

ABSTRACT

BANERJEE, LOPAMUDRA TRIPATHI. Patient-Centered Communication (PCC) and Emotion Management Among Indian Mental Health Professionals (Under the direction of Dr. Elizabeth A. Craig).

The Mental health professionals (MHPs), clinical psychologists and psychiatrists, of India are overburdened due to a lack of resources and excessive pressure at work. Largely populated cities and rural areas with a limited number of professionals, lack of public knowledge of mental illness, stigma, and poor infrastructure are long-standing mental health problems in India. Communication plays a major role in the treatment of mental illness both for patients and providers and their emotional wellbeing. This study aims to connect the application of patient-centered communication and emotion management of Indian MHPs. Clinical psychologists and psychiatrists ($N = 105$) were recruited from a publicly available website of MHPs in India and completed a Qualtrics survey. Study results suggest three significant findings, (a) information giving among MHPs in India is a valuable skill these professionals use in client interactions, (b) MHPs exhibiting more socio-emotional behaviors (e.g., displaying concern, compassion, openness, friendliness) predicted MHPs cognitive reappraisal (i.e., reinterpretation and perspective-taking), and (c) receiving valuable information from clients predicted MHPs experiences of less negative emotions in their work. Implications for developing communication skill training for MHPs to be administered during their formal education are discussed.

Keywords: Patient-centered communication, clinical psychologists, psychiatrists, emotion management, quantitative

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Patient-Centered Communication (PCC) and Emotion Management Among Indian Mental
Health Professionals

by
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DEDICATION

This work is dedicated to all the mental health professionals across the world who are working relentlessly alongside other healthcare workers to provide help in the COVID-19 pandemic situation. Thank you for your hard work, dedication, and commitment during this challenging time. The world is indebted to your service. You are the real heroes.

BIOGRAPHY

Lopamudra was born in West Bengal in India. After completing high school, she received her undergraduate degree in psychology from Asutosh College, Calcutta, India. After that, Lopa completed her master's in clinical psychology from the University of Calcutta in 2010. She continued her educational journey and completed the degree MPhil for two years to receive her license as a clinical psychologist in India. Lopa received a fellowship in the Tata Medical Centre. State of art cancer hospital in Calcutta and worked there as a psycho-oncologist. She also participated in multiple research work during her working period in the hospital. Lopa has experience working with children dealing with autism, ADHD, behavioral issues. She has practiced as a clinical psychologist in India for more than 6 years.

In Fall 2019, Lopa received admission to the master's program in the Department of Communication at North Carolina State University, Raleigh. Lopa also worked as an instructor in the Communication department at NCSU and taught two sections of the undergraduate public speaking course. Her research interests include mental health communication, health communication, and mental health issues in mental health professionals. In her free time, Lopa enjoys watching movies, dancing, and cooking.

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CHAPTER 1

Patient-Centered Communication in the Context of Mental Health

Communication is a key element in mental health care. No one is immune from mental illness and taking good care of one's mental health is as important as taking care of one's physical health. The treatment of mental illness involves a broad range of communication processes between patients and providers at different treatment trajectories. Depending on the nature of the illness, patient communication about their illness history is important in treatment. On the one hand, patients have opportunities to convey related symptoms, time, and duration of symptoms to mental health professionals. On the other hand, providers are equally responsible for executing appropriate and effective communication during the medical interaction. For example, clinicians might gather adequate information from the client in terms of history, perform a mental status examination, ask relevant and appropriate questions that will assist in making a diagnosis, or offer psychoeducation to the patient to make them aware of the illness and its treatment. More specifically, early research on person-centered therapy, highlights the expression of empathy, honesty, and non-judgment with clients, highly valued strategies used among psychotherapists (Rogers C, 1961). Although much of the research has explored the importance of patient-focused communication within medical contexts (see Epstein & Street, 2007; McCormack et al., 2011; Venetis et al., 2009 for studies on terminal health conditions like cancer), more recently, the application of patient-centered communication in mental health contexts is gaining attention (Gask & Coventry, 2012; Nieforth & Craig, 2020). Inherent in this research is the idea that effective patient-provider communication, in the context of mental health care, can increase patient satisfaction, treatment adherence, and quality of care. Although there

are fewer studies on post-consultation outcomes for providers, this is an important topic for researchers attending to this type of research (Kasirer, 1998).

Patient-centered care, “respects the individuality, values, ethnicity, social endowments, and information needs of each patient...The aim is the customization of care, according to individual needs, desires and circumstances” (Berwick, 2002, pp. 84-85). In general, there is widespread acceptability among people of the idea that physicians should use patient-centered communication (PCC) while interacting with their patients (Epstein, 2000). PCC is realized when patients are actively involved in the medical conversation by asking questions and sharing treatment choices. In some cases, a patient's emotional well-being is directly influenced by PCC when health professional's express empathy in their communication (Schofield et al., 2003). Epstein and colleagues (2005) suggest that PCC is balancing between two important groups of needs in patient interactions, (a) the need to diagnose and treat the patient (informational needs), and (b) the need to understand and involve the patients (emotional needs). Although previous studies have paid more attention to the informational needs of patients in medical contexts, emotional needs are also important in diagnosis and treatment (McCormack et al., 2011). In the mental health context, empathy is a significant part of the diagnosis and treatment of patients and clients. Rogers's (1946) foundational work describes empathy as a core concept in establishing therapeutic alliance and can be defined as communicating a sense of caring and understanding by the therapist, which might be communicated through respect, positive regard, and active listening.

