthcare interactions. My findings showed how doctors' self-disclosure impacted the doctor-patient interaction to enhance patient satisfaction regardless doctors' gender difference. In the following chapter, I conclude my study with a discussion of results.

Chapter Five: Discussion

The purpose of my study was to explore the connections between doctors' self-disclosure, gender, and patient satisfaction in doctor-patient interaction. Specifically, I sought to understand how participants make sense of their experiences of both male and female doctors' self-disclosure. In this chapter, I present the answers to my research questions, discuss the implications and limitations of my research, and address future research possibilities.

Revisiting the Research Questions

My first research question was, (RQ.1) How does the physician's self-disclosure impact patient satisfaction? The participants' comments during the focus group indicated that doctors' self-disclosure functions to foster the doctor-patient relationship. Put simply, disclosures enable doctors and patients to get to know each other. Patients are already filled with uncertainty during medical consultations. Because uncertainty can increase in interactions with a new or unfamiliar doctor, patients may be less likely to disclose salient health concerns in these situations. As one female participant noted, "you're telling them some of your personal health problems and so you want them to be able to share a little bit about themselves before you open up and share about yourself." A doctor's self-disclosure can thus make patients feel more comfortable about discussing their health issues in a medical encounter. Participants noted that the reciprocal sharing of personal information not only improved the quality of their relationships with their doctors, but it also increased their engagement in health care encounters overall. Patients felt welcomed when doctors at least remember something about them from previous interactions. Additionally, getting to know their provider seemed to increase participants'

engagement in conversations. For instance, one female participant noted that she wants her doctors to know her as a person, not just by her illness, which illustrates the importance of doctors demonstrating caring.

From a theoretical perspective, Uncertainty Reduction Theory asserts that people have a need to reduce uncertainty about others by gaining information about them. Such information allows people to predict others' behavior (Berger & Calabrese, 1975). Therefore, self-disclosure not only reduce patients' uncertainty, doctors can used it as a technique for fostering others' disclosure (Berger & Bradac, 1982). The choice to self-disclose differs due to individuals' relational goals, as well as the potential costs and benefits of disclosure. Patients become more engaged in interactions when they develop a good bond with their doctors. Doctors commonly talk informally about their interests to build rapport and put the patient at ease. For instance, one female participant described:

It might not be directly, or it might not be the doctor telling a story that oh this happened to me. But I always feel like there's some part of the conversation that is always going to be personal. That's how we communicate.

Similar to the Uncertainty Reduction Theory, my study indicates that patients need to reduce uncertainty by knowing about their doctors in order to communicate smoothly. Additionally, my findings indicated that doctors' self-disclosure functions as an effective interactive strategy to know each other. Furthermore, my study suggests that doctors' self-disclosure becomes more significant in long-term doctor-patient relationships. Patients become more comfortable discussing their health concerns more openly when they find a good rapport with doctors. The benefits of self-disclosure to build rapport is also supported by Communication Privacy Management (CPM) theory

(Petronio, 2002). CPM theory notes that people generally disclose to those with whom they feel close, believe they can trust with personal information, and are confident they will receive positive responses from. In this study, my participants' comments demonstrated that they felt warmth/friendliness and reassurance/comfort due to doctors' self-disclosure. Moreover, it appears the disclosure influenced their compliance and satisfaction by fostering an atmosphere of closeness, sympathy, and trust (Beach et al., 2004; Lussier & Richard, 2007).

However, participants' comments simultaneously illustrated that doctors do have to walk a fine line in terms of the quantity and quality of their self-disclosures. For instance, participants were dissatisfied with doctors' over-disclosure and irrelevant self-disclosure. Participants reported feeling uncomfortably, confused, and uncertain when doctors self-disclosed excessively or their personal comments were not related to patients' concerns. For example, one male participant noted doctors should, "not just [be] bringing in outside stuff about themselves." Another female participant expressed the same sentiment:

> I went to see a dermatologist way back and then he actually went to high school with my mom. So, he started disclosing all the stuff they did in high school. And I was like, "I really don't need to know that." But I agree. Finding a doctor . . . that has helped for disclosure purposes. Like saying, "Yeah, I've been through this", has helped a lot.

