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REVIEW ARTICLE

Understanding the role of positive emotions in healthcare communication – A realist review

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Abstract

Aim: To explore how the expression of positive emotions during the interaction between patients and providers can cultivate the patient-provider relationship.

Design: We conducted a realist review guided by the Realist and Meta-narrative Evidence Syntheses: Evolving Standards.

Methods: We systematically searched CINAHL, MEDLINE, PsychINFO and Scopus from inception to March 2019. Study selection and data extraction were performed blinded in pairs. From 3146 abstracts blinded in pairs, 15 papers were included and analysed. From each included paper, we extracted contexts, mechanisms and outcomes that were relevant to answer our research questions, creating a configuration between these elements (CMO configuration).

Results: Our findings suggest that in the contexts of person orientation and positive outlook, patient-provider relationships improve by communication conveying and eliciting positive emotions. We found six underlying mechanisms for this that form either direct or indirect pathways between the context and the outcome.

KEYWORDS
emotional aspects, nurse-patient relationship, psychological and social coping, review, therapeutic relationships

1 | INTRODUCTION

Suffering from an illness elicits emotions. Negative emotions, often referred to as concerns, or cues to concerns (Finset et al., 2013; Zimmermann et al., 2007), have been the focus of research for many years. While the functions of negative emotions have been thoroughly studied and described, little is known about the function of positive emotions in healthcare relations. Positive emotions have mostly been studied within the psychology field and seem to play a unique role in maintaining and promoting flourishing mental health, that is by widening the scope of attention (Fredrickson & Branigan, 2005), broadening behavioural repertoires (Fredrickson & Branigan, 2005) and increasing intuition (Bolte et al., 2003) and creativity (Isen et al., 1987). Studies show that positive emotions are linked to the accumulation of personal resources, such as self-efficacy (Ouweneel et al., 2011), resilience to adversity (Fredrickson et al., 2003; Gloria & Steinhardt, 2016), increased happiness (Fredrickson & Joiner, 2002) and psychological growth (Fredrickson et al., 2003; Vazquez et al., 2020; Waters et al., 2021). In addition, studies have shown an impact on bodily systems, such as reduced levels of cortisol and of an inflammatory response to stress (Steptoe et al., 2005), alterations in the frontal brain asymmetry (Davidson et al., 2003) and an increase in immune function (Davidson et al., 2003).

Nurses often have long relations with patients and are also often spending more time with the patient than physicians do, but little is known about how nurses deal with positive emotions in these relationships. By doing a realist review of existing literature, this paper will contribute to understanding of the outcomes of positive expressions of positive emotion and the mechanisms through which outcomes are reached and in which contexts.

2 | BACKGROUND

Emotions consist of affective, valenced reactions to meaningful stimuli (Frijda, 2008). Positive emotions thus include pleasant or desirable situational responses. Overall, there seems to be evidence that positive emotions build a variety of cognitive resources and increase patients' life satisfaction, well-being and functioning in general, as described by Fredrickson in the broaden-and-build theory (Fredrickson, 2001). The mechanism following broaden-and-build is that positive emotions broaden people's momentary thought-action repertoires and lead to actions that build enduring personal resources, thus enhancing coping in a demanding situation. As an example, joy creates the urge to play, which in turn increases physical, intellectual and social resources. The application of the "broaden hypothesis" to healthcare interactions would suggest that patients' thought-action repertoire may be enhanced or expanded when experiencing positive emotions (Fredrickson, 2001). Patients who experience positive emotions broaden their cognitive and social behaviours. Creative and integrative thinking and relationship-building behaviours (Fredrickson, 2001) express this. This has implications for the patient and nurse relationship, potentially strengthening problem-solving and shared decision-making. Further, the "build hypothesis" refers to a person's sustaining a positive emotional state, which over time can strengthen personal resources (Fredrickson, 2001). Specifically, it appears when it comes to building cognitive resources that this produces faster learning and improved intellectual performance. For example, patients' experience of positive emotions can help them sustain adherence to a healthcare regimen. This example underscores why nurses would want to support and harness a patient's positive emotion experience.

The theory broaden-and-build by Fredrickson (2001) focuses on the function of experiencing positive emotions with implications for well-being and coping. Both the social bond theory and the attachment theory are relevant to understand the relationship between patients and providers. Scheff (2000) draws our attention to "differentiation" that involves a balance between closeness and distance. Following this, an intact social bond should balance the individual needs of the patients and the healthcare provider, and the needs of a group. This is especially relevant to maintain social bonds with a group of people who are different from self, such as patient and nurse. Salmon and Young (2009) have developed attachment theories from Bowlby (1982), focusing on autonomy in dependent caring situations. Attachments are emotional bonds, leading a person (i.e. a patient) to seek proximity to a safe person (i.e. a nurse) when feeling threatened (Salmon & Young, 2009). The attachment theory therefore points to patients' need to feel that they are in relationships with nurses who genuinely care for them. In sum, attachment and social bond theory focus on the importance of having a secure attachment behaviour and of the acceptance to experience strong social bond in professional relationship.

