Couples with diabetes and health-care providers: a grounded theory of preferential relating

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Abstract

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Accepted for publication

14 October 2014

Keywords: chronic, decision making, diabetes, health care, illness and disease, medical family therapy, patient-provider, relationships

Background A collaborative health-care relationship is considered critical in managing chronic illness like diabetes. Poorly controlled diabetes can greatly diminish one's quality of life and lead to severe complications or even death.

Rationale Understanding how to improve the relationship between patients and their providers supports improved diabetes health outcomes.

Objective We conducted a grounded theory study to examine the types of relationships that diabetic patients and their spouses prefer to form with their health-care providers.

Results The analysis of in-depth interviews with 18 diabetic couples reveals four major relationship preferences that differ by the nature of caregiving and decision-making power demonstrated by the physician.

Conclusion Using illustrative examples, we show how the type of health-care relationship couples prefer is explained by their connection with one another and suggest implications for practitioners that expand current collaborative models of care.

Diabetes affects more than 25.8 million people living in the United States and is linked to serious medical complications.¹ Treatment can be challenging and often consists of monitoring blood-glucose levels, medication, exercise and dietary therapy. Collaborative, patient-centred care is considered the ideal approach in the treatment of chronic illness, of which shared decision making is a principal component. Both providers and patients are experts who contribute valuable information to medical decisions.² The need for long-term treatment and adherence to self-care for patients with diabetes makes it important to develop effective

relationships with their health-care systems, and more specifically their treating physicians. Our study explores health-care preferences of married couples when at least one partner has diabetes.

Background

Diabetes research indicates that positive patient-provider relationships are associated with treatment adherence,^{3–5} greater glycemic control⁶ and improved health-related quality of life.⁷ More specifically, satisfaction with physicians' communication and patient involvement

in treatment decisions is related to improved medication adherence.^{8–10} Patient participation in making treatment-related decisions is also related to increased feelings of self-care efficacy and self-management of diabetes.¹¹

Treatment for diabetes has become increasingly holistic and collaborative. In a critical review of literature, Daiki¹² concluded that provider-directed treatment was generally less effective. Lutfey¹³ found that providers are often flexible and strategic in their style of relating to patients with diabetes and may tailor their approaches to meet individual patient needs. Similarly, Montori *et al.*¹⁴ questioned expecting patients to fit into any particular treatment style and suggested that specific patients and providers engage in ways that work for those involved. Daiki¹² suggested that integrating different approaches to care might complement and enhance each other. Diabetes research unequivocally reflects the importance of the patient–provider relationship and demonstrates efforts to be increasingly collaborative in caring for patients with diabetes.

Another major influence on the experience and management of diabetes is the spousal relationship. For example, in a recent study, researchers found that participants were 26% more likely to acquire type 2 diabetes when a spouse has a history of diabetes.¹⁵ In another study, participants who were married demonstrated enhanced self-care efforts when compared to non-married participants.¹⁶ Marital quality has been related to disease self-management,¹⁷ health-related quality of life^{18–20} and diabetes health outcomes.²¹ Although spousal participation varies, partners are often closely involved in reinforcing patients' self-care efforts^{22–24} and their social support efforts influence health-care outcomes in meaningful ways.^{25–27} For instance, sharing meals is associated with decreased illness-related distress²² and partner's perceptions of diabetes is related to how patients with diabetes understand and manage their illness.²⁸

Research suggests that living and coping with diabetes is not an isolated experience,

rather it occurs in the context of a family system. In a recent study, researchers gathered responses from 2057 participants who were family members to someone with diabetes and found that their experiences were full of unique challenges and unmet needs.²⁹ This is congruent with our systems-relational lens that encourages us to understand that behaviour is embedded within multiple relational and larger systems.³⁰ The spousal subsystem is of particular importance given its intimate nature and executive position within the family. It can provide partners and other members of the family 'a supportive platform for dealing with the extrafamilial world'.³¹ Believing that the couple relationship is a central organizing component in how patients cope with diabetes and navigate their systems of care, we used this context for understanding patient preferences for their provider's way of engaging.

In this study, we explore health-care preferences of persons with diabetes and their spouse. Our purpose is to add to the literature that is considering care more systemically and expanding ideas about providing patient-centred care. Specifically, we privilege the marital relationship and its impact on health-care preferences and highlight nuances within known ways of providing care.