Patients tend to view the quality of doctor-patient relationships as being improved by appropriate self-disclosure from their providers, which indicates disclosure can influence patient satisfaction. Yet, my study also suggests that doctors have to carefully

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determine the amount and type of information to share to ensure the disclosure will be perceived as both meaningful and relevant. Navigating such decisions is tricky, particularly if the doctor does not know the patient or how they will interpret self-disclosures. As my participants' comments indicated, it can be really easy for a doctor to misjudge or make mistakes with self-disclosure that influence patient satisfaction.

To examine the influence of gender-role socialization on doctors' communication behaviors, I asked two research questions: (RQ.2) How is patient perception of physician self-disclosure influenced by the physician's gender? (RQ.3) How is patient expectation for physician self-disclosure in medical interactions influenced by the physician's gender?

In medical encounters, there is an extensive body of research on the differences in communication styles used by doctors and the results had largely been consistent with gendered stereotypes. In terms of doctor-patient interaction, research has found that male and female doctors adopt different communication styles where authoritative communication styles were mostly seen among male doctors, and affiliative communication styles were seen among female doctors. Research has also found that affiliative communication styles are positively connected to patient satisfaction because they exhibit more patient-centered behaviors (Anderson & Zimmerman, 1993; Buller & Buller,1987; Street & Buller,1987, Cousin & Schmid Mast, 2013). Therefore, the previous research has concluded patients tend to be more satisfied with female doctors as they use affiliative communication styles.

My findings were somewhat aligned with these existing bodies of research, as participants tended to prefer the affiliative communication styles that have previously

been positively associated with patient satisfaction. Unlike previous studies, the majority of the female participants in my study reported their male doctors showed more patient-centered behaviors than their female doctors. Male participants also preferred patient-centered behaviors but did not link these behaviors to specific genders.

Research suggests that female doctors tend to be more expressive and self-disclosing than male doctors (Jefferson et al. 2013; Roter & Hall, 1997, 2004; Shin et al., 2015; Wissow, 2004) based on traditionally feminine gender roles. However, my study didn't support the connection between gender-role socialization and doctors' self-disclosure. Specifically, participants in my study reported that both male and female doctors self-disclosed to patients in order to make patients feel comfortable about talking about their health issues openly. Moreover, my study indicated that doctors' appropriate self-disclosure tended to create a climate of closeness, sympathy, and trust regardless of whether it came from a male or female doctor. For instance, one female participant shared an experience of a male doctor's self-disclosure which made her feel warmth and reassurance. One of her family members was in a critical health situation and she was dealing with high levels of anxiety to make right decisions. At that time, the male doctor enhanced his credibility by disclosing, "if this was my mother, this is what I would do." The participant indicated his comments increased her the participant's compliance and satisfaction (Beach et al., 2004; Lussier & Richard, 2007). Ultimately, this is important to know because how the patient views his or her doctor and how that doctor communicates, determines the patients' likelihood of following advice (Ashmore & Banks, 2002).

The structure and contents of doctors' self-disclosure encouraged by both male and female participants included mostly relevant personal information connecting to

patients' concerns or situations (Frank et al. 2000). Other self-disclosures were about doctors' education/degrees/expertise regardless their gender differences. The majority of the participants noted that they want their doctors verbally disclose the information of their expertise areas. Only three female participants preferred their female doctors disclosing personal information specific to women's health issues during their medical check-ups (e.g., information about periods, breast examination) (Betts, Wilmot & Taylor, 2008; Mazzi et al., 2014). This also indicated the relevancy of doctors' self-disclosure to patients' issues/concerns/situations. Therefore, my study overall didn't find any expectations or reactions from participants to doctors' self-disclosure based on their performance of traditionally masculine and feminine gender roles.

Implications

In terms of doctor-patient interaction, this study offers a wide variety of theoretical and practical implications for health communication scholars, as well as doctors to enhance patient satisfaction.

From a theoretical perspective, my study challenges the existing research that affiliative communication styles are more common among female doctors than male doctors. My participants, and particularly the female participants, reported that male doctors used more affiliative communication styles than female doctors from their experiences. However, my findings do support the existing bodies of research that positively associate affiliative communication styles (for both male and female doctors) with patient satisfaction because it exhibited more patient-centered behaviors, (e.g., being friendly, energetic, caring, treating the patient as a person and as a partner) regardless of their gender. In addition, with regard to the existing studies, my study acknowledges the

influence of both male and female doctors' self-disclosure on patient-centered behaviors during interactions. However, my findings challenge the notion of traditional feminine gender-role socialization about doctors' self-disclosure. Specifically, in the female participants' experiences, female doctors were not viewed as performing in line with stereotypically feminine roles (e.g., enacting seen more interpersonally oriented behaviors or performing nurturing and caring behaviors) in comparison to male doctors.

