European Commission

Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma
MEM-TP

MODULE 3: PROFESSIONAL SKILLS
Unit 1: Intrapersonal skill development

Guidelines

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**Migrants & Ethnic Minorities
Training Packages**

Unit 1: Intrapersonal skill development

1. Objectives and Methods

1.1.   Objectives

Objectives of the Presentation:
- To identify key elements in communicating with migrants or ethnic minority patients.
- To recognise techniques related to intrapersonal outcomes aiming to improving health professional-patient interaction in culturally diverse contexts.

Objectives of the Activities:
- To identify the role of stereotypes in communication with migrants and ethnic minorities
- To identify communication and intrapersonal skills (empathy, active/reflective listening).
- To acquire the ability to manage stress situations in the health professional-migrant/ethnic minority patients interaction

1.2.   Methods

We suggest you to focus on activities as the contents of this Module require an experiential pedagogical approach. Each Unit includes various activities prepared to address different professional skills. The activities selected are to be adapted according to the level of skills' development of the trainees. Some activities are "core activities" (marked C.A.) and other are complementary.

Time	Objectives	Contents	Activity	Sources
5 min.	Identify the unit's objectives	Presentation of objectives	Presentation	*M3_U1 Presentation* **Slide 2**
20 min.	Identify the role of stereotypes in communication with migrants and ethnic minorities	Group work on confronting labels and stereotypes	Activity 1 (C.A.)	*M3_U1_A1 Activity Template version 1 or M3_U1_A1 Activity Template version 2*
15 min.	Identify key elements in communicating with migrants or ethnic minority patients.	Presentation of basic concepts related to communication with migrant and ethnic minority patients	Presentation Video Screening	*M3_U1 Presentation* **Slides 5-10** Video 1: *Incompetent vs. Competent Cultural Care*
15 min.	Awareness of the influence of nonverbal communication in health professional-patient interaction	Group work on symbolic meanings of hand gestures	Activity 2	*M3_U1_A2 Activity Presentation* Tables and chairs sufficient for 4 working groups
5-10 min.	Identify communication and intrapersonal skills	Empathy	Presentation	*M3_U1 Presentation* **Slides 12-15**

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30 min.	Acquire the ability of role taking	Work in small groups and group work on empathic process with migrant and ethnic minority patients	Activity 3 (C.A.)	*M3_U1_A3 Activity Template*
5-10 min.	Identify communication and intrapersonal skills	Listening Reflective listening	Presentation	*M3_U1 Presentation* **Slides 17-18**
40 min.	Acquire the ability of listening	Work in small groups and group work on reflective listening with migrant and ethnic minority patients	Activity 4 (C.A.)	*M3_U1_A4 Activity Template*
5-10 min.	Identify communication and intrapersonal skills	Emotions and emotional self-control techniques	Presentation	*M3_U1 Presentation* **Slides 20-22**
30 min.	Acquiring the ability to manage stress situations in the health professional-migrant/ethnic minority patients interaction	Individual work and group work on self-control techniques	Activity 5 (C.A.)	*M3_U1_A5 Activity Template*

Presentation

Slide 1: Title and authorship

Slide 2: Outline of the session

Slide 3: Objectives

Slide 4: Activity 1: Confronting labels and stereotypes
(Duration: 20 minutes)

We propose choosing between two different versions of this activity, pending on the participants' features. For more skilled professionals, we suggest version 2.

Version 1: This activity can be used both as an icebreaker and to introduce the concept and star a discussion on the questions proposed. Different labels with stereotyped features, both negative and positive, are randomly distributed among the participants.

1. Participants do not know the content of their own label and must interact with each other according to the labels exposed.
2. They share the reactions and emotions experienced in a group. Discussion on the origin of our own stereotypes, focused on the following questions:
- What information are the labels based on? Are they based on personal experiences with others? If so, in what context?
- Might "the other" be different in different situations?
- Are your assumptions based on things you have heard from others? Learned from the TV or movies? Learned in school?
- Is it possible that some of your negative images are wrong at least for some people?

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Version 2: This activity would consist in analyzing materials individually or in small groups (max. 5 people), presenting and discussing them. Therefore:

1.   Individual/group analysis of the material
2.   Presentation of this analysis by one of the participants
3.   Discussion on the presentation and the interaction

This activity is meant to use materials from the local context (e.g. leaflets, clinical guides) or case-studies produced by the own participants' experience.