Method

We utilized grounded theory methodology to articulate and explain couples' health-care relationship preferences.³² This method allows researchers to generate theory from data that are gathered and analysed systematically and reciprocally.³³ Considered a standard in qualitative research, grounded theory is especially suited for identifying categories,³⁴ understanding relationships among them³² and distinguishing the nuances within complicated processes.³⁴ The demands of simultaneous and careful data collection and analysis make it a rigorous methodology, as do the requirements of saturation. The ability to identify and explain complex phenomena makes grounded theory ideal for our research design.

Recruitment and description of participants

After gaining institutional review board approval to conduct our study, participants were recruited primarily from San Bernardino County in Southern California by marriage and family therapy students at (INSERT) University. We utilized convenience and snowball sampling methods to identify our target population of married couples in which one member of the spousal unit was diagnosed with diabetes.³⁵ Our aim was to recruit those who would engage in meaningful conversation regarding their experience of health-care relationships rather than ascertain the type of representativeness desired in quantitative research. Our focus was to reach the point of data saturation in which no new information was obtained about health-care relationship preferences. To participate in our study, the participants needed to meet two key requirements: (i) be married or cohabiting adults in a committed relationship, with at least one partner who has type 2 diabetes, and (ii) be willing to be interviewed together about their relationship and experiences with diabetes. Theoretical sampling was utilized throughout to further generate and refine emergent categories.

Our sample consisted of 18 married couples who had been together an average of 29 years. The average age of wives was 51; the mean for husbands was 52. Of the 18 couples, wives were diagnosed with diabetes in seven couples, and husbands were the identified patients in 10. The average time diagnosed was 8 years, ranging from 3 to 15. In one couple, both partners were diagnosed with diabetes. Although unique, this contextual factor does not inherently influence couple preferences for relating with their physician. Twelve participants referred to themselves as White/Caucasian and 14 as Hispanic with additional participants identifying as Filipino, two, Hawaiian, two, African-American, four, Armenian, one and Egyptian, one. Nine participants reported earning a high school diploma, 12 reported some college, and 15 participants had college degrees.

The interview transcripts

Semi-structured conjoint interviews lasting 1½ to 2½ h took place primarily in the homes of participants and were conducted by marriage and family therapy doctoral students who had already taken, or were concurrently enrolled in a qualitative research course. Although many couples have one partner who tends to lead conversations, the interviewers were able to elicit the experiences of both partners by validating more dominant speakers and asking more reserved partners direct questions relating to their experiences. Ethically, it was important for couples to understand that the purpose of these interviews was to conduct research, rather than provide therapy. In addition, we wanted participants to know that we would follow strict guidelines to maintain privacy among participant couples, some of whom were referred by one another. Prior to each interview, we discussed both of these issues, and to further protect patient privacy, identities were coded during transcription.

Questions addressed many aspects of the couples' experiences with diabetes although with particular interest in emotion, conflict, the health-care relationship and beliefs about systems of care. Questions were primarily 'action- and process-oriented'³⁶ and were strategically broad, designed to give couples freedom to explore these issues from their own narratives. For instance, an initial question about how couples engage emotionally was, 'How is the emotional work of the couple handled?' Additional question prompts included, 'Who notices the needs of the other', and 'How do you deal with diabetes?' Questions about experiences with health care began with 'In general, what has been your experience with health-care professionals?' with a follow-up questions being, 'What does he/she do to help?' Interviewers followed participants' leads, using explorative prompts to expand and deepen couple responses. When we finished transcribing the interviews, more than 400 pages of information were available for examination.

Analysis

Using conventional grounded theory methodology,³² data analysis began immediately, concurrent with data collection, and continued until the point of saturation. We first transcribed interviews verbatim. Next, we utilized open coding to group similar phenomena,³² searching for text describing the couple, their provider and the relationship between them. This allowed us 'to label, separate, compile and organize data'.³⁷ (p. 111) Reflective memos focusing on the relationship between codes and categories were kept throughout analysis.³⁷

The primary analytic tool was the constant comparative method in which data were compared and examined for similarities and differences. Independent coders compared codes and discussed emergent themes to ascertain interrater reliability. Axial coding helped us to further examine the relationship between and refine central categories. Peer review was employed to ascertain redundancies among the data to consolidate and reconcile codes as well as to examine the emerging theory as being accurate reflections of the data. Participant checks were also employed to further refine relationships between categories and determine the 'fit' or appropriateness of our final theory.³⁸