One possible reason for this finding could be because female doctors are violating the expectations of female patients (Burgoon, 1993; Burgoon & Jones, 1976). For instance, the majority of female participants expressed concerns or frustrations about female doctors who lacked the traditionally feminine communication styles (e.g., less dominant, more nurturant, or affectionate) which may have been what the patients were anticipating in the healthcare encounter. In contrast, female participants appreciated male doctors those who used feminine communication styles, even though they were not performing in line with stereotypically masculine roles (e.g., interpersonal distance, less empathy, or authoritative manners). Therefore, female participants' views may be indicative of cultural sexism in the workplace for female doctors, shaped by beliefs both about women in general as well as in a historically male-dominated occupation (Mumby, 2013). Although the number of female doctors has increased in recent decades (Association of American Medical Colleges (AAMC), 2015), my findings may indicate that female doctors struggle for acceptance because of their alignment (or lack thereof) with gender-role congruent expectations. Interestingly, male doctors did not seem to get evaluated negatively for adopting gender-role incongruent communication styles.

In terms of the practical implications, my study illustrates the importance of patient-centered behaviors used by doctors to increase patient satisfaction and therefore, it encourages both male and female doctors to adopt affiliative communication styles in interactions. Accordingly, my findings do encourage both male and female doctors to self-disclose as a means to demonstrate their desire to connect with the patient and foster the patient's disclosure. Moreover, my study identifies that regardless of gender differences, doctors must carefully navigate the emerging relationship with their patients to ensure self-disclosures will be received as relevant, meaningful, and not excessively personal. In the doctor-patient interaction, better relationships are important for achieving an accurate diagnosis, building trust with patients, and improving treatment compliance (Ha et al., 2010; Jenerette and Mayer, 2016; Roter & Hall, 2011; Street, 2002). It makes sense that doctors should use interpersonal relationship-building skills to achieve these goals. However, self-disclosure is a tool that must be used with caution. My research underscores the need for more training and research to help physicians learn how to navigate initial patient relationships and determine the quantity and quality of information to disclose so as to positively impact patient satisfaction.

Limitations

The scope of my findings is constrained by several limitations. From a methodological perspective, a focus group is not a large or representative enough sampling of people to be able to develop broad generalizations about all doctors or patients and how they ought to interact with one another. Therefore, my findings are only limited to the people who responded to my invitation to participate in the study. Second, recruiting for focus groups can be a challenge when the researcher is looking for

voluntary participants. For instance, though total ten participants scheduled the interview for my study, two participants didn't show up at the time of interview. Moreover, the demographics of my participants are fairly narrow. For example, women were slightly more represented within the focus group than men. In addition, the study had participants only from the United States and three Asian countries, which lacked data in terms of diversity. Future studies should engage methodological approaches that expand the number and diversity of participants, as so as to broaden the number of experiences with patient-provider interactions represented in the data.

From a theoretical perspective, my study is focused on doctors' gender performance of self-disclosure in isolation from other markers of identity (e.g., race, social class, sexuality, etc.). Studying how gender intersects with other forms of identity may make a difference in terms of how self-disclosure is received by patients. Additionally, the female participants in this study were especially critical of female physicians whose communication behaviors deviated from traditionally feminine gender roles. The interpretive focus of my study is somewhat limited for unpacking how issues of power and gendered forms of organizing in the medical field is shaping the unique communicative challenges for female physicians.

Areas for Future Research

The purpose of the study was to explore the impact of doctors' self-disclosure on patient satisfaction and examine whether gender influenced patients' perceptions and expectations. Patient satisfaction has become undoubtedly significant in health care. My study indicates that doctors' self-disclosure has the potential to positively influence patient satisfaction, regardless of the doctors' gender. From both theoretical and practical

perspectives, further research should more deeply examine the structure of what patients view as "appropriate" self-disclosure. This would require more research both on the types of information physicians tend to share, as well as how the sharing of various types of personal information are perceived by patients. Engaging physicians' viewpoints could also aid in expanding our understanding of how doctors make decisions regarding self-disclosure, particularly what factors influence the timing, quantity, and quality of information they choose to share. In addition, future studies might explore other cultural aspects of gender-role socialization on doctors' self-disclosure, which would address my study's limitations in terms of participant diversity. Certainly, other important identity categories among health care providers (e.g., race, social class, sexuality) may influence how patients perceive self-disclosures. Future research should seek to expand beyond gender performance to explore whether and how intersectional identities are salient to doctor-patient encounters, as well as how they influence communication and patient satisfaction. Moreover, further study could deeply explore the existing cultural sexism in the workplace for female doctors, shaped by beliefs both about women in general as well as in a historically male-dominated occupation in order to unpack how issues of power and gendered forms of organizing in the medical field is shaping the unique communicative challenges for female physicians.