Presentation

Slide 5
Stereotypes are generalizations or assumptions that people make about the characteristics of all members of a group, based on an image (often wrong and always partial) about what people in that group are like and how they behave[1]. Stereotypes lead to prejudices, stigma and discrimination[2]. Stigma can be defined as an adverse reaction to the perception of a negatively evaluated difference[3]. As such, it is not an attribute of the individual who bears the difference, but rather resides in interactions between the person with the difference and others, who evaluate that difference in negative terms[4]. Racism and discrimination strongly affect the health and well-being of those who suffer its consequences.

Activities in this Unit are based on the approach that prompts reflection and examination of one's own attitude instead of emphasizing on the passive acquisition of knowledge of different ethnic groups. Changing stereotypes is an individual task. Each of us should examine the assumptions that we make about others and ask ourselves where those assumptions come from.

Slide 6
Video Incompetent vs. Competent Cultural Care **https://www.youtube.com/watch?v=Dx4Ia-jatNQ**

Slide 7
According to Duffy et al, communication with a patient "*can be defined as **specific tasks and observable behaviours** that include **interviewing** to obtain a medical history as well as a patient's reason for the visit, **discussing** a diagnosis and prognosis, **giving instructions** on therapy and **information** needed for informed consent before undergoing any procedures, and **counselling** to motivate participation in treatment or to relieve symptoms*"[5].

Slide 8
Research evidence has shown the role of health professionals' warmth, negativity and listening in patient satisfaction[6]. *Research evidence indicates that there are **strong positive relationships** between a healthcare team member's **communication skills** and a patient's **capacity to follow through** with medical recommendations, **self-manage** a chronic medical*

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[1] Breslin, J. William. (1991). "Breaking Away from Subtle Biases" in *Negotiation Theory and Practice,* eds. J. William

[2] Link, Bruce and Jo Phelan. (2001). "Conceptualizing Stigma." Annual Review of Sociology 27:363–85.

[3] Susman, Joan. (1994). "Disability, Stigma and Deviance." Social Science and Medicine 38:15–22.

[4] Goffman, Erving. (1963). Stigma: Notes on the Management of Spoiled Identity. Englewood Cliffs, NJ: Prentice Hall.

[5] Duffy FD, Gordon GH, Whelan G, Cole-Kelly K, Frankel R, Buffone N et al. (2004). Assessing competence in communication and interpersonal skills: the Kalamazoo II report. Acad Med 2004; 79: 495-07.

[6] Stephen G. Henry et al. (2012). Association between nonverbal communication during clinical interactions and outcomes: A systematic review and meta-analysis. Patient Educ Couns. 2012;86:297–315 available at http://www.sciencedirect.com/science/article/pii/S0738399111003739#UH (retrieved January, 21 2015)

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condition, and **adopt preventive health behaviours**. *Studies conducted during the past three decades show that the clinician's* **ability to explain, listen and empathize** *can have a profound effect on biological and functional health outcomes as well as patient satisfaction and experience of care.* [7][8].

Slide 9

The **people-centered health care** identifies as relevant aspects **the culture of care and communication**, including informed decision making, respect for privacy and dignity, as well as response to needs in a holistic manner; and the establishment of responsible, responsive and accountable services, based on the principle of accessibility, affordability and ethics, as well as[9].*"A more people-centered and integrated approach to service delivery is expected to increase access to needed health services throughout the life-course; improve health and clinical outcomes; enhance continuity of care and* **satisfaction with services***; expand participation of users and communities in their own health care; improve providers' job satisfaction; reduce system inefficiencies and duplication of services; and facilitate intersectoral collaboration in order to address other wider determinants of health*[10]*"*

(Additional Information of people-centered health care model is included in M4_U1).

Slide 10

Language seems at best tangential in communication research, unless it is assumed that **language constitutes part of the process of message encoding and decoding** *that occurs during intercultural interaction. There is a continued interest in how* **nonverbal and verbal behaviour differ across cultures***, concerning mainly what transpires in the immediate context of meaning or message transaction* [11]*.*

Slide 11: Activity 2: Symbolic meanings of gestures
(Duration: 15 minutes)

- In pairs: Ask the participants to comment on different gestures with specific meanings in different cultural contexts and write a list with them.
- Group discussion: Images of hand gestures will be shown (Use PPT M3_U1_A1 Presentation). Participants are invited to indicate what emotions they associate with each one and present the list from the work in pairs.
- The group will identify other gestures that have different meanings in other cultures.

Presentation

Slide 12
Nonverbal behaviour has proved to be related to patient satisfaction[11]. Although **nonverbal communication is unlikely to immediately affect** patient physical or mental health, it may lead

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[7] IHC (2011). Impact of Communication in Healthcare. Available at http://healthcarecomm.org/about-us/impact-of-communication-in-healthcare/ (retrieved: July, 19 2015).