All researchers 'no matter how unstructured or inductive, comes to fieldwork with some orienting ideas'.³⁹ (p. 17) It seems appropriate to state our relationships with diabetes to enhance credibility.⁴⁰ The first author's interest in couples with diabetes results from having two family members diagnosed with diabetes, one of whom describes his relationship with his provider as highly problematic and the other who died from complications related to uncontrolled diabetes. The second author has a close friend who was diagnosed with diabetes several years ago and has experienced difficulty in relationships with both family members and health-care providers as a result. Furthermore, both of us are medical family therapists (MedFTs) who work in a hospital setting with patients diagnosed with diabetes and other chronic illnesses. We have seen firsthand how

positive patient-provider relationships impact treatment outcomes in beneficial ways.

Findings

This study investigated couple preferences for the health-care relationship when at least one spouse has been diagnosed with diabetes. Our analysis reveals two major dimensions that organize how couples prefer to relate to their health-care provider: decision making and caregiving. Within these two major dimensions, we found four specific preferences of provider to couple relationships: 'Employer', 'Colleague', 'Parent' and 'Sibling' (See Table 1). Results also reveal that couple preferences are maintained across daily and acute care, but are heightened by crisis. For instance, one couple who preferred emotional support was frustrated by their doctor's instrumental approach and described their frustration quickly escalating when she was critically ill. They needed hope and encouragement, and their doctor was focused on medical management. Differences in preferences were not identified within couple.

With regard to the dimension of decision making, some couples (eight of 18) reflect a preference for providers who make treatment decisions collaboratively. Much to our surprise, the slight majority (10 of 18) described wanting providers to make decisions for them. Within the dimension of caregiving, exactly half of the couples in our study have a strong desire for a provider who offers emotional support, while the other half of our couples prefer a more instrumental way of providing care. Below, we first describe the dimensions of caregiving and decision making and then consider each specific preference and the couple dynamics that support these.

Caregiving dimension

Some couples felt cared for through their physician's task-oriented activity aimed to quickly and effectively respond to treatment needs. One patient described, 'He acted immediately', when he learned the patient needed inpatient

Table 1 Dimensions of decision making and caregiving in defining patient preferences for relating with their health-care providers.

Caregiving dimension	Decision-making dimension	
	Hierarchical	Collaborative
Instrumental	Employer preference (5 couples)	Colleague preference (4 couples)
Relational	Parent preference (5 couples)	Sibling preference (4 couples)

care. Task-oriented activities included ordering tests, adjusting medication, introducing new treatment options, providing referrals or admitting someone to the hospital. A patient's wife explained, 'The doctors call him. ...they are monitoring him. ...[the] provider for him has been excellent'.

Other couples described the meaningfulness of emotional support, much like the type of concern and care that might be expected from a loving family member. Most often discussed was the importance of offering encouragement and expressing compassion or sensitivity. A patient spouse indicated, 'My wife's doctor is great; he takes the time to get to know you, he's really personable and warm; he treats you like you should be'. A different patient relayed frustration with a physician who did not live up to her preferences for caregiving:

He would say, 'Do you want me to save your ass?' It's like a regimen. When I almost went into a diabetic coma, my doctor... looked at me and just shook his head. It seems that there are few good doctors out there who really care.

This couple expressed a desire for more concern and sensitivity and described their physician as punitive, leading them to believe that he did not care about them.

Decision-making dimension

Couples who wanted providers to make treatment decisions willingly complied with physician prescriptions. For example, one participant said, 'Do I disagree? No, whatever they say... I believe, I do it'. Couples who preferred collaboration emphasized how important it was for them to have a say in their treatment or expressed dissatisfaction when providers made

decisions unitarily. A wife with diabetes discussed her frustration with her doctor in telling her, 'You can't have any more kids'. Instead of dictating her care, she wanted support in managing diabetes during pregnancy. Interestingly, couples in both categories wanted information and education on diabetes management: even those who were happy to follow doctor's orders wanted to understand the illness process and treatment.

Four types of preferences

By examining the dimensions of decision making and caregiving collectively, a clearer image of specific patient preferences emerges and four distinct types of relationships can be identified (See Table 1). Among couples who wanted to work collaboratively with providers, some privileged emotional support, while others preferred instrumental care. We label couple preferences for a collaborative, emotionally supportive relationship, a 'Sibling Preference', and those who wanted this same emotional support from a provider who made decisions for them, a 'Parent Preference'. Similarly, those who preferred provider-directed treatment differed in their preference for caregiving. Couple preferences for a collaborative, instrumental relationship we label 'Colleague Preference', and preference for a hierarchical, instrumental relationship an 'Employer Preference'.