With the exception of empathic opportunities, positive emotion communication has been largely overlooked in the field of healthcare communication. Studies that examine emotions have predominantly focused on negative emotions, that is by coding patients' expressions of negative emotions (Hafskjold et al., 2016; Humphris et al., 2019; Mellblom et al., 2014) and nurses' responses to these expressions (Finset et al., 2013; Hafskjold et al., 2018; Heyn et al., 2013). Empathy is regarded as the appropriate response to negative emotion. The rationale for health communication studies of empathy and the emphasis our field places on provider empathy did not come from the perspective of promoting a positive emotional affect state in a patient but rather to express understanding of a person's suffering. There has been a very limited focus on the expressions of positive emotions and how this cultivates healthy provider-patient relationships. The communication of positive emotions and recalling specific positive life experiences are thought to be a mechanism to enhance resilience and foster connections (Askelund et al., 2019; Fredrickson et al., 2003), both of which are important features of quality health care. According to Sbarra and Coan (2018, p. 50), "close relationships and social connections are central to human health." In line with this, there is a need of research that can increase our understanding of how emotions can affect the relationship-health associations (Sbarra & Coan, 2018).

2.1 | Primary study aims

Given the potential for nurses to promote and support positive emotions in patients, it is important to create a map of potentially helpful communication strategies in terms of their nature, features and volume to be used in practice, including how to train this. Hence, the aim of this realist review was to explore the expression of positive emotions in cultivating healthy relationships between patients and nurses.

Our research questions were as follows:

1. In what context(s) does communication lead to the experience of positive emotions by patients?
2. What are the mechanisms through which communication of positive emotions cultivate the patient-nurse relationship?
3. What are the patient-reported outcomes of expressions of positive emotions?

3 | THE STUDY

3.1 | Design

We conducted a realist review (Pawson et al., 2005), as we were interested in better understanding how the three elements on which a realist review builds, that is context (C), mechanisms (M)

and outcomes (O), of positive emotions potentially could affect the patient-nurse relationship. Typical for a realist review is to build CMO configurations from the extracted data. CMO configurations model how the social context shape causal mechanisms. We adhered to the Realist And Meta-narrative Evidence Syntheses: Evolving Standards (RAMSES) publication standards (Wong et al., 2013) as a guide throughout the process of conducting this review. The protocol for this review was registered in the Prospective Register of Systematic Reviews (PROSPERO), registration number: CRD42018088149. Box 1 describes some of the common concepts related to a realist review.

As a realist approach is theory-driven, the starting point lies in theory (Pawson et al., 2005). To answer our research questions, we searched the literature and identified relevant program theories – ideas about what makes an intervention work (Pawson et al., 2005). Our study is grounded in the theories described in the background; the broaden and build theory (Fredrickson, 2001), the social bond theory (Scheff, 2000), and attachment theory as suggested applied in clinical communication related to medical illnesses (Salmon & Young, 2009, 2017). Together, these theories support our search for answers to our research questions.

BOX 1 Glossary terms for realist review

Programme theory: A description of how the intervention is expected to generate the intended outcome and under what circumstances (often described as context–mechanism–outcome (CMO) configurations).

Context: Conditions constituting the "backdrop" of the intervention, including but not limited to personal, social or organizational aspects that influence the behaviour of mechanisms. Context can be broadly understood as any condition that triggers and / or modifies the mechanism. Because these conditions change over time, the context may reflect characteristics of those changes during the implementation of the intervention.

Mechanism: The generative force that leads to outcomes. It could denote the cognitive or emotional reasoning of the various actors in relation to the work, challenges and success of the partnership. When mechanisms are identified, this advances the synthesis from describing what happened to theorizing why it happened, for whom and under what circumstances.

Outcome: The intended or unintended result of the intervention. It can be proximal, intermediate or final.

CMO configurations: A heuristic that reflects on the relationship between context, mechanism and outcome in a particular program. As CMOs may be nested in each other, the outcome of one CMO could become the context for the next in the chain of implementation steps.

3.2 | Method

3.2.1 | Search strategy

We performed systematic searches for peer-reviewed literature in English in CINAHL, MEDLINE, PsychINFO and Scopus. The searches were performed by a trained librarian, with the first and last author discussing the search terms. We searched the databases using keywords for both free text and database-specific headings regarding positive emotions (gratitude, happy, supportive, joy, optimism, laughter, humour, playful and positive emotion, mood and affect) and relationships (nurse-patient relation, physician-patient relation and professional-patient relation). Because we expected that we would end up with few studies, and because we have not been able to find a previous review exploring this topic, we did not limit the search for date of publication. We performed the searches in January 2018 and repeated the same search strategy in March 2019.

3.2.2 | Source outcome

The screening procedure was a stepwise process, beginning with the screening of 3146 titles and abstracts using Covidence (covidence.org) to screen in pairs blinded. The first author screened all titles and abstracts in this first step, pairing with each of the four other authors who were screening about 800 papers each. The inclusion and exclusion criteria (Table 1), and how to include papers based on title and abstract, were discussed by all authors. A total of 2917 papers were found irrelevant for various reasons (wrong outcome was most common, i.e. provider outcomes, followed by wrong setting, i.e. paediatric patients, and wrong study design, i.e. case studies). Any disagreement about inclusion was discussed, and a consensus was reached. To ensure inter-reliability and to avoid single-observer methods, we evaluated the articles in double pairs and experienced that we had over 70% agreement on which articles should be excluded (Bordens & Abbott, 2021). The articles we had assessed differently, we reviewed again and agreed on which ones should be included based on the inclusion criteria. In a realist review, the selection of papers should be made on two criteria: relevance and

TABLE 1 Inclusion and exclusion criteria

Reasons for inclusion	Reasons for exclusion
Studies in English	Reviews
Studies including adult patients (18 and above)	Case studies
Studies investigating positive emotions – either specific emotions or positive emotions as a concept	Thesis and dissertations
Studies including empirical data from patients	Books or book chapters
	Papers from psychotherapy