Patient-centered communication in mental health contexts is important because these interactions are complicated. Patients can be unaware of their illness, hesitant to participate in the mental health consultation, decision-making process, and treatment. Some patients may express

an overreliance on health professionals as experts and shift responsibility for their own treatment to the professionals themselves (Tripathi et al., 2019), while some patients might have decreased cognitive ability due to the mental illness where it becomes difficult for MHPs to explain information and check patient understanding (Fukui et al., 2014). Research indicates that hindrances like these might affect a collaborative approach from the mental health professionals as they manage their fear of stigmatizing patients or worsening the patient's mental status (Paccaloni et al., 2005). Limited research exists to support patient-centered communication in mental health contexts. The current study is conceptualized to provide insights on the communication competence and the emotion regulation of mental health professionals in India.

Mental Health in India

Mental illness affects one in seven people in India and its contribution to the total disease burden doubled between 1990 and 2017 (India State-Level Disease Burden Initiative Mental Disorders Collaborators, 2020). According to the World Health Organization, India is the most depressed country in the world (India Today, 2018). Realizing the grave condition of mental health issues in India, the government launched its first National Mental Health Policy in 2014 and a revised Mental Healthcare Act in 2017 with the vision of providing affordable and equitable access to mental health care to everyone (Ministry of Health and Family Welfare, 2014). One of the main reasons India is facing an excessive number of mental health-related issues is the lack of awareness and sensitivity associated with a basic understanding of mental illness. The added stigma of disclosures and diagnosis of mental illness compounds the difficulties of seeking help and leads to vicious cycles of shame, stigma, and isolation (Bagechi, 2014). Some individuals' fear of social ostracism may cause them to hide their mental illness resulting in a delay in timely diagnosis and treatment for mental health disorders. Additionally,

there is a shortage of mental health professionals in India (Agarwal, 2015) and the current treatment infrastructure available in India lacks proper resource allocation, with physical health problems receiving precedence in terms of resource allocation (Bagcchi, 2014). With the growing number of mental illnesses and the low availability of providers and resources, the professional burden of mental health professionals in India is immense.

Approaches to patient care are also different in India (as compared to Western cultures), in that Indian culture perceives health professionals as experts in powerful positions. The expectation is that doctors are not questioned and mostly controls the flow of the information concerning health and treatment. Western cultures prefer individualism and autonomy in terms of providing care, whereas Indian culture prefers collectivism and family decisions (Datta et al., 2016). Indian patients are typically not encouraged to ask questions of their health professionals and play a passive role in the medical conversation. Also, within hierarchical power positions, health professionals are not encouraged to express emotional vulnerability during a medical interaction (Tripathi, Rastogi, & Jadon, 2019). The current study is interested in these very factors: how professionals perceive that they encourage patients to participate in the conversation, involve them in shared decision making, and express empathetic behavior while managing their own emotions.

Indian mental health professionals (clinical psychologists and psychiatrists) typically do not receive compulsory communication skill training as part of their academic curriculum. They are trained in acquiring clinical history from patients and completing mental status examinations; however, this training excludes PCC components in providing care. The researcher's initial idea was to explore whether there were differences between psychiatrists and psychologists in terms of providing PCC and understanding their own emotion management, given the high demands of

their work with minimal resources. However, upon doing a detailed literature review it seemed more reasonable to include all the mental health professionals (psychiatrists and clinical psychologists) and compare them based on the communication skill training they received (or did not receive) and their self-reported communication competence.

In conclusion, mental health workers are at greater risk of developing stress and burnout than other health professionals (Garcia et al., 2015). Stress and burnout can reduce the empathetic resources of MHPs and negatively impact the quality of interaction with their patients (Passalacqua & Segrin, 2012). This study aims to examine how the adoption of effective communication strategies assists in their emotion management, ultimately, providing a foundational look into the communication and emotional management of overburdened mental health professionals in India.

CHAPTER 2

India is the second most populated country in the world with a population of more than 1.3 billion people. The number of mental health professionals (MHPs) available is negligible compared to the entire population (Sharma, 2018) and according to reports from the Ministry of Health and Family Welfare (Agarwala, 2019), currently, India has 3,500 psychiatrists with projected needs of at least 13,000 more psychiatrists to achieve an ideal patient-to-physician ratio. The national crime records bureau indicates that the entire mental health workforce in India—including psychiatrists, clinical psychologists, psychiatric nurses, and psychiatric social workers—is approximately 7,000 while the preferred requirement is somewhere near 55,000 (Aggarwal, 2015). Additionally, research suggests the presence of significant treatment gaps in mental health among low- and middle-income developing countries like India indicating a lack of resources to provide effective mental health care (Tewari et al., 2017). Poor quality of care due to lack of infrastructure, involuntary admittance to institutions, abandonment by family members, restrictions due to stigma, and isolation are long-standing mental health-related problems in India (Patel et al., 2016). This research suggests an overburdening of work for MHPs and lack of resources in providing effective mental health care in these communities.