Preference for a parent

These couples (5) emphasized the importance of doctors' prescriptions and highlighted the meaningfulness of emotional support. They trusted in the expertise of their provider and reflected fondly on their close relationship or

on the physician's personal qualities like kindness or compassion. One husband stated, 'Well, we have had a good experience with professionals. The one we have now is the one my wife says is her half-relative. He is a wonderful person'. The couple discussed their doctor's dedication and relational style of interaction. They appreciated their doctor taking the lead on diabetes management, never disagreed with him and claimed to always follow his recommendations. Another husband described his doctor as 'closer to me than any family member' and explained that they never disagree with their physician, 'Whatever they [the physicians] say, I do it'.

Preference for a sibling

These couples (4) also privileged emotional support, but within the context of a collaborative, rather than hierarchical relationship. Their narratives highlighted the importance of encouragement, listening and making shared decisions. A wife with diabetes underscored the importance of emotional sensitivity and collaboration from her provider, 'Some people just bluntly tell it how it is, and I can't handle that... I can't hear someone say flat out you're going to kill yourself. I just can't hear that'. She then relayed that she's labelled as either a 'good' or 'bad' patient depending on whether or not she follows her doctor's orders. She indicated a preference for a provider that takes her specific needs into consideration rather than implementing a one-size fits all treatment and explained, 'I need someone to help me through it, and guide me, instead of saying, "you're doing it wrong"'. The couple reflected on the provider's kindness and the spirit of partnership they feel from him, similarly to how siblings might relate to one another in a mutually collaborative way.

Preference for an employer

These couples (5) expected the physician to prescribe treatment and provide instrumental care. They often described feeling satisfied with receiving advice and emphasized the importance of following doctors' orders, '[I] try to do the

things that he tells you that you need to do. That is one of the important things. He tells me what I need to do and I go, "yes"'. Instead of expecting to collaborate in treatment decisions, these patients trusted their doctors' prescriptions implicitly and valued action-based ways of providing patient care. This same patient husband emphasized how important it is for the doctor to provide him with information and direction related to diabetes treatment. When asked by the interviewer whether or not the provider cares he stated, 'I think if he didn't care he'd just say, "Okay you just go ahead and do what you're going to do"'. These couples consistently emphasized the role of their physician as one of leadership and action, much like might be expected of an effective employer.

Preference for a colleague

These couples (4) described a preference for a provider whose care is expressed instrumentally, but whose relationship is built on mutual influence. They emphasized the importance of negotiating treatment when they disagree with their doctor's ability to work efficiently. One couple described various tasks the physician completed and their physician's quick response to help during a time of crisis, 'The next thing he did was to take my blood/sugar level. ... He acted. He put me in the hospital, which was where I belonged because you need to be under a controlled environment'. When he disagrees with the provider he responds by telling his doctor readily..., 'I told her that I need to change to another medication. So I called her up and told [her that I] want to switch back'. He described an appreciation for how much his provider values his opinion and elevates him as a member of the treatment team.

Another couple who preferred a 'Colleague' relationship experienced significant frustration when a provider operated from a place of hierarchy instead of collaborative support. Despite their desire to be heard, their provider was reluctant to alter the patient's treatment plan when the couple was convinced that changes needed to be made. The couple relayed the following experience:

Before we were on the pump, I would give you two cents as far as I could throw him. Now that we are on the pump, he knows what is going on. But before, when her blood sugar was so darn high and low you would think that he would do something about it, and get it kind of leveled out... he just wasn't with the game at all.

They described not only their dissatisfaction with the physician's inability to receive input, but also his failure to accomplish tasks effectively. Like those who preferred an 'Employer', these patients indicated an appreciation for instrumental care, but wanted a say in their treatment.

Explanation of decision-making preferences

Couples who preferred that their provider take the lead on treatment decisions by assuming the role of 'Parent' or 'Employer' maintained an element of hierarchy in their spousal relationships. They seemed to subscribe to more traditional gender roles where the husband makes the decisions and tasks are specifically divided. One wife noted, 'I let him decide mainly the big things. As far as money goes, he knows more about it'. Another wife commented, 'We have our duties' and that indicated that when major decisions are made her husband will 'impose his power'. Male partners often answered questions about fairness or equality by stating that they 'don't think about it' or that equality does not play an important part in understanding their relationship. Husbands in this category seemed to frequently interrupt their wives or answer questions first. Interestingly, they tended to do the majority of the talking around issues related to equality or division of household tasks.