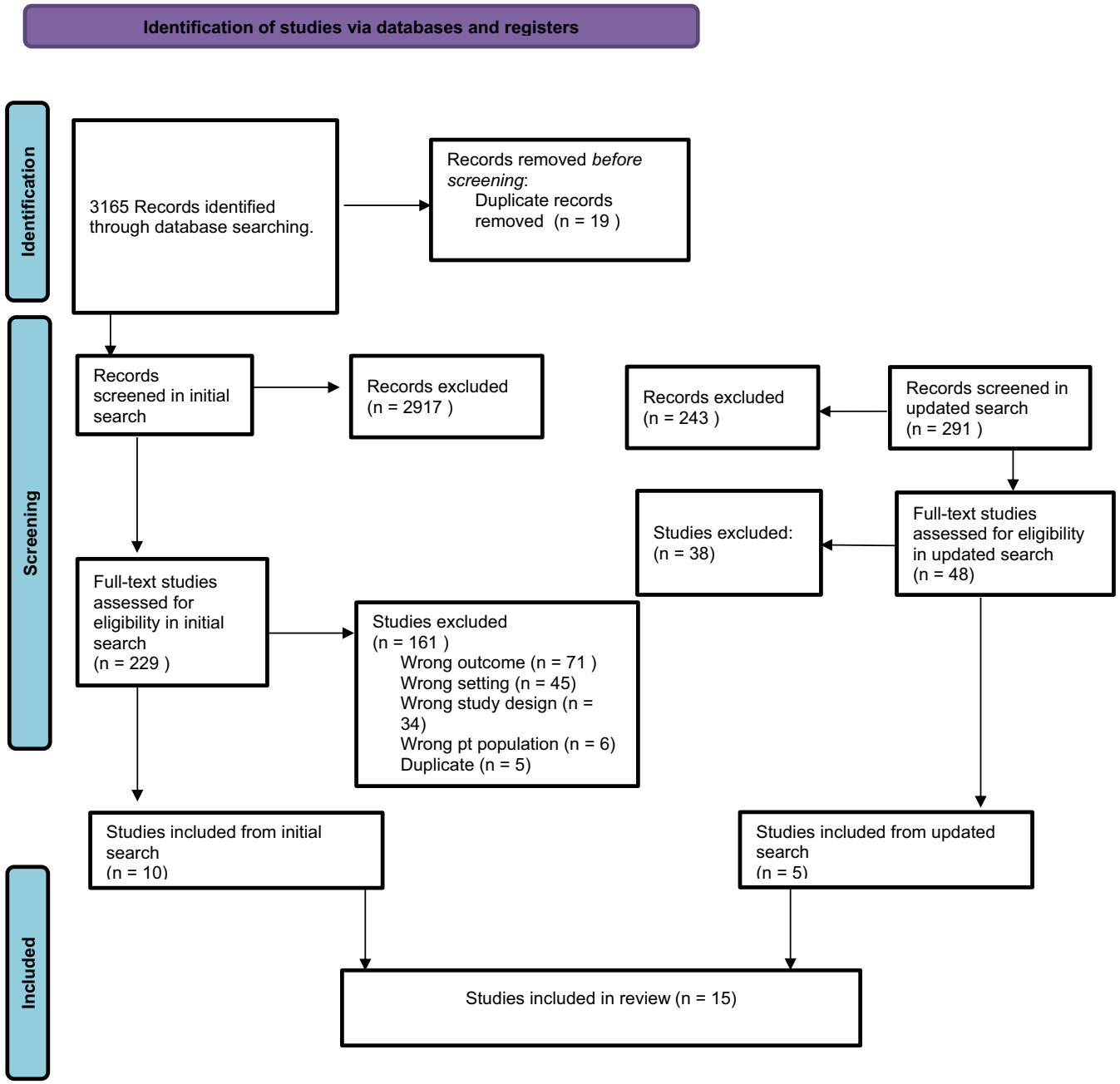

FIGURE 1 PRISMA flow diagram.

rigour (Wong et al., 2013). During the analysis process, we found that we needed to exclude some studies based on relevance. A large amount of the papers were reflective papers from psychotherapy (such as case descriptions). We decided to exclude psychotherapy as a context, as the relationship in psychiatry differs a lot from other encounters in health care (e.g. duration of relationship and reason for seeking help).

The remaining 229 full-text papers were each reviewed by two authors. When conflicts arose, the first author resolved these in discussion with another author, consulting the others when needed. After this step of the screening, we were left with 68 studies for inclusion. This was a larger amount than recommended in realist reviews. We found that humour was a frequent topic in these studies. Due to the intricate analysis related to a realist review, we decided to dichotomize positive emotions into "humour" and "positive emotions." The present paper reports on studies regarding "positive emotions." With the new refinement of our inclusion criteria, we excluded another 58 papers. The second search in March 2019 yielded 291 new results, of which 48 were considered relevant based on title and abstracts. The first author read all papers and found 10 papers to be relevant. These 10 papers were also read by another author for validation. Based on our inclusion criteria, we included 5 papers from this search. Hence, we ended up with 15 papers that were included for analysis (Figure 1).

3.2.3 | Data extraction and quality appraisal

To identify key elements that would enable us to answer our research questions, we created a table including aim of study, study design, method, population and setting, outcomes and mechanisms (positive and negative associations). Our research team used this table to extensively discuss and define terms (such as context, mechanism, and outcomes) and for rigour. In a realist review, Pawson argues for multiple measures of quality assessment (Pawson et al., 2005). The value of the study is assessed by determining rigour rather than applying judgement. When assessing rigour, we looked for study findings that would best inform our aim (Pawson et al., 2005). Through discussions in our research team, we searched for inferences drawn by the included studies, and if the evidence was sufficient to provide answers to our research questions. This was the first step into creating the CMO configurations that formed the basis for our analysis.