To sum up, my findings indicated patient satisfaction is positively connected to doctors' patient-centered behaviors, such as self-disclosure, regardless of physicians' gender identity. How a doctor connects with their patient influences how much information he or she will obtain during medical consultations and plays an important role in shaping their relationship. Support, empathy, compassion, and the desire to

reduce uncertainty and improve understanding are powerful motivations for self-disclosure to develop intimacy in interpersonal relationships. Yet, learning how to self-disclose appropriately remains a key concern for doctors. Regardless of gender differences, this study emphasizes the relevant, not excessive and helpful self-disclosure of doctors while communicating patients.

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Table 1

Participant Characteristics

Characteristic	Data
Age	20 to 38 years
Sex	Five females, three males (n = 8)
Ethnicity/Race	White/Caucasian (n = 5), Asian (n = 3)
Highest Level of Education	Bachelor's Degree (n = 4), Graduate Degree (n = 4)
Geographic Location	United States (n = 4) Asia (n = 4) followed by Bangladesh (n = 2), Pakistan (n = 1), Iran (n = 1)

Appendix A: Consent Form

Title: Self-Disclosure, Gender, and Patient Satisfaction in the Doctor-Patient Relationship

Investigators: Khadiza Tul Jannat and Dr. Anne Kerber, Department of Communication Studies, MNSU, Mankato

Description: The purpose of this research is to understand your experiences in interacting with doctors. Specifically, you are being asked to participate in a focus group with 5-7 other individuals regarding perceptions of doctors' communication practices, such as what are the top qualities you look for in a physician, and whether they ought to share personal information about themselves with their patients. ***Interviews will NOT include questions asking about individuals' health status or history. Instead, I will be asking about your perspectives on the kinds of physician communication practices and gender differences in communication styles that you find to be satisfying (or not) as a patient.*** We will discuss this form with you at the time of your focus group, and you will have the opportunity to ask any questions you might have about study and your rights as a participant.

Video and Audio Recording
With participants' permission, the interview will be video- and audio-recorded for the purpose of transcription. Agreeing to video- and audio-recording is a requirement of participation. ***Please note:*** Recorded video and audio will be retained for one year and then destroyed.

My initials following this statement indicate I agree that the interview may be video and audio-recorded _____

Confidentiality: Your answers will be kept confidential, as your name and any personally identifying details will not be included on the transcript or in any write-ups of the research. Consent forms will also be kept separately from the transcripts. All data will be kept on a password-protected laptop that Jannat alone will have access to. ***Please note:*** It is possible that others in the group may potentially identify you or share what you say outside of the focus group. All participants are asked to not reveal their fellow participants' identities or share the contents of the discussion to others.

Time Commitment: I anticipate it will take 50-90 minutes to complete the focus group for this project.

Risks and Benefits: You may develop greater personal awareness of your health care experiences, such as how a doctor's self-disclosure impacts patient satisfaction, because of your participation in this research. There will be no compensation for your participation in the study. The anticipated risks of participating in this research are

minimal but may include some emotional discomfort during or after your participation. Resources are available should you experience such discomfort: Minnesota State University, Mankato students may contact the MSU Counselling Center at 507-389-1455. If you are not an MSU student, you may contact the Blue Earth County Mental Health Center at 507-304-4319. **Please be advised:** Any cost incurred for seeking counseling resources will be your responsibility.

Right to Withdraw: Your participation in the research is entirely voluntary. Participants have the right to end their participation during the focus group if they experience discomfort or no longer wish to participate. If you wish to withdraw during the focus group, please notify Jannat immediately. You may also choose to withdraw after the focus group concludes and may contact either researcher to do so. **Please be advised:** Video and audio recordings will only be retained for one year. Because the transcripts and demographic surveys will not include identifying details, it may not be possible to remove your contributions if you wish to withdraw from the study after the recordings are destroyed.

Your decision whether or not to participate will not affect your relationship with Minnesota State University, Mankato, and refusal to participate will involve no penalty or loss of benefits.