Couples who preferred collaborative relationships with their providers, whether a 'Sibling' or 'Colleague', demonstrated more egalitarian couple relationships. They often reflected that they share tasks and as one patient stated, 'do what you gotta do' rather than operate based on clearly defined roles. They participated more evenly in the interview and when asked about equality, both spouses

responded to and underscored the importance of equality and teamwork. Some proudly drew a distinction between their relationship and a more traditional one. For instance, one couple happily discussed how they both worked full time and explained how they accommodate to the needs of one another. Another husband indicated, 'We're equal in every way: mentally, education, work, sharing responsibility with the kids'. He went on to say that he was a pharmacist and that at times, he disagrees with physicians. He stated, 'I advise him and so he knows about it and he is pretty cool about it... We work together'. Clearly, the couple expected to contribute to their health care in being elevated as a member of the treatment team. It is possible that for this couple, the husband's profession, as well as couple dynamics, influenced their desire for treatment collaboration.

Explanation of caregiving preferences

Couples who preferred providers to fill the role of 'Sibling' or 'Parent' felt cared for when the provider expresses emotional support. These couples more openly expressed their feelings about what it is like to live with diabetes and about other life-experiences, and were warm, affectionate or expressed love towards one another during the interview. For instance, one couple expressed pain around the management of diabetes. The husband cried several times during the interview as he reflected on his struggle. Another couple openly expressed heartache around changes in social support and status experienced due to immigration. These couples also emphasized the importance of kindness and compassion within their couple relationship. A husband explained that his wife calling to say she missed him 'really touched me' and stated, 'I love her so much.' Another husband described his wife as 'caring' and 'loving' and indicated that what he appreciates most about her is how caring she is. Not surprisingly, these warm and expressive couples felt cared for when their physician provides them with sensitivity and emotional support.

In contrast, patient couples who preferred more instrumental means of care demonstrated love through tasks or service, rather than through emotional support. For instance, a husband with diabetes explained that he knows his wife cares about him because 'she fusses about the meal'. He felt valued by her service and elaborated on how she washes his clothes and keeps a clean house. Couples within this category even talked about the lack of emotional expression in their relationships. One wife stated, 'He doesn't share feelings' and another indicated that her husband rarely shows emotion. The narratives show that couples who preferred instrumental care consistently emphasized how grateful they were for the things their provider did for them and described their marital relationship in ways that reflect an appreciation for service.

Discussion

Our findings reveal that patients with diabetes have unique preferences for how they connect with their provider. These seem largely impacted by how they engage in and understand non-health-care relationships. Namely, the spousal relationship seems to meaningfully influence health-care preferences. Although a top-down approach to health-care conflicts with best care practices, we speculate that there might be considerable difference between couples who *want* this type of health-care relationship and those who do not. A patient's opportunity to say how they would like to relate might in and of itself be empowering, even if they desire a less active role in making treatment decisions. This might be a significantly different experience than couples who want to equally contribute to decision-making processes but feel devalued or undermined by their provider.

Almost half of our couples (10 out of 18) felt cared for when their providers did instrumental health-care management on their behalf. They switched medications, ordered tests and facilitated other health-related changes to foster successful disease management. Perhaps

instrumental care enticed these couples to feel like their physician was doing all she could to take care of them physically. Among couples who emphasized the importance of emotional support (eight out of 18), it seemed as though their physicians' verbal expressions of comfort or hope led them to feel a sense of closeness with their doctor that they appreciated. For these couples, emotional support allowed them to feel as though their physician personally cared for them and had their best interest in mind.

Our data suggest that health-care preferences are largely impacted by couple relationship dynamics. This is not surprising when we consider the power of attachment. We learn about ourselves and others through early attachment experiences as we develop what Bowlby referred to as internal working models.⁴¹ These models frame our way of relating, and we carry them into subsequent relationships. Moreover, when our primary attachment relationship moves from parent to spouse, our ways of interacting continue to be refined and applied to our interactions with others.⁴² It follows that expectations for relating stemming from the couple relationship are transferred to the health-care relationship.