Compounding these issues is the current perception of health professionals in India and the effect these perceptions have on MHPs. Historically, in Indian culture doctors and healthcare workers were revered, trusted individuals, seen as respected figures whose primary interest was the welfare of the entire community (Paul & Bhatia, 2016). Even though doctor's have typically been revered, more recently, a study conducted by the Indian Medical Association found that more than 75% of doctors have seen violence at work by relatives of patients (Ambesh, 2016). This changing picture of the healthcare system could be due to multiple factors like growing

populations and the commercialism of the health care system, resulting in increased stress for many health professionals. International research indicates that MHPs experience greater burnout than other professionals in the medical domain (Garcia et al., 2015). The elevated levels of burnout can be attributed to the emotional nature of work dealing with negative emotions, consistent expressions of empathy, and appropriate presentations of positive emotion as part of the quality of care. In addition, aggressive, demanding, suicidal, irritated, and/or disruptive patients require concentrated effort on the part of these professionals (Bressi et al., 2009), affecting their ability to communicate effectively with their patients and influencing their own emotion management (Martins et al., 2010).

Communication is an important aspect of both the patient's and provider's emotional health and well-being. Much like in the United States, psychologists and psychiatrists in India receive differences in their training. Psychiatrists have a medical degree recognized by the Medical Council of India, are licensed to prescribe psychiatric medicines to their patients, and receive the most basic of communication skills training (acquiring patient history of illness) (Chatterjee & Choudhury, 2011). The curriculum for clinical psychologists typically does not include any separate communication skills training coursework (Rehabilitation Council of India, 2009). They are provided their license to practice as a psychotherapist after two years of education and professional certification. Some professionals may receive training for interviewing patients to execute mental state examinations, often considered to be their communication skill training. Some health professionals independently pursue some communication skill training beyond their professionals training, but they mostly focus on interviewing skills. While both psychologists and psychiatrists may receive some communication skill training as part of their academic curriculum, neither degrees have formal communication

skill training modules (Rajashree, 2011), nor do they receive focused attention on patient-centered communication training. For example, some research shows that Indian doctors are criticized for showing a dominant communication style, namely, a transactional, hierarchical style in communicating treatment, increasing frustration and negative feelings among patients (Tripathi et al., 2019), especially in rural areas (Fochsen et al., 2006). While mental illness remains less understood by most of the rural population—with many preferring to seek indigenous treatments over more formal psychiatric care or counseling (Roberts, et al., 2020)—patient-centered communication is even less understood within the context of mental health treatment in India.

Added structural barriers to providing effective mental health care, the growing provider-to-patient gap, and cultural challenges for MHPs that influence trust in diagnosis and treatment could influence mental health professionals' own emotional health. This quantitative study investigated MHPs in India and their perceptions of their own PCC and emotion management.

Patient-Centered Communication

Patient-centered communication is the customization of care where the informational and emotional needs of the patient are at the center of their care (Berwick, 2002). Research indicates physician's communication focuses on each patient's individuality, values, ethnicity, social endowments, and information needs. Ideal patient-centered communication includes introductions of themselves, clear and direct explanations, empathy with patients, nonverbal immediacy, careful listening, and appropriate use of humor (Epstein & Street, 2007). Communication processes like these result in patient participation and improved medical decision-making (Wanzer, et al., 2004). Some research suggests that when physicians communicate with respect and empathy, patients have enhanced treatment satisfaction and

improved treatment adherence (Stewart, 1984). Epstein and colleagues (2005) defined PCC as balancing two differing needs, diagnosis and treatment with patient involvement, or information and emotion. Ong et al. (1995) identified instrumental and affective communication as the two main purposes of communication during patient-provider interaction. Instrumental communication addresses the exchange of information, confirming the diagnosis, while affective communication relates to establishing rapport with the patient, expressing empathy, and having a non-judgmental attitude. The informational needs can be achieved by checking the patient's understanding of the situation, giving time to process the information, and asking them to debrief the instructions shared. For the affective needs expressing empathy, responding to the emotional state, and allowing them to vent can be helpful in decreasing patient uncertainty while providing emotional comfort through validation (Hong & Oh, 2019).

Shared decision-making involves both informational and emotional needs, where the patient gains a sense of empowerment when they are asked to be a part of their own decisions in treatment (Lambert et al., 1997). Certainly, information sharing among the patient and the provider, discussions about treatment options, and a mutually agreed upon final decisions are key components to patient well-being (Eliacin et al., 2014). More importantly, Charles and colleagues (1997) describe shared decision-making as an interactive process where providers and patients work collaboratively to set goals, explore health concerns, discuss treatment options, and come up with a plan of action. Although shared decision making is an important aspect of patient-centered communication in psychiatry (Drake et al., 2009), discussions of treatment with severely mentally ill patients (e.g., schizophrenia and bipolar disorders) might be challenging to achieve due to the patient's diminished ability to fully participate in their own care (Fukui et al., 2014), at times resulting in low levels of patient involvement (Goss et al., 2011). Because of

these challenges, research indicates that some psychiatrists find it unnecessary to engage in shared decision making with regards to medication or hospitalization (Hamann et al., 2009; Seale et al., 2006), while growing evidence suggests that people with mental illness are able to understand treatment choices and participate in decisions regarding their care (Carpenter et al., 2000; Patel, 2005). For example, with the chronic and complex nature of long-term treatment periods, due to comorbidity of different illnesses, mental health patients play an active role in clinical communication by providing a history of mental illness and ongoing communication regarding their current physical/emotional health and interruptions to daily living (Del Piccolo & Goss, 2012). While providers can share information regarding the illness, possible interventions, and evidence-based knowledge related to the illness, patients with mental illness can communicate their history, perspectives, and expectations for medical discussions and treatment (Drake et al., 2009). The American Psychological Association Presidential Task Force on Evidence-based Practice (2006) recommends the application of evidence-based practice in psychology and encourages psychologists to consider various client characteristics and needs while making shared decisions in a therapeutic setting. Consequently, shared decision-making should continue to be explored in the therapeutic context as more research is needed to investigate how therapists implement this in a clinical setting (Beyene et al., 2018).

