565.

Cultural aspects in the interactions between Finnish medical practitioners and non-Finnish clients: perceptions and strategies

Pro gradu-tutkielma

Jyväskylän yliopisto
Viestintätieteiden laitos
Soveltava kielitiede
1998

Carine Cools

JYVÄSKYLÄN YLIOPISTO

Tiedekunta **HUMANISTINEN**	Laitos VIESTINTÄTIETEIDEN
Tekijä Carine - Alfonsine - Antoinette Cools	
Työn nimi Cultural aspects in the interactions between non-Finnish clients and Finnish medical practitioners: perceptions and strategies	
Oppiaine Soveltava kielitiede	Työn laji pro gradu tutkielma
Aika hel.98	Sivumäärä 119

Tiivistelmä - Abstract

The primary focus of this thesis was to find out how non-Finnish clients deal with the intercultural interaction with Finnish medical practitioners, from the clients' point of view. The following research questions were addressed: 1a. What are the clients' most striking or salient experiences and/or observations from the intercultural medical encounter?
1b. How do the clients perceive, illustrate, and evaluate these intercultural experiences?
2. To which aspects of intercultural communication do the clients give meaning?
3. Have the clients developed any strategies in order to improve their communication with Finnish medical practitioners? In this qualitative study based on a multiple case study as a research strategy, ten cases (ten non-Finnish clients) were taken up.
Semi-structured face-to-face interviews were used as a data collecting method.
Based on the criteria of content-analyzis, thematic units were identified.
The following five areas playing an important role in the non-Finnish clients' intercultural interactions with their Finnish medical practitioners could be found:
1) nonverbal communication, 2) verbal communication, 3) assumptions,
4) expectations, and 5) strategies. The findings of this study highlight the presence of intercultural awareness by the non-Finnish clients. They indicate that the clients perceived situations, persons and their behavior as intercultural when they were different than what they would experience 'at home'. The findings also suggest a certain correspondence between the duration of the clients' stay in Finland, and their stage in Bennett's developmental model to intercultural sensitivity (1986). This study's findings also imply that the non-Finnish clients approached the intercultural interaction prepared and well-equipped. Strategies were consciously employed by the clients and used to enhance the communication situation. The implications to be drawn from this study emphasize the importance of adequate and sufficient communication between the non-Finnish clients and the Finnish practitioners, i.e. the implementation of well-considered intercultural communication strategies. Extensive investigation in future research could promote more knowledge and information to improve practitioner-client communication in an intercultural context.

Asiasanat: intercultural communication, practitioner-client communication in an intercultural context, verbal-and nonverbal communication, assumptions strategies, expectations.

Säilytyspaikka: Jyväskylän yliopisto/Tourulan kirjasto

CONTENTS

1. Introduction 1

2. Intercultural Communication 3

2.1. Nature and characteristics of culture 3
2.2. Role of culture and perceptions in communication 5
2.2.1. Physical determinants of perception 5
2.2.2. Environmental determinants of perception 5
2.2.3. Learned determinants of perception 6
2.2.3.1. Beliefs 6
2.2.3.2. Values 7
2.2.3.3. Attitudes 7
2.2.3.4. Worldview 8
2.2.3.5. Social organization 9

2.3. Nature and aspects of intercultural communication 10
2.3.1. Verbal communication 11
2.3.2. Nonverbal communication 13
2.3.2.1. Kinesics 14
2.3.2.2. Haptics 16
2.3.2.3. Proxemics 16
2.3.2.4. Paralanguage 16
2.3.2.5. The concept of time 17
2.3.2.6. Silence 18

2.4. Barriers to intercultural communication 19
2.4.1. Stereotypes 19
2.4.2. Prejudice 21
2.4.3. Assuming similarity 21
2.4.4. Miscommunication 22
2.4.5. Cross-cultural adaptation 23
2.4.5.1. High anxiety 23
2.4.5.2. Culture shock 23
2.4.6. Ethnocentrism 24

2.5. Theories in intercultural communication 25
2.5.1. Hofstede's dimensions 25
2.5.2. Low - and high - context communication 26
2.5.3. Verbal communication styles 26
2.5.4. Towards ethnorelativism: a developmental model of intercultural sensitivity 28
2.5.4.1. Intercultural development inventory (IDI) 30
2.5.5. Cross-cultural adaptation: an integrative theory 30

3. Practitioner-Client Communication 34

3.1. The importance of communication between practitioner and client . . 35
3.2. Problem areas in health care linked to communication inadequacies . 36
3.2.1. Compliance 37
3.2.2. Miscommunication and misinformation. 37
3.2.2.1. The intersubcultural nature of the practitioner-client relationship 38
3.2.2.2. Nonverbal communication, feedback and metacommunication 39
3.2.3. Unrealistic client expectations 40
3.2.4. Insensitivity 41
3.2.5. Dissatisfaction with health care services 42
3.3. How to improve practitioner-client communication? 43

4. Practitioner-Client Communication in an intercultural context 45
4.1. A practitioner-client intercultural health communication model 45
4.2. Observed problems in practitioner-client communication in an intercultural context. 47

5. Carrying out the research. 51
5.1. Research questions 51
5.2. Data collecting method and context 52
5.3 Data analysis 53
5.4. Multiple case study as research strategy 56
5.5. Qualitative research evaluation criteria 57

6. Findings 59
6.1. Nonverbal communication 60
6.2. Assumptions 68
6.3. Verbal communication 77
6.4. Expectations 88
6.5. Strategies 94

7. Discussion 100
7.1. Nonverbal communication 100
7.2. Assumptions 101
7.3. Verbal communication 101
7.4. Expectations 103
7.5. Strategies 104
7.6. Conclusion 105
7.7. Methodology 106
7.8. Limitations 107
7.9. Implications and recommendations 107

8. Bibliography 109

1. Introduction

Studies in intercultural communication and their valuable practical consequences have proved to play a necessary role in contemporary life. Although not valid for a great part of the world, progress in technology, such as improved transportation and communication systems, has enabled - or forced - people to go abroad to work or to study, and to communicate with people from other cultures. People working overseas, students participating in international exchange programs, business people representing their firms internationally, immigrants, and refugees, all these people need to face, have to come to terms, or are all influenced by intercultural communication or rather by its components, or its barriers.

Literature on intercultural communication is extensive and deals with training, theories, and principles that are instrumental to the achievement of success when interacting with people from diverse cultures (Gudykunst & Kim, 1984; Samovar & Porter, 1991, 1997; Seelye, 1994; Gudykunst, 1995; Dahl, 1995; Kim, 1995). Conducting research on intercultural communication indicates that one needs to find the specific surroundings where intercultural interactions presumably will take place. Therefore, intercultural communication research has been carried out in different contexts or settings which are related to, e.g. business, groups, negotiations, counseling, education, and health care.

In the field of health care communication in an *intra*cultural setting research has concentrated on a wide variety of topics, e.g. issues in interpersonal communication, health caregiver-patient relationship, communication in health care organizations, communication and public health: mass media and education issues, group communication and organizational communication in health care, and patient-centered care, to name a few (Pendleton and Hasler, 1983; Thompson, 1990; Ruben, 1990; Ray and Miller, 1990; Leiwo et al., 1990; Kreps, 1990; Kreps and Thornton, 1992, Sharf, 1997). Stressing the importance of the practitioner-client relationship has been the major concern for numerous researchers to study communication between practitioners and clients. Therefore, these have been regularly occuring topics in literature on health communication during the past fifteen years (Argyle, 1983; Bochner, 1983; Sharf, 1984; Ray and Donohew, 1990; Virtanen, 1990, Kreps and Thornton, 1992; Scherz et al., 1995). Compelling arguments have been advanced concerning the quality of communication between health care practitioners and clients. Kreps (1995) argues, that communication has a dramatic influence on the quality of health care. Moreover, he views human communication to be the key process of encouraging and maintaining effective doctor-patient relationships, which is essential to enhancing modern health care (Kreps, 1995:67).

Attempts to establish the link between intercultural communication and health care have been made during the past two decades. Literature on practitioner-client communication in an intercultural context can be obtained in health communication journals dealing with interculturality and in recent books on intercultural communication which include chapters relating to intercultural health care contexts or settings (Ruben, 1990; Kreps and Thornton, 1992; Witte and Morrison, 1995; Janhunen et al., 1996; Geist, 1996; Saarni,

1996). While the above-mentioned research is recent, the field of transcultural nursing was established thirty years ago and concentrated on differences and similarities among cultures with respect to human care, health, and illness based upon the cultural values (Geist, 1996:340). The fact that medical education has failed and probably still fails to integrate intercultural communication into its curriculum could explain the apparent limited information on this subject. There are enough specific case examples where health care practitioners and clients face difficulties when the culturally-specific beliefs and practices of clients are not discussed or considered in diagnosing and determining appropriate treatment. It would thus be of interest to learn more about these intercultural communication situations between practitioners and clients.

Probably all of us have experienced a health care situation where the practitioner's communication made a significant difference. In most health care situations the practitioners' technical competence is assumed as long as they are perceived as competent communicators (Ray, 1996:xv). When practitioner and client come from a different cultural background communication needs to be considered even more. Having to deal with the very reason for seeing the practitioner might in that case be of less importance than all the accompanying thoughts and doubts one encounters about the succeeding of the actual communication. Doubts which can range from what language to choose, how to describe the symptoms and/or the pain, to uncertainty about understanding the practitioner's instructions regarding medication, and behaving in the appropriate way. Communication in health care is a critical issue as it forms the basis from which we make subsequent decisions, including whether to comply with a health regimen, seek additional opinions, agree to organ donation, prevent mass health catastrophes, and even pursue lawsuits (Thompson, 1990). Considering non-Finnish clients in Finland, visiting the practitioner requires contemplation, e.g. how do non-Finnish clients communicate with the Finnish practitioners when their proficiency in Finnish is perhaps not sufficient for satisfactory understanding. How do they deal with situations when misunderstandings and miscommunication occur? What are the non-Finnish clients' assumptions of Finnish health care and how do these influence the intercultural communication situation? How do these clients perceive the intercultural interaction with their practitioners and what are the most important issues they report of these interactions?

In the empirical part of this thesis, based on 'multiple case studies' as a research strategy, the primary focus is to look at *how* ten non-Finnish persons deal with the intercultural interaction with Finnish health-care practitioners *from their/the clients' point of view*. In order to find that out I addressed the following research questions:

1a. What are the clients' most striking or salient experiences and /or observations from the intercultural health care encounter?

1b. How do the clients perceive, illustrate, and evaluate these intercultural experiences?

2. To which elements of intercultural communication do the clients give meanings?

3. Have the clients developed any strategies to improve their communication with the

Finnish medical practitioner?

The data collecting method used to conduct this research is based on semi-structured face-to-face interviews. The interviews were audio-taped, transcribed and content-analysis was carried out (see Krippendorf, 1980; Hirsjärvi & Hurme, 1982).

Before reporting on the actual research study, I will deal with issues of intercultural communication first. Then I will concentrate on the communication between practitioners and clients in an intracultural context. While combining intercultural communication and practitioner-client communication a review of the most important and relevant studies conducted in that field will be presented.

2. Intercultural communication

Defining intercultural communication can be done in a simple way when stating that "when interacting with someone from another culture, we are engaged in intercultural communication". In "The Silent Language" Hall deals with culture in its entirety as a form of communication and states that "culture is communication and communication is culture" (1959: 191). Culture is said to be the central ingredient of all discourse on intercultural communication (Blommaert, 1995: 16) and therefore, requires an explanation first.

2.1. Nature and characteristics of culture

It is not hard to understand Hall (1976:14) when he writes that *"culture is everything; there is not one aspect of human life that is not touched and altered by culture".* Numerous meanings have been given to culture. Most probably new definitions will come up each attempting to be better, more thorough, more complete than the other. Depending on the discipline in which culture has been studied, the definitions do vary. Concentrating on the anthropological and on the communicative definition of culture the definitions below have been presented.

When culture is viewed from an anthropological perspective Diamond, cited by Singer (1987:7), defines culture as follows:

> *"The worlds of café society, ethnic and sexual minorities, the social elite, professional or occupational groups and age cohorts each represent a shared but distinctive perpective that orders the repective field of expereince to provide identification and solidarity for its members. These conventional understandings provide their culture or their tacit theory of the world".*

Ladmiral and Lipiansky also view culture from the anthropologic approach and suggest:

> *"Elle désigne les modes de vie d'un groupe social: ses facons de sentir, d'agir ou de penser son rapport à la nature, à l'homme, à la techniqyes et à la création artistique. La culture se retrouve aussi bien les conduites effectives que les*

représentations sociales et les modèles qui les orientent (systèmes de valeurs, idéólogies, normes sociales...)" (1989:8).

To some people the word 'culture' itself seems to bring up already more problems than it solves. Two major problems accompanying the word 'culture' are said to be the *idea of*, and *the use of* culture (Scollon and Scollon, 1995). There appears to be very little agreement on what people mean by the idea of 'culture'. On the one hand, when speaking of culture one wants to talk about large groups of people. When emphasizing what these people might have in common one tends to, at the same time, play down the possible differences among them. At the other hand, when talking about such large cultural groups, one wants to avoid the problem of overgeneralization by using the construct culture where it does not apply, especially in the discussion of discourse in intercultural communication (Scollon and Scollon: 125). The other problematic is said to lie in the fact that there is an intercultural problem in using the word 'culture' itself. In English one talks about *high culture*, meaning the intellectual and artistic achievements of culture, and of *anthropological culture*. Hereafter, Scollon and Scollon (1995) use the anthropological approach for defining culture and say:

> *"Culture in its anthropological sense means any of the customs, worldview, language, kinship system, social organization, and other take-for-granted day-to-day practices of a people which set that group apart as a distinctive group. By using the sense of the word culture we mean to consider any aspect of the ideas, communications, or behaviors of a group of people which gives to them a distinctive identity and which is used to organize their internal sense of cohesion and membership"* (126-127).

The communicative approach of culture's definition according to Ruben offers the following:

> *"Culture is the complex combination of common symbols, knowledge, folklore conventions, language, information-processing patterns, rules, rituals, habits, life styles, and attitudes that link and give a common identity to a particular group of people at a particular point in time."* (1992: 413).

In their research, not intending to be of an anthropological kind, Scollon and Scollon (1995) point out that their purpose was to single out among all of the many aspects of cultural descriptions just those factors which have been clearly shown to affect intercultural communication. After over twenty years of intercultural research they claim that the major sources of intercultural miscommunication do not arise through mispronounciation or through poor uses of grammar but that they lie in the differences in patterns of discourse. Therefore, they view culture from a discourse approach. They provide four aspects of culture which are most significant for the understanding of systems of discourse and which have been shown to be major factors in intercultural communication. These are 1) *ideology*, 2) *socialization*, 3) *forms of discourse*, and 4) *face systems* (127-128).

Our ways of communicating depend largely on the culture in which we have been raised. In order to communicate fruitfully with someone from another culture one should be knowledgeable about culture's characteristics. It was Hall (1959) who stated that *"culture is communication"*, by which he emphasized the relationship of culture to our everyday life as well as its *dynamic* nature. Culture is also said to be *learned, transmissible* and *selective*, just like communication is. *Ethnocentricity* and *interconnectedness* are two other characteristics of culture, described by Samovar and Porter (1991). Other aspects mentioned by Ruben (1992: 419) are culture being *complex* and *multifaceted.*

2.2. Role of culture and perception in communication

Perception is usually thought of as a three-step process of selection, organization, and interpretation, *each of these steps being affected by culture* (Jandt, 1995: 137). They can be thought of as the ways in which persons experience the world. Perceiving the world in a certain way and the behavior these perceptions produce are a part of one's cultural experience, i.e. perceptions are rooted in culture. As we react to perceptions according to what we were taught by our own culture, we interpret them by engaging in the event of communication.

Perceptions, being part of every communicative event, are affected by various factors: 1) *physical determinants of perception* and 2) *environmental determinants of perception* belonging to the so-called not group taught perceptions, and 3) *learned determinants of perception* as being part of group-related perceptions and which constitute culture (Singer,1987: 9).

2.2.1. Physical determinants of perception

The physical determinants of perception are based on the fact that we all have the same sensory receptors to smell, touch, see, hear and taste. However, we know that no two individuals are identical physically. As no two individuals have identical physical receptors of stimuli, then it must follow, on the basis of physical evidence alone, that no two individuals can perceive the external world identically. This can be of important value considering the way and intensivity clients and foreign clients might react to pain, and how these reactions might be perceived by the practitioners.

2.2.2. Environmental determinants of perception

The environmental determinants of perception deal with factors affecting the perception of the stimuli at the conscious or subconscious level. For example, if someone extends his hand, we simply assume that his motive is to shake hands, and we react instantly by extending ours, without having to think consciously about 'why he did that?'. Also physical environment affects the way we perceive things, e.g. people from one part of the world may see colors in in a different way than people from other parts of the globe. Finnish people have numerous words for snow whereas in tropical areas of the world, snow might even be unknown. The relationship of stimulus to surroundings, often

exemplified by the Muller-Lyer illusion (two horizontal lines of the same length but each fenced off by different arrows, also belongs to this factor of perception.

2.2.3. Learned determinants of perception

The learned determinants of perception, also called the socio-cultural elements directly influencing the meanings people develop for their perceptions, cover the concepts of attitudes, values, beliefs, world view and social organizations. These learned determinants are said to be the most important factors in generating an individual's perceptions of the external world and will therefore be looked at in more detail.

2.2.3.1. Beliefs

Beliefs are basic units of thought establishing a relationship between at least two entities. They are ideas people hold about the truth or falseness of a given topic (Kreps and Thornton, 1992: 167). We all believe in many things and can sum up hundreds of things we believe or believe in. People have beliefs about events (Tschernobyl was/is a menace), about other people (she believes he is responsible), about religion (the Pope is the leader of the Roman Catholic church), and even about ourselves (I am a serious person). The importance of these beliefs is that they are learned.

Another important aspect of beliefs is that a differentiation can be made between different kinds of beliefs (Rokeach, cited by Singer, 1987). There are the *intermediate beliefs* which are said to be most central to a person. They are the basic beliefs that the individual believes that every other human also holds them. Because they are so basic they may be the least succeptible to change as we take them for granted and hardly ever consciously consider them. *The peripheral beliefs* are derived from the intermediate beliefs For example, beliefs about premarital sex can be considered peripheral because they are derived from one's beliefs about the Roman Catholic church. A differentiation made between the degree of believing shows that an individual can be more 'open' when he/she interprets more information coming from the outside world, and that an individual relying mostly on authority to determine his/her attitude toward information can be considerd more 'closed'. This has implications for intercultural communication. According to Singer, an individual or group that is more 'open minded' in their belief systems will be much more likely to try to understand another individual or group with a different belief system - and will be much better able to communicate with 'them' - than would an individual or group with a different belief system (1987: 29).

Barnlund approaches the subject of beliefs by stating that "similarity in systems of belief refers not to the way people view the world, but to the conclusions they draw from their experiences" (1997:31). By considering communicative styles, perceptual approaches and systems of belief, he argues that these overlap and affect each other, and thus do not exist or operate independently, which needs to be taken into account when dealing with intercultural communication.

2.2.3.2. Values

An important function of our belief systems is that they are the basis for our values. Values are the beliefs that evaluate or judge, and they often involve good or bad or right or wrong statements (Kreps and Thornton, 1992: 167). People, events or objects that bring us pleasure have a positive value and we think of them as good. Other which bring pain or are a disappointment have a negative value and we regard them as bad. When we understand the values of another culture, we can appreciate the behavior of its members and know how to treat them. As most problems in communication occur over deep cultural misunderstandings rather than specific behavior differences (Foster,1992:30), and as there are fundamental differences between the way various cultures view the essential facts of life, it is important to consider the traditional values of the culture in which we are engaged.

Values can also be classified into three levels of cultural importance: primary, secondary and tertiary (Samovar and Porter, 1991:110). Considering the most important values and which would be worth dying for or sacrifiying life are the primary values, such as democracy for most Western people. To the secondary values belong those that are important but not strong enough for the sacrifice of human life, e.g. environmental care in Europe. Tertiary values lie at the bottom of our value hierarchy, such as eating fish on Friday in Catholic families. It is important to remember though that all values depend upon the culture they derive from. For example, the tertiary value in western societies 'respect for elder' is of primary value in African, Muslim and Eastern cultures.

Emphasizing cultural variability Kluckhohn and Strodtbeck presented the concept of value orientations. They defined these as *"complex but definitely patterned ... principles ... which give order and direction to the ever-flowing stream of human acts and thought as these relate to the solution of 'common' human problems"* (1961: 4). The theory of value orientations, explained by Gudykunst and Ting-Toomey, is based on three assumptions: 1) People in all cultures must find solutions to a limited number of common human problems, 2) The available solutions to these problems are limited but vary within a range of potential solutions, and 3) while one solution tends to be preferred by members of any given culture, all potential solutions are present in every culture. The solutions offered were the following: activity orientation, human nature orientation, human-environment orientation and time orientation (1988:50-51). Although the initial focus of this theory was on subcultures, the dimensions are said to be rather narrow and, therefore less useful than broader schemas in explaining differences in communication across national cultural boundaries (1988:53). However, they have been a useful valuable concept for conducting intercultural communication research.

2.2.3.3. Attitudes

Attitudes are said to be the combination of thought, feelings and potential for action, based on how we balance out the various aspects of our value systems (Ellis and Mc.Clintock, 1990:18). This definition leads us to understand that our beliefs and values contribute to the development and to the content of our attitude systems. Also Greenberg and Baron use 'beliefs' and 'values' to define attitudes: "Attitudes are

relatively stable clusters of feelings, beliefs, and behavioral predispositions (i.e. intentions) towards some specific object" (1995:164). They go into more detail and suggest that attitudes are composed of three fundamental components: the evaluative component, the cognitive component, and the behavioral component. For example, the first snowfall may be received with hapiness and screams, or with groans and complaints. In the former case one enjoys the thought of making a snowman with the children, the latter case might indicate the car is broken and one has to bike to work, which one does not like. The example shows that attitudes have a great deal to do with how we feel. This aspect of an attitude refers to *the evaluative component.*

The cognitive component of attitude deals with the knowledge or what we believe to be the case about an attitude object. For example, some people believe that refugees obtain better financial help than they themselves do. These beliefs, whether accurate or totally false, comprise the cognitive components of attitudes.

Attitudes also have a *behavioral component.* The things we believe about something and the way we feel about it may have some effect on the way we are predisposed to behave. For example, if one can believes that aids is contagious (cognitive component), one will not like to visit a person who has aids (evaluative component). This may have some effect on the way one is predisposed to behave, i.e. one may want to keep distance from and avoid a person with aids (behavioral component) (1995: 164).

2.2.3.4. World view

The way we view the world or society is important because these views can also affect the perception of others. This can be explained by culture. Helman's definition of culture includes 'worldview' and says:

> *"Culture is a set of guidelines (both explicit and implicit) which individuals inherit as members of a particular society, and which tells them how to* ***view the world****, how to experience it emotionally, and how to behave in it in relation to other people, to supernatural forces or gods, and to the natural environment"* (1990:2).

When dealing with the characteristics of culture, it became clear that culture is at the basis of everything we are. *"Culture is everything humans have learned"* (Seelye, 1994:22). At its most basic level, culture shapes the interpretations and transmission of verbal and nonverbal messages. *"Culture is the lens through which we view the world. Each person has his or her own unique worldview developed from his or her culturally based experiences"* (Witte & Morrison, 1995:218-219).

The term 'world view' deals with a culture's most fundamental beliefs about its place in the cosmos, beliefs about God, beliefs about the nature of humanity and nature. Worldview refers to the philosophical ideas of being (Jandt, 1995: 214).

Especially in intercultural communication situations it is important to be aware of the existence of other world views besides our own. Awareness can lead to understanding. In an intercultural situation without awareness nor understanding of our partner's world view, we can find ourselves clashing with each other as we do not share a similar world view. An example of differing wordviews is the comparison between most Asians' and most Westerners' worldview. Whereas the consciousness of long, continuous history forms part of the worldview of most Asian people, which is sometimes called upon in discourse as explanation or justification for moving more slowly, for not rushing to conclusions, or for taking a longer perpective on future developments, Westerners are more likely to de-emphasize their own ancient historical heritage dating from Ancient Greece or before. They are more likely to emphasize the need for quickness in concluding negotiations, the need to bring about economical, political, or social change, and the need to 'keep up' with world changes (Scollon and Scollon, 1995: 128).

World views do not necessarily have to differ between cultures or countries being extremely far away from each other. Even in two Western cultural settings like the USA and Finland a noticeable difference in world view, by studying American and Finnish cultural speech, is to be seen. For example, when Finns and Americans talk about a same text and a same social drama, their talk reveals two cultural models of identity and explanations for how those models are played out in two different cultural settings, the latter being influenced by world view. The most important aspects of the Finnish cultural speech would be the myth of sisu, equality of condition, autonomy, and choice. American cultural speech, however, would contain among others the myth of opportunity, equality of opportunity, independence, and choice (Berry,1995).

2.2.3.5. Social organization

Social organization refers to the way a culture organizes its members and its institutions. Geography and roles are an important part of social organization. The institutions of society such as armies, prisons, schools, universities, churches, mass media, and the health care system convey the values of a certain culture (Kreps and Thornton, 1992:169).

Like world view, the manner in which a culture organizes itself is directly related to the institutions within that culture. These institutions can be formal or informal. However, Samovar and Porter (1991) argue, that it is our family and our government that most influence our perceptions and the way we communicate. *Family,* because it has the greatest cultural impact on our development. For instance, children perceive family life differently in different cultures. It is quite common in Finnish families to see food being served with each person having his or her own plate. In Greek families it is often so that the food is served and eaten from a common bowl. *Government*, as it is influenced by history, which on its turn serves as the origin of cultural values, ideals and behaviors (p.87-88).

Dealing with social organization, Scollon and Scollon (1995:135-137) take the discourse approach and distinguish between Gemeinschaft and Gesellschaft (as a subdivision of

'face systems', see 2.1.). *Gemeinschaft* (meaning community), being an organic, community form of social solidarity, was originally based on the fact that individuals shared a common history and common traditions. As modern societies tend to be more contractual, rational or instrumental - by mutual agreement and to protect mutual interests - they developed into a corporate society, also called *Gesellschaft* (society). Two major types of discourse systems have emerged from this distinction: the social structure of becoming a member through natural processes of birth and grown within a family and a community, i.e. 'Gemeinschaft', and the goal-directed discourse systems into which one choosed to enter for utilitarian purposes, i.e. 'Gesellschaft'. Relevant to intercultural communication is to understand 1) in which contexts one of these forms of social organization is preferred over the other, and 2) that conflicts and misinterpretations may arise when individuals come from or represent a different organization.

2.3. Nature and aspects of intercultural communication

One way of defining intercultural communication goes as follows: *"Intercultural communication generally refers to face-to-face interactions among people of diverse cultures"* (Jandt, 1995:30). In a collection of frequently used terms in the field of Intercultural Relations Hoopes and Pusch (1979:6) approach intercultural communication from a broader viewpoint and formulate it as:

> *"referring to the communication process (in its fullest sense) between people of different cultural backgrounds. It may take place among individuals or between social, political or economic entities in different cultures, such as government agencies, business, educational institutions or the media. This includes non-verbal as well as verbal communication and the use of differing codes, linguistic or non-linguistic. Culture is viewed as having a major influence on the communication process."*

The basic aim of teaching intercultural communication, according to Seelye (1994) is to learn the students to communicate with people who do not share their own hue of cultural conditioning. This aim in itself can be regarded as a definition of intercultural communication. The way to reach this goal is to build bridges from one cognitive system to another. This means that we build bridges from our experience of knowing, our consciousness of things and judgement about them, towards persons from a different culture with 'their' experience of knowing, 'their' consciousness of things and judgement about them (Seelye:20-23).

While engaging in intercultural encounters one often realizes that in some situations communication has been successful, and in others not at all. Satisfying and effective intercultural communication is something one has to learn. Awareness of certain elements or aspects that influence intercultural communication is an absolute necessity as these aspects have the potential to affect situations in which people from different cultural background come together. The most basic aspects of intercultural communication are said to be 1) perception, 2) verbal commmunication, and 3)

nonverbal communication (Hall, 1981; Jandt, 1995; Barna, 1997; Porter and Samovar, 1997).

As the role of perception in communication is of utmost importance, it is only logical to assume its influential role in intercultural communication. The human view of perception or the way people behave is relevant as well in one's own culture as when dealing with people coming from different cultural backgrounds. Perception and its sociocultural elements that directly influence the meanings people develop for their perceptions, have been dealt with in detail in part 2.2. (Role of culture and perception in communication), so that I will concentrate next on the second aspect of intercultural communication, i.e. verbal communication.

2.3.1. Verbal communication

The verbal language we use is the principal mean by which we express our thoughts and feelings. When communicating with someone from our own culture we usually do not experience difficulties in making ourselves understood. But when communicating with someone from a different culture, we need to adapt to the new situation. We may be able to use our own language, the language of the communication partner, or it is likely we need to speak a third language, which is neither ours or our partner's. Verbal language in an intercultural context also means dealing with issues of foreign language and language translation. One of the first modern observations of the relationship between language and culture has been stated in the Sapir-Whorf hypothesis (also known as the Whorfian Thesis or linguistic relativity) which says that language and its categories, i.e. grammar, syntax, and vocabulary, are the only categories by which we can experience the world (Whorf, 1956). Although this hypothesis has not been always regarded as confirmable or correct (Carrol, 1992), it nevertheless shows some basic elements which can cause difficulties when dealing with intercultural interactions. Languages are not so simple that they can be translated just by using a good bilingual dictionary. The reason is that there usually is no equivalence through translation. Sechrest, Fay, and Zaidi (1972) have identified five translation problems when engaging in intercultural communication:

1. vocabulary equivalence: also called lexical equivalence deals with conveying the meaning and the style of the original language, the nuance of words, and with words that have no good equivalence in another language. For instance, the Finnish word 'sisu' is very hard to translate adequately in another language, we can describe it as 'having guts', 'stick-with-it-ness', or 'being brave', but a real lexical equivalent does not exist.

2. ideomatic equivalence: is culture-bound and therefore it does not translate well. For example, the Finnish idiom 'se on pelkkää silmänlumetta' can not be translated by words, it needs to be paraphrased to understand its meaning: 'it's all (for) show'.

3. grammatical-syntactical equivalence: refers to non-existing equivalent parts of speech in the language into which a message is being translated. One often needs to understand

a language's grammar to understand the meaning of the words or sentence. For instance, 'minä kaaduin pyörä**llä**' might initially be misunderstood by German speakers as in German one tends to fall 'from' one's bike, and not 'with' one's bike: 'Ich bin **vom** Rad gefallen'.

4. experiental-cultural equivalence: deals with cultural differences between languages. How hard it can be to translate or explain the numerous different words Finns have for rain, hail or snow to someone who does not live in a country where cold harsh winters with different kinds of rain, hail or snow are common part of life.

5. conceptual equivalence: to contain a concept match is another difficulty in translation. Some concepts are culture-specific (emic) or culture-general (etic). For example, non-Finnish people might experience difficulties when Finnish person talk about 'vatsakipu', which does not indicate whether the pain is located in the liver, in the stomach or in the intestines.

Also patterns of thought or the mental processes of reasoning and problem solving, as a major component of culture can influence the intercultural interaction. Misunderstandings in intercultural communication can occur when interacting with two parties, each using a different method of solving problems (deductive vs. inductive). One of the most common problems we can encounter when talking with a person from a different culture is that 'they just don't think the way we do'. An illustration of thought pattern is provided by Kaplan. In an article on thought processes of different linguistic groups, Kaplan (1966: 15) has observed that while English writing - and thinking - is linear, those who speak and write Semitic languages (Arabic and Hebrew) seem to use various kinds of parallels in their thinking, and the writing and thinking of Chinese and Koreans is marked, according to Kaplan, by indirection. Of course, this does not concern all people of that certain linguistic group, the fact is that most people representing a linguistic group probably do so, most of the time.

'The foreigner's language' as an aspect of verbal behavior has been researched by Karol (1985) from a sociolinguistic perspective, and provides an analytical framework for the study of sociolinguistic deviance in the foreign language situation. A foreign language situation is said to be one in which at least two of the participants differ with respect to their cultural membership, the language spoken is non-native to at least one of the participants, and at least one non-native speaker's national identity is perceived by other participants as foreign (Karol, 1985:11).