If you have questions or concerns regarding this study, please contact Dr. Anne Kerber (anne.kerber@mnsu.edu or 507-389-1407) or Khadiza Tul Jannat (khadiza-tul.jannat@mnsu.edu or 507-351-7077).

If you have any questions about participants' rights and for research-related injuries, please contact the Administrator of the Institutional Review Board, at (507) 389-1242.

Statement of Consent: By signing this consent form you agree that you are at least 18 years of age and are willing to participate in the project entitled, "Self-Disclosure, Gender, and Patient Satisfaction in the Doctor-Patient Relationship".

_____   _____   _____
Signature   Printed Name   Date

Date of MSU IRB approval: 1246413

Who: Khadiza Tul Jannat and Dr. Anne Kerber (Minnesota State University, Mankato) are seeking individuals for research who want to share their experiences in interacting with doctors. Specifically, you are being asked to participate in a focus group regarding your perceptions of doctors' communication practices, such as what are the top qualities you look for in a physician, whether they ought to share personal information about themselves with their patients, and whether you find any gender differences in doctors' self-disclosure.

Interviews will NOT include questions asking about individuals' health status or history. Instead, you will be asked about your perspectives on the kinds of physician communication practices and gender differences in communication styles, you find to be satisfying (or not) as a patient. You will be asked to sign a consent form and to complete a brief demographic survey at the time of the interview. Jannat will discuss the consent form with you at the time of your interview, and you will have the opportunity to ask any questions you might have about study and your rights as a participant.

What: Participation in the study involves taking part in a face-to-face, 50-90-minute focus group with 5-7 individuals. With participants' permission, the focus group will be video and audio-recorded for the purpose of transcription. Your answers will be kept confidential, as your name and any personally identifying details will not be included on the transcript or in any write-ups of the research. Consent forms and the demographic survey will also be kept separately from the transcripts. All data will be kept on Jannat's password-protected laptop that she alone has access to. Please note: Recorded video and audio will be retained for one year and then destroyed.

Eligibility: To participate in the study, potential participants must be 18 years of age or older.

Please feel free to SHARE with family and friends who might be interested in participating in this study.

For more information, contact:
Dr. Anne Kerber at anne.kerber@mnsu.edu or (507)-389-1407 or, Khadiza Tul Jannat at Khadiza-tul.jannat@mnsu.edu or (507) 351-7077

IRBNet ID Number: 1246413

Appendix C: Email to Respond to Potentially Interested Subjects

Greetings,

Thank you for your interest in being part of my study on doctor-patient interaction. As you may already know, you must be at least 18 years of age or older AND be willing to discuss your experiences with doctors' communication practices, aspects of gender differences in physician communication, and patient satisfaction. Would you be available to participate in a focus group on **[June 8, Friday 12:30 p.m.]**? If this time does not work for you or you would like to discuss an alternative time, please contact me at the email or phone number listed below.

As I mentioned in my earlier email, I am sending you a consent form and a brief demographic survey that discusses the study and outlines your rights as a participant in research. You will be asked to sign the consent form and to complete the demographic survey at the time of the focus group, so I ask that you read through it document prior to our meeting. I will discuss it with you in more detail and can answer any questions you may have at that time. Please don't hesitate to contact me if you have any questions about it beforehand, though.

Please know this information will be kept confidential, as your name and any personally identifying details will not be included on the transcript or in any write-ups of the research. I will discuss it in more details with you before the focus group.

Again, please don't hesitate to reach out if you have any questions or need to reschedule our discussion.

Best,
Khadiza Tul Jannat, Minnesota State University, Mankato
khadiza-tul.jannat@mnsu.edu, 507-351-7077; **IRBNet ID Number: 1246413**

Appendix D: Thank You Message to Participants

Dear [Name],

Thank you once again for your participation in my study. I am grateful for the time and insights you shared with me.

As we discussed during the focus group, please be sure to keep your fellow participants' identities and the contents of the discussion confidential.

Additionally, please be advised that you have the right to withdraw your participation at any time and may contact me to do so. Do know that video and audio recordings will only be retained for one year. Because the transcripts and demographic surveys will not include identifying details, it may not be possible to remove your contributions if you wish to withdraw from the study after the recordings are destroyed.