3.3 | Analysis

The CMO configuration formula developed by Pawson and Tilley (1997) was used as an analytical tool for identifying recurring patterns formed by context, mechanisms and outcomes detectable across different studies and settings. First, we identified the outcome reported in each study. We found that different studies used slightly different wordings for similar concepts. Hence, we pooled together outcomes with similar content. One example was connectedness, intimacy and relationship, all categorized under the heading "patient-provider relationships." The final step was to determine what works for whom, how and under what circumstances by proposing CMO-configurations (see Figure 2). We searched for studies which have the patient-provider relationship as primary outcome, and we also analysed secondary outcomes.

4 | RESULTS

The included studies were published between 1994 and 2017. Most of the studies were qualitative, either using a grounded theory approach (Adamson et al., 2012; Radwin & Alster, 1999), phenomenological (Dowling, 2008; Fareed, 1996; Wright & Hacking, 2012), hermeneutic (Geanellos, 2005), hermeneutic phenomenological (McCabe, 2004), or content analysis (Appleton et al., 2018; Bala et al., 2012; McCarthy, 2014). Three studies had an observational design (Greene et al., 1994; Heyn et al., 2017; Terrill et al., 2018), one was a randomized controlled trial (RCT) (van Osch et al., 2017), and one used mixed methods (Gaucher et al., 2018). Most papers included in the review were from a European (Bala et al., 2012; Dowling, 2008; Fareed, 1996; Heyn et al., 2017; McCabe, 2004; McCarthy, 2014; van Osch et al., 2017; Wright & Hacking, 2012) or North American (Adamson et al., 2012; Gaucher et al., 2018; Greene et al., 1994; Radwin & Alster, 1999; Terrill et al., 2018) health context. One study was completed in an Australian health context (Geanellos, 2005). All but two studies (Heyn et al., 2017; van Osch et al., 2017) were performed in a hospital setting, being either an inpatient or outpatient clinic. All studies included are listed in Table 2.

In each article, the communication leading to positive emotion was examined in terms of the context where it occurred, the function or purpose of the emotion or the underlying mechanism it conveyed (e.g. reassurance), and the potential impact the emotion had on the patient or on the patient-provider relationship. The aggregated results are presented in the CMO configurations (Figure 2).

4.1 | Context

Context is the circumstance in which things happen (Pawson et al., 2005). The healthcare settings shared similarities, as most patients were treated for severe disorders and resided in a setting where they had less control. In these vulnerable situations, patients can either feel as if they were seen and met as a person or they can feel as if they are a burden. This was described in all studies and was the most meaningful context for our aim of understanding the relationship building. Different studies used different terminology for this context, such as individualized communication, or attending to each patients' needs. As these terminologies were described in the studies in a similar way as person-oriented communication, we decided to pool these aspects to the concept person-oriented context. Although "positive outlook and optimism" may be considered as part of person-oriented context, it is not a requisite. As we found that positive outlook was described specifically in many of the included papers, we decided to illustrate the CMO with positive outlook context as a separate box.

4.1.1 | Person-oriented context

Several studies display findings that a person-oriented context strengthens the patient-provider relationship (Adamson et al., 2012; Appleton et al., 2018; Bala et al., 2012; Dowling, 2008; Fareed, 1996) (Figure 2). Person-oriented context was described in the following themes and was related to both individual psychological traits and communication strategies.

Giving time and being there

Patients felt safe by knowing that somebody was present. This made them feel not alone and gave a sense of connection (Adamson et al., 2012). The presence described did not always equate with healthcare providers being physically close to the patient, the accessibility of the provider was considered a "caring presence" (Fareed, 1996).

Open/honest communication

Being vulnerable, patients described that their condition could give them a fear of the unknown. Hence, they valued open and honest communication, and many patients wanted detailed information in a language that they could understand (Fareed, 1996). This helped patients to better cope with their illness.

TABLE 2 Included papers

Article number (as listed in CMO)	Author(s)	Year	Title	Journal	Country	Method	Provider studied
1	Adamson, K., Bains, J., Pantea, L., Tyrhwitt, J., Tolomiczenko, G., & Mitchell, T.	2012	Understanding the patients' perspective of emotional support to significantly improve overall patient satisfaction	*Healthcare Quarterly*, 15(4), 63–69	Canada	Qualitative, descriptive, grounded theory approach	All hospital staff
2	Appleton, L., Poole, H., & Wall, C.	2018	Being in safe hands: Patients' perceptions of how cancer services may support psychological well-being	*Journal of Advanced Nursing*, 74(7), 1531–1543	England	Qualitative, exploratory	All hospital staff
3	Bala, S. V., Samuelson, K., Hagell, P., Svensson, B., Fridlund, B., & Hesselgard, K.	2012	The experience of care at nurse-led rheumatology clinics	*Musculoskeletal Care*, 10(4), 202–211	Sweden	Qualitative, exploratory	Nurses
4	Dowling, M.	2008	The meaning of nurse-patient intimacy in oncology care settings: From the nurse and patient perspective	*European Journal of Oncology Nursing*, 12(4), 319–328	Ireland	Qualitative, phenomenological	Nurses
5	Fareed, A.	1996	The experience of reassurance: Patients' perspective	*Journal of Advanced Nursing*, 23(2), 272–279	England	Qualitative, phenomenological	Physicians, nurses
6	Gaucher, N., Nadeau, S., Barbier, A., & Payot, A.	2018	Antenatal consultations for preterm labour: How are future mothers reassured?	*Archives of Disease in Childhood: Fetal and Neonatal Edition*, 103(1), F36–F42	Canada	Mixed-method design	Physicians
7	Geanellos, R.	2005	Sustaining well-being and enabling recovery: The therapeutic effect of nurse friendliness on clients and nursing environments	*Contemporary Nurse*, 19(12), 242–252	Australia	Qualitative, hermeneutic	Nurses
8	Greene, M. G., Adelman, R. D., Friedmann, E., & Charon, R.	1994	Older patient satisfaction with communication during an initial medical encounter	*Social Science & Medicine*, 38(9), 1279–1288	USA	Observational	Physicians

TABLE 2 (Continued)

Article number (as listed in CMO)	Author(s)	Year	Title	Journal	Country	Method	Provider studied
9	Heyn, L., Ellington, L., & Eide, H.	2017	An exploration of how positive emotions are expressed by older people and nurse assistants in homecare visits.	*Patient Education and Counselling*, 100(11), 2125–2127	Norway	Observational	Nurse assistants
10	McCabe, C.	2004	Older patient satisfaction with communication during an initial medical encounter	*Journal of Clinical Nursing*, 13(1), 41–49	Ireland	Qualitative, phenomenological-hermeneutic	Nurses
11	McCarthy, B.	2014	Patients' perceptions of how healthcare providers communicate with them and their families following a diagnosis of colorectal cancer and undergoing chemotherapy treatment	*European Journal of Oncology Nursing*, 18(5), 452–458	Ireland	Qualitative, content analysis	All hospital staff
12	Radwin, L., & Alster, K.	1999	Outcomes of perceived quality nursing care reported by oncology patients	*Scholarly Inquiry for Nursing Practice*, 13(4), 327–344	USA	Qualitative, descriptive, grounded theory approach	Nurses
13	Terrill, A. L., Ellington, L., John, K. K., Latimer, S., Xu, J., Reblin, M., & Clayton, M. F.	2018	Positive emotion communication: Fostering well-being at end of life.	*Patient Education & Counselling*, 101(4), 631–638	USA	Observational	Nurses
14	van Osch, M., van Dulmen, S., van Vliet, L., & Bensing, J.	2017	Specifying the effects of physician's communication on patients' outcomes: A randomized controlled trial	*Patient Education & Counselling*, 100(8), 1482–1489	Netherlands	RCT	Physicians
15	Wright, K. M., & Hacking, S.	2012	An angel on my shoulder: A study of relationships between women with anorexia and healthcare professionals	*Journal of Psychiatric and Mental Health Nursing*, 19(2), 107–115	England	Qualitative, phenomenological	Nurses, dieticians

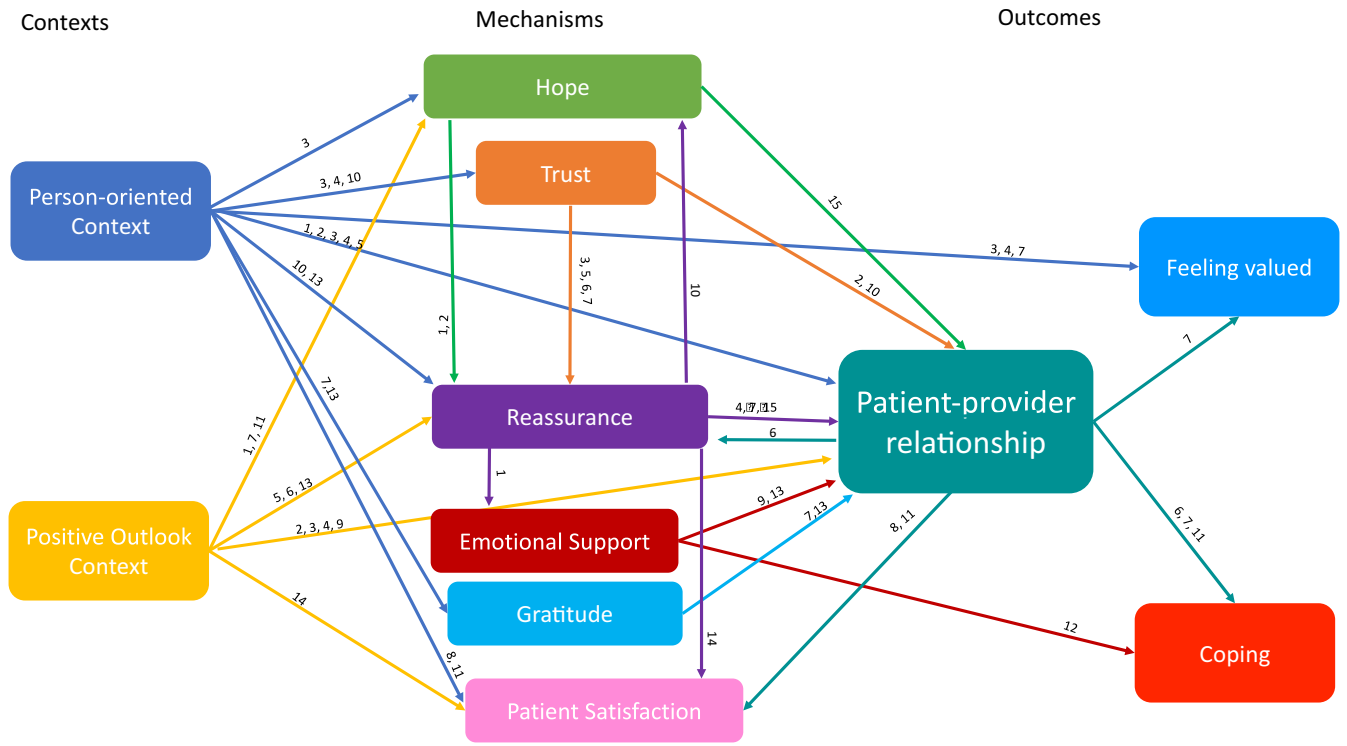

FIGURE 2 CMO configuration.

Genuineness

Patients explained how they could distinguish between providers that were genuine or not. Although both verbal and non-verbal communication relate to genuine behaviours, patients indicated that non-verbal behaviours were the predominant indicator for provider genuineness, such as physical touch, eye contact and smiling (Adamson et al., 2012; Appleton et al., 2018).

Empathy

Empathy was described by patients as providers taking their needs seriously (Bala et al., 2012). When providers cared about the patients and understood their situation, patients felt as if their feelings were justified (Adamson et al., 2012).

Patients also experienced providers that were not person-oriented, most often mentioned by patients to occur non-verbally, such as by the tone of voice (Fareed, 1996), body language (Bala et al., 2012) and not convey presence. In this context, patients felt secondary (McCabe, 2004), had diminished hope (Radwin & Alster, 1999), perceived sub-optimal support (Bala et al., 2012) or did not trust their providers (McCarthy, 2014) (Figure 3).

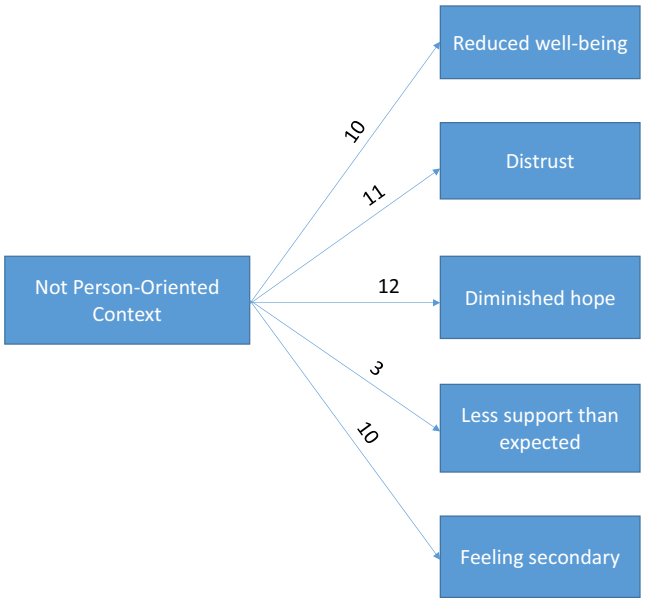

FIGURE 3 Not person-oriented context.

4.1.2 | Positive outlook context

A positive outlook context also was an important context for relationship-building (Appleton et al., 2018; Bala et al., 2012; Dowling, 2008; Heyn et al., 2017), in that a positive outlook and uplifting spirit from the providers gave patients hope and inspiration, which in turn was described as emotional support. Although this is not a required aspect of person-oriented care, it is implied. Responding appropriately to each patient as a unique individual means that providers also need to be aware of opportunities to allow patients to be positive. Patients described the importance to be allowed to be positive, as this helped them to experience uncritical acceptance. Some patients even described providers' positive outlook as making them

feel worthy of a conversation (Bala et al., 2012). The inverse was also described in another study, in that providers found it easier to connect with patients that had a positive outlook (Dowling, 2008).

4.2 | Mechanisms

We identified six mechanisms that imply either direct or indirect pathways between person-oriented context or positive outlook context and patient-provider relationship. These mechanisms are hope, trust, reassurance, emotional support, gratitude and patient satisfaction. The mechanisms are identified by our hypothesized research questions, by what we consider to be the most obvious mechanism and were guided by our program theories.

4.2.1 | Hope

Patients describe that being recognized by their providers contributed to their hope (Bala et al., 2012), as it made patients believe that the providers had not given up on them. This was important to the patients and strengthened the relationships with the providers (Wright & Hacking, 2012) (Figure 2). Patients also described a strengthened hope due to providers' knowledge of their condition. When providers conveyed to patients that they were not alone with the disease or condition, this was perceived as comforting (Adamson et al., 2012; Appleton et al., 2018) (Figure 2).

4.2.2 | Trust

Trust was formed based on the knowledge and skills of the provider, the chemistry involved and self-reassurance (e.g. I trust the nurses because they know best) (Fareed, 1996). When providers attended to their patients' specific needs and approached them in a person-oriented way, patients trusted them (Bala et al., 2012; Dowling, 2008; McCabe, 2004) (Figure 2). Patients felt as if they were seen and heard when providers acknowledged that they knew them (Bala et al., 2012). One study described that nurses' competence and technical skills also contributed to patients' trust (Dowling, 2008). The feeling of trust was essential in establishing a relationship with providers (Appleton et al., 2018; McCabe, 2004) (Figure 2). Empathy was one aspect of person-oriented context that was emphasized, and patients found it easier to trust a provider that was empathic (McCabe, 2004).

4.2.3 | Reassurance

Patients felt reassured when providers approached them in a person-oriented way (McCabe, 2004; Terrill et al., 2018), because empathic behaviours made them feel more comfortable. When providers had a positive outlook, patients felt secure and reassured (Fareed, 1996; Gaucher et al., 2018; Terrill et al., 2018). Trust was connected to reassurance, and patients described that when a trusting relationship existed (Bala et al., 2012; Fareed, 1996; Gaucher et al., 2018; Geanellos, 2005), or when provided with hope (Adamson et al., 2012; Appleton et al., 2018) they felt reassured (Bala et al., 2012; Geanellos, 2005). The feeling of security contributed to the relationship (Dowling, 2008; Geanellos, 2005; Wright & Hacking, 2012) (Figure 2).

4.2.4 | Emotional support

Two of the studies included a coding system for communication of positive emotions, called positive emotion communication (PEC) (Terrill et al., 2018), which was used to analyse healthcare interactions (Heyn et al., 2017; Terrill et al., 2018). In both studies, the category called "Praise and support" was the most frequently observed category for the providers. This category was described as complementing, providing support for or affirming another person. Positive affirmation from the providers to the patients seemed to foster connections (Heyn et al., 2017; Terrill et al., 2018) (Figure 2).

4.2.5 | Gratitude

Patients and caregivers often express gratitude to their providers for being person-oriented (Geanellos, 2005; Heyn et al., 2017; Terrill et al., 2018). Patients were grateful for the kindness and thoughtfulness of the providers, which gave them a sense of belonging. This was an important feature of connecting with the providers (Geanellos, 2005). There were also examples of reminiscing and gratitude for experiencing good quality of life.

4.2.6 | Patient satisfaction

Some of our included papers examined patient satisfaction. One study reported that an optimistic communication contributed to patient satisfaction (van Osch et al., 2017). Providers´ engagement in their patients was also suggested as an important mechanism to improve overall patient satisfaction (Greene et al., 1994; McCarthy, 2014), and patients feeling supported (van Osch et al., 2017) (Figure 2).

4.3 | Outcomes

Our findings suggest that in a person-oriented or a positive outlook context, patients and providers form relationships, either directly or through different mechanisms. This clearly indicates that the expressions of positive emotions are cultivating healthy provider-patient relationships. These relationships gave patients reassurance (Gaucher et al., 2018), a feeling of being valued (Geanellos, 2005)

and helped them coping (Gaucher et al., 2018; Geanellos, 2005; McCarthy, 2014).

5 | DISCUSSION

This is the first study reviewing the role of communication conveying or eliciting positive emotions in health care. With a realist approach of analysing, we have provided a deeper understanding of the context and mechanisms of the expressions of positive emotions and how this fosters the patient-provider relationship. Even if we included all healthcare providers, 12 out of the 15 included papers included nurses. A recent meta-analysis highlights how patient-provider relationship has impact on patient outcomes (Kelley et al., 2014), and we hope our findings will give a better understanding of the expression of positive emotions in cultivating healthy provider-patient relationships.

In sum, all the 15 included papers suggest positive patient outcomes of one or more mechanism through fostering the patient-provider relationship. Nevertheless, the majority of the papers were descriptive and based on qualitative interviews. It is therefore difficult to demonstrate the long-term effects and the robustness of these effects. According to the broaden-and-build theory, broadened cognition creates behavioural flexibility that over time builds personal resources (i.e. mindfulness, resilience and social closeness) (Fredrickson et al., 2008). Even if the positive emotions in itself are not durable (i.e. hope and awe), the resources created are (i.e. optimism and inspiration / motivation). The majority of the papers also showed the positive influence of the relationship with nurses when they conveyed hope and when they showed empathy and compassion. Hope can also be a double-edged sword, and according to Abbey (2020), Nietzsche was one of the first philosophers to problematize hope to define the negative side of hope in his famous quote "Hope in reality is the worst of all evils because it prolongs the torments of man." For example, a person can have hope without having a positive (or optimistic) outlook, "e.g. I am choosing hope that my cancer will be treated, by I am not optimistic that I will survive this diagnosis."

In our first research question, we asked about what contexts the communication from healthcare providers led to patients experiencing positive emotions. As so many of the patients in the included papers mentioned aspects of person-oriented communication we named this context person-oriented context. Person orientation is a multi-faceted concept, as these studies display. Though the wording differs slightly from study to study, the description is compatible with person-centredness as defined by McCance et al. (2011): "an approach to practice established through the formation and fostering of therapeutic relationships … underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding". The words used by the patients were empathy, genuineness, attending to their needs and being honest and open. A person-oriented context was evident to the patients both verbally and non-verbally. Not surprisingly, patients most often mentioned providers' non-verbal behaviours as an indication of providers who were not person-oriented. In some studies, patients reported that non-verbal behaviours of healthcare providers contributed to comfort (Adamson et al., 2012) and reassurance (Fareed, 1996). However, the tone of voice could also amplify the power imbalance between patients and healthcare professionals, making patients feel secondary (McCabe, 2004). This is an example of how one mechanism can result in different outcomes given the context. One example of this was the description of task-oriented nurses, meaning nurses that were more interested in getting all their tasks done than taking time to talk to the patients as human beings. This would make patients feeling inferior and as a burden (McCabe, 2004). A recent meta-analysis found that patients reported more beneficial health outcomes, fewer symptoms and higher quality of life when they trusted their providers (Birkhäuer et al., 2017), which is an important element of person orientation. This is a particularly interesting finding, as providers may not be as aware of their non-verbal behaviour. We suggest nurses to be more attentive to their non-verbal behaviours and recommend communication skills training to be explicit on this.