[8] Mast MS. (2007). On the importance of nonverbal communication in the physician-patient interaction. Patient Educ Couns.2007;67:315-8. available at http://www.sciencedirect.com/science/article/pii/S0738399107000973 (retrieved January, 21 2015)

[9] WHO-WPRO, World Health Organization, West Pacific Region Office. (2007). People-Centred Health Care: A policy framework. Available at
http://www.wpro.who.int/health_services/people_at_the_centre_of_care/documents/ENG-PCIPolicyFramework.pdf (retrieved: January 12, 2015).

[10] WHO, World Health Organization. (2014). WHO Global Strategy on People-Centred and Integrated Health Services. Available at http://www.who.int/servicedeliverysafety/areas/people-centred-care/en/ (retrieved: July, 19 2015).

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to changes in health that are mediated through patient satisfaction or adherence to appointment and treatment, thus affecting health status[12]. Therefore, nonverbal aspects in the health professional-patient interaction play an important role, as **interpersonal judgment relies mostly on nonverbal and appearance cues** of the interaction.

Slide 13

Many aspects of nonverbal communication **often take place unconsciously**, e.g. changes in voice tone and body language, but health professionals can learn to **monitor their own nonverbal behaviour**. Smiling, eye-contact, leaning forward, expressive tone of voice and face, more nodding, may have a positive effect on patients. Dominant tone of voice, absence of smiling or looking away usually operates in the opposite direction. Moreover health professionals need to **be aware of their patient's nonverbal cues** and how they reflect patient's feelings.

Considering that the **same nonverbal behaviour can mean different things** depending on individuals and situations, it is essential to be cautious about interpreting the meaning of specific nonverbal cues. Nonverbal training should focus **on individual behaviour differences** instead of teaching one specific nonverbal behaviour. Moreover sincerity is recommended, as the more authentic the nonverbal behaviour of the professional, the more satisfied patients' are[13].

Slide 14

Regarding **language barriers**, as stated in Module 2, Unit 2: *Understanding what is said in health service encounters is often a challenge, even when the patient and health professional share the same language. For migrants*, ***basic fluency in the language of the host country may not be enough*** *to effectively communicate their health problem or understand what the health professional says.*

The essential features of healthcare communication rely on core communication skills, such as **open-ended inquiry**, **reflective listening** and **empathy**, as a way to respond to the unique needs, values and preferences of individual patients[14]. Such skills are even more relevant in communication with migrant and ethnic minorities.

Slide 15
Empathy
According to published literature[15], health professionals who display a warm, friendly, and reassuring manner with their patients are more effective. Empathy can be defined as a psychological process that encompasses a collection of **affective**, **cognitive**, and **behavioural** mechanisms and outcomes in reaction to the observed experiences of another[16]. Empathic processes affect how the health professional thinks and feels (**intrapersonal outcomes**), and behaves (**interpersonal outcomes**) with the patient. The **intrapersonal outcomes can be**:

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[11] IHC (2011). Op cit.

[12] Stephen G. Henry et al (2012). Op cit.

[13] Mast MS. On the importance of nonverbal communication in the physician-patient interaction. Patient Educ Couns. 2007;67:315-8. available at http://www.sciencedirect.com/science/article/pii/S0738399107000973 (retrieved January, 21 2015)

[14] Stewart M, Brown J, Donner A, et al. (2000). The impact of patient-centered care on outcomes. *J Fam Pract.*;49:805-807

[15] Contents have been taken from: Eric B. Larson, MD, MPH; Xin Yao, PhC (2005). Clinical Empathy as Emotional Labor in the Patient-Health professional Relationship. *JAMA. 2005;* 293(9):1100-1106 available at: http://jama.jamanetwork.com/article.aspx?articleid=200456 (retrieved January 20, 2015)

[16] Davis MH. *Empathy: A Social Psychological Approach.* Boulder, Colo: Westview Press; 1996

- **Affective**: including parallel (e.g. anxiety in the health professional at the sight of an anxious patient) and reactive emotions (e.g. a health professional's anger when observing a patient unfairly treated)
- **Non-affective** outcomes in a clinical setting are typically health professionals' estimation of patients' thoughts, feelings, and characteristics, as well as attributions about patients' behaviours and decisions.

Health professionals can understand a patient better, if the patient expresses more about his or her situation. Role taking is the most advanced process, in which the observer actively imagines the target's perspective and responds accordingly. Cognitive role taking involves inferring about thoughts, motives, or intentions. Affective role taking involves inference about emotions, e.g. the health professional imagines being in the patient's situation or imagines what the patient feels or thinks.

