Patient Education and Counseling 98 (2015) 1346–1351

Contents lists available at ScienceDirect

Patient Education and Counseling

journal homepage: www.elsevier.com/locate/pateducou

Communication Study

Emotions in primary care: Are there cultural differences in the expression of cues and concerns?

Barbara C. Schouten *, Sanne Schinkel

Department of Communication Science, Amsterdam School of Communication Research, University of Amsterdam, The Netherlands

ARTICLE INFO

Article history:
Received 20 March 2015
Received in revised form 12 May 2015
Accepted 23 May 2015

Keywords:
Immigrants
Turkish patients
Cues
Patients' emotions
General practice
Intercultural communication

ABSTRACT

Objective: This study compared native-Dutch and Turkish-Dutch patients' expressions of emotional cues/concerns and GPs' responses to these cues/concerns. Relations between patient's cues/concerns and GPs' perceptions of the patient's health complaint were examined too.
Methods: 82 audiotaped encounters with native-Dutch and 38 with Turkish-Dutch GP patients were coded using the VR-CoDES and VR-CoDES-P. Patients filled out a survey before each consultation to assess their cultural identification, Dutch language proficiency and health-related variables. GPs filled out a survey after each consultation to assess their perceptions of the patient's health complaint.
Results: Turkish-Dutch patients expressed more cues than native-Dutch patients, which was explained by higher worries about their health and worse perceived general health. GPs responded more often with space-providing responses to Turkish-Dutch patients compared to native-Dutch patients. Turkish-Dutch patients' cue expression strongly influenced GPs' perceptions about the presence of psychosocial problems.
Conclusion: Migrant patient-related factors influence the amount of emotional cue expression in primary care. GPs perceive these cues as indicating the presence of psychosocial problems and provide space for patients to elaborate on their emotional distress.
Practice implications: GPs should be trained in using more affective communication techniques to enhance elicitation of the underlying reasons for migrant patients' enhanced emotional cue expression.

1. Introduction

Patients' expressions of emotions and physicians' responses to these emotions are a core element of the medical communication process [1]. Worries related to patients' health complaints, psychosocial problems and life issues are important reasons to visit a physician and hence, are regularly brought into the medical consultation [2,3]. Patients might voice their negative feelings explicitly, so-called concerns, but oftentimes, they use more indirect hints to refer to underlying emotions, so-called cues or clues [4]. Previous research has indicated that expressing emotions is related to enhanced emotion-regulation, which in turn might reduce stress and have beneficial effects on patients' wellbeing [5,6]. In addition, physicians who respond to patients' emotions in an open and empathic manner can reduce patients' level of distress and increase levels of treatment adherence [7,8].

Unfortunately, physicians often react in a problem-solving manner to patients' emotion expression and generally respond better to the informational content of cues than to their affective content [9,10]. In medical encounters with migrant patients, dealing with emotions can be an even more challenging task. Cultural differences in emotional display rules, health and illness beliefs and communication styles might make it difficult for physicians to identify and adequately respond to migrant patients' emotion expressions [11–14]. Previous studies have indeed shown that physicians behave less affective toward migrant patients and perceive them as less emotionally expressive than patients belonging to the dominant culture [15]. There is less social talk in intercultural medical encounters, and less empathy and emotional engagement as compared to intracultural medical encounters [16–19]. Consequently, the establishment of rapport and mutual understanding, important prerequisites of delivering good quality health care, is often hard to achieve in consultations with migrant patients [20].

* Corresponding author at: University of Amsterdam, Department of Communication Science, Nieuwe Achtergracht 166, 1018 WV Amsterdam, The Netherlands. Tel.: +31 20 5253879; fax: +31 20 5253681.
E-mail address: c.schouten@uva.nl">b.?c.schouten@uva.nl (B.C. Schouten).

http://dx.doi.org/10.1016/j.pec.2015.05.018
0738-3991/

Although the above-mentioned studies have been valuable in gaining more insight into cultural differences in the dynamics of the affective communication process, there is a dearth of research looking specifically at possible differences between native-born and migrant patients' expressions of emotions and physicians' responses to their emotions. Compared to the native-Dutch population, migrant patients in the Netherlands visit their general practitioner (GP) more often [21], which might partly reflect a higher prevalence of mental distress and psychosocial problems in some ethnic minority populations. Indeed, prevalence rates of depression and anxiety disorders are higher among Turkish-Dutch patients than among native-Dutch patients [22]. Whether the higher prevalence of these psychological problems is reflected in more emotion expression among ethnic minority patients compared to native-Dutch patients during consultations in general practice is unknown. Therefore, the aim of the present study was to investigate whether there are differences between native-Dutch and Turkish-Dutch patients' expression of emotional cues and concerns as well as GPs' responses to these cues and concerns, by making use of the *Verona Coding Definitions of Emotional Sequences* ([23,24]; VR-CoDES), a consensus-based instrument that has been successfully applied in several health contexts [25–27].

The applicability of the VR-CoDES to consultations with migrant patients has been shown in two previous studies [26,27]. However, these studies either did not compare ethnic minority patients' emotion expression with those of the culturally dominant group [27], or did use a different healthcare setting than general practice (i.e. hospitals) [26]. The present study will address those gaps by comparing native-Dutch patients' with Turkish-Dutch patients' expression of emotional cues/concerns and GPs' responses. Additionally, we investigated whether the possible effect of patients' ethnic background on emotion expression is influenced by a number of patient-related characteristics, such as patients' cultural identification, their perceived general health, and their worries about the current health complaint. Previous research has shown that these variables might be related to the amount of emotional cues/concerns patients express [4,27,28], but it is unknown whether they interact with patients' ethnic background.

We also examined the relation between patients' expression of emotional cues/concerns and GPs' perceptions about the patient's health complaint, because it is possible that physicians' lack of affective behavior toward migrant patients can be explained by the fact that they insufficiently pick up migrant patients' worries. As mentioned above, cultural differences in emotional display rules could make it difficult for physicians to identify migrant patients' emotions. Hence, we investigated whether there are differences between native-Dutch and Turkish-Dutch patients in the relation between their expression of emotional cues/concerns and a number of GPs' perceptions, among which the extent to which they think psychosocial problems were present during the consultation and the perceived seriousness of the patient's health complaint.

In sum, we investigated: (1) differences in emotion expression between native-Dutch and Turkish-Dutch patients, (2) differences in GPs' responses to emotional expression between native-Dutch and Turkish-Dutch patients, and (3) differences in relationships between native-Dutch and Turkish-Dutch patients and GPs' perceptions about the patient's health complaint.

2. Methods

2.1. Participants and procedure

Six GP practices with eleven GPs (seven men, four women) in three multicultural cities in the Netherlands participated. Patients who had an appointment with the GP for themselves and were able to read in Dutch or Turkish, or were accompanied by someone who could read in Dutch or Turkish, were asked to participate by research assistants during three to ten days per practice. Patients who gave their informed consent filled out a questionnaire (available in Dutch and Turkish) before the consultation. Subsequently, each consultation was audio taped by the GP and after each consultation, the GP filled out a short questionnaire about the patient. Of all 377 eligible patients, 256 consented to participate (68%); 41 consultations were not audio taped properly and 52 questionnaires were not returned or contained too many missing values. In addition, 12 patients were Western immigrants and 31 were non-Western migrants from other origin than Turkey and were therefore excluded from analyses. Hence, the final sample consisted of 120 patients (native-Dutch $n = 82$, Turkish-Dutch $n = 38$; 59% of all patients who consented). The study was approved by the ethical committee of the Amsterdam School for Communication Research.

2.2. Measures

2.2.1. Patient and GP questionnaire

Patients' ethnic background was based on the ethnicity definition of the Dutch Central Bureau of Statistics [29]. Respondents with both parents born in the Netherlands were categorized as native-Dutch and respondents who were born in Turkey and/or have at least one parent born in Turkey were categorized as Turkish-Dutch. Cultural identification was measured by Stevens et al.'s ethnic identity measure [30], by asking patients to indicate the extent to which they feel they belong to the Dutch culture and the Turkish culture on a 5-point scale, ranging from (1) *totally disagree* to (5) *totally agree*. Because high correlations have been reported between GPs', patients' and researchers' assessment of migrant patients' language proficiency [31], patients' Dutch language proficiency was measured by a single self-report item assessing the extent to which they think they have command of the Dutch language (5-point scale, ranging from (1) *not at all* to (5) *excellent*).

Other variables measured were patients' gender, age, educational level, whether the patient had company during the consultation, worries about their current health complaint, and perceived general health. The two latter variables were assessed with a single item on a 5-point Likert scale, the first ranging from (1) *not worried at all* to (5) *extremely worried*, and the second ranging from (1) *excellent general health* to (5) *poor general health*.

GPs filled out a short questionnaire after each consultation, assessing their perceptions of the extent to which they think psychosocial problems were present during the consultation, the extent to which they think the patient's health complaint is serious, and the extent to which they think the patient's health complaint is troublesome. In addition, GPs had to indicate the extent to which they knew the patient. All variables were measured with a single item on a 5-point Likert scale, ranging from (1) *not at all* to (5) *very*.

2.2.2. Coding patients' emotional cues/concerns and GPs' responses

The *Verona Coding Definitions of Emotional Sequence* (VR-CoDES and VR-CoDES-P) [23,24] was used to code patients' cues/concerns and GPs' responses. Because results of a previous study showed differences between Turkish-Dutch patients who are accompanied by a family member who interprets for them during the consultation and Turkish-Dutch patients who visit their GP alone in amount of emotional cue expression [31], only patients' utterances were coded; utterances of accompanying persons were not coded. Concerns are clear and unambiguous expressions of unpleasant emotions that are explicitly verbalized, while cues are verbal or nonverbal hints suggesting an underlying unpleasant