Our second research question concerned the underlying mechanisms that made a person-oriented or a positive outlook context cultivate patient-provider relationship. From our CMO configuration (Figure 2), we found several different pathways for this, both direct and indirect. Some studies reported a person-oriented context as a key mechanism for different pathways within patient-provider interactions. Five studies described a direct link between person-oriented communication and connectedness (Adamson et al., 2012; Appleton et al., 2018; Bala et al., 2012; Dowling, 2008; Fareed, 1996), but mostly the pathways were rather intricate. Studying this with a realist approach gave us a much more nuanced understanding than any other type of review would. One reason for this was the CMO configuration (Figure 2), but also because we were guided by our program theory. Positive emotions have a broadening effect on the momentary thought-action repertoire in that they allow us to discard automatic responses and instead look for creative, flexible and unpredictable new ways of thinking and acting. By broadening our perspectives and actions, we tend to build important and lasting physical, intellectual, psychological and social resources (Fredrickson, 2001).

The papers did not mention positive emotions per se. However, positive emotions were closely related to healthcare providers´ positive communication (i.e. empathy, open and honest communication and emotional support), which initiates a positive appraisal process in the patient (Lazarus, 1999) that predict positive emotions and a positive behaviour. However, there are also examples of studies that show reverse outcomes of empathy, for example Graugaard and Finset (2000), underlining the importance to start from a person-oriented context in which patients' needs outweigh traditional communication conventions (such as being empathetic with everyone). Negative emotions are normal responses in difficult or stressful situations and being person-oriented implies acceptance of a range of emotions across a range of contexts.

Our last research question was about the outcome of expressions of positive emotions. Connectedness was experienced as positive both for patients and healthcare providers. Patients that reported feeling valued (Geanellos, 2005), had improved self-esteem (Radwin & Alster, 1999). Additionally, connections improved patients´ trust in their providers (Dowling, 2008; Wright & Hacking, 2012), which promoted patients´ feeling of security (Bala et al., 2012; Geanellos, 2005) and reassurance (Fareed, 1996). Patient satisfaction was also a reported outcome of connectedness (Greene et al., 1994). Interestingly, nurses also reported greater satisfaction when connecting with patients (Dowling, 2008). This mechanism came with a hesitation though, as too close a connection could be an emotional burden. This is in line with previous studies, reporting how nurses sometimes deliberately hold back to prevent themselves from burnout (Rochefort & Clarke, 2010).

Friendliness, liking and professional friend roles were important mechanisms to influence positive social bonds and acceptance. According to Scheff (2000), "social bonds involve mental and emotional attunement between persons" (p. 201) and make people feel valued and respected. People form these social bonds to fulfil the essential psychological need to be accepted (Scheff, 2000) and the need to belong to other people (Bowlby, 1982). This supports our assumption that communication that convey or elicit positive emotions can contribute to patients' health and influence the patient-nurse relationship in a positive manner. When nurses spend time with and get to know the patient, positive emotions (e.g. joy, gratitude, interest, hope) occur. In one study, the role of professional friend was described as maintaining a professional bond while approaching the patient in a personal, detailed way (Dowling, 2008). It is important to acknowledge that a social bond, or a professional friendship, also should allow for negative emotions. Hence, nurses still need to be attentive to patients' negative emotions. In one study, nurses implied that it was easier to connect with patients that had a positive outlook. This could put an undue burden on patients to be positive all the time.

A remarkable finding in this review was the variety of different concepts, especially in terms of emotions, used in the included papers. We discovered that there was a lack of consistency in the papers. One reason could be that we found mostly qualitative studies, which have less clear primary outcomes. Another reason could be that there is an inconsistency in the definitions of positive emotions. It is less clear from the studies included what are positive behaviours, and what are positive emotions. Contrary to expectations, this study did not find a clear description of positive emotion words connected to all the mechanisms. However, we found clear connections on how positive behaviour and positive outcomes improve positive relationship between patients and healthcare personnel.

5.1 | Limitations

We found few papers that described positive emotion words. One reason for this might be that the studies were not designed to test mechanisms, or positive emotion words, that could predict in what way the relationship between patients and nurses is affected. Nevertheless, we found clear distinctions between behaviour that triggers positive emotions and positive outcomes of the patient-provider relationship. Another important limitation is the lack of controlled studies and more longitudinal designs that could have predicted a more stable effect of the mechanism and outcomes. Most of the studies in our review were qualitative and had few participants. Also, the papers used in the study were primarily from European or North American contexts. Although this is beyond the scope of this paper, the predominant westernized focus of this work could be a limitation.

6 | CONCLUSION

Although less attention has been given to communication of positive emotions in health care as opposed to provider responses to patients´ negative emotions, our review provides evidence that the expressions of positive emotions should be given more attention. We found direct and indirect pathways demonstrating that communication strategies leading to positive emotions are central in developing and strengthening the patient-nurse relationship. By using a realist approach of analysing, we provide new and in-depth knowledge of the role communication of positive emotions play in cultivating patient-nurse relationships and directions for further research. Eliciting and responding to negative emotions is an important part of healthcare communication. However, this calls for a more balanced focus on positive and negative emotions in communication research and training.

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CONFLICT OF INTEREST

None.

DATA AVAILABILITY STATEMENT

All analysed data in this study are from published papers that are openly available (see Table 2 for included studies). The protocol is available in PROSPERO.

ETHICS STATEMENT

As this was a review, Research Ethics Committee approval was not required. The protocol for this review was registered in the Prospective Register of Systematic Reviews (PROSPERO), registration number: CRD42018088149.

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