It is pointed out that the study of sociolinguistic deviance in the foreign language situation (SDFLS) involves an interaction between describing behavior and proscribing behavior. The foreigner's language can be studied along a number of dimensions and from a variety of perspectives, i.e. studying SDFLS with reference to the *sex* of the speaker, with reference to *time* constraints, viewing the foreigner's language in terms of the *social roles* and *social relationships* that it can express, accounting for *topic* restrictions that the social role 'foreigner' implies, studying SDFLS in terms of the *sociolinguistic rules* scheme, accounting for the foreigner's language as it fits the *formality* of the situation, studying the foreigner's language in terms of how he/she can

handle *directness*, taking recourse to *politeness* categories, resorting to the *conversational analysis* scheme, and investigating SDFLS in the philosophical terms of *speech act analysis*.

In this study it is also suggested that the socio-psychological context as well as the foreigner's accompanying exolinguistic behavior significantly modify the native's attitude to the foreigner's language. Additionnally, the native's reaction toward the foreigner's language seems to be a function of linguistic, exolinguistic, behavioral and non-behavioral features, not of individual features. Finally, a distinction has been made in which four basic psychological categories of native speaker reactions toward the foreigner's language tend to occur: 1) irritation, 2) amusement, 3) acceptance, and 4) appreciation (Karol, 1985: 33-50).

I deliberately dealt with the above mentioned study of 'the foreigner's language' in more detail as it comprises, although from a sociolinguistic viewpoint, numerous aspects which play an important role in intercultural communication and its theories, e.g. directness vs. indirectness, time orientation, adaptation, and formal and informal situations.

2.3.2. Nonverbal communication

Communication is often thought of as being solely verbal, with words as the only means for speaking. The nonverbal part of communication, which does not use oral or written language to carry out its message, is a very important factor in influencing the communication process especially when one is going to interact with people from different cultures. Nonverbal processes deal with body behavior, and messages of space, time, and silence.

It is known that nonverbal communication plays several essential parts in social interaction such as communicating attitudes to others, expressing emotions, in supporting speech by enriching utterances, and managing synchronizing. Although nonverbal signals are used in similar ways in all cultures, there are also differences and these can easily cause misunderstandings (Argyle, 1982:65). Therefore, nonverbal communication plays an important role in the intercultural communication process. Nonverbal communication is important as we use the nonverbal actions of others to learn about their emotional states. Communicating nonverbally may be more convincing than verbal communication, especially when nonverbal communication contradicts the verbal communication. For instance when we are greeted by someone with a superfriendly voice but with hard cold eyes, we tend to believe what the eyes communicated to us, and not the words.

Significant for nonverbal communication is that it usually creates first impressions. Our first judgements of other people are most often based on the nonverbal signals they send us, e.g. eyes and voice. Mehrabian (1971:42-47) suggests that where we are confused about how we feel about another person, verbal messages account for only seven 7 percent of our overall impression, the remainder being accounted for by

nonverbal factors:

> Total Feeling = 7% Verbal Impact
> + 38% Vocal Impact + 55% Facial Impact

Like culture, nonverbal communication is invisible when concentrating on the word 'silent', implying that nonverbal behavior, like culture, tends to be elusive and often beyond our awareness (Hall, 1959).

Nonverbal communication, like culture, is also learned. For example, the way we wave good-bye is learned, we wave with the handpalm up while moving the hand from left to right. In the Middle East this gesture is used for calling a dog. The clothes we choose to wear in different situations, the jewels we wear, our hairstyle, our facial expression, our use of space and other signals are potential messages for others to decode. They all transmit messages to other people about how we choose to be perceived and indicate that nonverbal communication is omnipresent in the meaning that it is everywhere and in everything.

Before elaborating on the categories of nonverbal communication, it should be noted that, although nonverbal communication might be in some situations more dominant than the verbal communication, one should consider the importance of nonverbal communication in the *total communication process*. Verbal and nonverbal communication should be treated as an inseparable total, as the verbal and the nonverbal systems interrelate. The 'interpersonal synchrony' (Hall, 1983), which comprises the five basic functions of nonverbal communication presented by Argyle (1979): 1) conveying interpersonal attitudes, 2) expressing emotional states, 3) managing conversations, 4) exchanging rituals, and 5) regulating self-presentation, is exactly based on both the levels of verbal and nonverbal communication.

Many classification systems in the study of nonverbal communication have been developed (Hall, 1959, 1969; Knapp, 1978; Samovar, Porter and Jain, 1981; Gudykunst and Kim, 1984). The most often used categories in nonverbal communication are *kinesics* or body motion and physical characteristics, such as facial expression, eyecontact, *haptics* or touching behavior, *proxemics* or the study of our use and perception of social and personal space, *paralanguage*, which deals with 'how' something is said when considering for example intonation, pitch and voice, the *concept of time*, and *silence*.

2.3.2.1. Kinesics

Kinesic cues are those visible body shifts and movements that can send messages that influence communication. These movements can convey information about the psychological and/or the physical states of a person, regardless of that person's culture. The ability to read meaning into movement is universal. As we can expect, cultural differences may cause communication problems when we consider that each culture displays certain unique aspects of movement and posture as part of its cultural experiences.

Body posture

Posture and sitting habits can show us insight into a culture's deep structure and can be tied to cultural attitudes. Also the way of greeting and negating implies bodymovements and gestures specific for each culture.

Facial expressions

When communicating with people we are confronted with their facial expression that may influence our reactions to them. Although we are used to deal with facial expression when being involved in a communication event, the intercultural implications of these expressions are more difficult to evaluate. Some people claim that anatomically similar expressions may occur in everyone, but the meanings people attach to them may differ from culture to culture (Davis, 1975:47). One aspect of intercultural communication which is often said to be open to misinterpretation is this one of smiling or laughing. The most obvious and the most often misinterpreted form of this is what in the west might be called 'nervous laughter'. Perhaps it is only a difference in the amount of smiling and laughter under such conditions, but it has been widely observed that Asians in general tend to smile or laugh more easily that Westerners when they feel difficulty or embarassment in the discourse (Scollon and Scollon, 1995:143). This shows that that there are universal expressions but that people may have different meanings for these expressions. What appears to be a specific expression is always related to cultural experiences.

Eye contact and gaze

Occulesics is the study of communication sent by the eyes. The way we use our eyes is another aspect of nonverbal communication which helps us interpret meaning is the way in which we use our eyes to regulate and control the flow of communication.

We can send numerous messages just with our eyes in the way we establish, maintain or avoid eye contact, in the way we shift our eyes, squint, stare straight ahead, or even close our eyes. As mentioned previously that both culture and communication are learned, we can say that culture also modifies how much eye contact we engage in and who is the recipient of the eye contact.

A primary function of eye gaze, or the lack of it, is said to regulate interaction. Eye contact serves as a signal of readiness to interact, and the absence of such contact, whether intended or accidental, tends to reduce the possibility of such interaction (Harper, Wiens, & Matarazzo, 1978: 212). In research on nonverbal communication Knapp (1980) showed numerous factors to be related to the extent of eye gaze, including distance, physical characteristics, personality, topic, situation, and cultural background (190-194).

2.3.2.2. Haptics

The way we relate to and communicate with each other may be affected by our touching behavior, also called haptics. Touch can play an important part in human communication and relationships. During the early years of childhood touch has been the central means for expressions of warmth and caring among family members and close friends. Also in greeting situations we have learned to shake hands, to hug or to kiss. By the time we reach puberty our culture has taught us how to use our touching behavior in communicative events.

The kind of touch which is permissible will be determined by the culture we live in and our physical relationship with the other person. In some Asian cultures men may walk hand- in- hand on the street. British people appear to employ very little touching as do North Americans and Japanese. Levels of contact and comfort with touching may vary from one culture to another. It is important to know that cultures use touch differently, consequently the awareness of these differences may reduce problems when communicating interculturally.

2.3.2.3. Proxemics

The use of space, also called proxemics, plays an important role in human communication. It is concerned with seating and furniture arrangement, and with personal space.

Seating position and furniture arrangement as aspects of space are important nonverbal communicative element. In organizations and in group situations one can often notice how these elements can be associated with high (or low) levels of activity and leadership than others, and how they can refer for example to authority and hierarchy.

Another aspect of proxemics is the concept of personal space. Hall (1959) demonstrated that each person has a 'bubble' of space in which a person moves and in which he/she feels comfortable. Outside of that space is a second 'bubble' of space in which normal interpersonal contacts take place. Then outside of that is a third 'bubble' of public space. These spheres of space must be taken into account when communicating, especially when communicating interculturally. The net result of cultural differences in intimate and personal spaces is that, according to Scollon and Scollon, where norms are different, one will find the person with the smaller sphere constantly moving closer to the other, and that other person constantly movong back a bit to increase the space. It depends on the person's expectations of personal space, and those expectations depend, in part, on how space is used in that person's culture (1995:146).

2.3.2.4. Paralanguage

Paralanguage, also called vocalics or the nonverbal elements of the voice refer to any message that accompanies and supplements language. With spoken language, paralinguistic cues such as loudness, rate of speaking tone, interjections, pitch variation, and use of pauses can have a major influence on whether and how one reacts to the

individual and his or her verbalizations (Ruben, 1992:200).

Jandt (1995) presents elements of paralanguage, which include *vocal qualifiers*, such as intensity (loud/soft), pitch (high/low), and extent (drawl and clipping), vocal characterizers, such as laughter and sobd, and vocal segregates, such as 'uh', 'um', and 'uh-huh' (p.82).

It is remarkable how paralanguage can provide a basis for inferences about content and character just made just from people's sound production. For example, paralanguage cues can help us in drawing conclusions about people's educational background, emotional state, age, intelligence, interest in a topic, and regional background.

2.3.2.5. The concept of time

The study of our use of time, also called chronemics, is a nonverbal aspect of communication and subject to cultural diversity. How a culture structures and manages time has a salient influence on intercultural communication. Whereas Hall (1969) argued that there are two basic dimensions of time, *monochronic* (M-time) and *polychronic* (P-time), Erickson and Schultz (1982) suggested the distinction between *kairos* and *chronos* as concepts of time.

In monochronic cultures, time is experienced and used in a linear way, comparable to a road extending from the past into the future. It simply means that one feels that things should be done one at a time. The schedule might take priority above all else and be treated as sacred and unalterable (Hall and Hall, 1989:13). In polychronic cultures people prefer to maintain multiple threads of different activities. They attend to and do many things at once, they want to keep current on everything simultaneously (Ruben, 1992: 422).

The distinction between kairos and chronos is not quite the same as that between monochromatic and polychromatic senses of time. As Scollon and Scollon (1995) have pointed out, chronos time means 'clock' time contrasting kairos being 'appropriate' time. In the context of business things tend to be done by clock time, e.g. hours are kept on employees. Appropriate time or kairos time paces events according to when it is appropriate for them to occur, e.g. traditional farming. Everything depends on the weather over which farmers usually have no control (p.191).

Another time distinction suggested by Hall (1981:138-139) is the distinction between formal and informal time. He has stated that formal time involves basic relationships, like learning the numbers of weeks and days in a year. It includes our outlook toward the seasons of the year. However, geographically spread cultures may have different calendars and cultural differences may range to more subtleties regarding a culture's view of nature and its impact on formal time. The rules of informal time are not explicitly taught, and usually function below the level of consciousness. To understand informal time and the individual's use of it, we need to know something about the culture and the context. Varying concepts of punctuality and our reactions to having to wait can ascertain a culture's attitude towards time.

Scollon and Scollon (1995), from a discourse approach, presented another time concept in which they distinguished between *time urgency* and the *concept of the Golden Age*. 'Time urgency' (called Utopian time) is described by being a syndrome of behavior in which the person continually tries to accomplish more than can be humanly accomplished, and is based solidly on the belief in progress. This sense of time is no longer a cultural characteristic of this one generation of American males, but it has become as well a characteristic of the Asian 'salaryman', so Scollon and Scollon. The concept of the Golden Age is characterized by pointing out to the past and considers the present time to be a degenerate period. From an intercultural point of view it is stated that if two people differ in their concept of time beteen the Utopian and the Golden Age, they will find it difficult to come to agreement in many areas of their discourse (Scollon and Scollon, 146-147).

2.3.2.6. Silence

Silence sends us nonverbal cues concerning the communication situation we are in. When being involved in conversation we can experience the various meanings of silence like for instance oppressive, calming, excusing, shyness, embarrassment and condemning silence.

As the empirical part of this thesis will deal with intercultural communication between Finnish people and non-Finnish people, I want to go more into detail and elaborate on the nonverbal aspect of silence, which often is attributed to Finnish people.

Research on Finnish conversation suggests that Finnish culture may be a communication-reticent culture, in which silence is valued or at least tolerated to a greater extend than for instance in English-speaking cultures (Lehtonen & Sajavaara, 1985; Sallinen-Kuparinen, 1986).

In 'The silent Finn' Lehtonen and Sajavaara (1985) deal with the problem of Finns being negatively stereotyped because of their frequent use of silence. In 'The silent Finn revisited' (1997) the problem of 'the silent Finn' has been taken up again and an attempt has been made to answer the origin of the stereotype of the silent Finn, the reasons for this stereotype, and its consequences in interaction and intercultural communication. A number of characteristics have been listed as being indicative of Finns as a silent nation, which basicly deal with the national perception of self, the national character as metaphor, and with Finland naturally being a silent culture. As conclusion it is suggested that Finns have certain features in their communicative behavior that strike the non-Finnish people as different. The most important conclusion though, deals with the origin of the problem, that at least in part, comes from the difficulties inherent in cultural perceptions, where people make use of their own conceptual categories to organise their observations of the behavior of others. This means that a Finn may be considered uncommunicative and quiet by representatives of certain cultures, while others may think that he/she is bound to excessive gestures and spontaneity. Lehtonen and Sajavaara also pointed out the highly misleading terminology of 'silence' which depends on the type of culture that it is applied to. They argue that

applications of concepts valid in one culture, where they may be highly pertinent and appropriate, to another cultural environment is often done under the assumption that the concepts are universal (277-279).

Like the previous elements of nonverbal communication discussed, also silence has numerous intercultural implications. The use of and the reaction to silence varies from culture to culture. An example of intercultural implications of silence will be shown next.

Carbaugh (1996) for instance, draws a cultural comparison between Finnish and American linguistic patterns. For example, two of the Finnish conversation rules are: 'don't state the obvious' and 'if speaking, say something worthy of everyone's attention'. When comparing American and Finnish communication, considering these rules might throw a light on why Finns are often perceived by Americans as silent people. When these Finnish conversation rules meet other systems of communication, like an American one, difficulties can arise. Because Americans sometimes talk about such things that are on the surface, and because Finns as a rule prefer the talk go beyond that surface, Americans can seem to Finns, according to Carbaugh (1996:223), to be superficial. At the other hand we could imply that Finns, as a consequence of communicating according their conversation rules, can seem to Americans to be silent.

> *"These conversation rules, however, seem linked to what some Finns call 'the no name culture' or the minimal use of personal names, to a general devaluing of 'small talk (as Americans produce it), and to a unique Finnish form of it, to many uses of silence (because of the need to produce proper speech), to Finnish themes of modesty and distance, as well as to the cultural status of talk itself"* (Carbaugh, 1996:223).

2.4. Barriers to intercultural communication

Whenever we consider and discuss ideas, topics or problems in intercultural communication we need to be aware that these should be understood as framed by our cultural milieu. This means that each of us who might have to encounter obstacles or barriers when communicating interculturally, will evaluate and react differently to them due to our own cultural background and experiences. Barriers to intercultural communication include 1) stereotypes, 2) prejudices, 3) assuming similarity instead of difference, 4) miscommunication, 5) cross-cultural adaptation and 6) ethnocentrism.

2.4.1. Stereotypes

One of the first issues that regularly occurs when dealing with people from different cultures are stereotypes. Ellis & Mc. Clintock (1990) explain stereotype as the term one uses to describe the mental pictures, the emotional reactions and the behaviour one displays when one classifies according to general type, rather than attending to the specific characteristics displayed by an individual example of that type.

Stereotypes are said to be determined by the degree of familiarity with the group being stereotyped, and the amount and quality of contact with the other group (Triandis, 1977).

Analysis of stereotypes, as influential on communication, resulted in four generalizations presented by Hewstone and Giles (1986): 1) Stereotypes are the results of cognitive biases stemming from illusory correlations between group membership and psychological attributes. 2) They influence the way information is processed, so that favorable information is remembered about ingroups and more unfavorable information is remembered about outgroups. 3) Stereotypes create expectancies about others, and individuals try to confirm these expectancies, and 4) stereotypes constrain others' patterns of communication and engender stereotype confirming communcation, i.e. they create self-fulfilling prophecies.

Any form of stereotyping is potentially an obstruction to successful intercultural communication, because it blinds us to the real differences that exist between the people engaged in an communicative event. Although one may think of stereotypes as being negative judgements, they can also be positive.

Research conducted by Scollon and Scollon (1995:159-161) pointed out the problem of *positive stereotyping* being one of seeing members of different groups as being identical. They presented two aspects of positive stereotypes: 'lumping fallacy' and 'solidarity fallacy'. 'Solidarity fallacy' occurs when the grouping is based on falsely combining one's own group and some other group. For instance, an Italian man might falsely include is group, Italian men, with Americans on the belief that they had the emphasis on talkativeness in common, while ignoring the major differences between their groups. 'Lumping fallacy' occurs when the person making the false grouping is doing so in reference to two other groups. For instance, when Westerners consider all Africans to be members of the same group without taking into consideration the major differences among these groups.

When ascribing negative qualities to feature or appearance of people stereotypes are called negative (Ellis & Mc. Clintock, 1990:24).

Negative stereotypes, according to Scollon and Scollon (1995), can be analyzed by a five-step process. During the initial step two cultures or groups are contrasted on the basis of some single dimension. In the second step one focuses on this artificial and ideological difference as a problem for communication. The third step requires to assign a positive value to one strategy or one group and a negative value to the other strategy or group. The fourth step is to regeneralize this process to the entire group while one reasserts the original binaristic contrast as a negative group contrast. During the final step these characteristics are assumed to be genetic or racial characteristics (158-159).

2.4.2. Prejudice

Whereas stereotypes can be positive or negative, prejudice refers to the irrational dislike, suspicion, or hatred of a particular group, race, religion, or sexual orientation (Rothenberg, cited by Jandt, 1995). Prejudice can also be defined as a particular dangerous form of stereotyping because it is said to be resistant to change (Ellis & Mc. Clintock, 1990). They also report that there is some evidence to show that although prejudices may be acquired in much the same way as stereotypes, they are accompanied by a stronger emotional reaction.

An example of prejudice would be the attitude that foreigners should not be in positions of power because they are not as competent or effective as the own fellow countrymen/women. This might lead to discrimination, referring to treating people differently because of prejudices. Obviously, prejudice is a negative attitude and discrimination is the behavior that follows from it.

Brislin (1988) dealt with prejudice thoroughly and presented six different ways in which prejudice can express itself. These ways are: red-neck racism, symbolic racism, tokenism, arm's length prejudice, real likes and dislikes, and the familiar and unfamiliar. *Red neck-racism* occurs when certain people believe that members of a given cultural group are inferior according to some imagined standard, and that the group members are not worthy of considerate treatment. *Symbolic racism* can be found when members of one culture, or co-culture, have unfavourable feelings about another culture because they believe the 'outside culture' is threatening their group. *Tokenism* means the practice of giving official favor to representatives of special groups in society only to produce an appearance of fairness. It is a form of prejudice that is often difficult to discover. Often the prejudiced party does not want to admit that it guards negative feelings and is, in fact prejudiced. It may even engage in 'token' activities to 'prove' its impartiality. *Arm's-length* describes people engageing in what appears to be friendly behaviors with out-group members on certain occasions, but holding these same people at 'arm's length' in other surroundings. *Real likes and dislikes* exist because people actually use behaviors that members of the in-group find distasteful. When those behaviors evolve, such as arriving late if one values promptness, prejudice can occur. *Familiar and unfamiliar* deals with situations when people choose to associate only with individuals and groups just like themselves. Human beings usually do no like the unfamiliar. Therefore they tend to what is familiar and avoid what they are unaccustomed to. Though this is said to be a mild form of prejudice, it is nevertheless prejudice.

2.4.3. Assuming similarity instead of difference

One of the first things one tends to do when being abroad is looking for what is familiar, or similar to one's own culture. It is often so that one expects to 'manage' in a foreign culture by assuming that there will be enough similarities in order to cope and to communicate. But it is of extreme importance to realize the diversity of cultures as well as the diversity of communication aspects. When assuming similarity between cultures one can be caught unaware of important differences. Without being alert to

a culture's possible underlying differences and the need to learn new rules for functioning, persons going from one culture to another might face immediate difficulties.

According to Barna (1997) the confidence that comes with the myth of similarity is much stronger than with the assumption of differences, the latter requiring tentative assumptions and behaviors and a willingness to accept the anxiety of 'not knowing'. Only with the assumption of differences, however, can reactions and interpretations be adjusted to fit 'what's happening'.

Critics to this viewpoint, such as Brislin (1981) and Samovar, Porter and Jain (1981), however, do stress the importance of perceiving cultural similarity as it might lead to a basis for interaction, for out-group rejection, for finding common ground, and establish rapport. But I want to hold on to Hall's view (1981) who states that the reality which we experience is constructed according to variable cultural patterns, and these differences are the crucial factors in our attempts to understand and communicate experience. However arduous it might be, the ability to see differences should be considered as a desirable and valuable addition to one's intercultural experience.

2.4.4. Miscommunication

Miscommunication can be a barrier preventing the flow of intercultural communication as well as a consequence of an unsuccessful intercultural encounter. When people from different cultures do not understand each other fully, or when they misunderstand each other based on misstatements or on misinterpretations we can talk about miscommunication. Research on miscommunication has been conducted when dealing with different cultures and with nonnative speaker discourse (Banks et al., 1991). They reported on some of the causes in intercultural encounters, e.g. the cultural difference of the persons involved, linguistic failures, failed pragmatics and problems of identity (103-120).

Dealing with verbal communication, the spoken language one uses when being involved in an intercultural interaction, which mostly for at least one of the parties will be a foreign language, can be considered as a reason for miscommunication to occur. Differences in vocabulary, syntax and idioms can cause difficulties. More often it is the dual meaning of words, meaning different things in different cultures, causing miscommunication. Simple words like 'yes' and 'no' can be perceived as hazarduous and cause uncertainty due to the cultural meaning given to them.

In nonnative speaker discourse, which usually is the occasion when communicating interculturally, miscommunication can result from nonengagment. This happens when there is non-communication due to tiredeness or avoidance, or communication break-off meaning an abrupt termination of the communication event. Miscommunication can be either a misunderstanding, when a mismatch between the speaker's intention and the hearer's interpretation occurs, or an incomplete misunderstanding, where one or more people perceive something has gone wrong. Socio-cultural and grammatical

miscommunication, nature and function of second language conversation and recognizing incongruities represent some of the researched miscommunication types (Gass et al., 1991:121-145).

Considering the aspects of nonverbal communication discussed, miscommunication due to nonverbal misinterpretations is to be assumed. As many nonverbal expressions vary from culture to culture, their meaning might not always be clear nor understood, they become a barrier. People tend to perceive only that which has some meaning or importance to them, they interpret it through the frame of reference of their own culture. The lack of comprehension of nonverbal cues prevents effective communication. Learning the meanings of new nonverbal cues would be a first requirement when interacting with someone from a different cultural background.

2.4.5. Cross-cultural adaptation

The adaptation of people from one culture to another culture may bring various problems, such as high anxiety and culture shock. These adaptation situations can be potential problems or barriers to intercultural communication, but at the same time they can also be accompanying concomitants or side effects of intercultural communication.

2.4.5.1. High anxiety

As one might face uncertainties while engaging in intercultural experiences, one is apt to deal with feelings of anxiety or stress, which are influential on both our mind and our body. Consequent reactions are likely to be in the form of defense like withdrawal or hostility. Anxiety is said to be the affective (emotional) equivalent of uncertainty which we may experience to some degree any time we communicate with others. Feeling uneasy, tense, worried, or apprehensive about what might happen can cause us anxiety. It is an affective response to situations based on the anticipation of negative consequences (Gudykunst, 1995:12).

Barna (1997) argues that anxiety is not only distinct but often underlies and compounds the use of stereotypes, the assumption of similarity, and miscommunicaton. Anxious feelings usually tend to permeate both parties in an intercultural interaction and this can lead, in the worst case, from inappropriate reactions, intolerable self-esteem to overcompensation and aggressivity, preventing effective communication to take place.

2.4.5.2. Culture shock

Culture shock can be seen as a barrier to successful intercultural communication as well as a consequence or an accompanying side effect of intercultural communication. First introduced by Oberg (1960), culture shock appears when people from one culture go for a longer period to another culture. They might have to cope with differences in language, climate, transportation, food, housing, andwith differences in social standards of behavior. This having to cope with different situations can lead to frustration and

to a sense of hopelessness. People might get a strong urge to interact only with members of their own nationality. They start feeling lonely and have difficulties in communicating their feelings to others (Brislin, 1981:156).

According to Brown (1990:35) culture shock is a common experience for a person learning a second language in a second culture. He explains culture shock by referring to phenomena ranging from mild irritability to deep psychological panic and crisis. Brown argues that culture shock is associated with feelings in the learner of estrangement, anger, hostility, indecision, frustration, unhappiness, sadness, loneliness, homesickness, and even physical illness.

Four stages of culture shock have been identified: Oberg and Foster (cited by Adler 1987: 26-27) describe the development of the 'illness' of culture shock taking place in four stages:

1. initial euphoria.
2. irritation and hostiliy
3. gradual discovery
4. near or full recovery

Other terms referring to culture shock are self-discovery shock, role shock and transition shock. Cultural fatigue has been suggested by many as a more accurate description of what usually occurs. The fatigue, described by Seelye (1994:60), is said to be occasioned by energies spent in an exaggerated concern for hygiene, by having to work harder to do simple things such as use the telephone or catch a bus, by the constant irritation of dealing with people who don't know how to get things done.

Culture shock can also become the culprit for 'ethnocentrism', which on its' turn shows another barrier preventing effective intercultural communication.

2.4.6. Ethnocentrism

Ethnocentrism means the belief that one's own race, nation and group are better and more important than others. Kreps and Thornton (1992) describe ethnocentrism as the tendency to interpret or to judge all other groups, their invironment, and their communication according to the categories and values of our own culture (p.173).

Being ethnocentric to the extreme can be a major hindrance to intercultural understanding as the latter assumes us to be broadminded, interested and tolerant towards people from other cultures. Ethnocentrism would impede that. Like culture, ethnocentrism is something we have learned unconscioulsy and therefore it is - initially - unintentional. Avoiding ethnocentrism is a learning process which requires conscious and continuing effort.

Bennett (1986) suggests in his developmental model of intercultural sensitivity that there are three stances which indicate ethnocentrism. Assuming an ethnocentric base,

the meaning a learner attaches to cultural differences will vary from total denial of its existence to the minimization of its importance. The respective states are called: *1) denial, 2) defense*, and *3) minimization.* Each of the states has a subdivision but I will deal with them later (in 2.5.4.). In the process of developing intercultural sensitivity, this barrier of ethnocentrism has to be overcome so that one switches in the next state, called ethnorelativism.

2.5. Theories in intercultural communication

> *"Theory construction should be a central concern in intercultural communication research. They are the creations of useful explanations so that we can understand the world around us. They structure and provide meaning to an otherwise chaotic world."* (Wiseman and Van Horn, 1995).

2.5.1. Hofstede's dimensions

Hofstede's dimensions belong to the theories about cultural differences affecting intercultural communication. In 1983 Hofstede published the results of his study of over 100.000 employees of a multinational corporations in 53 countries and in 3 regions. In an attempt to locate value dimensions across which cultures vary - by means of questionnaires - he identified four dimensions that he labeled 1) individualism, 2) masculinity, 3) power distance, and 4) uncertainty avoidance.

1) individualism versus collectivism: this dimension refers to how people define themselves and their relatonships with others. The emphasis is placed on individuals' goals in individualistic cultures and on group goals having precedence over individualistic goals in collectivistic cultures. Individualistic societies stress the "I" identity, as well as individuals' initiative and achievement. In collectivistic societies the emphasis is on the "we" identity, and on belonging to groups (Gudykunst and Ting-Toomey, 1988: 40). Also other theorists isolated this dimension of cultural variability, e.g. Hsu, 1981; Westen, 1985; Kluckhohn and Strodtbeck, 1961; and Yum, 1987a. Triandis (1986) suggested for example, that members of collectivistic cultures draw sharper distinctions between members of ingroups and outgroups, and perceive outgroup relationships to be more intimate than members of individualistic cultures.

2) masculinity versus feminity: masculine cultures are labeled as those who strive for maximum distinction between what men and women are expected to do. They stress assertiveness, power, and material success. Those labeled as feminine cultures stress people, quality of life, and nurturance. They also permit more overlapping social roles for the sexes.

3) *power distance*: refers to the extent to which power, prestige, and wealth are distributed within a culture. High power distance cultures accept power as a basic fact in society, and stress coercive or referent power, while low power distance cultures believe power should be used only when it is legitimate and prefer expert or legitimate power (Gudykunst and Ting-Toomey, 1988: 47). Cultures high in power distance tend

to be more authoritarian and may communicate in a way to limit interaction and reinforce the differences between people, whereas in low power distance cultures the opposite tends to occur.

4) uncertainty avoidance: is identified to the extend to which people in a culture are made nervous by situations they perceive as being unstructured, unpredicatble, or unclear. Cultures high in uncertainty avoidance have a lower tolerance for uncertainty and ambiguity, which expresses itself in higher levels of anxiety and energy release, greater need for formal rules and absolute truth, and less tolerance for people or groups with deviant ideas or behavior (Hofstede, 1979: 395). Cultures low in uncertainty avoidance will have lower stress levels and weaker superegos, and accept disagreement and taking risks more than high uncertainty avoidance cultures.

Critics on Hofstede's dimensions were numerous, e.g. not being representative of other members of the culture (apart from the multinational corporations), empirical questions concerning validity of the items used to construct one or two of the indices, his theory not being applicable to interpersonal communication, and his theory being developed from a Western social science point of view. However, Hofstede's dimensions have proved to be useful in explaining observed cross-cultural differences in interpersonal communication and they can be used as well to make extremely specific predictions of cultural differences.

2.5.2. Low - and high - context communication

The concept of low - and high - context cultures was popularized by Hall (1976) and differentiates cultures on the basis of the communication that predominates in the culture. In *low-context cultures* verbal messages are elaborate and highly specific and tend to be highly detailed and redundant. Verbal abilities are highly valued, and logic and reasoning are expressed in verbal messages. In *high-context cultures* most of the information is either in the physical context or internalized in the person. Very little is in the coded, explicit, transmitted part of the message. High-context cultures decrease the perception of self as separate from the group. They are more sensitive to nonverbal messages; therefore they are more likely to provide a context and setting and let the point evolve (Jandt, 1995: 201-203).

Gudykunst and Ting-Toomey (1988) suggest the dimensions of low - and high - context communication and individualistic-collectivistic to be isomorphic. "All cultures Hall (1976, 1983) labels as low-context are individualistc, given Hofstede's scores, and all of the cultures Hall labels as high-context are collectivistic in Hofstede's (1980, 1983) schema" (Gudykunst and Ting-Toomey, 1988:44).

2.5.3. Verbal communication styles

Gudykunst and Ting-Toomey (1988) and Levine (1985) argue that low - and high - context communication appear to be the predominant forms of communication in individualistic and collectivistic cultures, respectively. Consequently Hofstede's dimensions and Hall's low- high context schema have been used to explain verbal

stylistic variations across cultures. Four verbal dimensions of communication style have been researched because of the potential theoretical contributions they can offer to the study of language and culture.

1) Direct versus indirect style: research conducted by Johnson and Johnson, 1975; Park, 1979; Katriel, 1986; and Clansy, 1986 showed differentiation between style differences in different cultures. The cultural variability dimensions of individualistic/collectivistic cultures, and low-and high-context have been used to explain the direct versus indirect style, which refers to the extent speakers reveal their intentions through explict verbal communication. Gudykunst and Ting-Toomey (1988: 100-105) define the direct verbal style as referrring to verbal messages that embody and invoke speakers' true intentions in terms of their wants, needs, and desires in the discourse process. The indirect verbal style, in contrast, refers to verbal messages that camouflage and conceal speakers' true intentions in terms of their wants, needs and goals in the discourse situation.

An example of this style differentiation presented by Park (1979) shows how Korean people do not make negative responses like 'no', or 'I disagree with you'. They tend to use more frequently than North Americans circumlocutory expressions, such as 'I agree with you in principle', or 'I sympathize with you' (p.88). And according to Hofstede's dimensions most Koreans belong to a collectivistic culture, opting for an indirect style, whereas most North Americans belong to an individualistic culture, using a rather direct style.

2) Elaborate versus succinct style: this dimension relates to three verbal stylistic variations. The first is elaborate style, which refers to the use of rich, expressive language in everyday conversation. The second style, called exacting style, states that one's contribution in language interaction ought to be neither more nor less information than is required (corresponding with Grice's concept of 'quantity maxim', 1975). The succinct style includes the use of understatements, pauses, and silences in everyday conversation. The cultural variability dimension of uncertainty avoidance and low/high context have been used to explain the elaborate versus succinct style.

The use of an elaborate style characterizes many Middle Eastern communication patterns, which are moderate on Hofstede's (1980) uncertainty avoidance dimension, and are high-context cultures. The use of an exacting style is characteristics of people in many Northern European cultures, which are low to moderate on Hofstede's uncertainty avoidance dimension, and are low-context cultures. The succinct verbal communication style is characteristic of people in many Asian cultures and some American Indian cultures in North America, which are relatively high on Hofstede's dimension on uncertainty avoidance, and are high-context cultures (Gudykunst and Ting-Toomey, 1988:105-108).

3) Personal versus contextual style: the cultural variability dimension of power distance and low/high context have been used to explain these style differences. Whereas personal style is individually-centered refers to the use of certain linguistic devices to enhance the 'I' identity, contextual style is role-centered and refers to the use of certain linguistic signals to emphasize the sense of 'role' identity. Albert (1972)

and Yum (1987b) came to the conclusion that the style of speaking tends to reflect the overall values and patterns of a culture. Contextual style of speaking then refers to the use of language to reflect hierarchical social order and asymmetrical role positions. The personal style of speaking refers to the use of language to reflect egalitarian social order and symmetrical relational positions.

Examples of societies using a contextual style of speaking are many of the African cultures, which score high on Hofstede's power distance dimension and are high-context cultures. Examples of societies using a personal style of speaking are for instance the North European cultures, scoring low on Hofstede's dimension of power distance, and being low-context cultures.

4) Instrumental versus affective style: this dimension relates to the instrumental verbal style, which is sender-oriented language usage, goal-oriented in verbal exchange, and relies heavily on the digital level to accomplish goal objective. It also relates to the affective verbal style, which is receiver-oriented language usage, process.oriented in verbal exchange, and relies heavily on the analogic level to negotiate relational definition and approval. The cultural variability dimensions used to explain these styles are individualistic/collectivistic cultures and low/high context.

Most Arabs, representing collectivistic, high-context cultures tend to engage in an affective style of verbal interaction. The United States and some European cultures such as Switzerland and Denmark tend to engage in an instrumental style of verbal interaction, and represent indidividualistic, low-context cultures (Gudykunst and TingToomey, 1988: 112-116).

2.5.4. Towards ethnorelativism: a developmental model of intercultural sensitivity

In an attempt to understand 1) why people behave as they normally do in the face of cultural difference, 2) how they are likely to change in response to education, and 3) what is the ultimate goal toward which our efforts are expended, Bennett (1986) discussed 'personal development' in terms of stages of growth as these relate to intercultural sensitivity. In the case of intercultural sensitivity, the organizing key concept is *fundamental cultural difference.* The experience of difference is taken as basis to the developmental continuum. The early stages of the model correspond with varieties of ethnocentrism. The latter stages correspond with varieties of ethnorelativism, with this terms opposing 'ethnocentrism'.

A developmental model of intercultural sensitivity

The ethnocentric states and their stages

I. Denial
a. Isolation
b. Separation

II. Defense
a. Denigration
b. Superiority
c. Reversal

III. Minimization
a. Physical universalism
b. Transcendent universalism

The ethnorelative states and their stages

IV. Acceptance
a. Behavioral relativism
b. Value relativism

V. Adaptation
a. Empathy
b. Pluralism

VI. Integration
a. Contextual evaluation
b. Constructive marginality

Each of these states with their stages are of importance in the process to intercultural sensitivity. Although presented rather from a linear perspective, this does not need to be so. Depending on time, individual development and striving, persons might go forth and back, swop certain stages, spend months in one stage and only a few weeks in another.

People who wish to employ this model, so Bennett (1986), should keep in mind that the phenomenology of difference is the key to intercultural sensitivity. They should know that the construing of difference necessary for intercultural sensitivity is that of ethnorelativism. The key to ethnorelativism is the idea of 'process'. Ethical behavior must be chosen with awareness that different viable actions are possible.

2.5.4.1. Intercultural development inventory (IDI)

Hammer (1997) designed a self-assessment instrument of intercultural sensitivity, called the intercultural development inventory (IDI), which comprehensively captures the elements of Bennett's model. The IDI focuses on specific patterns of human behavior in order to assist people in better understanding the dynamics of their interaction with others, and on how individuals construe their social world in terms of dealing with cultural differences between themselves and people from other social/cultural groups.

The purpose of the IDI can be summarized in four points:

1) to help increase respondents' understanding of the developmental stages of intercultural sensitivity.

2) to evaluate the effectiveness of various training, counseling and education interventions.

3) because it is a feedback instrument, it can be used to improve people's intercultural skills, and to assist in making decisions to work or live in a culturally diverse setting.

4) to identify cross-cultural training needs of individuals and groups within a foreign country context or within a domestic, culturally diverse organizaton setting.

The two basic approaches for administering the IDI are *1) the individual focused approach* which is designed to provide immediate, individual-level profiles of IDI results to each participant in the training program, and to increase individuals' awareness about their orientations toward cultural differences; 2) the second approach is to administer the IDI for the purpose of obtaining a *group assessment* and could be administered prior to a training program, and a group profile developed.

The strengths of the IDI lay in the fact that it is designed as well for individuals as for groups. It is a self-scoring instrument which provides feedback to respondents concerning their general orientations or viewpoints toward cultural differences, i.e. their intercultural sensitivity.

2.5.5. Cross-cultural adaptation: An integrative theory

Whereas Bennett's model (1986) describes and analyzes different stages in a person's development to intercultural sensitivity, Kim (1995: 176-193) takes the stage of cross-cultural adaptation and looks at it as a process over time. In addition, he offers an

explanation of the structure of this process by presenting the key constituents influencing the degree in which individuals adapt to a new and unfamiliar culture.

The process of cross-cultural adaptation entails three stages: 1) *deculturation* (unlearning) and *acculturation* (learning), 2) *the stress-adaptation-growth-dynamic*, which implies that the disruptive experiences of deculturation and acculturation reflect stress. These defensive or protective stress reactions generally accompany adaptation responses. What follows the stress and adaptation responses is then called a subtle internal transformation of growth, and 3) *the intercultural transformation.* Three interrelated aspects of the sojourner's intercultural transformation are specified a the key outcomes of the cross-cultural adaptation process: functional fitness, increased psychological health and intercultural identity.

In an attempt to identify the structure and its constituent factors that help explain the different rates at which the cross-cultural adaptation process takes place, Kim conceptualizes the strangers' communication activities in two basic interdependent dimensions: personal communication, and social communication. A model of Kim's structure (1995: 188) shows a clear overview of all the dimensions and constructs of cross-cultural adaptation.

Table 1. Dimensions and constructs of cross-cultural adaptation

DIMENSIONS	CONSTRUCT
1. Host Communication Competence	Host Cognitive Competence Host Affective Competence Host Operational Competence
2. Host Social Communication	Host interpersonal Communication Host Mass Communication
3. Ethnic Social Communication	Ethnic Interpersonal Communication Ethnic Mass Communication
4. Environment	Host Receptivity Host Conformity Pressure Ethnic Group Strength
5. Predisposition	Preparedness Ethnicity Personality
6. Intercultural Transformation	Functional Fitness Psychological Health Intercultural Identity

The first three dimensions of the cross-cultural adaptation process deal with the strangers' abilities to communicate with people from the host cultures.

New in this model is the inclusion of the dimensions of **a) environment** and **b) predisposition**, which influence and do effect on the strangers' adaptation process. Kim (1995:184-187) elaborates on these dimensions as follows:

a) Environmental *conditions* are identified as affecting the stranger's adaptations process:

1) *host receptivity,* referring to the to the degree to which a given environment is structurally and psychologically accessible and open to strangers

2) *host conformity pressure*, referring to the extend to which the environment challenges strangers to adopt the normative patterns of the host culture and its communication system. This is often reflected in the expectations the natives routinely have about how strangers should think and act, hereby exerting pressure on the strangers to adapt to the host cultural milieu

3) *the strength of the stranger's ethnic group* is closely influenced by the degree to which a given host environment exerts receptivity and conformity pressure on a stranger.

b) Predispostion as a dimension of the cross-cultural adaptation process deals with the internal conditions of the strangers themselves prior to resettlement in the host society. Conditions such as preparedness, ethnicity, and personality traits characterize predispostion.

1) preparedeness includes the mental, emotional, and motivational readiness to deal with the new cultural environment including understanding of the host language and culture.

2) ethnicity refers to various characteristics of strangers pertaining to their distinctiveness as a people. Ethnic characteristics play a crucial role in the cross-cultural adaptation process as it affects the ease or difficulty with which the stranger is able to develop communication competence in a given host society and participate in its social communication activities.

3) personality traits include the context of the stranger's personality, which serves as the basis upon which he/she pursues and internalizes new experiences with varying degrees of success. Personality traits that help facilitate the strangers' adaptation by enabling them to endure stressful challenges and to maximize new learning are *openness* and *strength,* which help define the strangers' overall personally disposition to 'push' themselves in their adaptation process.

These five dimensions and the corresponding constructs constitute the structure of cross-cultural adaptation, eventually leading to the stranger's intercultural transformation (=dimension 6). Cross-cultural adaptation is seen by Kim (1995) as a collaborative effort, in which a stranger and the receiving environment are engaged in a joint venture.

As such, so Kim, one can not overemphasize the important role the host society can play to embrace the stranger and facilitate his or her adaptive effort (1995: 192).

Having defined, explained, and gone down in the field of intercultural communication I will next deal with 'practitioner - client communication'. Before linking up these two topics to 'practitioner - client communication in an intercultural context' I want to refer to the ideological orientation of intercultural communication, relevant to this particular study.

Blommaert (1994) criticizes the topic of intercultural communication being often directed at very specific kinds of communication. It is said to often stand for business negotiations, international diplomacy, and the vast area of human experience captured under the term 'living overseas', almost invariably involving a Westerner (white Europeans or North Americans) and a member of a typically non-western society. This leads to the conclusion, so Blommaert, that there seems to be some kind of 'typical' form of intercultural communication and a more 'marginal' type of intercultural communication. The latter type does not seem to attract many researchers' and trainers' attention as it is rather the 'typical' form of intercultural communication they are interested in. But this 'typical' intercultural communication does leave the vast majority of people unaffected, who, nevertheless, often are involved and confronted with actual intercultural encounters. And it is even less relevant to many professionals who have to deal with people from other cultures on a regular basis. Raising these questions Blommaert stands up for giving some attention to the ideological level of intercultural communication: the level of beliefs, perceptions, opinions, attitudes about intercultural communication as these do influence the actual processes of intercultural communication, as well as the post-hoc interpretations of these events in terms of ethnic or cultural stereotypes. When studying the intercultural communication between Finnish medical practitioners and non-Finnish clients I want to approach this domain of study: 'practitioner - client communication in an intercultural context' from an ideological viewpoint, i.e. oriented at improving real-life contacts between people from different cultural groups. This can be realized, so Blommaert, not by contributing to the construction of societal myths, but by clearly separating myths from established facts.

3. Practitioner-client communication

When writing about issues in health care one is immediately confronted with the specific contextual vocabulary which implies the inherent difficulties language can contain. The words 'practitioner' and 'client' as used throughout this thesis are deliberately chosen out of many other possibilities. Practitioner, doctor, physician, health care provider are all synonyms and do not actually seem to be value-laden or causing semantic difficulties. This is different with the word 'patient' which represents many problems. Sharf and Street (1997) share this view and elaborate on these words. They argue that 'patient' is a problem-laden word and that it denotes illness instead of health and recovery. 'Patient' derives from the Latin 'pati' and signifies suffering or enduring, connoting a sense of passivity or helplessness. The word 'client' also derives from the Latin roots 'klei', meaning to bend or to lean, and 'cluere', in the sense of to listen or to hear. Other names suggested for 'patient' could be 'survivor', 'citizen', 'partner' and 'health care consumer', the one trying to be more neutral than the other. But still, these words sound unfamiliar and some have not even achieved wide consensus in discussions of health care. Throughout this thesis I have chosen to use the word 'client' in a very broad sense and free of connotations. When referring to literature I tried to adopt the words the authors used whenever this was stylistically appropriate.

Literature on practitioner-client communication has been rather sparse. Wyatt (1991) conducted literature research on medical literature dealing with physician-patient relationships and came up with surprising results. She examined articles published between 1983 and 1989 looking for topics dealing with physician-patient relationships. The articles reviewed did not reflect a major concern for these relationships in medical literature. Less than 1% of the articles related to relationships with patients. The lack of articles concerned with physician-patient relationships is an indication, so Wyatt, of the continuing power of the biological model in medicine, where communication is seen as an exchange of information between physician and patient, and is not indentified as problematic. Another reason for the lack of articles on this special relationship, Wyatt explains, could be the editors' and readers' failing to see the relevance to the practice of medicine, and therefore the articles might not be submitted or published. But, the articles that did deal with the topic indicate that physicians do look for effective ways of eliciting patient concerns. Physicians also try to improve patient satisfaction with their medical treatment in order to prevent malpractice suits and to feel better about their own work. Doctors want to know, Wyatt argues, how to persuade people to follow medical advice and to live healthier lives.

However sparse the literature on this topic, still some interesting, lively books and articles have been produced dealing with this intriguing subject - despite the not always available latest years' issues -. Unfortunately this has not always been because of the outstanding quality or success of communication. Research indicates that clients are usually satisfied with the medical care they receive from doctors, but are dissatisfied with the communication accompanying that care (Pendleton & Hasler, 1983; Thompson, 1990; Leiwo et al., 1990; Ruben, 1990; Argyle, 1983; Tate, 1990; Kreps, 1990). Most often practitioner-client communication lacks effectiveness and is a focus of dissatisfaction for both parties involved.

Researchers have been investigating the importance of effective and satisfying communication between practitioners and clients. Conducted research has attempted to find out the problem areas in health care linked to communication inadequacies. Additionally, researchers have tried to improve the practioner-client communication by developing guidelines for better communication between the two parties involved.

3.1. The importance of communication between practitioners and clients

Considering the role or the importance of communication in health care, we have to take into account the fundamental relationship between human communication and health care (Ruben,1990:51). It is **communication** that initiates the relationship between a client and a health care practitioner.

The importance of communication between practitioners and clients can also be paraphrased as the communicative demands of health care practice. Kreps and Thornton (1992:2) give reasons for the important role of communication in health care:

> *"Human communication is the singularly most important tool health professionals have to provide health care to their clients. Not only do health care providers offer their services to consumers through communication contact, but they also gather pertinent information from their clients, explain procedures and regimens to clients, and elicit cooperation among members of their health care team through their ability to communicate".*

Reports from various studies collected by Pendleton & Hasler (1983) show that clients value good communication with their practioner as they want to be involved in the decisions which are made in the consultation room. Adequate communication should contain information, being an important dimension as it affects the client's knowledge and understanding of health, and how to fight against unwanted procedures. Additionally, due to ineffective communication practitioners may fail to diagnose problems accurately or notice them at all. Good communication is reported to implicate in the outcome of medical care but also in the client's decision to use medical services.

It is said that the communication between practitioner and client is crucial not only to client satisfaction with the health professional, but also to the health-care delivery process itself. Effective message sending, so Thompson (1990:27), should be necessary for both a) client communication of symptoms and physical problems, and b) practitioner communication of instructions. In addition, the relationship between a patient and a health-care professional should be initiated through communication that occurs between them (Thompson, 1990:27).
The importance of improved communication between practitioner and client, reported by Sharf (1984:4-5), is twofold. Firstly, adequate communication should create a cooperative relationship that involves the practitioner and the client, the practitioner and the client's significant family and friends, and the practitioners and other health care professionals. Secondly, improved communication should create adherence, referring to the contractual practitioner-client relationship as well as to the attitude of the client toward a prescribed regimen, in the way that it outgrows cooperation.

Research on how patients conceptualize, represent, and evaluate health care encounters, indicates that providers' interpersonal communication and relationship competencies are basic to patient's constructions, assessments, and reconstructions of their health care encounters (Ruben, 1993). These findings also show, so Ruben (1993), that providers' communication skills may play a fundamental role in patient's assessments of the quality of care they have received.

Kreps and Thornton (1992:45) note that health care practitioners who work towards harmonious and productive relationships, experience that with good communication, problems can be more readily diagnosed, clients can be more easily satisfied, and the work setting can be enhanced for the health professional.

The importance of communication between practitioner and client having been clarified, a closer look at the origin of the problems follows.

3.2. Problem areas in health care linked to communication inadequacies

Considering the intitial position of both client and practitioner, one must take into account two important aspects.
Firstly, I want to stress that one deals with the initial inequality between practitioner and client. The client usually is in the minor position of looking for help in some form. He or she finds him or herself in an unfamiliar, intimidating surrounding, which may create a sphere of dependency on someone. Unfortunately, the following view on practitoner-client relationship is still accurate and shapes the entire interaction: *"The relationship between the professional and those he serves is characterized by an inequality in which the professional holds the balance of power"* (Pellegrino and Thomasma, 1981:210).

Secondly, practitioners seldom have had training in communication skills. Although progress has been made, numerous practitioners still would make their assessments of quality of care based only on clinical and technical criteria, clinical and technical skills or competencies of providers, and the manner in which clients are treated medically (Ruben, 1990:53).

When intending to find the problem areas in communication between practitioner and client, it is self-evident these problems are experienced by both practitioner and client. But, as it is the client who, from the beginning being in the weaker position, feels ill, and finds himself in the unpleasant and sometimes embarrassing situation of needing help, I will consider the communication problems from the client's point of view in theory as well as in practice, later on in the actual study.

The following five problem fields in the delivery of health care, listed by Kreps and Thornton (1992:6) are:
1. Low levels of client compliance/cooperation
2. Miscommunication and misinformation
3. Unrealistic client expectations
4. Insensitivity
5. Dissatisfaction with healt care services

Various researchers came up with similar problems or with issues not literally identical with Kreps', but still in the scope of his five problem areas (Ley, 1983; Bochner, 1983; Cartwright, 1983; Sharf, 1984; Thompson, 1990; Ruben, 1990; Kreps, 1990).

3.2.1. Compliance

Compliance is an often occurring aspect in practitioner-client communication meaning the client's willingness and ability to follow through on a prescribed plan of treatment. Although compliance is most often considered as a problem practitioners experience caused by their clients, this tendency of viewing this concept is changing. Sharf (1990) and Kreps & Thornton (1992) both identify that 'compliance' often seems to be the desired outcome of practitioner-client interaction connoting the client's accomodating the practitioner, or better said, compliance mostly indicates a one-way practitioner orientation. However, reacting to this one-sided view, Sharf (1990) argues that to simply expect compliance based on the practitioner's authority or ethos will often not be the most effective way of persuading or stimulating cooperation. Also Kreps & Thornton (1992) prefer to speak about compliance in terms of cooperation between the client and the practitioner, where responsibility for health care results are shared both by the client and the practitioner.

From the practitioner's viewpoint, poor compliance or non-compliance deals with issues as client's failure to cooperate with keeping health care appointments, follow healt care regimens, use prescribed drugs correctly, or proceed by the rules of the health care institution (Lane, cited by Kreps and Thornton, 1992,6). Client's non-compliance though might create health hazards and lead to a waste of resources and frustration on the part of the doctor (Stone, cited by Thompson, 1990:37). Non-complying clients, Ley (1983:102) suggests, can be classified along two dimensions according to whether their non-compliance is intentional or unintentional, and according to whether or not they have adequate or inadequate information. Especially important in this study while taking the clients' side, this second classification shows the significance and the need of the practitioners informing their clients. However, increased client feedback also could improve the practitioner's communicative performance (Ley, 1983:104). The above mentioned tendency to change the meaning of the concept of compliance has resulted in attempts being made considering compliance as a two-way process involving both practitioner and client. Clients could participate in this process, e.g. increased client feedback could improve the practitioner's communicative performance (Ley, 1983:104), which would benefit both parties in the contribution of the health process.

3.2.2. Miscommunication and misinformation

The misinterpretation of communication or miscommunication is an often occurring problem in the communication between practitioner and client. This means that the meanings the clients create in response to messages sent to them, are very different from the meanings that were intended. Miscommunications are said to be caused by ineffective use of messages and feedback in health care (Kreps & Thornton, 1992:10).

West & Frankel (1991:179) explain miscommunication between practitioner and client

in function of the context in which the communication situations take place. They argue that miscommunication can occur depending on the practitioner's speech style changes in different clinical contexts. The practitioner's use of 'doctor talk' may result in failure of the client's understanding. Miscommunication can also be based on non-technical language and may even be based rather on 'hearing' than on 'understanding' problems. Another factor inclined to cause misunderstanding in communication is the accuracy of client's written records, which may not be in relation with the client's verbal concerns (West & Frankel:179-181).

Dealing with using and misusing language, Sharf (1984:15) reports of medical doctors being accused of using unnecessarily complicated jargon, even among themselves. She presents an example a practitioner wrote in a medical magazine: *"patients ambulate, visualize, articulate, and masticate when the rest of us walk, see, talk, and chew"* (Sharf,1984:15).

Medical jargon, the difficult or strange language used by health care professionals, may have many advantages for the practitioners. For the clients though, the practitioner's use of jargon might result in client's being misinformed. A client, being inexperienced with practitioner's talk could believe he or she understood the message alright, and nevertheless have misunderstood it completely. Medical jargon should be avoided if the client is not familiar with the terminology. The situation of a client being unable to understand his practitioner can result in a dissatisfaying experience, and the relationship between the two parties involved may be threatened.

Research conducted on how much medical terminology patients understand, revealed that there still is a need for enhanced communication skills on the part of the health professionals (Thompson & Pledger, 1993). The results of the mentioned study suggest that medical practitioners need to be even more aware of the terminology gap that exists between them and the patients and need to adapt their langauge to match the knowledge level of the patient.

Miscommunication does not only result from the use of difficult medical terminology. The very special cultural background of both client and practitioner play an important role in the communication situation. We will deal with this next.

3.2.2.1. The intersubcultural nature of the practitioner-client relationship

Ruben introduces this inspiring view on the nature of the practitioner-client relationship and explains that we should see it essentially as an intercultural relationship (1990:57). He notes that the term 'intercultural' refers to a circumstance in which interpersonal communication needs two distinct cultures, each with its own characteristic symbols, meanings, conventions, rule structures, habits, values, communication patterns, social realities, and 'significant stories', that are shared with others belonging to a particular social system or subsystem. Each social system or subsystem, so Ruben, is to evolve its own system culture that serves to distinguish it in subtle and sometimes not so subtle ways from other social systems (p. 57). Because of human's ability to adapt to, and/or adapt the cultures of other social systems, he continuous, human behavior can at once

confirm, validate, and transmit that culture to others in the social system. Ruben argues that through this process persons -in our case health care professionals- all become who and what they are, and enculturated into in their own subsystem cultures, this interaction between them and clients being one of intercultural communication (p. 57).

Considering the definition of a subculture, being a group of people with clearly identifiable values that exists within the geographical boundaries of a dominant culture (Kreps and Thornton, 1992:160), Ruben calls the communication between practitioner and client being of an **intersubcultural** kind; between representatives of two quite different subsystems (1990:58). Miscommunication and misinformation, being communication difficulties may be inclined to appear in the practitioner-client relationship as both parties *"live in essentially two different realities, bring different backgrounds, expectations, understandings, knowledge, sensitivities (and insensitivities), communication behaviors, and interpretative conventions to the interaction"* (Ruben, 1990:58).

As the intersubcultural practitioner-client relationship essentially is of an intercultural kind, the elements of intercultural communication then are applicable to the intersubcultural nature of the relationship. Problems or confusions in understanding nonverbal messages for instance, do not come from the fact that practitioner and client come from a different culture. They do derive from the fact that their subcultures differ; they are a result of the practitioner belonging to the subculture of practitioners communicating with a client, belonging to the subculture of clients seeking help. A shy, stammering client trying to tell his problems does not act in that way because the practitioner and he or she come from a different culture. The client most likely acts that way because the subculture where he comes from respects doctors because of their subcultural background. This will make the client unsure and his verbal behavior might deteriorate for example in stammering.

3.2.2.2. Nonverbal communication, feedback and metacommunication

The intersubcultural nature of the practitioner-client relationship could have consequences for the communication flow as such: misunderstandings due to variable nonverbal behavior, and lack of feedback and metacommunication. Miscommunication can occur when practitioner and client have different ideas of sending, receiving and express nonverbal signals. Nonverbal systems and the respective characteristics they mediate are applicable to the practitioner-client communication situation. As practitioner and client come from different backgrounds, from different subcultures, and as each of the nonverbal systems include messages that may affect innumerable communication situations, it is not hard to imagine that miscommunication and misinformation situations can easily occur. Especially in the health care context Leiwo et al. (1990, 9) argue that nonverbal communication plays an important role and can be wrong interpreted as the norms for hearer and speaker happen to be different, and as the clients in the particular practitioner-client situation may show deviant and unusual behavior. They also indicate the practitioner usually being the dominant part in the conversation, controlling the interaction nonverbally by speaking longer and by having longer pauses.
Another problem clients can be confronted with is the lack of practitioner's feedback.

Feedback is said to be a communicated response to another individual's communication (Kreps and Thornton, 1992:25). Practitioners allowing their clients to give feedback is beneficial for the whole communication process. In that way practitioners can obtain information about the level of understanding and knowledge the clients have, eventual misinformation or miscommunication may come to light and can still be corrected. Sharf (1984:16) pleads for communication in health care to include feedback, whereby the client is encouraged to summarize and react to what the practitioner has said. It is also important for practitioners to give feedback as it communicates to the client that the practitioner is interested in his or her view on the particular situation (Kreps and Thornton, 1992:26).

Metacommunication refers to talking about communication. "Metacommunication is communication about communication; the communicator is given feedback about the way he or she is communicating. Metacommunication is a primary tool in socialization because of rules of interaction are learned from metacommunicative processes" (Kreps and Thornton, 1992:26). As mentioned above, metacommunication belongs to the category of feedback, only that it deals with communication as such. Considering metacommunication in the health care context means that practitioners and clients have the potential possibilty to talk to each other about their communication situation. It would be advisiable for clients to metacommunicate as they regularly may question the practitioner's way of describing the treatment procedure, providing information, or giving advise. They may wonder why the practitioner was so harsh, why did he or she laugh at that particular moment, why did he or she choose these particular words. Metacommunication could clear up misconceptions and misunderstandings.

One should keep in mind the importance of adequate communication and memorize that miscommunication between practitioner and client, due to unprecise and ineffective information, could endanger the client's diagnosis and therapy. Miscommunication in health care could indeed be a matter of life and death.

3.2.3. Unrealistic client expectations

When clients goes to see a practitioner, they have the expectations of being listened to and eventually being treated and healed. This first encounter of telling their story to a man or a woman they hardly know, usually means the initial step to a satisfying or a dissatisfying relationship. If this expectation has been unfullfilling, the practitioner-client relationship will suffer. When a client's expectations are not met, this could result in that person to become unwilling or unable to meet or hear the words of the other, the practitioner in this case (Thompson, 1990:33).

In an attempt to measure communicative satisfaction in doctor-patient relations Schneider and Tucker (1992:19) come up with results indicating patients' expectations of a doctor-patient relationship. The four significant communication factors are relationship maintenance, professional competence, waiting time, and social etiquette. Although these expectations sound realistic and feasible, we should consider them as unrealistic as clients still have the need to come up with these factors and mention them as potential wishes in their relationship with practitioners.

Conducting studies on doctor-patient communication reported by doctors, Jaspars et al. (1983:143) indicate the main category of communication difficulties between doctor and patient to be the interference of some sort in the transmission of information. But, as we are dealing with the clients' problems, we could as well understand these doctors' difficulties as potential client's expectations that can not always be fulfilled. The interferences are said to be of three types: cognitive, emotional and social. Considering **cognitive interference**, we notice that clients often have more than just one problem they want to talk about to their practitioner. They expect attention, and assume the practitioner can deal with these problems simultaneously. These clients' expectations may create though confusion for the practitioner. **Emotional interference** deals with the clients' anxiousness, shyness, depressiveness or nervousity. The clients expect the practitioner to be an understanding, sensitive person. This expectation can not always be fulfilled. The practitioners may as well experience an adverse reaction to the client by being bored or irritated. **Social interference** can occur when client and patient come from a different social background. The client expects a certain behavior from the practitioner, which may not always weigh up the clients' expectations.

Kreps and Thornton report on studies that have indicated that health practitioners and clients tend to stereotype one another (1992:8). They argue that stereotyping, misinformation and inflexibility may be caused by unconscious, nonverbal cultural cues and information. Popular doctor series on television usually idolize the doctors' clinical and social abilities and they become public heroes. Clients should be warned for these unrealistic stereotypes putting the health practitioners in an untenable position, and moreover, practitioners could never meet these clients' expectations (Kreps and Thornton, 1992:8).

3.2.4. Insensitivity

Various factors can contribute to insensitive communication between practitioners and clients. The lack of showing warmth and friendliness by practitoners can be perceived as insensitive behavior by the clients. Still it is exactly the amount of warmth and friendliness shown by the practitioners which can be positively related to satisfaction in the client-practitioner relationship, as well as the practitioner's perceived interpersonal involvement and expressiveness (Thomspon,1990:30).

The insensitivity of practitioners treating clients as object is an often occuring problem. Yet, although clients should be treated as consumers rather than objects and should be given more responsibility and control, data indicate that practitioners control interactions, and are dissatisfied by client's attempts to assert control (Thompson,1990:34).

I mentioned before that practitioners should need to be aware of the terminology gap that exists between them and their clients. It would be only sensitive of the practitioners and beneficial for the patient satisfaction, when the practitioners should be able to adapt their language to the client's level (Thompson and Pledger, 1993:94).

Considering Schneider's and Tucker's article again on measuring communicative satisfaction in doctor-patient relationship leads to two of the four factors earlier referred to: waiting time and social etiquette (as mentioned above in 3.2.3.) which are, when not kept up with, also related with insensitivity. Long waiting times can be a source of irritiation for the clients and may be perceived as insensitive of the practitioner. Social etiquette includes aspects like practitioner's use of foul language, practitioner's way of dressing - are both considered as cognitive components -, and the way the practitioner expresses self-confidence - behavioral component - (Schneider and Tucker, 1992:26).

Insensitivity is said to be the greatest source of dissatisfaction people do feel about the health care system (Kreps and Thornton,1992:9). Especially 'burn-out', being *"the wearing down from the chronic emotional pressures of human service work, characterized by physical, emotional, and mental exhaustion, by a decreasing sense of personal accomplishment, and by a tendency to depersonalize care recipients"*, is a factor that regularly occurs in the health care sector (Ray and Miller, 1990:100). Clients do suffer from being treated by burn-out personel and perceive them as insensitive. Having stressed the importance of interpersonal communication beween clients and practitioners, being beneficially for the client-practitioner interpersonal relationship, it is somehow ironic then to note how Ray and Miller (1990:100) describe this interpersonal relationship to be the major cause of burn-out among all human service workers, health-care professionals included.

Kreps and Thornton (1992:9) stress the previous mentioned health care problems such as cooperation/compliance, miscommunication, and unrealistic expectations to be strongly related to insensitive communication.

3.2.5. Dissatisfaction with health care services

The problem areas in health care presented above linked to communication inadequacies are at the same time, and rightly so, persuasive reasons for dissatisfaction. Client's dissatisfaction with health care will probably always find its origine in the relationship between clients and practitioners. Especially the nowadays constraints and demands on professionals working in health care services may be a hindrance to improve this relationship. This is also described by Ruben (1990:58):

> *"Collectively, demands on workers to be more productive, cost-conscious, technologically competent, and marketing oriented are often mentioned as having exacerbated barriers to improvements in caregiver-patient relationships".*

The next thing to do is to be concerned with a serious consequence this might bring; people in need of health care services may be reluctant or even avoid seeking professional help (Kreps and Thornton, 1992:10).

Considering the extreme importance of practitioner-client communication in the health care sector, we will look next at how practitioner-client communication can be improved in order to obtain a better communication between them.

3.3. How to improve practitioner-client communication?

Literature on health communication pleads for a better communication between practitioner and client, and suggestions for discourse strategies are presented (Jaspars et al, 1983; Ley, 1983; Pendleton and Hassler, 1983; Argyle, 1983; Sharf, 1984; Thompson, 1990; Ruben, 1990; Kreps, 1990; Leiwo et al., 1990; Kreps and Thornton, 1992). The authors' main concern and suggestion is the training of practitioner's communication skills.

Having dealt with the problems of practitioner-client communication Kreps and Thornton (1992) offer an initial guide to enhancement. To improve the practitioner-client relationship, being the major focus of health communication and research, Kreps and Thornton (1992:44-64) urge practitioners to understand the importance of the establishment of a clear and effective contract with their clients. They also strongly suggest them to aknowledge the far-reaching dimensions of a therapeutic relationship. Practitioners should take into consideration the components of such a relationship such as empathy, trust, honesty, confirmation, and caring. The health care interview, being of uttermost importance in health communication, should be carefully divided into planning, preparation (with the core on time and space) and the development of the interaction. They present as well procedures for asking questions, communicating findings, and terminating the interview.

In her attempt to improve practitioners' communication skills Sharf (1984) intends to broaden the practitioners' fan of awareness on the importance of practitioner's attitudes, and the impact and consequences of using and misusing language. She stresses the underlying meaning of relationships; how they look, sound and feel, and she deals in detail with nonverbal communication. Support-giving skills advice practitioners how to give support to anxious and misfortuned clients. Like Kreps and Thornton she deals with the medical interview and how practitioners should procede in such a way that it is an agreeable and comfortable situation for both parties involved. Sharf (1984) presents a medical interview self-assessment checklist that helps practitioners identify and further develop the communication skills that they use during the medical interview. The checklist depicts the face-to-face interaction between practitioner and client and is discussed in five communicative functions of the practitioner: putting the patient at ease, eliciting information, maintaining direction, maintaining rapport, and bringing closure.

Recent research approached the need for practitioner-client communication improvement and offered numerous suggestions for enhancement.

In an analysis of the doctor-patient relationship (Virtanen, 1990) the results indicate that this relationship is composed of the following contributing factors: empathy of doctors, competence of doctors, concordance between doctors and patients, general satisfaction, flexibility of services and amount of medical information provided. As these factors do not purely deal with communication as such, however, empathy, concordance, general satisfaction and provided medical information do have their basics in communicative events. Moreover, it are the communicative events that initiate the relationship between client and practitioner.

Narratives in the health care context are also said to play an important role in the practitioner-client relationship:

> *"The illness narrative is a story the patient tells, and significant others retell, to give coherence to the distinctive events and long-term course of suffering. The plot lines, core metaphors, and rhetorical devices that structure the illness narrative are drawn from cultural and personal models for arranging experiences in meaningful ways and for effective communicating those meanings"* (Kleinman, 1988:49).

Sharf (1990) expands on physician-patient communication as interpersonal rhetoric and considers the narrative approach. Patients' rhetoric is said to include ways in which they use verbal and nonverbal idioms to communicate bodily states and emotions of distress and how they create metaphoric language that reflects the personal meaning of their illness (Sharf, 1990:223). By listening to the stories clients tell about their health, practitioners could learn a great deal. They might obtain more information with regard to the client's way of living, cultural background and other factors that could have a potential influence on the client's sickness and healing process. In her conclusion though, Sharf suggests the narrative approach as a co-method next to the medical interview as a desired tool to gain information from the client.

Research on training practitioners to obtain better communication skills, and offering them the various possible approaches, ideas and advices are the initial steps to an enhanced practitioner-client communication. The final steps though have to be taken by the health care professionals themselves in that way that they are aware of the communication needs and that they show a sincere interest in developing their skills to communicate better with clients. When awareness is present, action may follow and clients can benefit from satisfying practitioner-client relationships.

Living up to these expectations will also be the initial goal in the following chapter when dealing with he impact of intercultural communication on the health-care setting, being an important social context that is extensively influenced by culture.

4. Practitioner-client communication in an intercultural context

Whereas practitioners and clients, even belonging to a similar culture - notwithstanding their deriving from a different subculture - , may encounter communication problems, it is just obvious that communication difficulties will occur when both parties come from two different cultures. To reduce or to overcome these problems we must first of all be aware of the utmost importance of communication and its' crucial impact on making decisions concerning diagnosis and treatment. As we have seen so far, effective communication is the first prerequisite for a well-functioning practitioner-client relationship and is a necessary step for creating mutual understanding. Moreover this is true where people from two different cultures have to interact with each other in the health care context. Considering practitioner-client communication in an intercultural context we automatically deal with the elements of intercultural communication presented above, playing an extreme even vital role in the interaction between the two parties involved. A communication model where practitioner and client come from two different cultures, each with his or her unique world view, will show us how the effectiveness of communication varies depends on certain factors.

4.1. A Practitioner-Client Intercultural Health Communication Model

Figure 1 illustrates the practitioner-client health communication model presented by Witte & Morrison (1995:220). The model shows practitioner and client, each with their own worldview developed from their particular culturally based experiences, and indicates the varying communication paths depending on whether there is a high or a low cultural distance and high or low mutual understanding between practitioner and client. The practitioner-client interaction can be viewed as follows:

Practitioner and client are both deep-rooted in their own worlds. This is indicated by the two sets of concentric squares, each set representing practitioner's and client's distinct worldview. **Square 1** symbolizes all aspects that occur within a person's mind or constitute the self. It represents the personal characteristics such as physical characteristics (e.g. attractiveness, eye color, body build), sex, age, race, personal experiences, and genetic background. **Square 2** stands for the social characteristics of the person. This includes all the characteristics mentioned in square 1 but also encompasses the clients' and practitioner's interpersonal relationships with other people. **Square 3** encompasses the elements from square 1 and 2, but also signifies environmental characteristics, being beyond a person's immediate control, such as the weather, structural elements of society (e.g. socio-economic status, social organizations and roles), economic conditions and geographic considerations.

Practitioner and client will confront matters of health and disease from their own personal, social and environmental background. As we know from the perception in communication, worldviews have a thorough and pervasive influence on practitioner's and client's interpretation and transmission of messages related to health and disease. We can see from the model that the more similar practitioner and client are in an

interaction, the more effective the communication between them. The model shows (figure 1) that if there is low cultural distance between practtioner and client, the communication path is apt to be straight and unhindered, leading to high mutual understanding. At the other hand, if there is high cultural distance beteen the participants, the communication path is prone to be difficult, and full of obstacles leading to a twisted, croocked and assymetric path resulting in low mutual understanding.

As mentioned above the elements of intercultural communication have an important impact on the practitioner-client relationship in an intercultural context. Singer (1987) wrote:

> *"Other things being equal, the higher the degree of similarity of perception that exists among a number of individuals, the easier communication among them is likely to be, and the more communication among them is likely to occur. Conversely, where there is little or no communication among individuals there tends to be a decrease in similarity of perception, which in turn tends to make further communication more difficult"* (p.61).

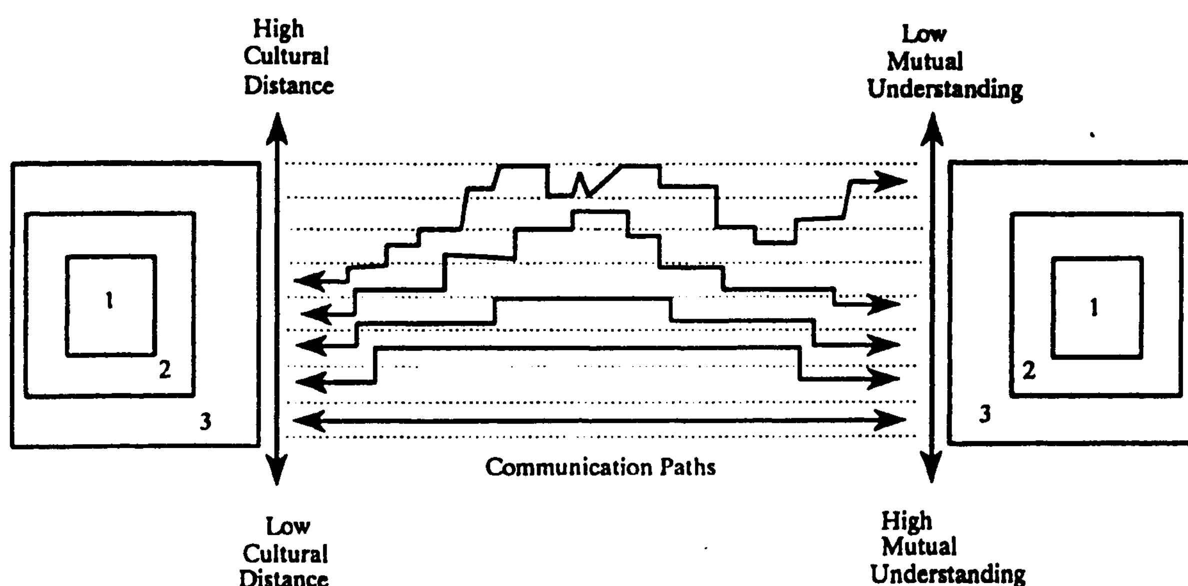

Figure 1. Practitioner-Client Intercultural Health Communication Model (Witte & Morrison,1995:220).

Exactly, one of the important elements of intercultural communication dealt with (2.2) was 'perception', including the aspects of beliefs, values, attitudes, world view and social organizations. In the model shown above (figure 1) it comes to light that it is by and large perception being responsible for the quality of the intercultural communication event. Also the other elements of intercultural communication like verbal and nonverbal processes do find their place in the intercultural health communication model. Witte & Morrison report that when communicating about health and disease with practitioner and client having similar perceptions (including similar worldview, attitudes, beliefs, values), it is likely that both parties will have similar definitions for verbal and nonverbal

messages. Conversely, differring perceptions will lead to misunderstandings due to different definitions for the same messages (1995:220-221).

Research conducted in this field dealt with issues regarding communication, and will be enlightened in the next chapter.

4.2. Observed problems in practitioner-client communication in an intercultural context

Literature on intercultural health care deals with problems in communication as a consequence of the intercultural encounter. It also reflects on the awareness of the power of culture comprising the aspects of intercultural communication such as the different beliefs, values, attitudes, worldview, and verbal and nonverbal messages that affect both practitioner's and client's behavior (Templeton-Brownlee, 1978; Kleinman, 1980; Bochner, 1983; Sharf, 1984; Stein, 1990; Kreps and Thornton, 1992; Geist, 1994; Witte and Morrison, 1995).

> *"What is clear in just about every examination of health and culture is that 'miscommunication, noncompliance, different concepts of the nature of illness and what to do about it, and above all different values and preferences of patients and their physicians limit the potential benefits of both technology and caring"* (Payer, 1989:10).

Witte and Morrison describe 11 distinct but interrelated categories where miscommunication can occur regarding health-related messages due to differences in definitions of verbal and nonverbal messages: ethnomedical systems, mind-body connection, role of religion, individualism-collectivism, role of the family, gender, communication patterns, practitioner-patient relationship expectations, etiology/treatment relation, medical pluralism, and within-group diversity (1995:221-130). They also introduce 2 cultural specific variables influencing health-related behaviors being fatalism and family values. Two key issues that need to be considered by intercultural health communication experts, they suggest, are to develop mutual understanding and to motivate adherence to health-related messages (p. 245-246).

In her book 'Medicine and Culture' Payer compares four western countries, e.g. Germany, England, France and the United States with similar mortality statistics (cited by Kreps and Thornton, 1992:165-167). She discovered that all four countries with internationlly respected health systems have quite different cultural views and treatments of different **illnesses** (being a state or length of time of being unwell, which may be caused by a disease) and **diseases** (meaning that they can be caught and passed on if infectious; also subject of medical studies). The health care of each country was found to be based on national character and cultural norms. In Germany, a country claimed to stress the heart, an authoritarian romantic model is said to predominate with an emphasis on blood pressure and the circulatory system. England's health care is said to be focused on the stomach and the bowels whereas the French are supposed to pay major attention on the stomach and the liver. Aggressive models based on viruses and germs should predominate the United States. Another interesting topic discusses the different

treatments given for the same illness or disease in each of these 4 countries. Generally, treatment and diagnosis are said to result from the view these particular cultures have of the body and its functioning. In France, a culture that emphasizes beautiful, intact bodies, few hysterectomies and caesareans are reported to be undertaken by surgeons. However, the United States are claimed to be the leaders in these kinds of operations. An important conclusion can be drawn from this research:

> *"Choice of diagnosis and treatment is not necessarily scientific but based largely on cultural concerns. Health care providers and their clients need to be aware of the power of culture when they make health care decisions. They also need to reflect on the differing beliefs, values, attitudes, and world views that affect both their behavior and the behavior of the client"* (Kreps and Thornton, 1992:167).

Biases in intercultural communication, according to Kreps and Thornton, are explained as dissemination through socialization (1992:170). It is exactly socialization that is conveyed through the earlier mentioned barriers, e.g. stereotyping and ethnocentrism (K.&T.:171). Through stereotyping and ethnocentrism the intercultural practitioner-client relationship will suffer from ineffective communication and lack of gaining confidence. The concept of 'pain' for instance, is very subject to these barriers discussed. In a southern German hospital where I worked, some health care workers tended to say that patients coming from countries further south from Germany, having undergone the same surgery as the German patients, could not cope as well with pain in the way the German patients could. They stereotyped these 'foreign' patients as being oversensitive to pain. They judged them according their perceptions of 'how much pain one is allowed to feel', and additionaly they tried to force their perspectives of pain upon these patients. This was done by refusing to immediately supply painkillers to the suffering patients. Purely based on their perception of the patients' lower threshold of pain, they also 'jokingly' diagnosed them with a new disease called 'das Syndrom Méditérannée'.

Also Tannen (1986: 41) deals with this topic and writes how medical doctors can have a difficult task determining the extend of pain felt by clients of different cultures: *"Patients of Mediterranean background may show extreme reactions while experiencing far less pain than is being felt by an American Indian who is rigid and silent."*

In an Australian case study, Pauwels (1994) takes up the issue of applying linguistics into intercultural communication to training programs for professionals working in culturally diverse contexts. The study examined the views of a range of health professionals on language and communication issues in intercultural encounters. Health professionals' experiences with communication issues and difficulties in intercultural encounters provided significant clues for gaining an understanding of their views on language and communicaton problems in these intercultural encounters. Some of the most important findings were that health professionals had received little or no formal knowledge of language and communication by means of literature, courses or seminars. They had only linked communication difficulties in intercultural encounters, if these occured, as a result of the absence of a shared language or if they were linked to the 'non-English speaking background' of the clients' incomplete knowledge of, or incorrect

use of English phonology. Health professionals saw the absence of a shared language between them and the clients as a major cause of communication difficulties or even of breakdown in intercultural encounters due to language. It was also claimed that the health professionals showed a limited understanding of the relationship between language, communication and culture. The impact of cultural differences on the use of language in intercultural settings, so Pauwels, was recognized in relation to metaphorical expressions of health and illness -taboos- (1994:201-203). According these findings Pauwels concluded that linguistic input into cross-cultural communication training programs should build upon the trainees' knowledge and understanding of the role of language in cross-cultural settings -which she did and which was still in progress at the time (1994:207).

In their cross-cultural study of patient participation Young and Klingle (1996) attempt to assess the effects of patient participation on patient commitment to medical decisions and patient satisfaction. They also examine cultural barriers related to patient participation. It was predicted that cultural norms influence patients' assertiveness and their self-and response-efficacy regarding patient participation that, in turn, influences patient participation. The investigation supported the claim that patient participation increases patient commitment to medical decisions and patient satisfaction. It was also said that patient participation is higher for the 'Mainland American' patients than 'Asian American' patients. Cultural background was shown to be related to perceptions of participation. The study confirmed the claim that Asian patients are less assertive and participate less than Mainlanders. It was said, however, that although Asian-American patients may hold beliefs that they could participate, they may find it more culturally desirable to avoid conflict and negative interactions with their physician by communicating less assertively than Mainland Americans. However, assertiveness was not related to patient participation (1996:29-53).

In a research conducted on problems in health communication in a South-African multiclinical setting Herselman (1996) presupposes that because of their different perceptions and frames of reference regarding health care, it is unlikely that doctor and patient communicate with total accuracy. His research findings reveal the following problems in communication between doctor and patient: (1) the doctor's lack of knowledge and understanding of the patients' health beliefs and behavior, (2) the defensiveness, strange, and apparently unintelligible techniques that patients use to provide information, (3) unshared meanings between doctor and patient, (4) conflicting emotions, dissatisfaction, submissiveness and acquiescence among patients and unacceptable behavior, e.g. patients witholding information, nonadherence to treatment. Herselman does not offer ready solutions. He invites, however, the persons being involved in multicultural clinical settings to regard them as challenges to increase communication efficiency. He suggests that both doctor and patient have a role to play. Doctors should acquire greater awareness of patients' shortcomings, abilities, expectations, and perceptions whereas patients should be more actively participating in a situation that holds a key to their well-being (1996:153-170).

A study conducted in Finland in 1996 examined the dental health behavior and the use and need of dental services by foreign students studying in Finnish institutes of higher education, and the ability of dental care personnel to take care of patients coming from different cultures (Saarni, 1996). Relevant for this particular study were among others the following findings: It was shown that integration into Finnish academic society was associated with foreign students' oral health habits, use of dental services and perceived health. Independent factors were associated with perceived good health were young age, getting help from neighbours when needed, not feeling onself lonely in Finland and being satisfied with one's study achievements in Finland. Getting help from neighbours was associated with dental visits and knowledge about oral diseases. Loneliness was found to be linked with dental visits, frequency of dental check-ups and frequency of using sweet drinks. The use of health services was associated with the ability to speak Finnish and with having a Finnish spouse. Factors associated with a change in tooth cleaning habits after arriving in Finland were the ability to speak Finnish, having a Finnish spouse and having a Finnish parent. Concerning the interaction with the dental personnel, it was common to have language difficulties when treating foreign patients: most often they had language difficulties with students coming from Africa, Asia and East.Europe. Of the personnel 60% had had other problems too. For instance, they considered it difficult to motivate students to have prophylactic and periodentic treatment. To facilitate the treatment of foreign patients, the dental personnel had suggested courses for personnel, information for the students, and more information material in foreign languages and longer appointments. The findings from this study suggest the importance of intercultural adaptation in a new cultural surrounding as well as the communication topic between clients and health care workers coming from different cultural backgrounds.

Having dealt with the theory and with recent studies on intercultural communication and on practitioner-client communication in an intracultural and intercultural setting, I shall examine next how intercultural communication comes to light in the encounters between Finnish practitioners and non-Finnish clients.

5. Carrying out the research

This qualitative study is based on a multiple case study as a research strategy. The data collecting method used are semi-structured face-to-face interviews.

5.1. Research questions

In this thesis I will look at how 10 foreign clients deal with the intercultural interaction with Finnish medical practitioners. In order to find that out I addressed the following research questions:

1a. What are the clients' most striking or salient experiences and/or observations from the intercultural medical encounter?

1b. How do the clients perceive, illustrate, and evaluate these intercultural experiences?

2. To which aspects of intercultural communication do the clients give meaning?

3. Have the clients developed any strategies in order to improve their communication with Finnish medical practitioners?

A clarification of these research questions looks as follows:

By informing about the clients' most striking experiences from the intercultural medical ecounters I intended to obtain general and detailed information about how they approached the intercultural situation, how they handled it, and what were the most common problems.

Question 1b will clarify the clients' 'stories'. As the data collection method is based on interviews with the clients about their experience with the Finnish medical practitioners, I needed to rely on their preception of the situation. By telling their experiences I expected them to recall anecdotes, and that they would be able to give examples about certain observations they might have made. Evaluation of their experiences can be of great importance considering implications for further research and for improving communication between Finnish medical practitioners and non-Finnish clients.

When addressing question 2, I want to find out in how far the clients have been aware of the situation as being intercultural. I am interested in finding out whether their perceived situations, difficulties, or misunderstandings correspond with any aspects of intercultural communication.

With question 3 I intend to explore the range of strategies (if any) the clients might have adopted in order to be understood and to obtain a satisfying communication situation. With strategies I mean the different tactics they might have used with regard to preparations or adjustments to be equiped with to face the intercultural medical interaction.

5.2. Data collecting method and context

I used semi-structured face-to-face interviews focusing on the respondents' (=interviewees) perceived recalled communication experiences between the interviewees and the Finnish medical practitioners. The semi-structured quality of the interview allowed freedom for the respondents to elaborate on issues that were significant to them. All the interviews were carried out in English, were tape-recorded and transcribed, both with the respondents' permission. The interview transcripts were verified with the respondents, and they also agreed to the possible quoting of their statements in this thesis.

The interviews were carried out in autumn 1996 by ten persons from nine different countries: Egypt, Iran, Germany, Great-Britain, Belgium, the Netherlands, China, U.S.A. and Russia.

The criteria for selection were twofold: a research like this, dealing with delicate and intimate topics as to conceal reasons for visiting the practitioner, the eventual admitting of perhaps not so succeeded conversations due to a lack of language command, lack of assertivity in a foreign culture, and misunderstandings might present a realistic threshold to and even withdrawal of participation. Considering the reasons above, the first criterium then was the *willingness* of the informants. Once when a certain degree of trust was established between the informants and me, the second criterium: *availability* of the informants had to be agreed upon. Once the persons had confirmed to participate to this study appointments were made. All ten participants who agreed to participate have been interviewed, so that the response rate was 100%.

Being informed about the main issues the interview would cover, all ten persons agreed to be interviewed and tape-recorded. The actual interviewing took place in different surroundings depending on the persons' time and other factors like work, children and transport. Five interviews were conducted in my place. Three persons invited me over to their home. For one client it was more convenient to meet in one of the university library's interviewing rooms, and another person invited me over to his office. During all the ten interviews the interviewee and me sat at a table with the tape-recorder between us. The duration of the interviews varied between thirty-five minutes and ninety minutes. This makes an average of sixty-two and a half minutes. Depending on the interviewees' actual number of experiences, on their need to tell about their experiences, on their assessment of what was meaningful to be told, on their sharpness of observation, and not at least on their level of awareness the duration of the interviews was longer or shorter.

On the whole the interviews worked out fine. By one person, although the time and place were settled well in advance, there seemed to be a kind of a rush as he still had another appointment. Some persons were rather excited and had an urgent need to tell about their experiences. This sometimes lead to very long monologues and seemed at times irrelevant. However, afterwards I realized that these talks were very important as the rapport between the interviewee and me was established in a quicker and stronger

way. This also created a sphere of trust into which I could enter more easily without being too inquisitive. For the interviewee it functioned as a process of realization in which sometimes certain viewpoints changed throughout the interview situation.

There were four women and six men, ranging in age from 21 to 33 years. None of the respondents had Finnish parents or Finnish as mothertongue. The respondents had spent at least 6 months in Finland, maximum 7 years. For 6 of the respondents Finland was the first foreign country they lived in. The 4 other respondents had spent a considerable amount of time abroad before they came to Finland. Reasons for the clients' stay in Finland were: involvement in a relationship with a Finnish person, and/or to study, and/or to work. All of the 10 persons spoke at least one foreign language apart from their native tongue, from which Finnish was one. The clients' level of proficiency in Finnish varied. All the respondents had visited a Finnish medical practitioner during their stay in Finland previous to this study.

5.3. Data analysis

The interviews were content-analyzed (Krippendorf, 1980; Hirsjärvi & Hurme, 1982). I will first describe my proceedings according to the content-analysis, and then I will provide an example to clarify.

- I transcribed the audio-taped semi-structured face-to-face interviews so that I could focus directly on the respondents' statements.

- In order to identify and to reorder the data I attached codes to them, i.e. I coded the data into 22 thematic units. According to Krippendorf (1980:62-63) thematic units are identified by their correspondence to a particular structural definition of the content of narratives, explanations, or interpretations. They are distinguished from each other on conceptual grounds and are contrasted with the remaining portion of irrelevant material by their possessin the desired structural properties. In this particular study the thematic units were partly based on occurring themes in the interviews (transcripts), and they partly reflected directly the interview questions asked. This coding at a very general level is a first step toward organizing the data into meaningful categories. The role of coding in such a conceptualization is to undertake three kinds of operations: a) noticing relevant phenomena, b) collecting examples of those phenomena, and c) analyzing those phenomena in order to find commonalities, differences, pattern, and structures, and has also been explained as 'a way of identifying and reordering the data, allowing the data to be thought about in new and in different ways (Coffey, 1996:34).

These thematic units allowed me to characterize what each stretch of the interview was about in terms of general thematic content, relating to the topics of the interview elicitations and responses. I identified the following thematic units:

1. Clients' perceptions of having received a wrong treatment, or of practitioners having made mistakes.

2. Clients' perceptions of the way how the practitioner broke the news, the nature of their sickness.

3. Use of language between client and practitioner, e.g. which language was spoken, translations, misunderstandings.

4. Aspects of the interaction perceived as strange.

5. Aspects of the interaction perceived as not so good.

6. Aspects of the interaction perceived as good or very good.

7. Perception of clients' communication with a medical practitioner in their own culture.

8. What did the clients do to be made understood.

9. Practitioner's use of difficult medical vocabulary.

10. Practitioner's speech style.

11. Clients interrupting the practitioner and vice versa.

12. Disturbances by telephone calls, personnel coming in our out.

13. Pauses in practitioner's talk.

14. Clients' expectations when visiting the practitioner.

15. Misunderstanding due to communication.

16. Expectations about practitioner's educational background.

17. Hierarchy between clients and practitioners in Finland vs. in home-country.

18. Seating position of client and practitioner.

19. Practitioner's dress code; olfaction; artefacts and presence of medical instruments.

20. Proxemics, eyecontact and haptics in communication between client and practitioner.

21. Facial expression, body posture and paralanguage in communication between client and practitioner.

22. Assumptions and experiences of Finnish health care; general satisfaction with practitioner.

- From these 22 thematic units I identified 5 different categories, also called 'response themes'. These categories are useful to deal with text segments from the transcripts. Once the categories have been established they are applied to the remainder of the data; this leads to refinement and to the discovery of new commonalities or patterns, i.e. they serve as an ordering system for the data content (Seliger and Shohamy, 1989: 205). The following categories were then used in this study:

1. verbal communication referring to the verbal communication between practitioners and clients concerning the used language, translation, miscommunication and misunderstanding, use of difficult medical vocabulary, practitioner's speech style, interruptions (thematic units 2-3-7-8-9-10-11-15)

2. nonverbal communication referring to the nonverbal communication between practitioners and clients concerning seating position, dress code, smell, presence of medical instruments, proxemics, eyecontact, haptics, kinesics, paralanguage, pauses (thematic units 13-18-19-20-21)

3. expectations referring to clients' expectations when visiting the practitioner concerning communication, practitioner's educational background (thematic units 14-16)

4. strategies what did the clients do to be made understood, to make the communication effective, did they prepare beforehand, did they use a dictionairy etc. (thematic unit 8)

5. assumptions referring to clients' assumptions of the Finnish health care, as well as to clients' positive and negative experiences (thematic units 1-4-5-6-12-17-22)

The following interview extracts from respectively the British, the Dutch and the Iranian client show how I came to the thematic unit: 'use of language between client and practitioner, e.g. which language was spoken, translations, misunderstandings'

- *"they try and think of the words very, really clearly and, I think maybe they were concentrating much more on what I was saying, and well, hopefully, they had a bit of more empathy".*

- *"I felt really also guilty that I couldn't make myself clear in Finnish and that I was asking so much things and that there was this miscommunication".*

- *"I just wanted to know about, because I would become, you know, more comfortable if I knew what he is doing, so that would be very important for me, I have to be talked to but he didn't, so that made me not feel somehow so comfortable".*

Another thematic unit: 'clients interrupting the practitioner and vice versa' was coded according to the following extracts from respectively the Chinese, the German and the British client:

- *"usually I don't interrupt people".*

- *"usually it is my style, but I think I adapt, I know quite well how people act and especially when feel that they feel a bit unsure when they for example use a different and foreign language, and so I think I didn't interrupt him because I'm afraid that he doesn't say anything anymore when I do that".*

- *"I'm really not the kind of person that does interrupt people, but I asked them to clarify the words much better and I found out how could I explain, because I was explaining so many times what has happened to doctors and so, in the end I got it just right, and so nicely, concise short, straight to the point and there is no misunderstanding".*

The category or response theme I identified from these 2 thematic units was 'verbal communication' (8 thematic units were coded that fell into this category). In this way I coded the 22 thematic units and identified the 5 categories.

It should be mentioned that I am well aware of the problems involved when studying 10 persons from 9 different countries, i.e. the very varying circumstances like the different practitioners the clients visited, and the different reasons why they went to the practitioner. Therefore, I do not intend to make any generalizations, and I want to use 'multiple case study' as a research strategy.

5.4. Multiple case study as a research strategy

A case study approach is not a method as such but rather a research strategy within a number of methods may be used - and these may be either qualitative, quantitative or both - (Hartley, 1994). Whereas a single case study can provide valuable information about the research question(s), the research might be strengthened by the addition of a second case or more. However, it is generally agreed upon that managing more than 12 case studies is not feasible or weakens the method. It is said that the key feature of the case study approach is not method or data but the emphasis on understanding processes as they occur in their context (Hartley,1994). Therefore, case studies are idealy suited for exploration of issues in depth.

After the data have been collected and analysis is being undertaken one needs to report the case studies in an insightful way, about the case itself but also more generally about behavior and processes. Generalizations from case studies are said to be weak in their capacity. Hartley (1994) takes up this problem and tackles it in two ways. First of all he questions what is really meant when talking about 'generalizing from data'. He makes a distinction between the quantitative and the qualitative research approach.

In the quantitative research approach generalization is said to be achieved through the ability to sample cases (respondents) which are typical in specified ways of the population; *"if the sample is correctly drawn, then the results are deemed to be applicable (generalizable) to the specified population"* (p. 225).

Considering qualitative research it is the detailed examination of processes, resulting in detailed knowledge about the processes underlying the behavior and its context which can help to specify the conditions under which the behavior can be expected to occur. Thus the basis of the generalization, according to Hartley, is about the existence of particular processes, which may influence behaviors and actions in persons, assuming the context in which those processes occur is taken into consideration. Yin (1981) argues that case studies as analytic units should be considered on a par with whole experiments, i.e. there are repeated observations within a particular environment. This approach is said to gain particular value in the context of research which includes multiple cases, as undertaking more than one case study clearly increases confidence in the findings.
In the field of educational research Bassey takes the view that:

> *"an important criterion for judging the merit of a case study is the extent to which the details are sufficient and appropriate for a teacher working in a similar situation to relate his decision making to that described in the case study. The relatability [sic] of a case study is more important than its generalisability"* (Bassey, 1981:85).

5.5. Qualitative research evaluation criteria

Although qualitative research is an often used methodological procedure it seems one still has to take a stand and justify its use. Qualitative research has a long and distinguished history in the human disciplines. It is said to be a field of inquiry and it crosscuts disciplines, fields, and subject matter. In qualitative research the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry are stressed. Resistances from the quantitative research front though, tend to consider qualitative research as a) an assault on their tradition, whose adherents often retreat into a 'value-free objectivist science', b) unscientific, c) only explanatory, d) entirely personal, and e) full of bias (Denzin and Lincoln, 1994: 1-4). As a consequence the qualitative research methods' reliability and validity have been questioned.

However, as the traditional concepts of reliability and validy are purely statistically based, they can not be accepted as meaningful or implemented to be used in this study. Some methodologists even mentioned reliability and validity in qualitative research being irrelevant (Tynjälä, 1991: 388). Nevertheless, one can not conduct research of any kind without contemplating the relationship of qualitative research with the questions of credibility. Researchers then have highlighted that qualitative and quantitative methods can not be commensurable as they are based on different background conditions and objectives. Therefore, Tynjälä (1991) described qualitative research evaluation criteria, originally presented by Lincoln and Guba in 1985, which correspond with the following evaluation criteria used in quantitative research: internal validity, generalization,

reliability and objectivity. These corresponding qualitative evaluation criteria are as follows:

1. Credibility: this means that the researcher must be able to show that the produced reconstructions of the realities that one has studied and analyzed, do correspond with the original constructions.

2. Transferability: the results of a study can be transferred to another context. In how far this is possible depends on how similar the research environment and the environment of application are. Also Patton (1990), according to Tynjälä 1991, has been elaborating on the test environmental questions. He introduced the concept of 'extrapolarisation' which evaluates the research and its results as they are likely to be applicable in similar situtations but in unidentical cirmcumstances.

3. Dependability: refers to the 'multiple realities', meaning that the researcher should notice the external changes as well as the phenomena resulting from/during the research itself. For instance, how interviewees during an interview may go through a process in which their views on a certain topic may differ.

4. Confirmability: as in qualitative research the relationship between the researcher and his/her research is of a different kind than in quantitative research - a subjective point of view is unavoidable - confirmability then is a criterion that characterizes a solid, valid qualitative research. In other words when applying different methods of analyzis on the same data corresponding results should emerge.

In the next chapter the findings will be reported. The case studies personalize some of the complexities of the practitioner-client relationship in an intercultural context. They provide a vehicle for personal reflection; gaining insight and understanding which might be unattainable from another research strategy. All the non-Finnish clients involved in these case studies provide powerful accounts of their experiences, challenges, and accomplishments of their intercations with Finnish medical practitioners.

I want to emphasize again that this study has been conducted from the non-Finnish clients' perpective.

6. Findings

The medical instances the respondents visited varied from visiting general practitioners, specialized practitioners i.e., neurosurgeon, neurologist and gynaecologist, dentists, ophtalmologists, the nurse, the fysiotherapist and the maternity emergency room.

The reasons for visiting ranged from emergency situations like road accidents resulting in brain surgery, and twisting of knee and ankle; regular gynaecological examinations including Papa-smear tests and pregnancy examination; gynaecological operation i.e., lasertreatment for cancer of the uterus; dental check ups and toothextractions; eye tests to obtain a driving licence; check up and follow-up visits after operations, adjusting medications as well as to adjust fysiotherapeutic mobility; hereditary examinations; to complaints of skinproblems, lack of sunshine, tiredness, and problems with concentrating.

As mentioned before in chapter 1 and 5, this study will concentrate on the clients' perpective on their intercultural interaction with the Finnish practitioners.

In order to provide a valid representation of the essential features of the data I made use of one of the types of descriptive statistics, i.e. *frequencies*. These are used to indicate how often a certain phenomenon occurs and they are based on counting the numbers of occurrences. Through an examination of the frequencies I could see how common or how frequent certain occurrences were among the different clients. In this particular study the frequencies provided me with meaningful information on the measures used in the research even before certain patterns or comparisons were made, as well as initial insights, impressions, and understanding of the data. The frequencies in this study will be reported through tables and serve, in addition to the above mentioned reasons, the summarizing function of analysis. The analysis has been carried out by counting the absolute frequencies, such as the number of occurrences found in the sample. Presenting the frequencies as percentages would be unrelevant as the sample is small.

A summary of the findings is presented in Table 2. For each of the clients, the five response categories are ranked based on frequency. The last column presents the total of each category by all ten non-Finnish clients. The frequencies were calculated for each category and for each person. When a client's description made reference to items relative to more than one category, each was coded, counted an reported in Table 2, and will also be reported in every category it refers to. However, repetitious this may seem, it is only righteous as not every single thematic unit is only referrable to one category, e.g. positive assumptions most often correlate with positive verbal communication experiences, and therefore need to be reported in both categories.

As can be seen, the category of nonverbal communication ranked first implying that the clients' most observations were made in this category. The category of strategies ranked fifth and last. Considering the clients, as shown in Table 2 the client from the USA and the Iranian client provided the most descriptions of their perceived observations (both 83), followed by the clients from Belgium, Great-Britain, then by the Dutch and

the other American client (both scoring 71), and succeeded by the clients from Egypt, Germany, China and Russia, the latter with 46 descriptions.

Table 2. Frequency table of categories associated with non-Finnish clients' responses on their experiences with Finnish medical practitioners.

Category	Belgium	Netherlands	Germany	Great - Britain	Egypt	Iran	China	Russia	USA	USA	Total
nonverb. comm.	23	19	21	16	31	21	20	20	18	30	**219**
assumptions	23	20	10	20	17	25	20	10	22	19	**192**
verbal comm.	15	20	15	25	7	28	11	8	19	21	**169**
expectations	9	6	6	7	6	7	4	5	6	4	**60**
strategies	4	6	3	4	3	2	1	3	6	9	**41**
Total	**74**	**71**	**61**	**72**	**64**	**83**	**56**	**46**	**71**	**83**	**681**

6.1. Nonverbal Communication (NVC)

By all 10 the ten clients (and in total) the category of nonverbal communication ranked first. Table 3 shows the frequency of nonverbal clues reported by the non-Finnish clients.

Table 3. Frequency of nonverbal clues reported by the non-Finnish clients

	G-B	Bel	Germ	Neth	Egyp	Iran	Chin	Russ	USA	USA	**Total**
NVC	16	23	21	19	31	21	20	20	18	30	**219**

The observations made in the category of nonverbal communication will be reported per thematic unit, belonging to this category.

Pauses in practitioner's talk

The duration of pauses in speech, i.e. silence, as an aspect of nonverbal behavior has been taken up in this study as it might be a relevant occurring phenomenon among Finnish people, to which non-Finnish people might react upon. It is said that attitiudes towards the circumstances under which it is appropriate to speak or to remain silent, appear to vary between English and Finnish according to situational expects and demands. Moreover, it has been suggested that a Finnish person has a high degree of respect for the individuality of others and pays attention to 'grasping his /her own in spoken interaction'. This might make a Finnish person appear reluctant to speak or to use overt nonverbal signalling, in situations in which there is significant social distance between participants (Marsh, 1993: 119).

Pauses in the practitioner's talk were observed by all clients but did not have any implications for the conversation. The clients reported having observed pauses:

- and that they lasted *"a few seconds maybe, no longer"* (Belgium)

- when the practitioner was searching for words (Great-Britain, USA)

- when the practitioner was looking at what he wrote; *"I think he was thinking, probably just vocabulary or whatever"* (Germany)

- when the practitioner was writing (Iran, Egypt)

- and were just normal (China)

- on both parts -practitioner's and client's- *"because what we're talking about is so like, usually so precise, that I think we both pause to, like really formulate what we're trying to say, and I would say probably sometimes on their part they're pausing because they're kind of thinking what they're gonna say in English, on my part I'm pausing because I often when I'm talking about something important I have some little pauses, just again because I think that short time is so valuable I don't like to spend a lot of time on blather, I want to communicate very precisely and so I would say probably there are a lot of pauses"* (USA).

Seating position of client and practitioner

The following drawing was presented to the clients and they were asked to show their and the practitioner's seating position during their visit

Apart from the Chinese and the American client (who reported AC) and the German client (who reported AD) all clients reported sitting in position AB. Additionally some clients mentioned that they also experienced sitting in other positions. See Table 4.

Table 4. Seating position of non-Finnish clients and Finnish practitioners in Finland and in home-country reported by the non-Finnish clients

	in Finland	in Finland	in Finland	in home-country	in home-country
GREAT-B	AB	AC	AD	AD	
BELGIUM	AB	AC		AB	
GERM	AD			AB	
NETHERL	AB	AC		AC	AD
EGYPT	AB	AD		AB	
IRAN	AB			AB	VARIES
CHINA	AC			VARIES	
RUSSIA	AB			AC	VARIES
USA	AC			AB	
USA	AB			AB	VARIES

The seating position of client and practitioner has been different for most clients (8 of 10) from the seating position they were accustomed to in their home-country. Some clients for whom the seating position was the same at home as in Finland, did not give any particular meaning to it. Other clients reported on the difference and stated the seating postion of practitioner and client to be influential in the communication event. Examples of the clients' experienced seating situation were:

- The seating position influences the relationship with the doctor. In the Netherlands it would be AC or AD, *"It is more together, not like putting me down, it gives more possibilities to be like two human beings"* (Netherlands)

- *"I think in Belgium there would not be this possibility of AC, I think there is only a chair opposite ... typical Belgian when this man sits at the middle of his desk"* (Belgium)

- The Egyptian client did not think the seating position of practitioners and clients being influential on their relationship, nor in Finland nor in his home-country; *"it's all the same, AB, because usually you have to"* (Egypt).

- In China as well as in Finland, the client reported, the seating postion varies a lot; *"It's o.k. to me, because in China also we have the same location, sometimes here, sometimes there, it depends on how they put the desks in the room"* (China).

- The Russian client experienced the AB position in Finland whereas in Russia he reported it to be AC and other variants. He said the AB position to be more 'strong' for the patient who is sitting then behind the desk, in front of the practitioner; *"It's more intensive, it's more better for the patient and for the doctor, because he can see you and if he's quite a good doctor so, we can change our energy ... there are more channels for verbalization".*

- AB was seen more as a seating position to be found at a private doctor (Iran)

- An American client reported the AB seating position as 'classic' and 'influential' in the conversation, and he saw it as his task to remove this position; *"It always influences my conversation ... if the person doesn't know anything about this kind of thing, if they're not comfortable enough to get out of that, I view it as my task then to rise to the level of that and make sure that we're equal people on side of this equal side of this table and that I'm not going to accept, that I'm not going sit there and wait for pronouncements and so "*(USA).

- The former client also said to regard this seating postion as a problem of automatic deference with which he reported to have a problem with, and which he found to be from a cultural as well as a personal origin; *"I have just that kind of attitude that I don't automatically give to almost anybody some kind of respect as a status, it is for me they have to earn it, then they get it ... there's a lot of people who automatically defer and there's a lot of people who don't think it's normal to do either, but here I think -in Finland- that it's not normal to do like question the authority"* (USA.)

Practitioner's dress code

It was remarkable that all the ten clients spontaneously reported on the practitioners' dress code, i.e. a white coat, which often was reported to have a functional meaning.

All the ten clients reported the practitioners having worn a white coat. This was considered 'very tidy' (GB, Belg.), and was interpreted as 'modern doctors' (GB). The Egyptian client said: *"The doctor was dressed in white and so it should be, so that they look like angels, because they help and try to do their best for you".* A functional meaning of wearing the white coat was reported by the Iranian client as 'recognizable' and he also would like the doctors to have their name and title mentioned on tags pinned on the white coat. An American client experienced the Finnish medical practitioners wearing fancy clothes underneath their lab coat: a tie and a nice shirt. Another American client thought the white coat 'sticking out so much' here and found it more symbolic and also very practical as he too noticed the practitioners wearing some nice clothes underneath.

Olfaction

Olfaction did not proove to be a salient aspect for the clients' perception of nonverbal behavior. Seven clients said not having smelled anything special. The Egyptian client reported smelling 'medicals', one American client said to have smelt 'chlorine', and another American client mentioned the constant universal hospital smell, *"Hospitals all smell the same to me, you can immediately, if you put me blindfolded, I can tell you I'm in a hospital"*.

Artefacts, presence of medical instruments in practitioner's room

Clients' perceptions of artefacts in the practitioner's room were limited to the observations such like 'quite steril', 'lot of medical instruments', and 'very functional'.

The two clients who reported not to have noticed any particular presence of medical instruments, reacted on the interior of the doctor's room: *"It looked quite steril, not so specially nice, it might have been lot nicer, I think there was not any plant or anything, not any window, not the most fantastic room in the building ..."* (Belgium), and the Chinese client commented on the 'lots of books' in the doctor's room.

The German, the Russian and an American client observed a lot of medical instruments which did not make them afraid but they could imagine them being scary for other people. The presence of medical instruments made the Dutch client curious, whereas the Egyptian, an American and the Iranian client reported having been scared noticing them.

The doctor's room, according to the German client, was found very functional and reminded her of a hospital. Also one American client reported the doctor's offices as being very functional, and *"anything they need to do the job is there"*.

Proxemics between clients and practitioners

Proxemics between practitioner and clients were perceived as much larger here in Finland than in their home-country by the two American clients, by the Egyptian and by the British client. The distance between practitioner and client was seen here rather as functional. At the other hand for the Russian, Chinese and the Iranian client the distance experienced between practitioner and client was said to be just 'normal'. The following examples are the clients' recounted experiences involving their perception of distance in the interaction with their practitioner:

- The British client reported the distance between him and the practitioner to be larger than it would be with his doctor in Great-Britain; *"They just come closer then when they have to check, back tot the desk and stay there, I suppose there was more of a distance"*.

- When visiting the practitioner, the Belgian client experienced the practitioner coming rather close to come and look at the baby in the pram. The fact that the practitioner was perceived as a sort of person who is sure what he's doing, made the client think that practitioner and client came closer.

- The distance, the German client mentioned, was said to be mainly determined by the position of the chairs.

- The Egyptian client reported the distance to be much shorter in Egypt, i.e. *"the doctor is more near because he is talking with you much more, knows your family ... when you go and visit the doctor you become friends".*

- The Russian, Chinese and the Iranian client experienced the distance between the Finnish practitioner and them to be 'normal, acceptable'.

- In the USA the distance is said to be larger than in Finland, the two American clients reported; one American client reported that the distance between him and the Finnish doctors is perceived as: *"doctors always seem to be very careful, very clinical, and if they ever are in a personal or intimate zone, it's like because they're checking, it's very functional, otherwise they're in a very arm's length."*

- The other American client experienced the doctor as not very compassionate nor emotionally involved considering the seriousness of the client's illness: *"In fact my doctor barely even bonded with me, meaning like to get any closer to me".*

Haptics between clients and practitioners

Nine of the ten the clients reported that there was touching apart from the technical/functional one and when shaking hands. Examples of these observations were:

- An American client remembered that right before the surgery took place, the anaesthesist touched her in order to comfort her and calm her down: *"I remember though that the person who was putting me under, for the operation, she said: 'Okay', and started rubbing my hand, like in America the way it goes, I think, and she goes: 'I'll put a little needle in your hand, right, and don't worry, when you start counting ...".*

- The Egyptian client stated: *"The doctor he is a Finn, so he is like the Finns ... that means he doesn't touch you, he just checks you, inside, it's finished".*

- The Chinese client had a not very serious skin disease at the hands and had expected the Finnish doctor to touch and to look very carefully at the problematic place, which actually did not happen. She reported: *"I feel that Finnish doctors and nurses seem they don't want to touch you, I feel this very clear".*

- An interesting issue was mentioned by the Russian client who said that good doctors

would not touch so much. He gave a Russian idiom which accentuates the importance of communication between client and practitioner. It says that a good doctor should be able to make the client feel better just by talking.

Practitioner's facial expression

The clients' reports on the practitioner's facial expression varied a lot and depended from practitioner to practitioner. Most of the clients' described experiences dealt though with a specific interaction with one specific practitioner. The clients' observations were exemplified by the following statements:

- The British client said the doctors showed affection, *"they lived with you, friendliness, relaxedness in their face"*. At the other hand he reported: *"Not in one case they laughed, it was very matter of fact"*.

- When speaking with the doctor the Belgian client experienced relaxedness in the doctor's face: *"relaxed, definitely, and I think this sort of person that can give trust, I think he often smiled, yes he did"*.

- When visiting the general practitioner the German client mentioned his seriousness: *"I don't know if I managed to make him grin or something, because I was for sure smiling all the time because I found myself so stupid, but he was serious, serious but not unfriendly or something"*.

- The Dutch client called the practitioner's facial expression 'very blank' and reported having had the feeling he didn't take her serious, she said she thought he was even a little bit smiling at her: *"I see then in their facial expression like:'oh what is this girl telling me' ... Yes, I think they don't take me serious and they show by their facial expression"*.

- The outlook of the doctors and other people was said to be very important, the Egyptian client mentioned. He also stated the dentist was friendly, *"but as a Finn, that means he just talks and then it's finished"*.

- The Iranian client said he found the dentist was okay to his colleagues but not to him as a client, and felt the dentist's face was not meant for him but for his colleagues; *"he was all the time, you know, he was this kind of, social kind of looking guy, socializing a lot, but not to me of course because I think he just wanted to finish the job"*.

- The practitioner's facial expression was reported by the Chinese client as *"not very nervous but maybe a little"*.

- The Russian client experienced the practitioner's facial expression as *"normal, usual, nothing special"*.

- To one American client the dentist's face seemed to be a little bit too relaxed and it bothered her that he had his personal conversations with his colleagues.

- The other American client described the practitioners' face as very like neutral and careful and explained this as follows: *"I would guess it's because they have a lot of practice with covering up their emotions, it's the same as talking to anybody who has the profession where you have to keep your personal feelings quite apart from you professional side".* He also reported he experienced that the positive emotions by Finnish practitioners come through sometimes like a sense of humour.

Eyecontact between clients and practitioners

All the clients reported having had eyecontact with their practitioners. Examples of responses included:

- It was observed that the practitioners often were writing something, looking at their notes, charts and figures, during which no eyecontact was established (Belgium, Germany, Netherlands, USA, USA).

- The Chinese client experienced the eyecontact with the Finnish practitioner as normal. With the nurse she remembered: *"When she talked with me and she looked at my eyes, not very strictly but just the normal way, I didn't feel that she ignored me or something, just the normal".*

- The German client said there was not too much eyecontact between her and the practitioner, she had the impression he'd rather looked at his notes but she reported also that *"he was somehow a bit shy or unsure because of this English speaking, so it would match that he really didn't look at me, there are a lot of people in Finland, I experienced, that they don't really look at you while they don't know you".*

Practitioner's body posture

According to all the clients, the practitioner's body posture was said to be generally straight in a seating position, apart from the dentists who were standing.

Practitioner's paralanguage

The practitioner's paralanguage was generally perceived as rather monotonous. The clients reported observations of the practitioner's paralanguage included the following recollections:

- The British client thought the doctor's voice not to be compassionate enough, and also thought he spoke too fast.

- The doctor's voice was experienced as interesting, and it was characterized as 'bariton' by the Belgian client. He also reported the dentist having a rather sad voice: *"this sort of voice which suits to a dentist, and it was rather flat I think, yes, like monotonous".*

- The German client reported the practitioner's voice being deep with a very strong

Finnish accent, being nor lively nor monotonous.

- According to the Dutch client the practitioner's voice was serious, very slow and *"just like in one tone, rather monotonous"*.

- The Egyptian client experienced the practitioner's voice as monotonous.

- To the Iranian client the dentist's voice was said to sound very cold, factual: *"His voice was very cold, just saying what he has to say, he just looked as if he didn't want to speak but he had to"*. The dentist's voice also scared the client during their conversation: *"In the end I understood but it came harsh and sudden, it made me scared"*.

- The Chinese client thought the doctor's voice to be 'normal'.

- It was hard for the Russian client to describe the doctor's voice and he stated that voice depends on the doctor and his character.

- Both American clients perceived the doctor's voice as very plain, very kind of even, very monotonous. One American client described it as: *"like careful delivery, it's almost like they seem so detached, not very moderated"*.

6.2. Assumptions (ASS)

By 8 of the 10 clients (and in total), the category of assumptions ranked second (see table 2). Both clients from the USA had the category of verbal communication as second. The Belgian and the Chinese client both had an equal number of assumptions as from nonverbal communication. Table 5 shows the frequency of assumptions reported by each non-Finnish client.

Table 5. Frequency of assumptions reported by the non-Finnish clients.

	G-B	Bel	Ger	Neth	Egy	Iran	Chin	Russ	USA	USA	**Tot**
ASS	20	23	16	20	17	25	20	10	22	19	**192**

The clients' reported experiences and assumptions of their interactions with Finnish medical practitioners will be described as cases; per client/per country.

British client

Due to an accident the client had undergone brain surgery and had spent a few days at the hospital. He reported on positive experiences such as the very good, first class treatment at the hospital, and on the male nurse who looked after him, who tried to explain him

pictures in a book. He also commented on the helpfulness of the person from the international office, who arranged several things for him, i.e. appointment to a private doctor, transport facilities, reorganization plan for all his courses, and someone who translated the notes so that the British doctors could understand his case.

The client thought it strange to be taken back from the hospital of Kuopio to Jyväskylä in a taxi instead of in an ambulance as it was only a few days after he had undergone brain surgery. Also the, according to the client, non existing after care was perceived as strange: *"it was more the compassionate side, about being kicked out of the hospital after three days, having no home care, no one was coming to see me, that was quite a strange experience".*

Some of the things the client did perceive as not so good was that the doctor had forgotten to put anaesthetic in his chin, in which he did the stitches, *"and that really hurt"*. Another reason for him to feel unsatisfied was the following: *"apparently in the notes they said that they had put somekind of cottonwool bun in my nose during the operation to stop the bleeding, and when I went to the ear-nose-throat doctor he looked into me and said, he just couldn't find the thing in my nose, and it's not been found, so maybe it still is in".* The fact that the medical administrative workers at the hospital could not speak English, according to the client, and the meeting with another doctor who seemed not to know very clear what was going on, were other grounds for his dissatisfaction. In the end he reported wanting to go back to England to get English doctors: *"I'd had enough of Finnish, I suppose, it was quite, nervous an experience".*

The client experienced no real hierarchy between doctors and patients here in Finland, neither in England, he said it to be in both countries:*"pretty equal".*

When reporting on his general assumptions of the Finnish health care, the client again touched the apparent lack of an aftercare system. He stressed that the general service was fine: *"it was really good service, it was a bit, sometimes it was quite stressful with the language but it was generally okay".* Some doctors he claimed to be like *"kind of matter of fact and very, well just the need of not keep you alive but solve the problem, just get you out of this 'let nature take it's course', and there I can see that reflected in the health care system, he's going to the hospital and he's going out, and if you've got bruises, you can't coock, you can't walk, well you'll survive, you won't die or anything".* The interview was ended with the client's sentence: *"I think maybe they thought that I needed a good dose of sisu".*

Belgian client

This client visited the general practitioner in order to clear up a hereditary disease by taking a blood sample. He also visited the dentist. Medical practitioners were said to be very friendly and ready to use their English knowledge in the communication event. The Belgian client experienced the practitioners' friendliness and their wanting to help him as very positive and as respectful: *"I was respected as a person, that nobody was looking down on me or anything like that, and they were friendly as well as the dentist's assistent, and at least I had this feeling that they wanted to try as much as possible to make for me*

clear what was going on". One incident made him confirm again to be respected when during a visit the telephone rang and the medical practitioner asked the client whether he could answer the phone. *"I found it so incredible".* With regard to obtaining clear and right information, the client said the doctor did not always explain everything, but they always came to a certain conclusion: *"Even if I didn't understand this or that ... you know, his conclusions were always clear".*

He thought it to be strange that: *"Finnish as well as Belgian dentists always seem to ask you something while having lots of things in your mouth, and then you are even supposed to answer".*

The client criticized some Finnish dentist's ethnocentrism, i.e. that the Finnish dentistry is the best; *"some Finnish dentists think that there doesn't exist any Belgian dentist ... I think they have it a bit here this, that they have learned this dentists, that the quality of the dental care is so high here, that we come from somewhere rather low".*

He experienced no hierarchy between doctors and patient here in Finland, whereas in Belgium he reported 'this old feeling of hierarchy' still to be existing.

The client's general assumptions of the Finnish health care were the following: he thought the dentists to have very advanced systems here and said to trust the dental care system. He claimed to mistrust the strong trend of symptomatic care with 'tons' of anitibiotica and thought it to be frightening him: *"I will have fear when I have to go for the first time to the doctor here when I have an infection or something, I think I have a low trust to the Finnish health care system because I don't like this symptomatic care".* He explained this as follows: *"I think it goes together with this, so far still I find in Finland there is a bit over fear for allergic things and hygienics, I think in Belgium we are still a bit more like, 'it will come alright', ... I think it is a bit too much like, it goes together with putting helmets on the kids when going to play on the playground".* Not being able to choose your own doctor and the non-existing financial support when wanting to see practitioners of alternative medicine were two other disadvantages the client reported about the Finnish health care system.

German client

Due to a knee injury this client visited the general practitioner. The client's positive and the negative experiences were reported in connection with communication, i.e. language. She said to have perceived the interaction with the medical practitioner as good because she wasn't afraid and because she could somehow be sure that the practitioner would be able to speak English.

Nevertheless communication was perceived as not so good because of: *"actually the communication was not too much"*, and the apparent lack of feedback. Another reason for dissatisfaction was the fact she did not know which doctor she would see and what education or specialization he had. Due to this knee injury she had to visit a general practitioner here whereas in Germany she said she would have gone immediately to a sportsdoctor or to a specialist.

The client claimed not to think too much about hierarchy between practitioners and clients but stressed the importance of a good relationship between her and the practitioner. In spite of that she said she could not relate to the doctor: *"he was very, he was Finnish, stereotypes, but it was not because he's a doctor, no, it was more his personality, was er so ausstrahlt"*.

Considering the general assumptions about Finnish health care she pointed out that the German and the Finnish system were different. She thought the yearly university fee for students to be a good basic providence. The client reported to have an initial trust in the Finnish health care system: *"It's also of course some prejudice or whatever, but okay, we're in Finland, we're in Europe, and it's somehow everything on the same level, and I think Scandinavian countries have the reputation of having good social systems, health care and everything, so there was no fear"*. The fact of not being able to choose your own doctor was said to be a restriction in the Finnish health care system.

Dutch client

The client visited the general practitioner for a gynaecological check up and for back problems. She also had to undergo some minor dental operations.

This client had a strange experience with the Finnish general practitioner as she went for a regular Papa-smear test and she was told it had been done already: *"It was in the files so, I didn't notice it that they had been doing that, but either I do not remember or either they haven't told me ... but that was a very strange thing"*. She also thought it strange that no communication took place when taking X-rays, that the client will not be told anything and in the end one receives a written 'lausunto' from the practitioner.

The outcome of the Finnish dentist's work was perceived as not so good. This was based on the statement of the client's own dentist in the Netherlands. Due to her own dentist's evaluation she reported having no trust anymore in the Finnish dentist. Difficulties with communication were also said to be factors for dissatisfaction. The client perceived her experiences at the health centre 'a little bit confusing', she thought the services to be quite good but found there was too much personnel 'doing nothing' and too few people not willing to help her in English. This lead to frustration: *"I couldn't make myself clear, and the fact that I can't communicate what I want and that they can't tell me what's going on, and where do I have to go and what's the procedure and what kind of cards I have to take with me ... I mean they don't know that it is so difficult to get clear what you, how the system works"*.
When the client had to undergo an X-ray examination she reported having felt like a 'piece of cattle': *"like that people are doing something with you and you're just a body ... I didn't like that, I don't know but I don't like that so much"*.

The client mentioned the interaction with her practitioner to be disturbed once when someone came in to ask something. She reacted to this: *"I thought you shouldn't do that in hospitals when you have a patient"*.

The hierarchy between practitioners and clients in the Netherlands was said to be changing

into a more open atmosphere between the persons involved. The client experienced a 'different relationship' between practitioners and clients here in Finland: *"Finnish doctors are getting scared somehow to hear questions ... they are standing still for a moment or something or like: oh somebody is going to ask something".* She compared this with the Finnish classroom in which she experienced: *"pupils are not asking so much questions, so I thought that maybe also when Finnish people are with the doctor they don't ask what's going on".*

The client also mentioned she always seemed to perceive a lack of information when dealing with medical practitioners in Finland. She tried to explain this as follows: *"There's always some lack of information ... I don't know if it comes because of the language or because of different cultures or because of the hopsital system, maybe also in my own country I wouldn't know everything ... but at least I would like to know what's going on in my body etc. and the language makes it just another barrier ...".*

In general the client thought the Finnish health care system to be very good and cheap. Her dissatisfaction was said to be based on language problems. She mentioned there would be more communication in the Netherlands but then it would be more expensive there. In order to obtain a smoother integration of non-Finnish people into the Finnish health care system, the Dutch client advised there should be more 'well organized information' for foreigners: *"what are the different centres like Kyllönkeskus and YTHS, about the systems of private doctors and the public doctors, what are the different kind of services you can get and how they are related to each other, and what are you supposed to bring with you, and also how things are going if you have an appointment with the doctor and what are you supposed to do".*

Egyptian client

The client, having undergone a toothextraction, reported that the dentist did very well on the job. He also said having perceived everything as much cleaner here in Finland than at home. The general practitioner and the ophtalmologist were also visited by the client in order to get a medical certificate to obtain a driving license.

He experienced the practitioners as not talkative, not treating the patients as their friends but only as customers. It would have been important for him, so he stated, to have a strong relationship with the practitioner.

The client reported the interaction with the practitioner having been interrupted by phonecalls or a nurse coming in, but he said it did not disturb him.

He explained his perception of hierarchy between practitioners and clients in terms of relationships. In Egypt he claimed practitioners to be the client's friend: *"I think that in Egypt even the doctors are more near because they're talking with you much more, they know your family, and even if they don't they'd ask: how is your wife and so on ...you feel more friendly, and sometimes when you go and visit the doctor you become friends, and it's reassuring".* In Finland he noticed not having experienced a real emotional relationship between him and the practitioners.

In general the client thought the Finnish health care system to be of a very high, very good quality. He also mentioned the low costs of treatment in Finland whereas this would be different in Egypt: *"in Egypt each time costs a fortune, much more expensive than here"*. His positive evaluation of some aspects of the Finnish health care was already made up in Egypt where he mentioned it is said that: *"the Finnish nurses are the very best of the world"*.

Iranian client

The client visited the dentist for surgery. He reported the dentist having been technically very good at his job and having given him information in form of a leaflet.

The lack of communication between the dentist and the client has been stated to be the reason for his dissatisfaction. The client stressed how important it would have been for him if the dentist would have talked to him. He reported the following:

- *"well, it went ok, I had to go through it anyway, then he started, and he didn't say a word"*
- *"he didn't say what he was doing"*
- *"he was speaking to the nurse, they were laughing and at the same time doing this simple operation"*
- *"I just felt bad that it was going so harsh ... I'm not that sensitive but that was so sudden"*
- *"next they made a joke and they both laughed and he was carving here, so I was all the time scared that maybe if he cuts my tongue and so"*

Then the client tried to explain how communication might have had an effect on his perception of the whole situation:

- *" it's like he didn't have anything to say that, you know, it calms me down"*
- *"I have to be talked to, but he didn't, so that made me not feel somehow so comfortable"*
- *"That was the worst thing, that he worked, he worked as, he's good, but that he didn't have any idea what I felt ... "*

Another reason for dissatisfaction was said to be the client's perception of the dentist's 'physicalness': *"he just was, he was so physical and I also remember he, he did it once or twice, and then I was angry, I was going to tell him but, he didn't use surgery gloves and then he put his, he washed his hand and then he put it in my mouth, it was so yackie, I could, I can, I tasted his skin"*.

The client commented on this incident by stressing the lack of emotional communication. He also questioned the ethical aspect in medicine: *"I couldn't believe that a doctor acts like that, because I think they have some studies for ethics and how to treat patients"*.

The fact of personnel coming in and out was mentioned by the client but was not perceived as disturbing.

The client reported having noticed a hierarchy between practitioners and clients in Finland as well as in Iran, but he thought it would have been different in Finland *"because it is a modern country and so"*. He said: *"I just think the doctors think they really are some different creatures, that's what I felt, true, ... and that's what I hear from some Finns, doctors are so important big, of course everywhere it's important but, doctors are just being like God"*.

The client's general assumptions of the Finnish health care were based on this negative experience at the dentis's. He said to be satisfied by the technical aspects of the job, but dissatisfied by all the aspects mentioned before.

Chinese client

The client visited a general practitioner because of a skinproblem at the arm. She reported having positive thoughts about the quiet, nice surrounding of the health care centre, the cleanliness inside, the absence of strange smells, and the fact one could make appointments in advance which resulted in relatively short waiting times for the clients. Also the friendliness of the doctors and the nurses has been experienced as good.

The fact that the practitioner has not payed much attention to the problematic zone of the client's arm, was perceived as not so good. She reported this would be different when visiting a Chinese doctor: *"When I showed my skin, this part, he just took a glance and just looked and then it seems there was no reason and no solution, but if I went to China in the hopital for this kind of thing, I think the doctor would exam very carefully ... even if the Chinese doctor could not give me any suggestions, the fact that he or she worked very hard and tried to solve my problem would make me satisfied"*. The client said that due to this experience she felt that the Finnish doctors and nurses do not want to touch clients. She also perceived the doctors and the nurses as not so helpful because she did not receive enough information.

The client mentioned phonecalls and personnel coming in and out but did not experience this as very disturbing.

It was stated that no hierarchy has been perceived between Finnish practitioners and clients. In China it might be different: *"maybe I should say that the hierarchy in China is very very popular, and not very popular, but it is just everywhere ... because we live in a society for a long time we cannot recognize the hierarchy and if you're out of the society and you look back then you can realize it ... if you know the doctor personally there is no hierarchy at all and if you don't know the doctors, there may be some ..."* . To this question of hierarchy the client connected the concept of mutual respect between practitioner and client in China and said that since about 5 years every Chinese hospital has some kind of 'professional morality' which could be compared with the concept of medical ethics in the West.

The client's general assumptions about the Finnish health care correspond with the positive and negative experiences mentioned above: quiet surrounding, cleanliness, and friendliness of doctors and nurses. She also reported on the good equipment of the practitioners which

gave her some kind of confidence. Reasons for dissatisfaction were the unhelpfulness of practitioner and nurse by not being able to give her the required information for her skinproblem. As a result the client stated: *"I think maybe, so what I feel is, if I have no very serious problems I will not go to the doctor, I will try to solve the problems myself first, which is what I feel to be a common feeling among Chinese students here".*

Russian client

The Russian client had visited the ophtalmologist for an eye check up and for glasses to be prescribed. He said he had a quite good impression of his interaction with the doctor: *"everything was o.k., good equipment and good attention from the doctor".*

The client did report nothing about 'strange', 'positive' or 'negative' experiences.

Concerning the hierarchy between practitioners and clients he claimed: *"actually they are a little bit higher than the patients, strong just a little bit, because they're older ... in some sense like a teacher, but not always".* Hierarchy in Russia between practitioners and clients was said to be perceived the same as here in Finland: *"actually the same because the doctor is also someone like a teacher, but they are quite good in communication".*

American client

Due to an internal disease the client had to undergo gynaecological surgery. She visited the gynaecologist and was hospitalized for one day during which she had contact with nurses, her own gynaecologist and the anaesthesist.

The client reported on the nurses' brilliant English language skill which had made a big impression on her. Also the niceness and forwardness of the gynaecologist were perceived as positive. The anaesthesist's behaviour towards her shortly before the surgery was felt as comforting and homy: *"she says: o.k., and started rubbing my hand, like in America the way it goes ... I mean she made that special contact ..."*

Dissatisfaction was reported as the client said she was not always so satisfied with the information she received in a way that some important questions seemed to remain unanswered, and that the pathogens for her disease could not be identified. Other reasons for being dissatisfied were mentioned:

- not being able to choose your own doctor: *"here where you're supposed to bump into whoever you bump into, in the States we always go to the same doctor"*

- no instant service, long waiting times: *"when I hurt my ankle I could not go to the keskussairaala, I had to wait until somebody had looked at it, and in three hours then somebody looked at it, and then 'o.k. you can go', and it was so stupid to waste those many hours there ..."*

- disorganization in general: *"last year again I twisted my ankle and I went to the hospital, then they came up and they asked me: 'was that the left ankle or was that the right ankle*

5 years ago?' ". The client said she did not remember anymore and concluded from the doctor's question that it had not been written down 5 years ago, she experienced this situation as disorganized.

- the lack of communication which resulted in lack of information: *"I felt like at times they were not telling me everything or they did not have enough information on the subject, they were just kind of passing me through like cattle sometimes".* The client also experienced a lack of communication when the doctor seemed to talk only to her husband: *"they mostly directed their attention to K. although I would always sit sit the closest to the doctor, K. would sit towards the back, she* (the doctor) *would mostly talk to K., she didn't want to have to deal with me, sometimes that would p... me off because I would want them to know, I'm here, not there"*

The client reported that during a gynaecological examination the doctor asked her whether a medical student could come in and look through the microscope as something rare and special was to be seen. This was accepted by the client and she said not finding it disturbing but rather comical. Nevertheless the coming in and out of secretaries to drop off papers while the client was being examined, was perceived as disturbing by the client.

A hierarchy between practitioners and clients was said to be noticed but was also explained by the client as follows: *"well, they're flying on a higher plane than I would say we are, but then that is something you have to accept, they work hard and they do know their stuff ..."*

The client's reported general assumptions of the Finnish health care system were connected with her experience with the actual surgery she had undergone, which was claimed to be good, and with communication: *"here, it's like a fish trying to swim upstream, you're constanly trying to get the answers, you're constantly fighting to get into a place for an appointment or you're trying to communicate for whatever you have, so many things are against you, it's like a constant battle, but in the States you know, it's just like going down the river, and it's easy for you, you don't have to worry about language, about the closedness of the doctor, I wouldn't have to worry about making appointments ...".*

American client

The client visited the neurologist for a check-up and to adjust the medication. He also experienced interactions with gynaecologists while accompanying his wife to the prenatal clinic.

In general the client said to have a very good feeling about the Finnish health care. The level of service was perceived by the client as 'quite high' and 'very professional on the whole'. He also thought the practitioners to be usually very effective communicators although he claimed this might be due to his own interest in them being effective communicators: *"I'm trying to take a lot away because I think for me a doctor's time is a very valuable time".*

The client reported dissatisfaction about seeing a different doctor every time when visiting

the prenatal clinic. He said he thought the interaction between practitioner and client could be better: *"they could provide better service ... it was sort of typical doctor mind framed that they already had their mind made up on very many issues, only they were there to tell the patient something".* Another topic for his dissatisfaction were the phonecalls which he reported to be very much disturbing: *"phonecalls, I mean that's generally in Finland, that p... me off more than anything else in the world".* The client stated that in his home-country he would only let it happen once, he would go to a new doctor if it happened twice.

The hierarchy between practitioners and clients in Finland was perceived as 'huge'. The AB seating position of practitioners and clients partly accounted for the client's perceived hierarchy. Also the kind of automatic respect Finnish people tend to have and the fact that they normally do not tend to question the authorities were said to influence this hierarchy.

The client, being satisfied with the Finnish health care in general also reported that it seemed to him that in some areas Finnish health care lags behind medicine in other places, whereas in other areas they are half in front. He added: *"it seems too that a great deal is left to the individual personality of the particular doctor, there are a great deal of extremes here".*

Having a good feeling of the system as a whole he mentioned to be quite nervous being so far away from university hospitals here as it is there that complicated things are treated: *"as long as it is just something normally weird or normally abnormal, then it's quite o.k, but if I think getting hurt in an accident and if something weird is going on we're in the wrong area, so I'm always a little nervous".*

With regard to the aftercare system in Finland, the client reported to be very pleased and praised the amount of possibilities here. He also thought that only few people are aware and take profit of these possibilities of aftercare offered.

6.3. Verbal Communication (VC)

By 3 of the 10 clients, the German, the Egyptian and the Russian (and in total), the category of verbal communication ranked third. In the case of the Belgian, the Dutch, the Chinese and the both American clients it ranked second, whereas by the clients from Iran and Great-Britain it ranked first. Table 6 shows the frequency of verbal clues reported by the non-Finnish clients.

Table 6. Frequency of verbal clues reported by the non-Finnish clients

	G-B	Bel	Ger	Neth	Egy	Iran	Chin	Russ	USA	USA	**Tot.**
VC	25	15	15	20	7	28	11	8	19	21	**169**

The clients' reported experiences dealing with verbal communication in their interactions with Finnish medical practitioners will be described as cases; per client/per country.

British client

The client was brought into hospital by ambulance and had undergone brain surgery. The way the doctor broke the news to him about his situation and what was going to happen, was perceived by the client as 'real business like' and 'just facts': *"She said: 'well, you've fractured your face from here to here, and behind your nose, and as you see from your brain scan, there's blood coming out the front of your brain and so you have to attend in Kuopio hospital to give an operation' ... I never had an operation in my whole life, such a very serious one, so I was really shocked ..."*. The client suggested the doctor could have broken him the news more gently like: *"Well, this has happenend, so therefore this may be happening in your brain, and you'll be taken to, well this town, which is only 2 hours away by ambulance and you'll be seeing this doctor and ..."*. It was also claimed by the client that he might have been so upset because the news was so unexpected and came 'more as a surprise'.

Being in a hospital due to an accident, the client was exposed to a lot of people who tried to communicate with him and vice versa. The client's main contact person was a male nurse who, according to the client, 'highest spoke one word of English'. This did not seem to be an obstacle for an effective interaction to take place: *"He was very nice, he was really a friendly guy, really excellent bloke, very nice, and he took me to the shower every day, he was really helpful, and he didn't really need to speak anything, he was always laughing, I was smiling and saying funny things in Finnish"*. When the client did not understand everything what was being said to him the male nurse helped him by 'trying to explain the pictures in a book'. Apart from the male nurse being very helpful, the client mentioned the other nurses not being able to speak English: *"nurses and hairdressers I find, they don't speak English"*. The client reported having two acqaintences visiting him who then translated everything he wanted to be translated to the nurses.

With the doctors the client was able to communicate in English. He said that the doctors spoke English with a Finnish accent which did not bother him. The client perceived the doctors speaking more slowly when they had to speak English to him: *"they try and think of the words very, really clearly and, I think maybe they were concentrating much more on what I was saying, and well, hopefully, they had a bit of more empathy"*. One doctor was said to speak very good American English: *"he was using words that I never would have used at him"*. The client explained this as follows: *"it must've been because he could see for himself that I must've felt quite comfortable with him, because I could speak more freely"*.

The practitioner's speech style was perceived as rather authoritarian as the client reported he was just answering questions.

The client stated to have interrupted the practitioner when he really could not understand

what exactly the problem was and to avoid misunderstandings: *"I'm really not the kind of person that does interrupt people, but I asked them to clarify the words much better and I found out how could I explain, because I was explaining so many times what has happenend to doctors and so, in the end I got it just right, and so nicely, concise short, straight to the point and there is no misunderstanding".* The client could not remember being interrupted by the practitioner.

The whole communication event was perceived by the client as 'quite nervous an experience': *"it was kind of a frustration to me ... I wanted to get out and back to England, to get to English doctors because I'd had enough of Finnish".*

Communication between practitioners and clients in the client's home-country was perceived to be better and easier because he could speak in his own language, he could hear everything what was being said, and because he could actually explain what had happened. He added: *"in England they would've been more, the doctors would have explained more, well I hope so ... it might be more chatty, talk, be more in between maybe this and so, yes, wanting to know what university I am, or what are you studying, or just be more friendly".*

Belgian client

During his interaction with the general practitioner some misunderstandings occurred, the client reported. He said that some things did not become clear because of practitioner and client using a second language. The practitioner could not always explain everything, the client mentioned, but client and practitioner always seemed to come to a certain conclusion. Sometimes things did not become clear at all and then it stayed by that: *"there were certain points that I didn't understand, even when using English, and even when using hands and, there even came this point that I didn't understand and then we stopped this trying to find out".*

At the dentist's the language difficulties seemed to come more from the dentist's side: *"I think that the dentist didn't understand my question, it was more from his side that he got nervous .. he didn't get what was my question ... I don't think it bothered him but maybe he was a bit like unsure about his English anyway, and we were three of us, he and his assistent and me, and that he was like a bit maybe nervous that he had to show".* The client said the dentist did not seem to feel very comfortable when speaking English. The general practitioner's English did not come so fluent either, the client reported, although: *"I think he even has a better English than me, but maybe a long time ago and all of a sudden he has to use it".*

The client mentioned his potential fear of visiting a Finnish medical practitioner, when having a serious disease, being related to communication: *"I think this is a problem yes, because I think you never really get into the conversation when you're on this point. As I live here such a short time it never comes completely clear what's the point, also in the choire and in lots of places, in the daycare, like alright, I understand what it's all about*

but I miss always something, I misunderstand always something, about appointments or other things".

The practitioner's use of difficult medical vocabulary was perceived by the client to be limited to the initial explanations. The practitioner always started with difficult things and then he would ask the client whether he understood. Eventually he would then explain with other words. Regarding the practitioner's 'difficult medical vocabulary' the client differentiated between language problem and his personal problem -whether he read enough about 'medical things'. He sensed, so he reported, the practitioner thinking that when being an ignorant client, one just has to believe what the practitioner tells. The amount of information one receives as a client was said to depend also on how strong the client wants to know something.

The client commented on the practitioner's speech style related to information, i.e. in function of how the practitioner explained certain things, i.e. like starting with difficult matters and then asking the client whether he understood, and then adapting his language to the client's. The client thought the doctor would do exactly the same with Finnish people: *"he would rather use this doctor's language and if he would have somebody who knows all these things, you can explain things in shorter ways".*

The practitioner was interrupted by the client when the latter asked for explanations, the client reported. He stated the practitioner had never interrupted him.

The client perceived the interaction with the practitioner as 'sort of cosy' as the practitioner was friendly, interested in the children and not in *a hurry: "he didn't give me this sort of impression that he was a busy man and that he was sharp in time and these sort of things ... no, this sort of visits I like and in Belgium they maybe are even rare".*

Communication between practitioners and client in the client's home-country was perceived less satisfying than it was here in Finland. In Belgium, the client reported, one has to interrupt the doctor because otherwise one does not get said what one wants to say. Also the seating postion of practitioner and client in Belgium would traditionally be in the AB position with the practitioner sitting behind and at the middle of his desk opposite the client: *"typical Belgian".* Failing to understand doctor's talk does not only take place in intercultural situations: *"I still have this picture of a Belgian doctor, this somehow professor type, a bit older and not so tidy, it might be even blue or grey this coat, and a bit more using Latin names, and that you don't understand anything".*

German client

The client reported that going for the first time to the doctor here in Finland, due to a knee injury, did not make her afraid as she said she could be sure that the doctors would be able to speak English. She also stated that there was 'not so much communication necessary'.

When not knowing the right words in English she used a lot of nonverbal communication

which she said to use probably a bit more when speaking a foreign language: *"I had to show all the movements because I didn't know the word for 'knicken', it's bending, ... all the time we used the word 'broken' for 'gerissen', ... it was a bit of fun, but we got along quite well"*. Because practitioner and client not being able to use their mothertongue, the client perceived the situation as funny: *"I had to explain with stupid movements I did, while skiiing to break or to twist my knee and, but he, I think he was in such an official situation or whatever that he couldn't laugh at them, but I really found it funny such things and everybody tries to explain with feet and hands, but he was so serious and so, it could have been funny"*.

A misunderstanding took place as the client did not hear the right word and used 'stressed' instead of 'stretched' and both practitioner and client used 'stressed'. They both knew they used the wrong word but also knew what was meant by it: *"ja, we were first both talking 'stressed' because I used it first, and then he suddenly looked at me and said: 'it is stretched' and I said: 'yes, it is stretched', yes it is fun when you talk with somebody in a language which is not your mothertongue"*.

The client thought the practitioner's English was not too good and said that he seemed to understand her quite well but that he had problems expressing himself. She reported that he fit in 'her stereotype of Finnish people': *"he was a bit afraid of speaking English, that he is actually quite able to do it"*.

She stated that because of the practitioner's personality, because he did not talk too much, or because he was afraid of speaking English, the client perceived that the practitioner was not able to explain her more, which she would have wanted. She claimed there was no 'real communication' and thought there was a lack of feedback. The client said she could not really somehow relate to him, she perceived him as 'Finnish', 'stereoype', but claimed it was not because of him being a doctor: *"no, it was more his personality, was er so ausstrahlt"*.

The practitioner's speech style was mentioned in relation with authority and was said not to be authoritarian.

The client reported she did not interrupt the practitioner although this would be quite like her, but she adapted to the situation and explained why: *"usually it is my style, but I think I adapt, I know quite well how people act and especially when I feel that they feel a bit unsure when they for example use a different and foreign language, and so I think I didn't interrupt him because I'm afraid that he doesn't say anything anymore when I do that"*. She stated the practitioner did not interrupt her.

Concerning the interaction with her doctor at home, who is a homeopath, she reported he would take a lot of time for the client and has the attitude of treating clients 'on the whole approach'. Aspects of nonverbal communication, i.e. environmental factors, were said to be different at the practitioner's in her home-country: *"they have real, just it looks like not living room but like a workingroom, all the books, chairs to sit, and when they have to examine they go to another room or they have one part of the room where they* (the clients) *can lie and so"*.

Dutch client

The client reported on her visit at the dentist's. Although the dentist spoke a little English, according to the client, she thought the whole communication event to be a 'difficult thing' because she could not make herself clear nor could the dentist make her clear what was going on. She said that in general she was confused by the doctors' way of communicating because she had the feeling she could not make herself serious, meaning that she thought the doctors did not take her serious.

She stated that there was no communication at all which made her very scared: *"for my feeling there's no communication at all and the first three or four visits, because I had some difficulties with my teeth, we didn't communicate at all, and I didn't know what was going on, he was only saying like: 'well you have to get a new appointment and then come back', so I got more and more scared what was going to happen with my teeth".* The client also reported it disturbed her very much that the dentist did not communicate with her, but had a chat with his assistent: *"and last time I already asked for a female, female dentist or another dentist, and that she can speak a little bit more English, so that's what really caused me problems because I don't know what's going on and, well there was no communication, I was lying there with my mouth open and he is saying these Finnish things to his colleague and they are talking about whatever, kesämökki and that kind of things".*

As a result of the client's perceived 'no communication' she said not to trust the dentist anymore. Also she mentioned twice feeling guilty because of her unability to speak Finnish and she thought she might be asking too much: *"I felt really also guilty that I couldn't make myself clear in Finnish and that I was asking so much things and that there was this miscommunication ... I felt very guilty that I was such a difficult case maybe because then I heard from a Finnish friend that Finnish people don't ask so much questions, so then I finally kind of shut up".*

The client reported that both she and the dentist communicated in an agressive way and thought the whole interaction to be a vicious circle: *"maybe he thinks that I'm in an agressive way approaching him by asking so much questions and be maybe too direct or something, so he feels a bit like :'oh my goodness this girl is coming again', and I think: 'oh sh... he' s not going to tell me what's going on', so".*

According to the client, the doctors and dentist feel threatenend by the non-Finnish clients: *"dentists or doctors, they don't know how to handle these foreign people who are behaving and communicating in a different way, so maybe they feel threatened, and uhm, well, I think that's a very big issue now for the doctors and dentists because there are coming more and more foreigners so they shouldn't be afraid of foreigners and maybe their different communication".*

The practitioner's speech style was reported as being not authoritarian.

The client mentioned that she interrupted the dentist and the general practitioner when she asked them questions or when something seemed to be unclear. She said the dentist also

did interrupt her.

In her own culture the client perceived a more open atmosphere to be existing between practitioners and clients whereas she reported having experienced in Finland that: *"Finnish doctors are getting scared somehow to hear questions ... they are like standing still for a moment or like 'oh somebody is going to ask something' ..."*

Egyptian client

The client visited the dentist, a general practitioner and the ophtalmologist. He reported having had no difficulties with communication. The client said to have spoken Finnish to the extent he would not know the Finnish words and then he would have spoken English. He said he can understand much more Finnish than he can talk. When he did understand and sometimes even when he did not understand the practitioner's Finnish he asked whether he could say it in English, because he wanted everything to be clear: *"I understand but I want everything to be absolutely clear for me".*

He perceived the doctor's speech as purely centred on giving of information: *"he just spoke like: 'you have like that and you have like that and then it's finished', they don't speak personal things".* The fact that the practitioner sometimes answered the clients questions with 'en osa sanoa', made the client think he was not treated as a friend, as would be the case in Egypt. The client mentioned not wanting to judge the Finnish doctors but said he was being used to hear some comforting words from the practitioner in his home-country, which were important to him: *"I want to say about the doctors here don't talk, they don't treat the patients as their friends...yes they are just their customer, or there is no strong relationship ... in Egypt they treat them as their friends: 'no nothing will happen, there's no problem', but sometimes here when you ask the doctor: 'from where this comes?', he says: 'en osa sanoa' and then it's finished like that ... I don't know, I don't say that it's right or wrong, for me it's important".*

The client said not having been interrupted by the practitioner as he was always listening to him.

In his home-country, the client reported, communication between practitioner and client is perceived differently from in Finland. The client mentioned again the Finnish practitioner's 'en osa sanoa', and he stated that in Egypt the doctors lie and therfore would never say they would not know something. The lying, so the client claimed, has the function of making the client more comfortable and relaxed. Another aspect of communication the client mentioned was the presence of more proxemity of the doctors: *"I think in Egypt even the doctors are more near because he is talking with you much more, knows your family and even if he doesn't know you 'how is your wife...'.* In Finland the client perceived there was no emotional relationship established between him and the practitioners.

Iranian client

The client visited the dentist several times. He reported always having had a problematic

relationship with his dentist. Language was said to have been a problem but then the client stated he has been 'always ready for misunderstandings'. As the client thought his Finnish to be unsufficiently, he switched into English and so dentist and client spoke English together. The dentist's English was perceived as not so good and the dentist was said to speak only very few words. The client thought that if the dentist wanted to, he could speak better English: *"he is not good in speaking but if he would, if he, I know if he wanted to, he could"*. He also thought the dentist did not talk to him because he (the client) was a foreigner.
The fact that the dentist had a chat with his assistent made him scared: *"I think he really wouldn't treat other people like that because I'm a foreigner, I think so because as a Finn is no in that position, becauseI, I understand Finnish language and I , I saw that they are speaking of last weekend or of some stupid thing ... and yeah in fact they were -laugh- communicating that and uhm, then he asked who was this other friend, last time they were in some, some cottage, and she heard and said such a things, you know, but next I heard they made a joke and they both laughed and he was carving here -laugh- so, so I was all the time scared that maybe he cut my tongue or so ... and I was angry too..."*.

The main problem, so the client reported, was the total lack of information which made the client scared, not comfortable and not at ease: *"he didn't say what he is doing ... I wasn't comfortable because I didn't know what he is doing ... he couldn't, he couldn't explain: 'so now I'm doing that, now I'm that', he just said 'you have to do it' and then, it was in fact uhm so sudden ..."*. The dentist had noticed an infection and suggested to operate, on which the client had agreed but had assumed it would take place some time later. So when the dentist started operating without warning, according to the client, the latter became 'highly scared'.

The worst thing, so the client, was that the dentist seemed not to have any idea what the client felt, which was perceived by the client as a lack of psychological insight on behalf of the dentist.

During his last treatment, the client told, the dentist had another assistent who talked with the client and gave him information. The client perceived this assistent as 'good': *"they gave me another hoitaja, she's good, I like her because she speaks and she does nicely and she says what she's doing"*.

The client stressed again the importance of information and communication effecting the well-being of the client: *"I didn't give a damn that he's caring about me, but I just wanted to know about, because I would become, you know, more comfortable if I knew what he is doing, so that would be very important for me, I have to be talked to but he didn't, so that made me not feel somehow so comfortable"*.

The client said he interrupted the dentist only when he had something on his mind and when it was physically possible to speak - not having instruments in mouth.

In the client's home-country the client thought the doctors look more experienced because they look older.

Chinese client

The client visited the general practitioner because of having skinproblems. She reported no misunderstandings took place and neither there were language difficulties.

The client complained of having received too less information: *"I didn't get any satisfying suggestion for my skin ... I didn't get the reasons and the solutions so I don't think I got enough information"*.

She said to assume most Finnish people being able to speak English and stated not to worry about language: *"I think doctors they should speak English ... I don't worry about that"*.

The practitioner's speech style was perceived with relation to nonverbal communication, i.e. the pace of speaking: *"just like the most of Finnish people they are shy to speak Énglish I think, they a bit hesitate, and they are very slowly, hm, and also they just be careful they would not make any mistakes, just this way"*. She reported that the doctor was helpful when he didn not know a certain word: *"when he could not find the suitable words then he fetched the dictionnary to look up and then he told me"*.

The client mentioned she did not remember the doctor having interrupted her, nor did she remember to have interrupted the doctor: *"usually I don't interrupt people"*.

Russian client

The client went to see the ophtalmologist for check-up of his eyes. He reported not having had any difficulties. Later in the interview he said that there often occurred misundestandings: *"frequently, frequently very special words like, I don't remember exactly, something about the eyes"*. But as the client mentioned, he usually could understand the words because of the context. He said the doctor spoke very good English and the client himself could understand the doctor's English very well.

If there were matters the client did not understand he reported he would ask the doctor to explain: *"if I couldn't understand it first but then I asked it him and he'd explain me in details"*.

The client said the doctor sometimes used a difficult medical vocabulary, but then the client stated he had asked for more information and was given an explanation.

The practitioner's speech style was explained by the client in function of authority: *"it depends, actually they are a little bit higher than the patients ... because they are older, not always everyone, but I think he's higher, in some sense like a teacher, but not always"*.

The practitioner never interrupted the client, but the latter interrupted the practitioner when wanting more information, so the client reported. He said he interrupted the practitioner several times to ask for detailed information, wanting everything to be hundred percent clear.

In his home-country the client mentioned he would talk more because he then would be able to talk in his mother tongue. He would not shake hands so often as it seemed to him is the case here in Finland: *"here doctors prefer to shake hands, I don't know maybe they are doing it with foreigners, of course I cannot say it ... yes, all doctors I met in Finland shake hands and they introduce themselves".*

American client

The client had undergone gynaecological surgery and had interacted with several medical practitioners during her stay in the hospital. The client perceived that the Finnish practitioners would not be eager to speak English and those who would, so she argued, would be hard to find. She said it would frighten her when giving childbirth for example and having people around who would not speak English: *"... that is something that frightens me, if I want children or something, or I'm giving birth to a child or something then I don't exactly want to have to think in Finnish in order to get what I want".* She mentioned having experienced the nurses to speak wonderful English.

In order to understand everything what was being said, the client and her husband decided the conversation would go through the husband in Finnish, who would then translate it to his wife. This was done as the client wanted to make sure that no mistakes would be made as she thought her situation to be very serious. Sometimes she stated to have said some simple things in Finnish like her name, address and things like that. The client recalled some misunderstandings but they were said always to be cleared up right away. She reported realizing that misunderstandings might occur due to being a third person in the communication event where two other speak about you: *"of course, when you have a third party in every conversation you're going to miss something in the communication".* This situation of being a third party often disturbed the client as she was not always given the chance to interrupt and say 'I didn't understand'. But again, she claimed, these problems would usually be cleared up soon.

The client reported the practitioners being shy to talk about matters concerning sex: *"here I think they're a little bit more shy about talking about, they were a little bit reluctant to, uhm, I don't know, talk about the sexual nature and such things".*

Because the conversation mostly took place between the practitioner and her husband she felt ignored: *"they mostly just directed their attention to K. although I would always sit the closest to the doctor ... she would mostly just talk to K., she didn't want to have to deal with me, sometimes that would p... me off because you kow, I'm here not there ... but I always got what I wanted in the end".*

At times the client said she thought not having had enough information: "I felt like at times they were not telling me everything or they did not have enough information on the subject, they were just kind of passing me through like cattle sometimes". As a result of not having obtained enough information about the pathogens of her disease, the client perceived a lack of communication in the interaction with her practitioner.

The practitioner had not interrupted the client but vice versa happened, as the client told

her speech style being an interrupting one.

The client perceived the practitioner's speech style as related to authority: *"well, I've always had this opinion that doctors think very highly on themselves"*, to information: *"I really can't possibly grasp the concept of some things they're talking about, but I think if you're persistent and you keep on asking, you get what you want, you just need to work for it, sometimes working for it is very tiring"*, and to nonverbal communication, i.e. low context communication versus high context communication: *"in the US they're more direct and sometimes more direct isn't nice ... it's more sometimes like too direct ... and then sometimes it's not direct enough, somehow you basicly need to find a country between Finland and America where you can actually get a kind of like somehow direct answer where you get the answers you want"*.

American client

The client visited the neurologist for a check-up and to adjust the medication. The client reported to have employed a conscious communication strategy when speaking English with the practitioners, as the latter have to listen and to concentrate more carefully to the client's words.

The client thought that there were no misunderstandings as he said to notice the practitioners making it absolutely sure that no misunderstandings could occur: *"if we have to say on the misunderstandings they really seem to make absolutely sure that there is no misunderstanding, so if I say what I'm talking about, something what I want, they always really, especially with questions like medication levels or something like that, they really seem to be painstaking about making sure that they're not uhm any misunderstandings, especially if they have to do with medication, but uhm on other things too they seem to go over quite carefully, uhm you know whether there is exactly I'm talking about, and want and desire as a patient"*. It was also mentioned by the client that the practitiners seemed to be very careful about their communication to the client and vice versa.

In terms of the client's understanding, so he stated, the practitioners were said to be very competent and very effective communicators. The client reported to believe them to be effective communicators partly because he himself said to be interested so much in the practitioners being effective communicators: *"I'm trying to take a lot away because I think for me a doctor's time is a very valuable time, that you only can see one once in a while and it's usually regarded as something important and then I try to really get as much in communicative terms, I try to get as much out of that short period of time as possible"*. The client still explained this with other words: *"because I know they're really limited on time when they can see patients because their time is of such a valuable resource, and so I think that with them in many respects, once you establish, it's kind of like two modems, then when you establish the right connection, so if if I feel like, it's a very effective two flow communication ... I don't recall having felt so unsatisfied about you know, them comprehending what I say and me comprehending what they say"*.

Communication with nurses was said to be difficult. The client reported that he often tried to communicate with the nurses in Finnish because he thought they seemed to appreciate

it so much, because there would not be the status difference shown between a client and a nurse, and because he liked to try sometimes to practice his Finnish. Communicating in English with nurses was seen as not so easy: *"nurses, this is a very different story, ... it's not that they can't speak, it feels as they are extremely uncomfortable when speaking, it seems like although their level of English, it's so high, but they're still embarrassed to speak it. I don't figure out why because it's so much better for instance than my Finnish, but they're still embarrassed to speak it".* The client tried to find an explanation fot this behavior and said: *"I'm told for instance David March's research at working life or whatever indicates that sometimes generally there is this phenomenon of so called hypercorrectness that one, some Finnish people they're really embarrassed to speak a language poorly, and with nurses I really find that a lot".*

The practitioner's speech style was perceived as professional and competent, being related to information giving and prescribing of medicines. The client also described the practitioner's speech style as 'odd' : *"maybe it's not really speech style but they have this so called textbook English, that they've read so many texts, that often speaking just like straight out of the textwork and then they the words are weird".*

It was stated that the practitioner never interrupted the client but the client said he himself did interrupt the practitioner. He explained interrupting to be a part of his culture, and that he did interrupt to ask for information. The client reported having noticed that the practitioners had ever taken offence at him interrupting them.

The client mentioned that practitioner-client communication would differ with regard to proxemics: *"I think the doctors in the States are much like in a little bit scoser, especially if they're talking about something sensitive or something very, very deep subject, that's when a lot of doctors in the States would move around their desk and sit by you and coming to more personal distance and somehow would be more like people to people"* .

6.4. Expectations (EXP)

By nine of the ten clients and in total the category of expectations ranked fourth. One client from the USA ranked fifth for expectations but ranked fourth for the category of strategies. Table 7 shows the frequency of the expectations reported by the non-Finnish clients.

Table 7. Frequency of the expectations reported by the non-Finnish clients

	G-B	Bel	Ger	Neth	Egy	Iran	Chin	Russ	USA	USA	**Tot.**
EXP	7	9	6	6	6	7	4	5	6	4	**60**

The clients' reported experiences dealing with the expectations of their interactions with Finnish medical practitioners will be described as cases; per client/per country.

British client

As the client was involved in an accident he explained he had no time to really think about expectations but he reported having had the expectation that the practitioners to speak and understand English. He also reported that concerning communication he was to speak English very slowly and precisely, and he thought that it might be problematic: *"I was worried that uhm, that they'd have problems with communicating somehow, I was quite, sometimes I was quite right about that, that their English wasn't good enough, and of course it, I felt it wasn't their fault, it was just that, uhm the situation".*

Considering the educational background of the Finnish practitioners the client stated he had no doubts, that he had great confidence: *"I thought they were all very qualified, and very good health care system"* .

Belgian client

The client reported having expected the practitioners to speak and to understand English.

He reported to have expected the practitioner to be more curious about how medicine is practiced in his home-country: *"I would have liked for example more better that they were a bit more curious about how it goes there* (in Belgium), *that they would ask me how does it go there instead of having these prejudices that 'that's how it is there', even if they had never been and seen".*

Considering the client's reason for visiting the practitioner (probable inheritable liver disease) he consequently expected a bloodtest would be done. He also expected to meet 'nice people', and to meet somebody he 'could deal with'. The client stated that because not being Finnish he had some doubts about the interaction to work out well: *"I think, a bit always, this is in the back of my mind like 'who shall I have there, shall it work in this foreign country or shall it not?' ".*

The client reported not having expected difficulties concerning communication, finding the right words or making himself understood because he said he did not have to talk about his feelings: *"I think even with this problem, if it didn't get out, that none of us was able to understand each other what is it now there in Belgium, then I think we would have found it out anyway later, that I would call to Belgium and I would know this Latin name or so, but no, I didn't make problems of it. But I can easily think that if you have this sort of feeling matters, that's something else, or even if you have a depression or things like that, when you have to try to talk about your soul".*

Because of the Finnish 'symptom and antibiotica culture', as the client stated, he reported not having had so much confidence in the educational background of the practitioners: *"I will have fear when I have to go for the first time to the doctor here, when I have somethng, something else, an infection or something, I think I have a low trust to the*

Finnish health care system because I don't like this symptomatic care, where 'now your ears are good again, go off', and then the next cure". After being treated though by the dentist he revised his views and thought dentists to have very advanced systems here in Finland.

The client told that he had expected to find more possibilities for alternative doctors in Finland as in his home-country homeopaths, acupuncturists and other alternative practitioners are offical, meaning that as a client you are covered by your insurance.

German client

The client reported having expected the practitioner to speak and to understand English.

As the client visited the practitioner for an acute knee injury she told she had expected him to give her a bandage or a cream, which he did not do: " *... you expect something when you go to a doctor, or he didn't even take x-rays or something, so uhm, but I think it wouldn't have been different in Germany, I don't know".* The client stated she was somehow disappointed but did not know exactly why. Later she suggested that because of her hurting knee and feeling so uncomfortable, her disappointment resulted from not having been given a bandage, cream, or a further examination like X-rays.

As for the communicative part in her interaction with the doctor she mentioned having expected difficulties: *"but not really things which would interrupt the whole thing, just on the normal level, as it is with other people who don't speak their mothertongue".* She also stated that she expected somehow to 'act' it, meaning to use nonverbal communication such as gestures.

The client reported having had confidence in the practitioner and in his educational background. She explained not having known the exact training the doctor had received but assumed he had received a general training. Being in Finland influenced her degree of expectations, i.e. confidence in the practitioner: *"I think it would probably have been different when I, I mean, it's also of course some prejudice or whatever, but o.k., we're in Finland, we're in Europe, and it's somehow everything on the same level, and I think Scandinavian countries have the reputation of having good social systems, health care and everything, so there was no fear, it would probably have been different in Africa or whatever ... so, you have to trust the people probably".*

Dutch client

The client reported having expected practitioners to speak and to understand English.

The most important expectation for the client, so she reported, was to get information: *"I wanted to know what's going on, I had questions, I had a lot of questions and I wanted answers from that, I wanted to know what's going on, I have a problem and I want to have an answer".*

Before going to the dentist the client stated having had confidence in the dentist's abilities. After having had the treatment, and when her dentist in her home-country did not approve of the dental care being done in Finland, the client mentioned not having trusted the Finnish dentist anymore.

Egyptian client

The client reported having expected the practitioner to speak and to understand English.

He reported having had negative expectations such as the dentist might have hurt him while extracting the teeth, or that he himself might get sick: *"I think he'll hurt me so badly to take the teeth off, but he had to take it off because it was hurting, and it was the first time ... I knew it was possible that I will, that I will feel sick ... "*. Whereas in his home-country the client would have expected to establish an emotional relationship with his practitioner he did not expect this here: *"when you go to visit him he is just as a doctor and then it's finished ... I don't expect it because I know he is a Finn, but I don't say that the, all the Finnish people are all the same, I don't mean that the doctors are bad"*.

The client said having perceived the Finnish practitioners' directness and some aspects of verbal communication, i.e. distance, proxemics and facial expression, making him doubt the practitioner's educational background. Examples of the client's experiences are as follows:

- *"here they say strictly 'en osaa sanoa', ... the doctors in Egypt they lie because they make you relax, even if you feel real bad then you feel relaxed"*, which might implicate the client's expectation of practitioners lying instead of telling the truth.

- *"I think that this, don't be friendly, or you don't be near, they somehow effect ... but for Finnish people, because you know, I know how they are, so I think it is better, I mean that I don't touch a Finnish doctor ... but you, you know, it makes you to feel that they are less qualified ... maybe this is because I come from another culture"*.

Although the client reported having perceived the Finnish practitioners as 'not touching' and as 'not coming near', he still said to have confidence in them that they would treat him well and right.

Iranian client

The client reported having expected the practitioner to speak and to understand English.

He reported having expected to be treated as a human being. He also said having expected to obtain more information in form of verbal communication in order to make him feel more at ease: *"I just wanted to know what he's doing, it would be important for me if he would tell what he's doing, and then he would say everything he's doing, I'm not saying with scientific details which I cannot understand, but things like 'I do this and*

then I do that', emotional communication, this, that way I would expect".

Due to the client's former experience at the dentist, he had developed a negative expectation concerning communicating with Finnish practitioners: *"I thought they are skilled the doctors but I always have this idea that I think they cannot communicate".*

The client stated having expected the dentist to wear surgery gloves during the dental treatment, which did not happen, so he reported.

Concerning the educational background of the Finnish practitioners the client had no complaints and said he had confidence in their skills. He reported that in his home-country he perceived the doctors to be more experienced as they looked older.

The client stated he thought the dentist to be lacking in ethical professionalism as he laughed and made jokes during the dental surgery, which made the client very scared: *"I think he was, he was so, I couldn't believe that a doctor acts like that, because I think they have some studies for ethics and how to treat patients".*

Chinese client

The client reported having expected the practitioner to speak and to understand English, but she reported not to worry about this as she expected all doctors should be able to speak English.

Another expectation of this client was that she hoped to get information concerning the origin of the disease and that he would give her medicine.

The client reported having had no expectations about possible language difficulties.

She said having had confidence in the practitioner's educational background: *"I never think about it because I think the doctors should be very well educated".*

Russian client

The client reported having expected the practitioner to speak and to understand English.

He also stated having expected the practitioner to examine him and to prescribe him glasses.

Concerning the language he said to have expected some difficulties: *"of course I was afraid a little uhm about language, about language, but I knew that a lot of people in Finland have a good background of languages, so I was afraid, I was afraid probably my English, not his, English, yes, but everything was o.k., it was not a very big problem".*

The client reported having had confidence in the practitioner's educational background.

American client

The client reported having had no expectations of the Finnish practitioners to speak English as the verbal communication happened 'through' her Finnnish husband in Finnish.

She said though that once she will be in labour for childbirth she would expect people around her who will speak fluent English.

The client reported having had negative expectations: *"I was prepared for the worst, I didn't want to take any chances with the operation".* She said she also had expected to receive more information concerning the origin of her disease which she did not obtain: *"the really big lack of communication in this thing was where the hell did it come from".*

She said having had confidence in the practitioner's educational background: *"they know their stuff, ... sometimes they don't have enough research".* With research the patient explained that she would expect the doctors and nurses should have some refreshing seminars on patient communication: *"just refreshing courses on how to make the patient feel comfortable, what might be quite ordinary for them, for us it is completely new".*

American client

The client reported not having had the expectations of practitioners to speak or to understand English. Later during the interview the client stated he did have the expectation after all: *"I know they all know English and so then it is kind of, like uhm, like a default when I know I can speak English to them, but like in a different environment I may not have that expectation".*

The client stated that practitioner's competence would be more important to him than their linguistic ability: *"I would gladly spend some time with somebody who spoke not a word of English but who is very competent, and if we had it going through a translator and they're good enough I'd pay for the translator if there was a serious enough problem".*

He also mentioned having had extremely high expectations of the practitioners: *"I expect them to be extremely knowledgeable about what they're doing and to have a somekind of like princip desire to like help me out with whatever reason it is I'm coming to see them for".*

Client-centered or patient-centered communication was said to be the client's expectations of communication between him and his doctor: *"It must be so that I feel they're interested in my situation or interested in my outcome, then that's what I really expect of communication that they're really trying to find out what is the circumstance why this person is here to see me and what can I do to uhm make this situation you know with as best outcome as they can do, that's what I expect I guess, it's a uhm very neutrally respectful and very specifical ... and so I expect that they treat me like an*

individual".

The client reported being aware that he might be expecting more from the Finnish practitioners as he would from American practitioners but he reported not having bad feelings about it: *"the only thing technically I'm expecting more from them because I'm asking them to interact in a foreign language whereas I don't expect that of so many other people; on every day society level I feel guilty and bad that I can't interact with the Finnish people in Finnish more than I do and then when I do, it sounds so awful, with the doctor I don' have that at all because they're trained to deal with all kinds of people at all levels of society and I know they have a high standard of English, so I don't feel bad about it at all".*

Miscommunication was said to be one of the negative expectations the client often had: *"I think in Finland it is always in the back of my mind that miscommunication might occur".* Still he reported that he had so many interactions with practitioners here in Finland, that these were so positive that it seemed to him that like of any group out of any group in society he would at least expect it with doctors: *"just because they've always been so careful about the communication, I would expect it almost at every place except at the doctor".*

The client also reported to have very good confidence in the doctor, also because he said to have some personal friends who are doctors and he learned to know how solid their education has been and how long it took for them at the medical school.

6.5. Strategies (STR)

By nine of the ten clients and in total the category of strategies ranked fifth. By one American client the category of strategies ranked fourth. Table 8 shows the frequency of the employed strategies reported by the non-Finnish clients.

Table 8. Frequency of the of the employed strategies reported by the non-Finnish clients

	G-B	Bel	Ger	Neth	Egy	Iran	Chin	Russ	USA	USA	**Tot.**
STR	4	4	3	6	3	2	1	3	6	9	**41**

The clients' reported experiences of their employed strategies of communicating with the Finnish medical practitioenrs will be described as cases; per client/per country.

British client

- the client and practitioner spoke English, which was the client's mothertongue

- the client sometimes had his Finnish girlfriend to translate from Finnish into English

- the client adapted his English to the situation: *"I was to speak very slowly and very precisely"*.

- to avoid misunderstandings, the client wanted clear information and sometimes even interrupted the practitioner which he usually would not do: *"I'm really not the kind of person that does interrupt people, I was, I was, let me say, but I asked them to clarify the words much better and I found out how could I explain, because I was explaining so many times what has happened, and so in the end I got it just right straight to the point and there is no misunderstanding"*.

Belgian client

- the client started the conversation with the practitioner in Finnish and talked about the children

- then when he wanted to talk about his medical problem he switched into English: *"I still started maybe my first sentence in Finnish and then I asked: 'can I explain in English?' "*

- at the dentist the client reported he tried to explain himself in Finnish and in English

- the client reported he did not prepare for the conversation with the Finnish practitioners, nor did he look up words in the dictionary.

German client

- the client and practitioner spoke English

- the client reported having used nonverbal communication (gestures) when she did not know certain words: *"I had to show all the movements"*.

- the client reported she did not prepare beforehand what she was going to say neither did she look up words in the dictionary, which later, she said to have regretted: *"I thought why the hell didn't you look up things like 'Bänder', 'Kniescheibe' or something like that, I just didn't do it because I thought I could act it or whatever so, not in terms of language"*.

Dutch client

- the client reported that two years ago she always tried to speak Finnish with the practitioner because she said she thought it was 'like a step towards some kind of communication'

- the client said to have started the conversation with the dentist in Finnish to show she was willing to speak in Finnish but also to show she could not communicate in Finnish, and so that it would be better for her to communicate in English

- she said that later on she changed her strategy and decided to speak English: *"I just decided that I speak English and that I show that I'm just a foreigner, uhm like they see that my Finnish is not perfect, and that it's just better to communicate in English".* The client reported having consciously employed this strategy in order to avoid being confronted with the Finnish communication behavior: *"then when the contact is established, then I can speak Finnish, but I don't start, I tried, I try not to start in Finnish anymore because then they are communicating in the Finnish behavior that I don't get, also for the language and for the way things are explained, I don't know how a doctor relates to his patient, to his Finnish patient, but I don't get it, so, first English and then Finnish".* The outcome of her new strategy proved to be good: *" I felt better about it, I got better results so, I got to know better what I wanted".*

- the client mentioned that she wanted to have information on what is going on in her body, that the language was a barrier for her to ask questions but still: "I have decided that I'm going to use this new strategy: 'to ask questions' "

- the client said she felt by the facial expression of the dentist that he did not take her serious, this made her behave in a different way, i.e. instead of smiling she tried to have a serious face:: *"now if I'm going to the doctor I try to be very serious myself and not laugh because they don't take me serious, I try to talk very like uhm, I learned a bit from my* (Finnish) *boyfriend also, he's also very good at that, so I thought well maybe that's the way how in Finland people do communicate, being, having a very serious face, yeah, that's my -laugh- second strategy, I've built some strategies".*

- the client prepared her visit to the dentist in that way that she took her dictionary with: *"I took my sanakirja with, I was checking what was uhm toothache and uhm rootache or something".*

Egyptian client

- the client started the conversation with the practitioner in Finnish

- then, if he did not understand it anymore he would aks to switch into English in order to be sure to understand everything right: *"I want everything to be absolutely clear for me".*

- the client reported to prepare for the interaction with the practitioner by asking his

Finnish wife to translate some words for him beforehand. He said doing this in favor of the practitioner: *"so that I can say to him very clear, for him so, that I can say to him that everything is very clear for him".*

Iranian client

- the client reported having tried to speak Finnish at first

- then, when he saw he could not continue in Finnish, he switched into English: *"because this subject is so difficult, so I had to understand to speak the language that I can understand, so then I started to speak English".*

- the client said he did prepare somehow for his visit to the dentist: *"usually when I got to go I need to think about it ... if I've to speak in Finnish then I write down or ask something".*

Chinese client

- the client reported having spoken in English with the practitioner

- she said not to worry about having to speak a foreign language as she thought all doctors should speak English.

- the client said she did not prepare at all before visiting the practitoner's

Russian client

- the client reported speaking English with the practitioner and said he would ask questions

- he stated to prepare himself in that way that he used the dictionary to look up some words: *"because I use not my native language, but English, that is why I looked in the dictionary first, just to refresh several not so official definitions, of course I do that, I look before".*

- the client reported he wanted to understand everything the practitioner told him, if he would not understand he would ask questions: *"I tried to understand uhm, I don't remember exactly, but I tried to understand some uhm words which I didn't know and, how to say, to know something even in details, in details".*

American client

- the client reported having agreed beforehand with her Finnish husband that she would not speak and that the whole conversation would go through her husband and the practitioner in Finnish, who then translated everything for her in English. The client said that she and her husband were both ready to use this strategy: The client said to have employed this strategy because of the seriousness of the situation: *"when you're*

talking about something serious, you don't want to make one mistake, so I just used K. (the husband) *all the way through".* Another reason for the client to employ this strategy was because of nervousness: *"sometimes you get nervous, and when you get nervous you get distracted, so K. wants to make sure that I'm not missing anything in the conversation".*

- during a different situation the client visited the practitioner and spoke English with him which did not work out so well in function of the client's understanding: *"when you don't understand what they're trying to say, they draw these pictures, but you know, by the times they dealt with these pictures it looks like a road map, you can't figure out what they're trying to say to you, so you really haven't got anywhere".*

- the client mentioned that in one situation she still had after all directly addressed the doctor in Finnish as she became too tired to wait for her husband to finish his sentence

- she stated that the matters she did say in Finnish were short and simple: *"simple questions like your name, address, those are easy straightforward things you can answer yourself, explanations I would prefer that K. just interferes".*

- the client still explained thather husband always translated to her everything what the practitioners said: *"even though I don't need it, he does just for in case that, just to make sure that I understand".*

- she explained that as soon misunderstandings occurred, they were cleared up right away by asking questions

American client

- the client reported having spoken English with the practitioner which is the client's native tongue

- the client assured that in Finland he always consciouslly employs different communication strategies because (1) then the practitioners have to listen: *"I always speak with them in English because I think it's very easy for a, otherwise the doctor may already have made up his mind about something and this already, they tend to, because of their profession I think, think very quickly many times and they already, their mind is very far ahead of where, with the mouth, what they're speaking about",* (2) then the practitioners have to concentrate: *" I think the better they are in English the worse, the more likely there's that if they have a tendency to still want to play God, they'll do that, the better they are, because they don't have to think so much, especially I noticed the young ones, that when they have to stop and think, then it's much more likely that they'll start to interact and listen and find some common ground rather than just pronounce or tell".*

- the client explained how the conversation usually would take place: *"when I come in I immediately start in English, even though I'm quite able to express myself especially medically in Finnish, I never 'doctor doctor' uhm in Finnish, just because it it it plays*

into the old way of doing it and they immediately can, if they have a tendency to assume the uhm status differential, they'll do it, most people will, not just doctors, and so I immediately use it to uhm -clicks- bring them down to the listening level".

- in terms of preparation, the client explained he usually had a list of what he wanted to talk about as there usually are so many issues relaling to his physical condition, that it might be quite easy to talk about important matters but forgetting some others. He said to be very systematic in what he wanted to talk about.

- the client reported his strategy of speaking English with the practitioner to be an unearned privilege: *"it's something that I don't do very often ... there's no rational basis for it, I mean there's a basis for it but it's more like a cultural societal basis, but there's not uhm, I'm just glad I have that and I feel sorry for people who don't have it and then get stuck with a lousy doctor ... that kind of thing because it's, its, it just helps the situation, or I can compare the situation to the States, it's quite easy to get stuck with a lousy doctor and it seems they're operating with the same rougly mental framework than doctors here do, so there is nothing I can use there except than only my maybe other strategies, just my, yeah I have to divice other strategies there to get what I want sometimes because especially if some physicians already made up their mind about something so it will be very difficult to change their mind".*

- the client said to use sometimes Finnish words to clarify himself in the conversation, if there would be some question which he could quickly clarify with a Finnish word or phrase, he said he would do it but then he would immediately switch back to English. He said to be aware of it that for some people this could be some kind of 'power thing' but he explained it as follows: *"I think they would be correct, just because of the status, the professional status differential is usually so high between a doctor and a patient here, that usually I think, I can generalize and say it seems like many Finnish people are much more willing to straight accept what the doctor says and I think the culture where I came from is entirely different, it's it's expected that you can discuss with the doctor about options and suggest alternatives, where here I get the impression that that's not so much the case, altough I think it varies quite a bit with doctors, I heard some people who had very good doctors here and because you know, of the relationship they have with those particular doctor".*

- as for the client a doctor's time is avery valuable time, he reported to try to get as much out of it in communicative terms: *"I try to get as much out of that short period of time as possible, because I know they they're really limited on time when they can see patients because their time is of such a valuable resource and so I think that mix them in many respects once you establish, it's kind of like, it's like 2 modems, then when you estblish the right connection, so if if I feel like it's very effective 2 way flow communication".*

- the client stated that 'pausing' was considered as some kind of strategy from his as well as from the practitioner's side: *"I could say that there is probably pauses on both our parts because what we're talking about is so like, usually so precise, that I think we both pause to, like really formulate what we're trying to say, and I would say probably*

I would guess I'm sometimes on their part there pausing because they're kind of thinking what they're gonna say in English, on my part I'm pausing because I often when I'm talking about something important I have some little pauses, just again because I think that short time is so valuable I don't like to spend a lot of time on blather".

7. Discussion

The findings from this study (see Table 2) indicate that the clients' most salient experiences and/or observations are made in the category of *nonverbal communication*. The category of *strategies* containing the clients' least amount of observations. However, it is not the frequency of occurrences that automatically gives full meaning to the data. The clients' awareness, their ability to observe, and their way of perceiving situations and experiences proved to be overwhelming. The clients' observations provide this study with striking descriptions accentuating the elements of intercultural communication. Additionally, these descriptions show the impact intercultural communication has on the whole intercultural event.

By reporting about the findings, a sense of diminishing the client's nationality might seem to be advisable. However, using neutral words like 'respondents' or 'informants' would not accurately capture the nature of this study, i.e. as the research strategy was a multiple case study, and as it is partly the cultural background of each of these clients on which this study manifests the relationship between research questions and research conclusions or. When reporting about 'the German client' or the 'Iranian client', this is by no means intended to generalize about all the German people or about all the Iranian people, only about one German or Iranian client in a specific situation in which culture played a significant part.

7.1. Nonverbal communication

Considering the category of nonverbal communication it is noted that the clients indeed reflect upon aspects of nonverbal behavior. Dealing with proxemics, haptics, facial expression and paralanguage provide the following observatons. Whereas the German client comments on proxemics as being mainly determined by the position of the chairs, the clients from America, the British and the Egyptian client stress the larger distance between practitioner and client observed here in Finland. The aspect of haptics is described by the Chinese client's experience as unsatisfying which resulted in making a generalization: *"I feel that Finnish doctors and nurses seem they don't want to touch you, I feel this very clear"*. The Egyptian client's unsatisfaction with haptics (no touching) resulted in stereotyping: *"The doctor he is a Finn, so he is like the Finns ... that means he doesn't touch you, he just checks you, inside, it's finished"*. As for the practitioner's facial expression differences in the clients' perceptions and reactions are observed. For some clients the facial expression is perceived as 'not unfriendly', 'serious', and for the German client this is seen as a challenge 'to try to make him grin'. The practitioner's facial expression is also perceived as 'not meant for the client but for his colleagues', and as the conveyance of 'not being taken seriously'. Others then see the facial expression as 'positive', 'relaxed', 'too relaxed', and 'normal'. Paralanguage

obtains the notions of being 'monotonous' and 'flat'. Other descriptions illustrating the practitioners' paralanguage are 'not compassionate enough', 'harsh and sudden', 'detached', 'not very moderated', 'like careful delivery'.

7.2. Assumptions

The clients' assumptions about the Finnish health care are mostly based on the treatment they obtained, and on the communication event. Except for two clients, all are satisfied with the treatment. This is described with sentences like: 'very good, 'first class treatment', 'they have advanced systems in in the dental care', 'he did very well on the job', 'he was technically very good at his job', 'everything was o.k., good equipment'. Treatment experienced as unsatisfying is based on lack of touching in case of the Chinese client, and in the negative outcome of the dentist's work in case of the Dutch client.

Regarding clients' assumptions, communication can be regarded as an adequate measure for satisfaction. Apart from the Chinese client, all other clients contemplate communication playing a role in the practitioner-client interaction, and consequently influencing their assessment of the perceived situations. Positive assessments of communication seem to be based on 'being respected as a person', 'practitioners being ready to use their English', 'good attention from the doctor', 'nonverbal behavior, i.e. touching', 'they are very effective communicators'. Communication is assessed negatively and is describeded as: 'lack of information', 'too less communication', and 'no feed-back'. Other reasons why communication is perceived as negative are when 'communication seems to be a barrier, 'when asking questions, does not seem to be appropriate', 'when there is no emotional communication', 'when practitioners do not show enough compassion', and 'when practitioners are not talkative'.

Clients' assumptions based on different reasons than treatment and communication described as negative include: 'lack of an aftercare system', 'Finnish dentists' tendency towards ethnocentrism', 'interruptions of the conversations by telephone calls and other personnel coming in and out', 'tendency towards a symptomatic care', 'no financial support when visiting alternative medical practitioners', 'not being able to choose your own practitioner', 'long waiting times', and 'disorganization in general'. One positive assessment independent from communication and treatment made by the German client is the fact that Finnish health care has a good reputation which gave her an initial trust in the practitioner.

7.3. Verbal communication

The aspects of verbal communication expressed by the clients shed some light on the problematic of verbal language in intercultural interaction. Whereas the communication event is seen as 'quite nervous an experience', 'a difficult thing' by some clients, others perceive it as 'sort of cosy' and 'funny'. Apart from one American client the conversations with the practitioners were conducted in English. This was for seven of the clients a second language, whereas it was the native tongue for the client from Great-

Britain and for the other American client. Problems in verbal communication deal with (1) the practitioners' fluency in English which was assessed by some clients as inadequate, (2) directness, i.e. practitioners being too direct when informing the clients about their sickness, (3) misunderstandings as a result from practitioners' difficult vocabulary, from hearing words wrongly, and from being confused by the practitioner's way of communication. Others problems included (4) the lack of information, and (5) lack of emotional communication. The clients argued that the lack of information and of emotional communication influenced their trust in the practitioners, and their 'feeling at ease'. Emotional communication was also said to play an important role in decreasing the client's threshold of pain and fear. This relates to the theories of stress, consisting of high anxiety or tension, which are said to be quite common to cross-cultural experiences due to the number of uncertainties present (Barna, 1997:375).

The lack of emotional communication in dentistry, as is the case by three of the clients, is also confirmed by the results of a study, indicating that people do not perceive dentists as caring, helping people, instead, practitioners tend to be characterized as being remote and primarily interested in money. The study also reveals the importance of a dentist's personal behavior playing a role in shaping the clients' attitudes towards dentistry. Without the technical expertise to judge the dentist, clients will base their evaluation on the dentist's interpersonal behavior. When clients were asked what dentists should do to reduce anxiety, most of the clients' suggestions were linked with increasing and improving communication, for example, initial explanation, and warning about pain. (Rouse, 1989:243).

The clients' perceptions of the practitioner's speech style were observed as being related to authority and to information.

It is noted by 8 of the 10 clients that they did not interrupt the practitioner during the conversation. Only in one case it was said that the practitioner interrupted the client (Dutch). The ability of several clients to articulate their awareness of intercultural dynamics was striking. Also their conscious adaptation to, and explanations for perceived different situations were astonishing. For instance, the German client claimed to come from an interruptive culture, but consciously did not interrupt the practitioner. She said she adapted to the situation in being courteous, i.e. realizing the practitioner's unsure command of English, her interrupting him might have stopped the conversation flow. The British client reported having adapted to the situation by interrupting the practitioner, something he said he would never do at home. This interrupting was done while wanting clear information. The Dutch client, who experienced numerous problems with verbal communication with the practitioner, reflected upon these problems and tried to provide an explanation. She perceived the whole verbal communication event as aggressive, and called it a vicious circle. This was explained as follows: she asked too many questions from the practitioner who was not used to be confronted with these, he did not answer very much, she asked more, and this resulted in both of them reacting aggressively to one another.

Reflecting upon the German and the Dutch client's perceptions about communication: *"the communication was not too much", "there was no communication at all, which*

disturbed me and made me confused" and their comments on the apparent lack of feedback brings us to the cultural perceptions of silence and talkativeness, or taciturnity and volubility as Scollon and Scollon (1995:39-40) point it out. They present the extreme contrast between involvement and independence being the difference between speaking (or communication) and silence (or non-communication). Classifying speech on the side of the involvement, and silence (non-communication) on the side of independence, they nevertheless clarify that there are silences which can be interpreted as high involvment as well. For instance when sharing a very intimate situation one can communicate to each other a high degree of involvement while remaining completely silent. Taciturnity and volubility are said to be lesser extremes of non-communication and communication although these are very relative terms. There are no absolute taciturn or voluble individuals, groups, cultures or societies. Considering the perceived 'non-communication' by the two clients mentioned before, one should remember again the conclusion made by Lehtonen and Sajavaara (1997) where they state that Finns have certain features in their communicative behavior that strike the non-Finnish people as different. Most important though is the consideration of the difficulties inherent in cultural perceptions, where people make use of their own conceptual categories to organise their observations of the behavior from others, which might explain these clients' observations.

7.4. Expectations

As to the clients' expectations all the clients except one expected the practitioners to speak and to understand English. By the one client who did not expect this, the conversation was in Finnish through a third person. The following expectations in communication were noted: a native speaker of English had expected difficulties in communicating as he realized he had to speak slow and precisely to be understood by the practitioners. One client had expected the 'normal' language problems one encounters when speaking a second language, but she also said to be sure to overcome them by making use of nonverbal behavior. 'Always being ready for misunderstandings', 'the idea of practitioners not being able to communicate', 'obtaining information', 'obtaining answers on questions', 'the inablity to find the right words' and 'miscommunication' are other examples of the clients' expectations concerning communication. With regard to the practitioner the following expectations were expressed: 'being extra knowledgeable', 'having the principled desire to help', and the 'communication to be client-centred'.

Other expectations included: 'the practitioner being more curious about medicine in the client's home-country', 'being treated as a human being', 'adequate treatment and prescriptions', the negative expectations of 'pain', and 'fear', 'being prepared for the worst'. One client stated being very aware of the fact that he expects more from the practitioners in Finland than at home as he expects them to interact in a foreign language.

The clients' confidence in the practitioner's educational background seems to be based on the clients' assumptions of practitioners having obtained a good and difficult training, and on Finland being a European country and being famous for its' good social and

health care system. Symptomatic care and too easily prescribing of antibiotics were seen by one client as a reason not to have confidence in the practitioner's educational background. One client differentiated between having confidence in the practitoner's clinical abilities, but not having confidence in his interrelational skills. The practitioner, using a different nonverbal behavior than the Egyptian client was used to, e.g. haptics, proxemics and facial expression, became less trustworthy in the client's eyes.

7.5. Strategies

All but one American client used English as conversation language with the practitioner. For two of these clients English was their native tongue. For the clients who did not have Finnish as a mothertongue, English was the second possible option. Some of the clients consciously started the conversation first in Finnish for the following reasons: 'as a kind of small talk previous to the matters of health and sickness', 'as it seemed to be a step towards some kind of communication', and 'to show that communicating in Finnish does not work'.
A different and compelling strategy was employed in which the client brought her Finnish husband to the practitioner. The conversation between the practitioner and the client's husband then was held in Finnish, and was translated by the husband into English to the client. This strategy was employed because of 'the seriousness of the situation', and 'the nervousity which might lead to making mistakes'. The client though was a third person in the communicative event and perceived this as a disadvantage as she often felt ignored.

Apart from choosing the language, it was remarkable that for most of the clients it was of an utmost importance that everything what has been said during the conversation should be absolutely clear. During an intracultural client-practitioner interaction this kind of wish is self-evident. The remarkability lies in the explicitness of the clients expressing this wish. Asking questions was the main employed strategy to obtain clarifications of the words, to avoid misunderstandings, to know more what is going on, to receive clear information, and not to make any mistakes. The absence of a shared language, as Pauwels (1994) suggested in her study, might have reinforced the clients' explicit need to be clearly and well informed in order to gain trust and a feeling of security.

A fourth strategy dealt with the clients' preparing themselves for the visit to the practitioner's. The preparations clients made ranged from asking relatives or friends to translate difficult words into Finnish, writing down a list with questions for the practitioner and with topics one wants to be discussed, to looking up words in a dictionary.

Other strategies the clients used to gain success in the conversation with their practitioners deal with adaptation to the situation, such as speaking more slowly and precisely, interrupting the practitioner, using nonverbal behavior such as gestures and changing facial expression, and pausing. Pausing was said to be a strategy from the client's as well as from the practitioner's side in order to really formulate very carefully what one is trying to say and to think about how to say things in a foreign language.

The strategies discussed above show that the clients came to the interaction with a certain kind of readiness, conscious preparedness for dealing with the intercultural situation. This strengthens Kim's 'integrative theory' (1995) as for the part of predisposition, where it is said that strangers' preparedness and personal traits, i.e. the mental, emotional, and motivational readiness to deal with the new cultural environment including understanding of the host language and culture, help facilitate their adaptation in the host culture

7.6. Conclusion

The objective of this study was to find out how the ten non-Finnish clients would deal with the intercultural interaction with the Finnish health care practitioners.

Considering the research questions the clients' most striking and salient experiences and/or observations dealt with - in concordance with the categorization of the data - a) verbal and nonverbal communication, b) their assumptions of the Finnish health care system, c) their expectations and d) their strategies.

How the clients perceived, illustrated and evaluated their intercultural experiences was observed to be very much linked with the research question: *to which aspects of intercultural communication do the clients give meanings?* Throughout the interviews, as presented in the results the clients gave voice to elements of verbal and nonverbal communication (see 6.1. and 6.3.). By stating their assumptions, expressing their expectations and by describing their employed strategies the clients' descriptions gave evidence of their worldview with its values and attitudes. Additionally, they touched aspects of intercultural communication such as adaptation, stereotyping and prejudices, and the tendency to evaluate (see 6.2., 6.4. and 6.5.).

Overall, the findings indicate that the clients perceived persons, their behavior, and situations as intercultural when they were different than what they would experience 'at home'. This would confirm Lee's and Boster's data from a study that attempted to recast uncertainty reduction theory from a cognitive perspective (1991). One of their data indicate that people perceive intercultural partners to be less similar to themselves (1991, 203). In other words, when the clients in this study reported on intercultural aspects in their interaction with Finnish medical practitioners, these were based on perceived differences in the interaction between practitioners in Finland and in their home-country.

In the intercultural communication context, unless one is aware of it, 'difference' usually is considered as an 'experienced difference' (koettua erilaisuutta) which is able to cause misunderstandings. Presupposing that awareness of perceiving difference is present, 'difference' can result in knowledge. Moreover, associating 'difference' with a highly developed intercultural alertness and cultural relativism, can be regarded as enriching and desirable (Salo-Lee: 1996, 14-15).

Considering that 'difference' does interfere with caution in decoding nonverbal symbols, signs, and signals, and that the confidence that comes with 'difference' requires tentative

assumptions, behaviors and a willingness to accept the anxiety of 'not knowing' (Barna, 1997: 375-376) can lead to the following statement: Taking into account the findings of this study, the clients' assumptions of differences - contrary to the assumptions of similarities - could be evaluated as positive and might imply them having reached a certain stage of intercultural sensitivity. In an attempt to apply the findings of this study to Bennett's developmental model to intercultural sensitivity, in which the key organizing concept is 'difference', the ten clients seem to 'float' between the stages of minimization and integration. Furthermore, in this particular study, there seems to be a certain correspondence between the duration of the clients' stay in Finland, the total frequency of their descriptions in all the categories mentioned, and their stage in the developmental model to intercultural sensitivity. For instance, one of the American clients who has been four years in Finland, had the highest frequency of descriptions (83), and could be placed in the stage of integration. In contrast to the American client, the client coming from Russia has been one year in Finland, had the lowest frequency of descriptions (46), and seems to fit into the stage of minimization.

The third research question posed: *have the clients developed any strategies in order to improve their communication with the Finnish medical practitioners?* This question has to be answered in the affirmative. All the clients interviewed, reported having approached the intercultural interaction prepared and well-equipped, i.e. they consciously employed strategies to enhance the communication situation with their practitioner. Serious considerations about speaking or not speaking a certain language, switching into another language, bringing in a third party to the practitioner's office are a few examples of the employed strategies. These strategies can be considered as extra efforts the non-Finnish clients had to make, those extra efforts which Finnish clients in Finland would perhaps not even have to think of, nor consider.

7.7. Methodology

The presupposition for me starting a study like this: obtaining information from non-Finnish people about their interactions with the Finnish medical practitioners, was that it should be conducted with a qualitative research method. I am convinced that a quantitative research method would not have succeeded to gather the variety and the amount of information as I obtained with the interviews. Also the possibilities of expanding the respondents' response range by going deeper into the matter when some topics were very interesting, relevant, or unclear would not have been possible when dealing with a quantitative research method. The ability to get involved in the experience of others, told in their own words, while utilizing their own value and belief frameworks would have been virtually impossible without these face-to-face interviews. Interviewing as a qualitative data collection method then, has proven to be well selected. The interviews provided me with a vast bundle of tapes and transcript papers with rich, varying, intruiging, surprising, sometimes funny and sometimes distressful data. At first sight it seemed to be an overwhelming amount of data to deal with, but the content analysis established itself as a clear and logical qualitative data analysis method to work with.

Having applied the qualitative evaluation criteria, as described by Tynjälä (1991), in this

study (see chapter 5.5) presupposes sufficiently expounded data and adequate illustrations about the research context. In conducting this research I aimed at meeting these presuppositions as I presented sufficiently detailed information about the research context (see chapter 5.2.), dealing with selection criteria, and with the description of the actual interviewing situation and duration. Also the original quotations of the interviewees throughout the chapters dealing with the findings and the discussion (chapters 6 and 7) contributed to meet the presuppositions mentioned.

7.8. Limitations

The fact that only two of the ten persons could communicate with the practitioner in their native tongue, that one person reported about her interaction in which she was verbally passive, the practitioners who did not speak their mother tongue, and me who interviewed the persons in English also might set some limitations to this research. Previous studies though, conducted in Finland, in the USA and in Australia had to deal with similar issues but these did not seem to be a major obstacle in obtaining sincere data (Herselman: 1996, Pauwels: 1994, Ruben: 1993, Saarnio: 1996, Young and Klingle: 1996). Talking in a language different from the native language can always result in miscommunication. However, these kind of situations naturally tend to create the space and possibility to ask, to ask again, and to make sure everything has been understood, something which would not have been possible when using questionnaires or quantitative data collection methods.

7.9. Implications and recommendations

Perhaps the most significant implication to be drawn from this study is that communication between clients and practitioners representing different cultural backgrounds should be encouraged. Some of the current findings suggested the lack of information and of emotional communication which lead to feelings of fear and increased sensitivity for pain. This communication, whether it is verbal or nonverbal, is an absolute necessity for creating an atmosphere which 1) is able to keep open the channel for constant information exchange, 2) allows each individual, as well client as practitioner, to behave according to their own cultural communication pattern, and 3) which gives space to gain mutual respect and understanding. Remembering that the crucial variable when treating culture and communication is not fundamentally the langauge that is used, but the patterned ways in which the language is used, and the cultural meanings associated with them (Carbaugh, 1995: 60) might open some new perspectives for mutual understanding. Providing practitioners with a range of adequate communication strategies will inevitably decrease misunderstandings, frustrations, aggressivity, scaredness, and dissatisfaction between clients and practitioners.

The implementation of well-considered communication strategies in the intercultural medical context will lead to lessen the clients' threshold of fear, and consequently their threshold of pain. This presupposes training in intercultural communication for medical practitioners, which should include the heightening of awareness, that people from different cultures may experience world wide similar phenomena such as pain in a different way than one is used to in one's own home-country. The central theme of fear

and/or pain regularly occurred in the non-Finnish clients' talks and should be carefully considered. Whereas some people in Finland tend to consider alleviation of pain as 'hömpötystä', and tend to administer far too less sedatives for their terminally ill clients, Dutch practitioners were recently reproached by administering too much morfine to their suffering clients. Whereas in the United States piercing children's ears, by inflammation of the middle ear, is considered as unethical due to the severe pain it causes, it still was a standard procedure till the mid 1990's in Finland.

Finnish medicine may have through history and traditions another way of dealing with pain, or might consider pain as something which naturally belongs to sickness and treatment and might therefore need no further consideration. Non-Finnish clients then should feel to be in good hands, as well as they should be allowed to experience acceptance just in the way how they are and with the cultural aspects they bring about. It would be wrong to implement pressures of a world view to non-Finnish clients - and to any clients - in which they feel compelled to deal with fear and pain in a way they are not used to. They should not have to think like the British client stated: *"I think they thought I needed a good dose of sisu".*

Future research on this topic could bring forward more valuable findings when taking into account as well the viewpoints of the Finnish practitioners dealing with non-Finnish clients.

A practical consequence of this study is to provide more adequate and available information for the non-Finnish clients visiting any medical instance here in Finland, e.g. information leaflets and info-boards in various languages, as well as contact persons trained to deal with non-Finnish clients' questions and formalities.

This period - the 1990's - in which Finland is strongly opening itself for foreigners of many different cultural and ethnic backgrounds coincides with the strong changes within the Finnish culture itself. Medical practitioners must pay respect that also among the Finnish population, which used to be in international comparison rather homogenious, as well in values of the people as in their way of living, strong changes take place. These changes may result in the need of revision of policies in treating Finnish clients. This makes the need of research on the field of intercultural practitioner-client communication in Finland even more important than the size of foreign population would indicate: The same kind of alertness and value free open attitude towards the client, which seems to be a very central aspect in good multicultural practitioner-client relation, would help the practitioner to face different kinds of clients alltogether. Research in the intracultural context brings valuable information for inlanders too.

The findings of this study, the number of and the still increasing growth of non-Finnish persons coming to Finland should indicate continuing research in this area. More extensive investigation in future research should promote more knowledge and information to improve practitioner-client communication in an intercultural context. This could enable the design training units etc., which could be of practical use in preparing medical personnel for dealing sufficiently with all clients in general and non-Finnish clients in particular.

8. Bibliography

Adler, P. 1987. Culture Shock and the Cross-Cultural Learning Experience. In L. Luce and E. Smith (Eds.), Toward Internationalism. Boston: Heinle & Heinle., 24-36.

Albert, E. 1972. Culture patterning in Burundi. In J. Gumperz and D. Hymes (Eds.), Directions in Sociolinguistics. New York: Holt, Rinehart and Winston.

Andersen, J. F. and Powell, R. 1991. Intercultural Communication and the Classroom. In L.A. Samovar and R.E. Porter (Eds.), Intercultural Communication: A Reader. Belmont, CA: Wadsworth.

Argyle, M. 1979. New Developments in the Analysis of Social Skills. In A. Wolfgang (Ed.), Nonverbal Behavior: Applications and Cultural Implications. New York: Academic Press.

Argyle, M. 1983. Doctor- Patients Skills. In D. Pendleton and J. Hasler (Eds.), Doctor-Patient Communication. London: Academic Press, 57-75.

Argyle, M. 1992. Intercultural Communication. In S. Bochner (Ed.), Cultures in Contact: Studies in Cross-Cultural Interaction. Oxford: Pergamon Press, 61-79.

Banks, S.P., Ge, G. and Baker, J. 1991. Intercultural Encounters and Miscommunication. In N. Coupland, H. Giles and J. M. Wiedman (Eds.), Miscommunication and Problematic Talk. Newbury Park: Sage, 103-120.

Barna, L.M. 1997. Stumbling Blocks in Intercultural Communication. In L.A. Samovar and R.E. Porter (Eds.), Intercultural Communication: A Reader. Belmont: Wadsworth, 370-379.

Barnlund, D.C. 1997. Communication in a Global Village. In L.A. Samovar and R.E. Porter (Eds.), Intercultural Communication. A Reader. Belmont, CA: Wadsworth, 27-36.

Bassey, M. 1981. Pedagogic Research: On the Relative Merits of Search for Generalization and Study of Single Events. Oxford Review of Education 7 (1), 73-93.

Bennett, C. I. 1986. Comprehensive Multicultural Education: Theory and Practice. Boston: Allyn & Bacon.

Bennett, M. J. 1986. Towards Ethnorelativism: A Developmental Model of

Intercultural Sensitivity. In M. Paige (Ed.), Cross-Cultural Orientation. New Conceptualizations and Applications. Lanham: University Press of America, 27-69.

Berger, C. R. and Calabrese, R 1975. Some Explanations in Initial Interactions and Beyond: Toward a Developmental Theory of Interpersonal Communication Research 1, 99-112.

Berry, M. 1995. Cultural Coding of Plausible Problems and Credible Solutions. Paper submitted for publication in the International and Intercultural Communication Annual. 30 October 1995.

Blommaert, J. 1995. Ideologies in Intercultural Communication. In O. Dahl (Ed.), Intercultural Communication and Contact. Stavanger: Misjonshogskolens Forlag, 9-27.

Bochner, S. 1983. Doctors, Patients and their Cultures. In D. Pendleton and J. Hasler (Eds.), Doctor-Patient Communication, London: Academic Press, 127-139.

Brislin, R. W. 1981. Cross-Cultural Encounters: Face-to-Face Interaction. New York: Pergamon Press.

Brislin, R. W. 1988. Prejudice in Intercultural Communication. In L. Samovar and R. Porter (Eds.), Intercultural Communication: A Reader. Belmont, CA: Wadsworth., 339-344.

Brown, H. D. 1990. Learning a Second Culture. In J. M. Valdes (Ed.), Culture Bound: Bridging the Cultural Gap in Language Teaching. New York: University Press.

Carbaugh, D. 1995. Are Americans Really Superficial? Notes on Finnish and American Cultures in Linguistic Action. In L. Salo-Lee (Ed.), Kieli ja Kulttuuri: Oppimisessa ja Opettamisessa. Jyväskylä: Jyväskylän Yliopisto. Viestintätieteiden Laitos, 53-61.

Carbough, D. 1997. Finnish and American Linguistic Patterns: A Cultural Comparison. In L. Samovar and R. Porter (Eds.), Intercultural Communication: A Reader. Belmont, CA: Wadsworth., 221-226.

Carrol, J.B. 1992. Anthropological Linguistics: An Overview. In W. Bright (Ed.), International Encyclopedia of Linguistics. New York: Oxford University Press.

Cartwright, A. 1983. Prescribing and the Doctor-Patient Relationship. In D. Pendleton and J. Hasler (Eds.), Doctor-Patient Communication, London: Academic Press, 177-192.

Christman, N. J. and Maretzki, T. W. (Eds.), 1982. Clinically Applied Anthropology:

Anthropologists in Health Science Settings. Culture, Illness, and Healing 5. London: D. Reidel Publishing Company.

Clansy, P. 1986. The Acquisition of Communicative Style in Japanese. In B. Schieffelin and E. Ochs (Eds.), Language Socialization Across Cultures. Cambridge: Cambridge University Press.

Coffey, A. and Atkinson, P. 1996. Making Sense of Qualitiative Data. Thousand Oaks, CA.: Sage Publications.

Dahl, O. (Ed.) 1995. Intercultural Communication and Contact. Stavanger, Misjonshogskolens Forlag.

Dasen, P. R., Berry, J.W. and Sartorius, N. (Eds.), 1988. Health and Cross-Cultural Psychology: Towards Applications. Cross-Cultural Research and Methodology Series, Vol. 10. Newbury Park: Sage Publications.

Davis, F. 1975. Inside Intuition. New York: Signet.

Davison, R. 1985. Ethical Conflicts in Medicine as a Consequence of Poor Communication. Paper presented at the Summer Conference on Health Communication, August, Evanston, IL.

Denzin, N.K. and Lincoln, Y.S. (Eds.), 1994. Handbook of Qualitative Research. Thousand Oaks, CA.: Sage Publications.

Ekman, P., Friesen, W., and Ellsworth, P. 1972. Emotion in the Human Face: Guidelines for Research and an Integration of the Findings. New York: Pergamon Press.

Ellis, R. and Mc Clintock, A. 1990. If You Take My Meaning: Theory into Practice in Human Communication. New York: Routledge.

Erickson, F. and Schultz, J. 1982. The Councelor as Gatekeeper: Social Interaction in Interviews. New York: Academic Press.

Foley, R. and Sharf, B. F. 1981. The Five Interviewing Techniques most frequently overlooked by Primary Care Physicians. Behavioral Medicine 8, 26-31.

Foster, D.A. 1992. Bargaining Across Borders: How to Negotiate Business Successfully Anywhere in the World. New York: Mc Graw-Hill.

Gallois, C., Giles , H. , Jones, E., Cargile, A.C., and Ota, H. 1995. Accommodating Intercultural Encounters: Elaborations and Extensions. In R. Wiseman (Ed.), Intercultural Communication Theory. Thousand Oaks, CA: Sage, 115-147.

Gass, S.M. and Varonis, E.M. 1991. Miscommunication in Nonnative Speaker Discourse. In N. Coupland, H. Giles and J.M. Wiedman (Eds.), Miscommunication and Problematic Talk. Newbury Park: Sage, 121-145.

Geist, P. 1996. Negotiating Cultural Understanding in Health Care Communication. In L.A. Samovar and R.E. Porter (Eds.,) Intercultural Communication: A Reader. Belmont: Wadsworth.

Greenberg, J. and Baron, R. 1995. Behavior in Organizations: Understanding and Managing the Human side of Work. Englewood Cliffs, NY: Prentice Hall.

Grice, H. 1975. Logic and Conversation. In P. Cole and J. Morgan (Eds.), Syntax and Semantics: Vol.3. Speech Acts. New York: Academic Press.

Gudykunst, W.B. and Kim, Y.Y. 1984. Communicating with Strangers: An Approach to Intercultural Communication. New York: Random House.

Gudykunst, W.B. and Ting-Toomey, S. 1988. Culture and Interpersonal Communication. Newbury Park: Sage.

Gudykunst, W. B. 1995. Anxiety/Uncertainty Management (AUM) Theory. In R. Wiseman (Ed.) Intercultural Communication Theory. Thousand Oaks, CA: Sage.

Hall, E. T. 1959. The Silent Language. New York: Doubleday

Hall, E.T. 1969. The Hidden Dimension. New York: Doubleday.

Hall, E. T. 1976. Beyond Culture. New York: Doubleday.

Hall, E. T. 1981. The Silent Language. New York: Doubleday.

Hall, E.T. 1983. The Dance of Life. New York: Doubleday.

Hammer, M. R. 1997. A Measure of Intercultural Sensitivity. The Intercultural Development Inventory (In Press) In S.M. Fowler and M.G. Mumford (Eds.), The Intercultural Sourcebook: Cross-Cultural Training Methods. Vol. II. Yarmouth: The Intercultural Press, 1-10.

Harper, R. G., Wiens, A. N., and Matarazzo, J. D. (Eds.), 1978. Nonverbal Communication: The State of the Art. New York: Wiley.

Hartley, J.F. 1994. Case Studies in Organizational Research. In C. Cassel and G. Symon (Eds.), Qualitative Methods in Organizational Research. A Practical Guide. London: Sage Publications.

Helman, C. G. 1990. Culture, Health, and Ilness. (2nd. ed.). London: Wright.

Herselman, S. 1996. Some Problems in Health Communication in a Multicultural Clinical Setting: A South African Experience. Health Communication 8 (2), 153-170.

Hewstone, M. and Giles, H. 1986. Stereotypes and Intergroup Communications. In W. Gudykunst (Ed.), Intergroup Communication. London: Edward Arnold.

Hirsjärvi, S. and Hurme, H. 1982. Teemahaastattelu. Helsinki: Gaudeamus.

Hofstede, G. 1979. Value Systems in Forty Countries. In Eckensberger, W. Lonner and Y. Poortinga (Eds.), Cross-Cultural Contributions to Psychology. Lisse, The Netherlands: Swets and Zeitlinger.

Hofstede, G. 1980. Culture's Consequences: International Differences in Work-related Values. Beverly Hills, CA: Sage.

Hofstede, G. 1983. Dimensions of National Cultures in Fifty Countries and Three Regions. In J. Deregowski, S. Dzuirawiec, and R. Annis (Eds.), Explications in Cross-Cultural Psychology. Lisse, The Netherlands: Swets and Zeitlinger.

Hofstede, G. 1984. National Cultures and Corporate Cultures. Paper delivered on LIFIM Perspective Day, Helsinki, Finland, December 4.

Hoopes. D. S. and Pusch, M. D. 1979. Multicultural Education: a Cross Cultural Training Approach. Intercultural Network, Illinois: Inc. La Grange Park, p. 6.

Hsu, F. 1981. Americans and Chinese (3rd ed.). Honolulu: University of Hawaii Press.

Janhunen, H., Kirveskangas, L., and Kivinen, A. 1996. Ulkomaalaisen Kohtaaminen Vastaanotolla. Jyväskylän Sosiaali-ja Terveyspalvelukeskuksen Monisteita. Harjoitustyö Kansainvälistyvän Työn PD-Koulutus. Jyväkylä: Jyväskylän Yliopisto, Täydennyskoulutuskeskus.

Jandt, F.E. 1995. Intercultural Communication. Thousand Oaks, CA: Sage.

Jaspars, J., King, J., and Pendleton, D. 1983. The Consultation: A Social Psychological Analysis. In D. Pendleton and J. Hassler (Eds.), Doctor-Patient Communication. London: Academic Press, 139-160.

Johnson, C. and Johnson, F. 1975. Interaction Rules and Ethnicity. Social Forces 54, 452-466.

Kaplan, R.B. 1966. Cultural Thought Patterns in Intercultural Education. Language Learning, Vol. XVI, Nrs. 1 and 2, 15.

Karol, J. 1985. The Foreigner's Language. A Sociolinguistic Perspective.

Oxford:Pergamon Press.

Katriel, T. 1986. Talking Straight: Dugri Speech in Israeli Sabra Culture. Cambridge: Cambridge University Press.

Kim, Y.Y. 1995. Cross-Cultural Adaptation: An Integrative Theory. In R. Wiseman (Ed.), Intercultural Communication Theory. Thousand Oaks, CA: Sage Publications, 170-194.

Kleinman, A. 1980. Patients and Healers in the Context of Culture: An exploration of the Borderland between Anthropology, Medicine, and Psychiatry. Berkeley, CA: University of California Press.

Kleinman, A. 1988. The Ilness Narratives: Suffering, Healing & the Human Condition. U.S.A.: Basic Books.

Kluckhohn, F. and Strodtbeck, F. 1961. Variations in Value Orientations. New York: Row, Peterson.

Knapp, M. L. 1978. Nonverbal Communication in Human Interaction. New York: Holt, Rinehart and Winston.

Knapp, M. L. 1980. Essentials of Nonverbal Communication. New York: Holt, Rinehart and Winston.

Kreps, G. L. 1990. Communication and Health Education. In E. B. Ray and L. Donohew (Eds.), Communication and Health: Systems and Applications. Hillsdale, New Jersy: Lawrence Erlbaum Associates, Publishers, 187-203.

Kreps, G. and Thornton, B. C. 1992. Health Communication: Theory and Practice. Prospect Heights, IL: Waveland Press, Inc.

Krippendorf, K. 1980. Content Analysis: An Introduction to its Methodology. Beverly Hills: Sage Publications.

Ladmiral, J. R. and Lipiansky, E. M. 1989. La Communication Interculturelle. Bibliothèque Européenne des Sciences de l'Education. Paris: Armand Colin.

Lee, H.O. and Boster, F.J. 1991. Social Information for Uncertainty Reduction During Initial Interactions. In S. Ting-Toomey and F. Korzenny (Eds.), Cross-Cultural Interpersonal Communication. Newbury Park: Sage, 189-212.

Lehtonen, J. and Sajavaara, K. 1985. The Silent Finn. In D. Tannen and M. Saville-Troike (Eds.), Perspectives on Silence. Norwood, New Jersey: Ablex, 193-201.

Lehtonen, J. and Sajavaara, K. 1997. The Silent Finn Revisited. In A. Jaworski (Ed.), Silence. Interdisciplinary Perpectives. Berlin: Mouton de Gruyter.

Leiwo, M., Timonen, A. and Toivanen, P. 1990. Terveydenhuollon Viestinnästä ja sen Ongelmista. Helsingin Yliopiston Fonetiikan Laitoksen Monisteita. Mimeographed Series of the Department of Phonetics. University of Helsinki. N:O 17.

Levine, D. 1985. The Flight from Ambiguity. Chicago: University of Chicago Press.

Ley, P. 1983. Patient's Understanding and Recall in Clinical Communication Failure. In D. Pendleton and J. Hasler (Eds.), Doctor-Patient Communication, London: Academic Press., 89-108.

Lincoln, Y.S. and Guba, E.G. 1985. Naturalistic Inquiry. Beverly Hills: Sage Publications.

Marsh, D. 1993. The Social Distance Factor in Research and Commentary on the Finnish Intercultural Communicator. In J. Lehtonen (Ed.), Kulttuurien Kohtaaminen. Jyväskylä: Jyväskylän Yliopisto. Viestintätieteiden Laitos, 91-119.

Mc Daniel, E.R. and Samovar, L.A. 1997. Cultural Influences on Communication in Multinational Organizations: The Maquiladora. In L.A Samovar and R.E. Porter (Eds.), Intercultural Communication: A Reader. Belmont, CA: Wadsworth, 285-289.

Mehrabian, A. 1971. Silent Messages. Belmont, CA: Wadsworth, 42-47.

Oberg, K. 1969. Culture shock: Adjustment to New Culture Environments. Practical Anthropology 7, 177-182.

Park, M. 1979. Communication Styles in Two Different Cultures: Korean and American. Seoul, Korea: Han Shin Publishing Company.

Patton, M. Q. 1990. Qualitative Evaluation and Research Methods. London: Sage Pubications.

Pauwels, A. 1994. Applying Linguistic Insights in Intercultural Communication to Professional Training Programs: An Australian Case Study. Multilingua 13-1/2, 195-212.

Payer, L. 1989. Medicine and Culture: Notions of Health and Sickness in Britain, the U.S., France, and West-Germany. London: Victor Gallancz LTD.

Pellegrino, E.D. and Thomasma, D.C. 1981. A Philosophical Basis of Medicine Practice. Oxford: Oxford University Press.

Pendleton, D. and Hasler, J. (Eds.), 1983. Doctor-Patient Communication. London:Academic Press, Inc.

Pendleton, D. 1983. Doctor-Patient Communication: A Review. In D. Pendleton and J. Hasler (Eds.), Doctor-Patient Communication. London: Academic Press., 5-75.

Ray, E.B. and Donohew, L. (Eds.), 1990. Communication and Health: Systems and Applications. Hillsdale, New Jersey: Lawrence Erlbaum Associates, Publishers.

Ray, E.B. (Ed.), 1993. Case Studies in Health Communication. Hillsdale, New Jersey: Lawrence Erlbaum Associates, Publishers.

Ray, E.B. (Ed.), 1996. Case Studies in Communication and Disenfranchisment. Hillsdale, New Jersey: Lawrence Erlbaum Associates, Publishers.

Ray, E.B. and Miller, K.I. 1990. Communication in Health Care Organizations. In E.B. Ray and L. Donohew (Eds.), Communication and Health: Systems and Applications. Hillsdale, New Jersey: Lawrence Erlbaum Associates, Publishers, 92-111.

Rouse, R. A. 1989. A Paradigm of Intervention: Emotional Communication in Dentistry. Health Communication 1 (4), 239-252.

Ruben, B. D. 1990. The Health Caregiver-Patient Relationship: Pathology, Etiology, Treatment. In E. B. Ray and L. Donohew (Eds.), Communication and Health: Systems and Applications. Hillsdale, New Jersey: Lawrence Erlbaum Associates, Publishers, 51-68.

Ruben, B. D. 1992. Communication and Human Behavior. New Jersey: Prentice Hall.

Ruben, B. D. 1993. What Patients Remember: A Content Analysis of Critical Incidents in Health Care. Health Communication 5 (2), 99-112.

Saarni, U. 1996. Ulkomaalainen Suomalaisessa Opiskelijahammashuollossa. Kansaneläkelaitos: Sosiaali-ja Terveysturvan Tutkimuksia 9. Helsinki: Hakapaino Oy.

Sallinen-Kuparinen, A. 1986. Finnish Communication Reticence: Perception and Self-Reported Behaviour. Studio Philologia Jyväskyläensia 19. Jyväskylä: University ofJyväskylä.

Salo-Lee, L. 1996. Kieli, Kulttuuri ja Viestinitä. In E. Saksala (Ed.), Me ja M u u t Kulttuurienvälinen Viestintä, Jyväskylä: Gummerus Kirjapaino OY., 6-36.

Samovar, L. A. and Porter, R. E. 1991. Communication between Cultures. Belmont, CA: Wadsworth.

Samovar, L.A., Porter, R.E. and Jain, N.C. 1981. Understanding Intercultural

Communication. Belmont, CA: Wadsworth.

Scherz, J.W., Edwards, H.T. and Kallail, K.J. 1995. Communicative Effectiveness of Doctor-Patient Interactions. Health Communication 7 (2), 163-177.

Schneider, D. E. and Tucker, R. K. 1992. Measuring Communicative Satisfaction in Doctor-Patient Relations: Health Communication 4 (1), 19-28.

Scollon, R. and Scollon-Wong S. 1995. Intercultural Communication: A Discourse Approach. Oxford: Blackwell.

Sechrest, L., Fay, T.L., and Zaidi, S.M. 1972. Problems of Translation in Cross-Cultural Communication. Journal of Cross-Cultural Psychology 3(1), 41-56.

Seelye, H. N. 1994. Teaching Culture: Strategies for Intercultural Communication.Lincolnwood, IL: National Textbook Company.

Seliger, H.W. and Shogamy, E. 1989. Second Language Research Methods. Oxford: Oxford University Press.

Sharf, B.F. 1984. The Physician's Guide to Better Communication. Glenview, IL: Scott, Foresman and Company.

Sharf, B.F. 1990. Physician-Patient Communication as Interpersonal Rhetoric: A Narrative Approach. Health Communication 2 (4), 217-231.

Sharf, B.F. and Street, R.L. 1997. Patient as a Central Construct: Shifting the Emphasis. Health Communication 9 (1), 1-13.

Singer, M.R. 1987. Intercultural Communication: A Perceptual Approach. Englewood Cliffs, NJ: Prentice Hall.

Stefani, L.A., Samovar, L.A., and Hellweg S.A. 1997. Culture and its Impact on Negotiation. In L.A. Samovar and R.E. Porter (Eds.), Intercultural Communication: A Reader. Belmont, CA: Wadsworth.

Stein, H. F. 1990. American Medicine as Culture. Boulder, COL: Westview Press.

Tannen, D. 1986. That's not what I meant! New York: Ballantine Books.

Tate, P. 1983. Doctors' Style. In D. Pendleton and J. Hasler (Eds.), Doctor-Patient Communication, London: Academic Press, 75-89.

Templeton-Brownlee, A. 1978. Community, Culture, and Care: A Cross-Cultural G[illegible] for Health Workers. Saint Louis, MI: The C.V. Mosby Company.

Thompson, C. L. and Pledger, L. M. 1993. Doctor-Patient Communication: Is Patient Knowledge of Medical Terminology Improving? Health Communication 5 (2), 89-97.

Thompson, T. L. 1990. Patient Health Care: Issues in Interpersonal Communication. In E. B. Ray and L. Donohew (Eds.), Communication and Health: Systems and Applications. Hillsdale, New Jersey: Lawrence Erlbaum Associates, Publishers, 27- 50.

Triandis, H. C. 1977. Interpersonal Behavior. Monterey, CA: Brooks/Cole.

Triandis, H. C. 1984. A Theoretical Framework for the More Efficient Construction of Culture Assimilators. International Journal of Intercultural Relations 8, 301-330.

Triandis, H.C. 1986. Collectivism vs. Individualism: A Reconceptualization of a Basic Concept in Cross-Cultural Psychology. In C. Bagley and G. Verman (Eds), Personality, Cognition, and Values: Cross-Cultural Perspectives of Childhood and Adolescence. London: Macmillan.

Tynjälä, P. 1991. Kvalitatiivisten Tutkimusmenetelmien Luotettavuudesta. Kasvatus 22 (5-6) 387-399.

Virtanen, V. 1990. Potilas-Lääkärisuhde Perusterveydenhuollossa. Duodecim 109, 1178-1182.

West, C. and Frankel, R.M. 1991. Miscommunication in Medicine. In N. Coupland, H. Giles and J. M. Wiemann (Eds.), Miscommunication and Problematic Talk. Newbury Park: Sage, 166-194.

Westen, D. 1985. Self and Society. Cambridge: Cambridge University Press.

Whorf, B.L. 1956. Language, Thought, and Reality. Cambridge: M.I.T. Press.

Wilson, G. L., Hantz, A. M and Hanna, M. S. 1992. Interpersonal Growth through Communication. Dubuque, IA: W.C. Brown.

Wiseman, R. L. and Van Horn, T. 1995. Theorizing in Intercultural Communication. In R.L. Wiseman (Ed.), Intercultural Communication Theory. Thousand Oaks, CA: Sage Publications, 2-8.

Witte, K. and Morrison, K. 1995. Intercultural and Cross-Cultural Health Communication: Understanding People and Motivating Healthy Behaviors. In R.L. Wiseman (Ed.), Intercultural Communication Theory. Thousand Oaks: Sage Publications, 216-247.

Wyatt, N. 1991. Physician-Patient Relationships: What Do Doctors Say? Health Communication 3 (3), 157-172.

Yin, R.K. 1981. The Case Study Crisis: Some Answers. Administrative Science Quaterly, 26, 58-65.

Young, M. and Klingle, R. S. 1996. Silent Partners in Medical Care: A Cross-Cultural Study of Patient Participation. Health Communication 8 (1), 29-53.

Yum, J. 1987a. Korean Philosophy and Communication of Five Ethnic Groups in Hawaii. In R. Bostrom (Ed.), Communication Yearbook 7. Beverly Hills, CA: Sage.

Yum, J. 1987b. The Practice of uye-ri in Interpersonal Relationships in Korea. In D. Kincaid (Ed.), Communication Theory from Eastern and Western Perspectives. New York: Academic Press.