If you experience any emotional discomfort because of your participation in the study, resources are available to you. If you are Minnesota State University, Mankato student, you may contact the MSU Counselling Center at 507-389-1455. If you are not an MSU Student, you may contact the Blue Earth County Mental Health Center at 507-304-4319. Please be advised that any costs incurred for seeking counseling resources will be your responsibility.

Best,

Khadiza Tul Jannat, Minnesota State University, Mankato

khadiza-tul.jannat@mnsu.edu, 507-351-7077

IRBNet ID Number: 1246413

Appendix E: Interview Protocol - Focus Group Interview

Introductory script: Thank you for taking the time to talk with me today. As I mentioned when we schedule this meeting, I would like to discuss your experiences in the medical consultations focusing on doctor-patient interaction. Before we begin, I need to ask you to read the consent form, which describes the purpose of my study, and sign at the bottom to indicate that you agree to be a part of this research project. Additionally, I need to ask you to complete the demographic survey and return it to me after the interview. Please know that I will keep your answers to these questions confidential, which means that any potentially identifying information about you will be removed from write-ups of this study. You should keep the identity of others in this group confidential and not reveal what was said by anyone here to others outside of the focus group. *Please note:* I have no control over what others in the focus group will say outside the focus group. During the interview, if you need a break or want to discontinue the participation, you may ask me directly. Finally, you should know that you always have the option to not answer any question that is asked. If at any point, you do wish to withdraw from the focus group, please let me know. You may also choose to withdraw after the focus group concludes and may email me to do so. Please be advised that the video and audio recordings will only be retained for one year. Because the transcripts and demographic surveys will not include identifying details, it may not be possible to remove your contributions if you wish to withdraw from the study after the recordings are destroyed. Do you have any questions for me before we get started?

Participants will be asked to sit in a circle. I will ask the questions and open it up for dialogue to whoever is interested in talking about the particular issue. When everyone

is ready, I will start the interview by asking some ice-breaking questions such as, "What is your favorite color or hobby?" Then, I will begin the interview questions:

Questions:

(1) What are the top three qualities that you look for in a doctor? Why are these qualities important to you?

(2) Imagine you are meeting a new doctor for the first time. What are some of the kinds of communication behaviors **you would want** them to use to help you feel comfortable discussing your health? Why?

(3) What are some kinds of health communication behaviors you **would not want** a doctor to use to help you feel comfortable discussing your health? Why?

(4) Do you prefer to see a male or female doctor? Why?

(5) Think about a time when a doctor shared information about their personal life with you during a healthcare visit. What did they tell you? How did the information come up? Was the doctor male or female? How did you feel about this information being shared with you? How did the sharing of this information affect the way you thought about this doctor?

(6) *For those who haven't had the experience of having a doctor self-disclose to them*: Have you had a healthcare encounter where you feel your relationships with a doctor could have been strengthened by them sharing personal information? If yes – why? If no – why not?

(7) What kind(s) of personal information would you want a female doctor to share with you during a healthcare visit? Why?

(8) What kind(s) of personal information would you want a male doctor to share with you during a healthcare visit? Why?

(9) Are there any other identity categories (for example, race, sexual orientation, age, social class) that influence on what kind of communication behaviors you expect from your doctors?

(10) Is there anything else about your doctors' communication behaviors that you'd like to share with me?

(11) Do you have any questions for me?

Appendix F: Brief Demographic Survey

The following survey is being sent to you as a participant in the research project entitled "Self-Disclosure, Gender, and Patient Satisfaction in the Doctor-Patient Relationship." We are collecting this data to understand the demographics of participants in this research project in aggregate. You will be asked to complete the survey prior to the focus group in a place of your choosing. Please note that the information you will provide is confidential and will not be attached to your specific interview responses. Should you experience discomfort with answering any of the questions, you may leave them blank.

When you are finished completing the demographic survey, please return it to the researcher after the interview. If you have any questions about the survey, please contact either Dr. Anne Kerber at anne.kerber@mnsu.edu or Khadiza Tul Jannat at khadiza-tul.jannat@mnsu.edu

1. What sex do you identify as?
- Male
- Female
- Other – Please specify:

2. How old are you (in years)? _____

3. What is your ethnicity? (Circle all that apply)
- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic
- Hispanic-White
- Native Hawaiian or Pacific Islander
- White/Caucasian
- Other – Please specify:

4. What is the highest level of education you have completed?
- Less than high school degree
- High school degree or equivalent (e.g., GED)
- Some college
- Associate degree
- Bachelor's degree
- Some graduate school
- Graduate degree – please specify: