Patient Education and Counseling 96 (2014) 151–158

Contents lists available at ScienceDirect

Patient Education and Counseling

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

Communication Study

How psychiatrist's communication skills and patient's diagnosis affect emotions disclosure during first diagnostic consultations

Lidia Del Piccolo *, Olivia Danzi, Nives Fattori, Maria Angela Mazzi, Claudia Goss

Department of Public Health and Community Medicine, University of Verona, Verona, Italy

ARTICLE INFO

Article history:
Received 19 March 2014
Received in revised form 21 May 2014
Accepted 3 June 2014

Keywords:
Communication skills
Emotion disclosure
Psychiatry
VR-CoDES
Psychiatric consultation

ABSTRACT

Objective: To describe how emotions are disclosed during psychiatric diagnostic consultations and the contribution of the psychiatrists in facilitating their expression.
Methods: Descriptive naturalistic study. Sixteen psychiatrists recorded their first consultations with 104 patients. Emotions and the immediate response given by the psychiatrist were coded with the *Verona Coding Definitions of Emotional Sequences*. For each disclosed emotion, the potential link to preceding expressions with affective content (cue or concern) was checked and the immediate response given by the psychiatrist was coded.
Results: Most emotions were expressions of anxiety in terms of psycho-physiological or cognitive correlates. Concerns were present in 94% of the consultations, 47.6% were not linked to previous cues/concerns. Cues which became concerns and concerns which were further elaborated by the patient were those that had been acknowledged and handled by the psychiatrist by actively providing space to their expression. Compared to all other diagnostic groups, patients with mood disorders talked more explicitly and more often about their feelings.
Conclusion: The type and frequency of expressed emotions varies with patient diagnosis, suggesting different cognitive processes underlining psychopathology.
Practice Implications: Psychiatrist's competence in providing space by using active listening skills is essential to uncover patients emotions.

1. Introduction

Emotions may be viewed as whole-body responses that signal personally relevant, motivationally significant events [1]. As stated by Levenson [2] "Psychologically, emotions alter attention, shift certain behaviors upward in response hierarchies and activate relevant associative networks in memory. Physiologically, emotions rapidly organize the response of disparate biological systems... to produce a bodily milieu that is optimal for effective response". Therefore, to be adaptive, emotions need to be regulated using a range of cognitive and behavioral processes concerning the experience and differentiation as well as their attenuation and modulation [3]. This regulation permits flexibility in emotional responding in accord with one's momentary as well as one's longer term goals in any given situation [4,5]. Psychiatric patients very often present difficulties in identifying and managing emotional states and studies on communication in healthcare demonstrated that with the increase of psychological discomfort also emotionally laden expressions rise [6,7]. Moreover, Aldao et al. [8] have delineated the relationship between various emotion regulation strategies and specific mental disorders. Therefore a psychiatrist should be able to facilitate patients to express and to name emotions and then to suggest strategies that may help the patient to regulate them [9]. Indeed, helping patients to verbalize their feelings, besides serving diagnostic purposes, facilitates emotion regulation [10], predicts competent coping [11,12], generates greater patient satisfaction with interpersonal care [13] and increases collaboration [14,15].

In a previous study on how emotions are dealt with in first diagnostic consultations in psychiatry [16], we showed that vague expressions of emotion, defined as cues, were more frequent than explicit references to negative emotions, labeled as concerns. This proved how, also in a psychiatric context, patients tend to express their feelings by using vague and ambiguous terms and may benefit from the aid of a sensitive clinician who helps them to recognize and make explicit their inner emotional state. Nevertheless, this process

* Corresponding author at: Department of Public Health and Community Medicine, University of Verona, Policlinico G.B. Rossi, Piazzale L.A. Scuro 10, 37134 Verona, Italy. Tel.: +39 045 8126412; fax: +39 045 585871.
E-mail address: lidia.delpiccolo@univr.it (L. Del Piccolo).

http://dx.doi.org/10.1016/j.pec.2014.06.001
0738-3991/

of making explicit a feeling may be the outcome of two different *modus operandi*: the patient introduces a negative experience that affects him/her emotionally and the psychiatrist, by the use of clarifications, active listening, direct requests for self-disclosures helps the patient to explicate this affect, or the psychiatrist, on the basis of the symptoms reported and a closed-ended inquiry interprets the emotional state of the patient by verifying diagnostic hypotheses. In the first case communication is guided by the complaints and hints of the patient [17] and the process is patient-centered [18,19], in the second case emotions are verbalized on the basis of the clinician's suggestions and their expression is based on a doctor-centered process.

To our knowledge, although a detailed description of the emotion-regulation strategies across psychopathology is well documented [8], a description of the type of emotions which emerge during first diagnostic consultations and the verbal process that solicits their appearance has not been reported in literature. Therefore, the aim of the present study is twofold: to describe which emotions emerge in relation to patient's diagnosis and how they become manifest during first diagnostic consultations in psychiatry, adopting sequence analysis to describe the verbal process that permits emotional disclosure. A detailed analysis of the process that leads to the explicit expression of emotions, may help trainers to direct their attention on the communication skills that show to be more effective in helping patients to become aware of their affective states. This in turn may contribute to improve diagnostic and therapeutic processes.

2. Methods

2.1. Participants and procedure

The study sample has been described in previous papers [16,20]. Nine hired psychiatrists and seven residents in psychiatry participated, all of whom had at least 3 years of psychiatric experience working in the South Verona community mental health service (CMHS). They gave written informed consent to have some of their outpatient consultations audio-taped between December 2003 and March 2004. In order to encourage their participation at the study they were asked to indicate the day(s) on which they would be available for audio-taping and left free to decide the number of consultations they wished to contribute. Patients who were asked to participate were informed that the recordings would have been used to study how doctors responded to their problems. The study was approved by the local ethics committee.

The hired psychiatrists and the residents in psychiatry, from now on defined psychiatrists, were 9 men, had a mean age of 38 years (range 29–57, sd = 9.7) and a mean number of psychiatric practice of 10.8 years (range 3–32, sd = 9.2). The mean number of audio-taped consultations for each psychiatrist was 6 (range 1–15). One hundred and four consultations were collected, 59 from hired psychiatrists, 45 from residents in psychiatry. All patients came for the first time or for a new episode of illness, they were all new to the psychiatrists and gave written informed consent to be recorded. Data on patient gender and diagnosis (ICD-10) were obtained from the South Verona psychiatric case register.

2.2. Measures

2.2.1. Verona Coding Definitions of Emotional Sequences (VR-CoDES)

The consultations were transcribed and analyzed with the VR-CoDES [21,22], to code patients' expressions of emotional distress. These expressions are defined as:

CONCERNS: "clear and unambiguous expressions of an unpleasant, current or recent emotion, that is explicitly verbalized, with or without a stated issue of importance". Therefore any reference to an event or a situation that worried the patient without an explicit mention of an emotion, is not considered as a concern.

CUES: " verbal or nonverbal hints which suggest an underlying unpleasant emotion that lacks clarity" (e.g. Expression with vague references to an underlying emotion "*I feel so strange*", emphasis "*it is terrible*!", "*my nights are sleepless*" "I've lost a lot!", metaphors "*I have a knot in the stomach*", unusual words to describe symptoms "*My body is boiling*", "*These butterflies in my eyes*", non-verbal behavior, repetitions, references to situations "*My wife is fed up with me*!" "*My work is very stressful*" or behaviors "*This two weeks, I eat and eat, incredibly!*").

A certain amount of cues, during the course of a consultation, might become a concern (explicit emotion). This happens either because the physician actively asks for the emotion or because the patient spontaneously elaborates the cue. Concerns, in turn, may be further elaborated by the addition of other related emotions.

Given a cue or a concern, all immediate health provider verbal reactions are coded, adopting a descriptive – not evaluative – approach. These health provider reactions are always classified as responses that may fit into two main dimensions: (1) The response *explicitly* or *not explicitly* refers to the cue/concern; this dimension indicates whether the verbal reaction of the health provider maintains the wording or the key elements of the cue/concern to which it refers to and (2) the provider response *provides space* or *reduces space* for further disclosure of the cue/concern; this dimension represents the function of the verbal reaction in terms of cue/concern disclosure.

For a detailed description of the coding process, the VR-CoDES manuals are available for free on internet at: http://www.each.eu/verona-coding-systems.

2.2.2. Coding of emotions

As defined in the VR-CoDES [21], *explicit* emotions are called *concerns* and are defined as any conscious experience related to depressive or anxious mood or to a combination of Ekman and Friesen's list of basic emotions [23,24] with a negative connotation.

Based on how it was expressed, it could be coded as a cue.

In this study the list of possible emotions was classified as follows:

1. All explicit emotional expressions that referred to somatic correlates of anxiety (restlessness, nervousness, irritation, anguish, panic attach).
2. All explicit emotional expressions that referred to cognitive correlates of anxiety (fear, worry, concern).
3. All expressions of unhappiness, sadness, sorrow, discontent, dissatisfaction, disappointment, letdown, frustration, depression.
4. Anger, hostility.
5. Shame, embarrassment, guilt.
6. Disgust, bother, annoyance, contempt.
7. Surprise also in terms of shock.

2.2.3. Coding of the process that leads to an explicit expression of emotion (concern)

The first step in the coding procedure is to identify cues and concerns according to the coding rules of the VR-CoDES manual [21]. The provider expression – verbal or nonverbal – immediately following a cue or concern expressed by a patient should be coded as the response. Only cues/concerns and health provider responses are considered as speech units of interest, but all speech turns (if the doctor or the patient takes the floor to speak) are numbered. A speech turn begins when the person (physician