Slide 16: Activity 3: Empathising with the patient
(Duration: 30 minutes)

The activity has two parts:

The first part consists of working in groups of 4-5 to describe a difficult situation experienced by a patient from a migrant or ethnic minority background. Fill in the template describing and explaining the situation *(M3_U1_A3 Activity Template):*
1. How you would feel in the patient's situation;
2. Imagine the patient feelings and thoughts.

Second part is a group discussion on the answers written on the template (*M3_U1_A3 Activity Template*).

Presentation

Slide 17
Listening
According to Subiela JA, **the capacity to listen** properly is the **ability** that allows us **to capture** what the other person is communicating and **to confirm** that we are receiving and understanding the message. **Listening involves an active process** in which our senses, our intellect and emotions operate[17]

Reflective listening[18] in the health context is a technique seeking to understand a patients' message, then offering the message back to the patient to confirm the message has been understood correctly. This technique facilitates the reaching of agreements, favours decision-making and obtaining answers, and it can help to avoid conflicts. It is equally as important to listen, as to show we are listening. In addition, it is essential to pay attention not only to "what" is said (content) but also the "how" it is said.

Slide 18
Most references[19],[20],[21],[22],[23] on this issue recommend to:

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[17] Subiela García, JA et al. La importancia de la Escucha Activa en la intervención Enfermera. Enfermería Global, nº 34, Abril 2014.
[18] This module uses **reflective listening** instead of active listening as in IHC (2011). Impact of Communication in Healthcare.
[19] Virshup BB, Oppenberg AA, Coleman MM. Strategic Risk Management: Reducing Malpractice Claims Through More Effective Patien-Doctor Communication. American Journal of Medical Quality 1999;14(4):153-9.

- Avoid distractions.
- Not interrupt but show you are listening by sounds such *yes, uhm, aha*, or similar.
- Note nonverbal cues emitted by the patient, as they can contain important information.
- Keep eye contact, adequate tone of voice and posture.
- Interpret the message without changing the meaning, thus indicating you have listened, prompting the interlocutor to continue speaking.
- Empathise with the patient's point of view, which doesn't mean agreeing but just viewing things from their perspective.
- Show respect about the person's feelings also with appropriate facial expression.
- Reflect the emotional state of the patient with words and nonverbal communication.
- Ask only necessary questions.
- Summarise to confirm the information and to avoid misunderstandings.

Slide 19: **Activity 4: Reflective Listening**
(Duration: 30 minutes)

Get into groups of three. Each member should play a different role: health professional, migrant or ethnic minority patient and observer.
- The person playing the role of a migrant or ethnic minority patient will have to explain a real or invented conflictive situation in the health service or a personal story about their health condition.
- The health professional will practice reflective listening.
- The observer must note all the positive and negative aspects related with the use of the technique.

They will then exchange roles so that each member of the group has the opportunity to experience each one of the three situations. Once finished, participants should:
1. analyze what situation was easier to handle
2. compare different perceptions

Presentation

Slide 20
Emotions and emotional self-control techniques
Emotions are inherent to the human being and are present in all aspects of our lives and, of course, they are present while working in health services[24]. Because our emotions affect our actions, it therefore becomes essential to have an adequate level of emotional management skills in order to:
- Provide a better service
- Feel better

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20 Llacuna Morera J. La comunicación no verbal (I): ¿cómo interpretar los gestos de nuestro interlocutor?. Formación Médica Continuada. 2000;9:576-87.

21 Rodriguez Bayón, A, Pérez Fuentes, F. Escuchar, algo más que oir. Formación Médica Continuada en Atención Primaria. Vol 6. Núm. 10. Diciembre 1999.

[22] Mast MS. On the importance of nonverbal communication in the physician-patient interaction. Patient Educ Couns. 2007;67:315-8 available at http://www.sciencedirect.com/science/article/pii/S0738399107000973 (retrieved January, 21 2015)

[23] Stephen G. Henry et al (2012) Op cit.

[24] Cadman C, Brewer J. (2001). Emotional intelligence: A vital prerequisite for recruitment in nursing. J Nurs Manag. 9:321–4.

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Slide 21
According to Goleman,[25] emotional intelligence consists of:

1. **Knowing one's emotions**. Self-awareness, recognizing a feeling while it happens.
2**. Managing emotions**. Handling feelings so that they are appropriate; realizing what is behind a feeling; finding ways to handle fears and anxieties, anger, and sadness**.**
3. **Self-motivation**. Putting emotions in order to achieve a goal; emotional self-control over gratification and stifling impulses.
4. **Recognizing emotions in others**. Empathy and social awareness.
5. **Handling relationships**. Managing emotion in interaction with others.

Slide 22:
Cognitive dissonance and automatic thoughts are relevant, as they influence our thoughts, feelings and behaviour. It is, therefore, essential to detect these dissonances and to re-think[26]. Labelling and stereotypes are examples of automatic thoughts.

Slide 23: Activity 5: Confronting difficult situations and emotions ("Re-thinking")
(Duration: 30 minutes)
The activity consists of individual work, followed by a group discussion (about 10 min.) after task 2 is finished.

Task 1 Choose a difficult situation experienced at work where migrants or ethnic minorities were involved. Describe it and explain how you handled it, considering the emotions that you felt. You can use the template to record the information (M3_U1_A5 Activity Template).

Task 2 Analyse the situation and then reconsider your thoughts and feelings (M3_U1_A5 Activity Template).

Recommended Reading

- Eric B. Larson, MD, MPH; Xin Yao, PhC (2005). Clinical Empathy as Emotional Labour in the Patient-Health professional Relationship. *JAMA. 2005;* 293(9):1100-1106 Available at: http://jama.jamanetwork.com/article.aspx?articleid=200456 (retrieved January 20, 2015)
- IHC (2011). Impact of Communication in Healthcare. Available at: http://healthcarecomm.org/about-us/impact-of-communication-in-healthcare/ (retrieved: July 19, 2015)
- Mast MS. (2007). On the importance of nonverbal communication in the physician-patient interaction. Patient Educ Couns. 2007;67:315-8. available at http://www.sciencedirect.com/science/article/pii/S0738399107000973UH (retrieved January, 21 2015)
- McGarty, Craig; Yzerbyt, Vincent Y.; Spears, Russel (2002). Social, cultural and cognitive factors in stereotype formation. Stereotypes as explanations: The formation of meaningful beliefs about social groups. Cambridge: Cambridge University Press. pp. 1–15.
- Stephen G.Henry et al (2012) Association between nonverbal communication during clinical interactions and outcomes: A systematic review and meta-analysis. Patient Educ Couns. 2012;86:297–315 available at

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[25] Goleman, D. (1996). *Emotional Intelligence* (London 1996)
[26] McGarty, Craig; Yzerbyt, Vincent Y.; Spears, Russel (2002). Social, cultural and cognitive factors in stereotype formation. Stereotypes as explanations: The formation of meaningful beliefs about social groups. Cambridge: Cambridge University Press. pp. 1–15.

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http://www.sciencedirect.com/science/article/pii/S0738399111003739#UH (retrieved January, 21 2015)

- WHO-WPRO, World Health Organization, West Pacific Region Office. People-Centred Health Care: A policy framework. Geneva: WHO, 2007.
http://www.wpro.who.int/health_services/people_at_the_centre_of_care/documents/ENG-PCIPolicyFramework.pdf (retrieved: January 12, 2015).

Complementary Reading

- Breslin, J. William. (1991). "Breaking Away from Subtle Biases" in *Negotiation Theory and Practice,* eds. J. William
- Cadman C, Brewer J. (2001). Emotional intelligence: A vital prerequisite for recruitment in nursing. J Nurs Manag. 9:321–4.
- Davis MH. (1996). *Empathy: A Social Psychological Approach.* Boulder, Colo: Westview Press.
- Duffy FD, Gordon GH, Whelan G, Cole-Kelly K, Frankel R, Buffone N et al. (2004). Assessing competence in communication and interpersonal skills: the Kalamazoo II report. Acad Med 2004; 79: 495-07.
- Goffman, Erving. (1963). Stigma: Notes on the Management of Spoiled Identity. Englewood Cliffs, NJ: Prentice Hall.
- Goleman, D. (1996). *Emotional Intelligence* (London 1996)
- Holliday, A. (2011) Intercultural Communication and Ideology. London: Sage
- Link, Bruce and Jo Phelan. (2001). "Conceptualizing Stigma." Annual Review of Sociology 27:363–85.
- Susman, J. (1994). "Disability, Stigma and Deviance." Social Science and Medicine 38:15–22.
- Stewart M, Brown J, Donner A, et al. (2000). The impact of patient-centered care on outcomes. *J Fam Pract.*;49:805-807
- Virshup BB, Oppenberg AA, Coleman MM. (1999). Strategic Risk Management: Reducing Malpractice Claims Through More Effective Patient-Doctor Communication. American Journal of Medical Quality 1999;14(4):153-9.
- WHO, World Health Organization. (2014). WHO Global Strategy on People-Centred and Integrated Health Services. Available at http://www.who.int/servicedeliverysafety/areas/people-centred-care/en/ (retrieved: July, 19 2015).