When couples relate to one another in more egalitarian ways, they seem to transfer this same expectation onto their provider, assuming a collaborative health-care relationship in which they share power. However, when couples conform to more traditional roles, collaboration becomes less expected and the provider's expertise is privileged. This seems to reflect a transfer of internal working models from one relational context into another. Previous research seems to corroborate this idea by finding that patients who experience a dismissive attachment style seem to relate to their providers in ways that lead to poorer health outcomes in managing diabetes.^{43,44}

Given the traditionally inherent power differential in the doctor-patient relationship, providers are in a unique position to set the groundwork for an effective working relationship. We encourage providers to ask patients

about their expectations for the health-care relationship to tailor treatment to meet patient needs (See Table 2). Furthermore, enhanced reflexivity about preferred approaches to patient care might help providers consider ways to adjust when patients prefer something other than the provider's natural inclination. This might be especially useful when there is an impasse in patient care.

Couple and family interactions might provide a unique window into patient health-care preferences. Observing couple interactions and asking couples how they make decisions might offer useful information (See Table 2) about how to best join with them in the management of their illness, particularly when couples have difficulty directly expressing their needs to their provider. For instance, do patients and their spouse make decisions together or unitarily? Do they seem openly affectionate and expressive, or do they emphasize how loved ones help them manage diabetes day-to-day? Approaching patient relationships with these kinds of questions in mind, as well as observing whether or not the patient's relationships reflect a more traditional or dynamic family structure, might provide valuable information about how to best interact to meet particular patient needs. As our results suggest, a universal approach to health care is questionable, even when it is a collaborative or a shared decision-making approach.

Although the results of the present study are fruitful, a few limitations should be noted. With the exception of one couple, the partici-

pants were all located in Southern California and were married heterosexual couples, which excludes same-sex partners and those who are unmarried but cohabiting. In addition, 15 of the 18 couples identified themselves as religious, with a large representation of Catholics and Seventh-day Adventists. It should be noted that the area in which interviews were collected is known for a higher-than-normal percentage of these affiliations. A majority of the couples identified themselves as White or Hispanic, and we hope that future studies address the needs of wider racial and cultural populations. Finally, our mean age for participants shows that our sample represented a somewhat older population. It is possible that a younger sample might have unique preferences for the health-care relationship.

We hope that future research will address some of the questions that resulted from this study, including the diverse ways that patients may feel empowered within their health-care relationships. Because this was a qualitative study with an appropriately small sample size, further study might include the empirical testing of the preferences for relating found in this study among a larger sample of participants. Our work as medical family therapists (MedFTs) influences our perspective that therapists working within health-care settings might be in a position to effectively facilitate effective patient-provider relationships, and we anticipate that future research will further address more specifically how this can be performed. For example, MedFTs might meet

Table 2 Questions providers can use to draw out couples' styles of preferential relating

Questions gathering information about past experiences with providers	What have your experiences with other providers been like? <ul style="list-style-type: none"> • What has worked well? • What hasn't worked well? What do you need most from me as a provider?
Questions eliciting preferences about couple style of relating	How do the two of you usually make decisions? <ul style="list-style-type: none"> • Is this the way that you've always done things? • Is there another way that you'd prefer decisions be made?
Questions creating plan for preferred patient-provider way of relating	Some patients prefer that I tell them what I think is best. Others want to have an equal say in what we do. What do you think you'd like from me?

with patients before or after medical encounters, or intervene alongside physicians during appointments. Individual meetings might highlight patient beliefs related to their illness and care, debriefing past negative health-care experiences and discussing ways to connect and communicate with their physician.

From a systemic point of view, we are curious to know how providers' spousal and familial relationships impact their styles of working with patients. At present, there is little research on the emotional and relational experiences of health-care providers and we believe that there is a need for further study around these processes. Our findings indicate that connections between patients and providers are multilayered and we hope that additional research will centre around the development of interventions specifically targeted towards improving these relationships. We understand that couples find themselves on a continuum of styles of relating, rather than neatly defined categories, and we hope that future studies will further address the nuances of these relationships. Finally, we recognize that family systems are much wider than the couple relationship, and we anticipate that further study will expand the focus to include the interactional patterns of non-spousal family members, gendered ways of experiencing and providing care and the larger community.

References

- 1 American Diabetes Association. Diabetes statistics. American Diabetes Association homepage [Internet], 2011 [updated 2014 Jan]. Available at: <http://www.diabetes.org/diabetes-basics/diabetes-statistics/?loc=DropDownDB-stats>, accessed 4 October 2013.
- 2 Chong WW, Aslani P, Chen TF. Shared decision-making and interprofessional collaboration in mental healthcare: a qualitative study exploring perceptions of barriers and facilitators. *Journal of Interprofessional Care*, 2013; **27**: 373–379.
- 3 Colby JI, Wang F, Chhabra J, Pérez-Escamilla R. Predictors of medication adherence in an urban Latino community with healthcare disparities. *Journal of Immigrant & Minority Health*, 2012; **14**: 589–595.
- 4 Gimenes HT, Zanetti ML, Haas VJ. Factors related to patient adherence to antidiabetic drug therapy. *Revista Latino-Americana de Enfermagem*, 2009; **17**: 46–51.
- 5 Maddigan S, Majumdar S, Johnson J. Understanding the complex associations between patient–provider relationships, self-care behaviours, and health-related quality of life in type 2 diabetes: a structural equation modeling approach. *Quality of Life Research*, 2005; **14**: 1489–1500.
- 6 Lee Y, Lin J. How much does trust really matter? A study of the longitudinal effects of trust and decision-making preferences on diabetic patient outcomes. *Patient Education and Counseling*, 2011; **85**: 406–412.
- 7 Mancuso J. Impact of health literacy and patient trust on glycemic control in urban USA population. *Nursing & Health Sciences*, 2010; **12**: 94–104.
- 8 Heisler M, Bouknight RR, Hayward RA, Smith DM, Kerr EA. The relative importance of physician communication, participatory decision making, and patient understanding in diabetes self management. *Journal of General Internal Medicine*, 2002; **17**: 243–252.
- 9 Piette JD, Schillinger D, Potter MB, Heisler M. Dimensions of patient-provider communication and diabetes self-care in an ethnically diverse population. *Journal of General Intern Medicine*, 2003; **18**: 624–633.
- 10 Schoenthaler AM, Schwartz BS, Wood C, Stewart WG. Patient and physician factors associated with adherence to diabetes medications. *The Diabetes Educator*, 2012; **38**: 397–408.
- 11 Heisler M, Vijan S, Anderson RM, Ubel PA, Steven J, Hofer TP. When do patients and their physicians agree on diabetes treatment goals and strategies, and what different does it make? *Journal of General Internal Medicine*, 2003; **18**: 893–902.
- 12 Daiki I. An expanded model of diabetes care based in an analysis and critique of current approaches. *Journal of Clinical Nursing*, 2008; **17**: 310–317.
- 13 Lutfey K. On practices of 'good doctoring': reconsidering the relationship between provider roles and patient adherence. *Sociology of Health and Illness*, 2005; **27**: 421–447.
- 14 Montori VM, Gafni A, Charles C. A shared treatment decision-making approach between patients with chronic conditions and their clinicians: the case of diabetes. *Health Expectations*, 2006; **9**: 25–36.
- 15 Leong A, Rahme E, Dasgupta K. Spousal diabetes as a diabetes risk factor: a systemic review and meta-analysis. *BMC Medicine*, 2014; **12**: 12.
- 16 Bohanny W, Wu SF, Liu CY, Yeh SH, Tsay SL, Wang TJ. Health literacy, self-efficacy, and self-care behaviors in patients with type 2 diabetes mellitus. *Journal of the American Association of Nurse Practitioners*, 2013; **25**: 495–502.

- 17 Trief PM, Ploutz-Snyder R, Britton KD, Weinstock R. The relationship between marital quality and adherence to the diabetes care regimen. *Annals of Behavioral Medicine*, 2004; **27**: 148–154.
- 18 Fisher L, Chelsa CA, Chun KM *et al.* Patient-appraised couple emotion management and disease management among Chinese American patients with type 2 diabetes. *Journal of Family Psychology*, 2004; **18**: 302–310.
- 19 Trief PS, Himes CI, Ordendorff R, Weinstock RS. The marital relationship and psychosocial adaptation and glycemic control of individuals with diabetes. *Diabetes Care*, 2001; **24**: 1384–1389.
- 20 Trief PM, Wade MJ, Britton KD, Weinstock RS. A prospective analysis of marital relationship factors and quality of life in diabetes. *Diabetes Care*, 2002; **25**: 1154–1158.
- 21 Trief PM, Morin PC, Izquierdo R *et al.* Marital quality and diabetes outcomes: the IDEATel project. *Families, Systems & Health*, 2006; **24**: 318–331.
- 22 Franks MM, Sahin ZS, Seidel AJ, Shields CG, Oats K, Boushey CJ. Table for two: diabetes distress and diet-related interactions of married patients with diabetes and their spouses. *Families, Systems, & Health*, 2012; **30**: 154–165.
- 23 Gonder-Frederick LA, Cox DJ, Ritterband LM. Diabetes and behavioral medicine: the second decade. *Journal of Consulting and Clinical Psychology*, 2002; **70**: 611–625.
- 24 Stephens MAP, Franks MM, Rook KS, Iida M, Hemphill RC, Salem JK. Spouses' attempts to regulate day-to-day dietary adherence among patients with type 2 diabetes. *Health Psychology*, 2012; **32**: 1029–1037.
- 25 Gerstle JF, Varenne H, Contento I. Post-diagnosis family adaptation influences glycemic control in women with type 2 diabetes mellitus. *Journal of the American Dietetic Association*, 2001; **101**: 918–922.
- 26 Khan CM, Stephens MA, Franks MM, Rook KS, Salem JK. Influences of spousal support and control on diabetes management through physical activity. *Health Psychology*, 2013; **32**: 739–747.
- 27 Trief P, Sandberg JG, Ploutz-Snyder R *et al.* Promoting couples collaboration in type 2 diabetes: the diabetes support project pilot data. *Families, Systems, & Health*, 2011; **29**: 253–261.
- 28 Searle A, Norman P, Thompson R, Vedhara K. Illness representations among patients with type 2 diabetes and their partners: relationships with self management behaviors. *Journal of Psychosomatic Research*, 2007; **63**: 175–184.
- 29 Kovacs BK, Nicolucci A, Holt RI *et al.* Diabetes attitudes, wishes and needs second study (DAWN2): cross-national benchmarking indicators for family members living with people with diabetes. *Diabetic Medicine*, 2013; **30**: 778–788.
- 30 von Bertalanffy L. *General Systems Theory*. New York: George Braziller, 1968.
- 31 Minuchin S, Fishman HC. *Family Therapy Techniques*. Cambridge, MA: Harvard University Press, 1981.
- 32 Strauss A, Corbin J. *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*, 2nd edn. Thousand Oaks, CA: Sage Publications, 2007.
- 33 Rafuls SE, Moon SE. Grounded theory methodology in family therapy research. In: Sprenkle DH, Moon SM (eds) *Research Methods in Family Therapy*. New York: Guilford Press, 1996: 64–82.
- 34 Woolley SR, Butler MH, Wampler KS. Unraveling change in therapy: three different process research methodologies. *American Journal of Family Therapy*, 2000; **28**: 311–327.
- 35 Nelson T, Allred D. Survey research in marriage and family therapy. In: Sprenkle DH, Piercy FP (eds) *Research Methods in Family Therapy*. New York: Guilford Press, 2005: 211–237.
- 36 Echevarria-Doan S, Tubbs CY. Let's get grounded: family therapy research and grounded theory. In: Sprenkle DH, Piercy FP (eds) *Research Methods in Family Therapy*. New York: Guilford Press, 2005: 41–62.
- 37 Charmaz K. The grounded theory method: an explication and interpretation. In: Emerson R (ed.) *Contemporary Field Research: A Collection of Readings*. Boston, New York, NY: Little Brown Company, 1983.
- 38 Smith K, Biley F. Understanding grounded theory principals and evaluation. *Nurse Researcher*, 1997; **4**: 17–30.
- 39 Anfara VA, Mertz NT. *Theoretical Frameworks in Qualitative Research*. Thousand Oaks, CA: Sage, 2006.
- 40 Bogdan R, Biklen S. *Qualitative Research for Education: An Introduction to Theory and Methods*. Boston, MA: Allyn & Bacon, 1982.
- 41 Bowlby J. *Attachment and Loss: Vol. 1. Attachment*. New York: Basic Books, 1969.
- 42 Bowlby J. *A Secure Base*. New York: Basic Books, 1988.
- 43 Ciechanowski P, Katon W, Russo J, Walker E. The patient-provider relationship: attachment theory and adherence to treatment in diabetes. *The American Journal of Psychiatry*, 2001; **158**: 29–35.
- 44 Ciechanowski P, Russo J, Katon W *et al.* Influence of patient attachment style on self-care and outcomes in diabetes. *Psychosomatic Medicine*, 2004; **66**: 720–728.