These types of interactions require professionally skilled communicators. Yet, little is known about how mental health professionals in India perceive their ability to provide patient-centered communication. Therefore, it is important to understand how mental health professionals understand their communication competencies in the clinical setting in relation to the communication skill training they received. Given this, the following hypothesis is proposed.

H1: Mental health professionals who received communication skill training will report higher levels of patient-centered communication competencies (e.g., information-giving, information receiving, information verifying, socioemotional behaviors, and shared decision making) than professionals who did not receive communication skill training.

Mental Health Professionals and Emotion Management

In general, research indicates that avoiding emotions can damage mental health (Martins et al., 2010). This applies to patient-provider contexts, as well. Incorporating patient-centered communication into practice has been positively related to patients' emotional wellbeing (Kinmonth, 1998; Piette et al., 2000). For example, health professional's expressions of positive emotions in a medical conversation are associated with positive health outcomes and satisfaction with the quality of care (Di Blasi et al., 2001; Hojat et al., 2011; Street et al., 2009). Patients evaluate health professionals more positively, report higher levels of satisfaction with treatment, and are more compliant with doctor's advice when doctors express empathy during a medical encounter (Kafetsios et al., 2014; Carmel & Glick, 1982). However, there exists sparse literature regarding the physician's communication and its relation to their own emotion regulation or the "process by which individuals influence which emotions they have, when they have them, and how they experience and express these emotions" (Gross, 1998, p. 275). Even for MHPs, recognizing, processing, and accepting their own emotions is important for their own professional development. For example, proper management of both positive and negative emotions promotes goal achievement and facilitates interpersonal communication (Verziletti et al., 2016). These emotion management strategies are most commonly implemented through cognitive reappraisal and emotion suppression (Gross, 1998).

Cognitive reappraisal—reinterpretation and perspective taking—brings a conscious change in cognitive functioning (Gross, 2008). The aim is to perceive the emotion eliciting situation in a different way, thus reducing its negative impact, and deriving more positivity. Emotion suppression is the modulation of a behavior to inhibit the emotion expression associated with that specific behavior. Previous research has indicated that cognitive reappraisal is an adaptive emotion regulation strategy with positive outcomes like greater life satisfaction (Haga et al., 2009), self-esteem and better social relationships (John & Gross, 2004), reduced stress-related experiences (Moore et al., 2008), and positive affect (Balzarotti et al., 2010). Physicians employing strategies like cognitive reappraisal exhibit empathy expressions and effective patient-provider communication (Finestone & Conter, 1994). However, in general, research indicates that emotion suppression consists of maladaptive strategies causing significant negative affect and negativity in social exchanges and communication with others (John & Gross, 2004). Emotion suppression is associated with a higher risk of developing worse interpersonal functioning and higher levels of psychopathology like depression and anxiety (Moore et al., 2008; Dennis, 2007; Gross & John, 2003).

The demanding nature of mental health work and a professional's ability to effectively communicate with their patients/clients suggests that Indian mental health professionals might face challenges to their own emotional health. Burnout, or the psychological condition that develops as a result of the inability to cope with high levels of stress (Maslach, 1987), is common among mental health professionals (Bassett & Llyod, 2001; Brown & Pranger, 1992; Bregar et al., 2011). A large body of international literature suggests that psychiatrists experience higher levels of burnout than other physicians (Bressi et al., 2009; Deary et al., 1996). Importantly, burnout impacts many communication processes between patients and providers.

Stress and burnout symptoms can negatively impact the empathetic resources of the provider, reducing the quality of interaction with the patient (Passalacqua & Segrin, 2012). Additionally, previous research has indicated that clinicians become stressed before communicating difficult news (Shaw et al., 2013). They feel frustrated with patient's non-compliance in treatment, feel pressure to help the patient to become illness-free, and at times feel powerless against the illness itself (Meier et al., 2001). Unfortunately, even though clinicians are trained in assisting clients to manage their emotions, these professionals are not often trained to deal with extreme emotions. This results in clinicians engaging in avoidance behaviors deemed not helpful to the patient (Yagil & Shnapper-Cohen, 2016; Luff et al., 2016). These avoidant behaviors are reinforced by the perceptions that medical professionals should be strong and emotionally detached to maintain a sense of authority (Rosenfield & Jones, 2004). This emotional detachment can have negative consequences on health and wellbeing, especially among those in service sectors (Zafp, 2002). Ultimately, managing emotions has some influence on workplace communication (Weiss & Cropanzano, 1996; Kiefer, 2005; Seo & Barrett, 2007), yet less is known about emotion management among MHPs in India. Therefore, the following hypotheses are proposed:

H2: Mental health professionals' perception of their own communication competencies (e.g., information-giving, information receiving, information verifying, socioemotional behaviors, and shared decision making) predicts their emotion regulation at work (e.g., cognitive reappraisal and emotion suppression).

H3: Mental health professionals' perception of communication competencies (e.g., information-giving, information receiving, information verifying, socioemotional behaviors, and shared decision making) predicts their work-related positive and negative emotions.

Method

Participants

A sample of 105 clinical psychologists 84% ($n = 89$) followed by psychiatry 13.2% ($n = 14$) was obtained. Two participants indicated they had both degrees. The sample consisted of 75% ($n = 77$) females and 25% ($n = 26$) males with two respondents not entering the gender. A majority of the participants worked full time in private practice in India 30.2% ($n = 32$), followed by those holding faculty positions in private/ semi-government institutes with private practice 12.3% ($n = 13$) and faculty positions in government institutes 9.4% ($n = 10$), employee in private hospitals with no practice 9.4% ($n = 10$), employee in government hospital with or without private practice 12.3% ($n = 13$), employee in private hospital with private practice 8.5% ($n = 9$), 2.8% ($n = 3$) reported faculty in private or semi-government institute with no private practice, and 15.1% ($n = 15$) indicated the others category. The participants were mostly from the southern states of India 41.51% ($n = 44$), followed by eastern states of India 35.85% ($n = 38$). Twenty-one percent ($n = 23$) were from northern states of India.

Procedures

After obtaining University IRB approval, survey data were collected from MHPs in India (i.e., psychiatrists and clinical psychologists). A convenience sampling method was used based on publicly available emails of MHPs on two Indian websites. These websites were from the two largest mental health organizations in India where a majority of MHPs were listed as licensed and practicing in India. The first website contained a list of approximately 1,400 psychologists among which 700 had their email addresses and contact details attached for public use. All 700 email addresses were copied from the website to an excel spreadsheet to maintain recruitment records. A recruitment email and survey link were initially sent to all clinical psychologists.

Approximately 400 email addresses indicated a failure in sending the email message. The response rate for clinical psychologists was 29%. For the list of psychiatrists, almost 600 emails were recorded. The same procedure was followed for the psychiatrists, with 200 emails sent without any delivery issues. After getting notifications of the nonfunctional email addresses, the researcher deleted and created a separate email list of only functional emails. Other professionals excluded from the final participant list included professionals who responded indicating that they no longer worked in India, have a clinical degree but no longer practiced, or were retired. The response rate for psychiatrists was 8.5%. The questionnaire was open for two months from August to September 2020. Two biweekly reminder emails were sent to encourage participation. A questionnaire was administered using Qualtrics, beginning with a detailed informed consent form followed by multiple sets of scale items and demographics. Participants were allowed to stop participating at any time without penalty. No identifiable information from participants was requested to conform to NCSU's IRB norms. The questionnaire took approximately 15 minutes to complete. A progress bar was placed at the bottom of the Qualtrics survey as a way to encourage participants to complete each section. Among professionals who followed the survey link, 103 questionnaires were incomplete at the time of closing the survey. Those responses were not included in the data analysis.

Measures

Communication Skill Training

Mental health professionals were asked whether they had received any communication skill training. Based on yes/no answers, two groups of mental health professionals were organized. Sixty-nine percent ($n = 73$) had some type of communication skill training and 31% ($n = 33$) did not have any kind of formal communication skill training.

Medical Communication Competence Scale

This scale is typically used to measure physician perceptions of their own communication competence (36 items) and patient communication competence (39 items) in a medical/clinical setting. Items were averaged for each dimension (see Table 1). For the current study, the researcher used the physician version, with modified language for MHPs. Items represented four dimensions of competence: information giving, information receiving, information verifying, and socioemotional behaviors. Mental health professionals were asked to report on the degree to which they, “provide good explanations to my patient/client,” and “ask patient/client the right question,” and “are warm and friendly.” Scores ranged from completely disagree (1) to completely agree (6) (7 = not applicable) with a Cronbach’s alpha of 0.93.

Shared Decision Making

The physician’s version of the shared decision-making questionnaire developed by Scholl, et al. (2012) was modified for MHPs. With this 9-item scale, MHPs indicated how much they completely disagreed (1) or completely agreed (6) on each statement on a 6-point Likert-type scale. (7 = not applicable) Items included statements such as, “I tell my patients that there are different options for treating his/her medical condition” and “I help my patient understand all the information.” Cronbach’s alpha for this scale was 0.88.

Emotion Regulation

The 10-item emotion regulation questionnaire developed by Gross and John (2003) was used to measure the emotional regulation of MHPs. Items were related to emotional experiences, how professionals feel inside, emotional expression, and how mental health professionals express their emotions through talking and behaving. Items included statements such as, “When I want to feel more positive emotion (such as joy or emotion), I change what I am thinking about”

and “When I am faced with a stressful situation, I make myself think about it in a way that helps me stay calm.” Participants reported on a 6-point scale ranging from completely disagree (1) to completely agree (6). Dimensions of the scale included cognitive reappraisal ($\alpha = 0.91$) and emotion suppression ($\alpha = 0.90$).

Positive and Negative Emotion

The short version of the positive and negative affect scale (PANAS) developed by Watson (1988) was used. The scale consisted of several words that described different feelings and emotions. The participants were asked to rate the extent they feel positive and negative emotions (e.g., interested, excited, distressed, and scared) in the last week related to their work, where 1 = very slightly/not at all and 5 = extremely. The positive affect scale demonstrated a Cronbach’s alpha of 0.87 and the negative affect scale demonstrated a Cronbach’s alpha of 0.82.

Data Analysis

The researcher ran descriptive statistics and a Pearson-product correlation for continuous variables (see Table 1). For hypothesis one, the researcher ran an independent sample t-test to test for differences in communication competencies (i.e., information giving, information receiving, information verifying, socio-emotional, and shared decision making) between MHPs who had received communication skills training and those who had not. Hypotheses two and three were analyzed using a multiple regression, where the predictor variables were information giving, information receiving, information verifying, socio-emotional behaviors, and shared decision making, and the criterion variables were emotion regulation (H2) and positive and negative emotions (H3).

Results

An independent sample t- test was conducted to test hypothesis one, which was not supported. Mental health professionals who received no communication skill training ($M = 5.76$, $SD = 0.512$) reported more information giving to their clients than those who received some communication training ($M = 5.43$, $SD = 0.624$) ($t(104) = -2.034$, $p = .045$). There were no significant differences among the two groups of mental health professionals with regards to information receiving ($t(104) = 0.825$, $p = 0.411$), information verifying ($t(104) = -0.097$, $p = 0.923$), socio-emotional behavior ($t(104) = -0.615$, $p = 0.540$), or shared decision making ($t(104) = -0.472$, $p = 0.638$).

For hypothesis two the predictor variables were information giving, information receiving, information verifying, socio-emotional, and shared decision making, while the criterion variable was emotion regulation (e.g., cognitive appraisal and emotion suppression). A multiple regression produced a significant model for cognitive reappraisal ($F(5, 100) = 3.962$, $p < 0.05$, $R^2 = 0.165$) (see Table 2). As MHPs engaged in more socio-emotional behaviors (e.g., being open and honest, warm and friendly, showing the patient they cared about them, making the patient relaxed or comfortable), the more that predicted their own cognitive reappraisal process ($\beta = 0.257$, $t(100) = 2.114$, $p = 0.037$). Additionally, test results revealed that there was no prediction of Indian mental health professionals' perceptions of communication competence on their emotion suppression. A multiple regression produced a non-significant model for emotion suppression ($F(5, 100) = .544$, $p > 0.05$, $R^2 = .026$).

For hypothesis three the predictor variables were information giving, information receiving, information verifying, socio-emotional behaviors, and shared decision making, while the criterion variable was work-related positive and negative emotion. The regression revealed

that Indian mental health professionals' perceptions of communication competence did not predict their work-related positive emotions ($F(5, 100) = 1.633, p = 0.158, R^2 = 0.075$) (see Table 3). A multiple regression produced a significant model for negative emotions ($F(5, 100) = 6.181, p < 0.01, R^2 = .236$). MHPs receiving more information from their clients predicted experiencing less negative emotions at work ($\beta = -0.352, t(100) = -2.178, p = .032$).

Discussion

The current study examined the perceptions of Indian MHPs, their communication competence in a clinical/medical setting, and emotion management. Previous research has shown that mental health professionals are at greater risk of developing mental health issues and experiencing greater burnout than other health professionals (Bassett & Llyod, 2001; Brown & Pranger, 1992; Bregar et al., 2011). The challenging nature of their work, with limited resources in developing countries like India, makes the situation even more complex. This study's focus on Indian MHPs resulted in three significant findings, (a) information giving among MHPs in India is a valuable skill these professionals use in client interactions, (b) MHPs exhibiting more socio-emotional behaviors (e.g., displaying concern, compassion, openness, friendliness) predicted cognitive reappraisal (i.e., reinterpretation and perspective-taking), and (c) receiving valuable information from clients predicted MHPs experiences of less negative emotions in their work. Not only do these findings expand this literature from an Eastern cultural perspective, but it highlights the importance of negotiating information exchange and socioemotional behaviors in facilitating MHPs emotion regulation, an indicator of the management of stress-related to burnout.

Although hypothesis one was not supported, meaningful interpretations can be made from these findings. Results from hypothesis one revealed that among the five factors of

communication competence—information giving, information receiving, information verifying, shared decision making, and socio-emotional behaviors —surprisingly, information giving was significantly higher among the MHPs who received *no* communication skill training ($M=5.76$, $SD=0.512$). Research has indicated that information sharing is an initial process in patient-centered communication in developing trust with patients (Ong et al., 1995). Although differences were found in the unexpected direction, this might indicate that MHPs with *no* communication skill training understand the importance of building trust among their clients through information giving in mental health conversations. This might also be the case for those *with* communication skill training, as the mean for this group was also high ($M = 5.43$, $SD = 0.624$). For clients, receiving valuable information regarding their diagnosis and care could give them a sense of autonomy and make them feel validated; while this same process for professionals might assist them in more skillfully eliciting necessary information for diagnosis and care; ultimately, benefiting client and MHP efficacy in care.

Another explanation for this finding is that information giving in mental health care is often labeled as psychoeducation, where the patient is made aware of the mental illness, its symptoms, and a course for treatment. Indian population has limited knowledge about mental illness, so when seeking help for mental health issues it is customary for professionals to provide patients with the necessary information so patients and their families can make appropriate decisions regarding care. The group with no communication skill training scored a little higher in this subscale. However, that does not necessarily indicate that they are better in the PCC context as it is a multifaceted concept. Although, this might suggest that information giving in mental health care contexts in India is highly valued, irrespective of communication skill training.

Though there were no significant differences in the other subscales of communication competence among these two groups, this could be due to the way communication skill training was conceptualized and measured in the current study (i.e., yes/no). The MHPs could have interpreted this item as interviewing skills in a mental status examination (e.g., general questions eliciting history, symptoms) or patient-centered communication skills as the researcher intended. Even though psychiatrists and clinical psychologists were not different in terms of shared decision making, information verifying, information receiving, and socioemotional behaviors, descriptive statistics showed that 69% of the sample did report receiving some type of communication skill training. This indicates that MHPs perceive themselves as being trained in communication. Future research should sample proportionately from both psychiatrists and clinical psychologists, while clearly conceptualizing communication skills training in order to test for differences. These efforts could add to the reliability of the study and possibly reduce the chances of making a Type II error (e.g., suggesting there were no differences in the communication skills training groups, when there could be differences).

Second, results of hypothesis two suggest that MHPs in India who perceived themselves to be demonstrating care for the client by building a trusting relationship with the client through openness, honesty, and compassion (e.g., socioemotional behaviors), engaged in cognitive reappraisal as an emotion regulation strategy. For MHPs, their psychotherapy training includes teaching effective emotion management techniques to clients, while orienting clients to identify their own maladaptive emotional responses. In this process, MHPs remain nonjudgmental with effective expressions of empathy. These qualities are important foundations in administering effective psychotherapy. It is possible that these professionals are not only advising their clients to follow these strategies, but they are applying honesty and compassion to themselves,

facilitating cognitive reappraisal and maintenance of their own emotions. For example, two components of cognitive reappraisal—reinterpretation and perspective-taking—are associated with experiences of better affective, cognitive, and social outcomes when compared to suppression (Richards & Gross, 2000; Gross & John, 2003; English et al., 2012). Additionally, the proper management of positive and negative emotions promotes goal achievement (Verziletti et al., 2016), while perspective taking brings a conscious change in cognitive functioning (Gross, 2008). It stands to reason that if MHPs view themselves as building trust and showing concern and compassion for clients, then they would invest in efforts that would facilitate perspective taking and the reinterpretation of negative behaviors of clients. For example, if a patient is not complying with a therapeutic plan or complaining of little improvement related to their mental health, MHPs might become frustrated. Through cognitive reappraisal, instead of expressing anger and frustration toward the patient, the MHP might address the situation with a deeper understanding of the patient's behaviors related to their illness. Ultimately, the MHP could aim to attribute client communication, emotions, and events differently, possibly reducing the negative impact that maladaptive behaviors from clients might have on their own personal and professional.

However, the relationship between patient-centered communication (including socioemotional behaviors) and cognitive reappraisal requires further testing. Previous research has shown that physicians employing strategies like cognitive reappraisal exhibit empathy expression and effective patient-provider communication (Finestone & Conter, 1994). First, future research should examine a reciprocal relationship between socioemotional behaviors and cognitive reappraisal. Additional analyses could indicate that cognitive reappraisal predicts MHPs employing socioemotional behaviors in client/provider interactions. Additionally,

although the regression analysis was not fully supported, other PCC variables (e.g., information giving, information receiving, information verifying socioemotional behaviors, and shared decision making) indicated small to moderate positive correlations with cognitive reappraisal. There were no significant correlations between patient-centered communication variables and emotion suppression. Emotion suppression as a regulatory strategy was also the lowest mean among study variables ($M = 3.60$) with the highest variance ($SD = 1.28$). Emotion suppression consists of maladaptive strategies causing significant negative affect and negativity in social exchanges and communication with others (John & Gross, 2004) and is associated with a higher risk of developing and maintaining depression and anxiety (Moore et al., 2008). These nonsignificant correlations might indicate a renewed focus among those training Indian health professionals in cognitive reappraisal techniques. Additionally, while planning for a communication skill training program, socio-emotional behaviors should be a part of the curricula, as these behaviors appear to be predicting healthy emotion regulation among MHPs. Being aware of this link might assist MHPs in managing their stress and burnout and could bring more clarity to developers of communication skills training opportunities.

Finally, study findings also revealed that when Indian MHPs reported information-receiving from clients as an important part of their work, they experienced fewer negative emotions in their work. Drake and colleagues (2009) argued that patients with mental illness can significantly influence treatment by providing health history and sharing their perspectives on their own illness. Additionally, some research indicates that honest communication reduces uncertainty in treatment procedures for both patient and provider, especially when the diagnosis is complicated (Luff et al., 2016). If clients are providing useful information that aids MHPs in their ability to do their work well, the MHP might feel less frustrated by obstacles in obtaining

important client information, contributing to their overall emotions related to client care. Additionally, experiencing negative emotions at work has been found to be related to burnout (Szczygiel & Mikolajczak, 2018), specifically, feeling overburdened and experiencing emotional exhaustion (Maslach & Jackson, 2001) whereas experiencing less negative emotions at work has been shown to help in proper rapport establishment, expressing empathy, and having nonjudgmental attitudes toward patients (O' Connor et al., 2018). In the current study, correlational analyses indicated that negative emotions had a low to moderate, indirect relationship to information verifying, socioemotional behaviors, and shared decision making, indicating that these patient-centered communication competencies do have associations with experiencing less negative emotions while MHPs perform their jobs. The source of the negative emotions could have any origin, but what is important is that these negative emotions typically hinder effective communication in work settings. Surprisingly, results did not show that communication competence predicted MHP's positive emotions in their work. This could be due to the fact that experiencing positive emotions at work is a multifaceted concept that is broadly connected with other factors like professional efficacy and job satisfaction, not just communication competence.

Implications, Limitations, and Future Directions

These findings might extend current examinations of patient-centered communication, namely, by focusing on the mental health of the provider. Previous research has shown that mental health professionals are at higher risk of developing mental health issues due to work-related pressure (O'Connor et al., 2018) indicating a need for patient-centered communication skill training among MHPs. This study is one of only a few focused on mental health and patient-centered communication (Nieforth & Craig, 2020). Examining the different features of patient-

centered communication in mental health contexts might illuminate these processes and outcomes unique to mental health professionals' viewpoints connected to their own wellbeing; specifically, information giving among MHPs is a valuable skill, MHPs expressions of warmth and openness predict their ability to reappraise client maladaptive communication, thus providing opportunities to receive valuable information from their clients and lessening the impact of negative emotional experiences at work. These components create opportunities for the effective administration of psychotherapy and psychiatry. In the future, institutions and education systems committed to providing communication skill training of MHPs should consider dedicating specific courses on patient-centered communication techniques and skills. These skills could prove to boost adaptive emotion regulation strategies in support of clients/patients but could also facilitate use among MHPs in improving their own mental health.

Second, the sample from this study was from an Indian, collectivistic cultural background with high power distance. Doctors in countries with high power distance are more likely to see themselves in a position of responsibility and position themselves as experts (Verma et al., 2016). This powerful position of doctors, assigned by the culture, makes them more practical in their emotional expressions. Culturally, it is typically not welcomed that a person in a powerful position will become vulnerable and express emotions to a greater extent. This might make the application of patient-centered communication more complex in Indian culture. Concurrently, the majority of the participants were female psychologists. There exists research evidence that shows gender differences in terms of emotion regulation. Women are more aware and concerned with others' emotions than men (Brody & Hall, 1993; McClure, 2000). Other research has indicated that women are better at expressing empathy than men (Rueckert & Naybar, 2008). Some gender role theories suggest that men are more likely to engage in emotion suppression

(Tamres et al., 2002). Although the current sample included a majority of psychologists, the majority of the research in mental health-related research focuses on psychiatrists. Additional research is needed to examine the role of the MHP, sex, and culture on their use of patient-centered communication and their own emotion management in their work.

There were a few limitations in the current study. First, the researchers acknowledge the small sample size and unequal representation of mental health professionals in the sample. In the future, efforts should be made to have equal representation of both groups of clinical psychologists and psychiatrists. Second, the scales used to measure variables like emotional wellbeing (i.e., PANAS scale) among MHPs should be considered. Using a more generalized scale to measure emotional wellbeing might have offered more specificity related to wellbeing and not just self-report on emotions experienced at work. Third, communication skill training was not operationalized in a way that differentiated it from interviewing skills of mental health professionals. Operationalizing the communication skill training with aspects of patient-centered communication could reveal more knowledgeable insights about the actual training of these professionals in India. Researchers did provide MHPs with open-ended responses to report the type of communication training they had received. Future studies could code and categorize the type of training reported, allowing the researcher to expand the attributes of the independent variable (e.g., eye contact, showing empathy, being direct) and conduct additional analyses. Fourth, the study sample was acquired by gathering emails from publicly available websites. Many of the emails were not functional. In the future sampling frames and techniques could be more systematic in order to provide more generalizability in the findings. Finally, the data were collected during a time of pandemic which might have influenced response rates. This study

should be replicated at a time when the added stress of a pandemic might not be influencing participants' ability to take the survey or their responses.

Conclusion

This current study provides meaningful information about patient-centered communication from an eastern cultural perspective in the mental health context. It adds to the literature by connecting PCC with the experiences of MHPs in India. It is important to understand how mental health professionals employ different strategies of PCC in their clinical communication benefitting the emotion regulation of them and emphasizing the empathetic expressions. Future research should examine patient-centered communication in non-western contexts to test its conceptual usefulness; however, these findings could be used to formulate a standardized communication skill training program for MHPs in India focused on information giving and socioemotional behaviors as a way to decrease stress for mental health patients and providers.

CHAPTER 3

Working as a clinical psychologist in India for almost 6 years, I know the importance of communication as a mental health professional. I understand the lack of knowledge people have about mental illnesses and the immense stigma that prevents many people from coming to a therapist and seeking treatment. I worked in a state-of-the-art cancer hospital in India for almost two years where my interest in communication skills training grew. I was interested in understanding how providers managed breaking bad news to patients and their families and the transition from curative to palliative care. Fortunately, I got the chance to interview some of the oncologists working in that hospital to understand how they applied different communication strategies and how they handled difficult conversations (Datta et al., 2016). This experience was formative and has guided my current work while in my MS program. While conceptualizing this study I thought about difficult conversations in mental illness contexts, patient involvement in the treatment procedure, and communication techniques that may be helpful in the process. As a licensed clinical psychologist in India, I had never received any kind of communication skill training during my academic career which included specific elements of patient-centered communication. Most of my communication education and experience concerned rapport establishment and acquiring illness history from patients by asking relevant questions. Consequently, there were many points in the conceptualization and execution of the study that require elaboration.

The current study began with an interest in understanding the communication competence of MHPs in India. There exists sparse literature on the application of PCC in mental health contexts, especially from eastern cultures. The study's initial interest was to compare two groups of mental health professionals, psychiatrists, and clinical psychologists; however, there

was so little in the literature to support a hypothesis, the two groups were combined and more focus was placed on comparing MHP's communication skills training. The research aim was to explore whether these professionals had received communication skill training and if that was an important component in their perceptions of their own communication competence. In retrospect, this was an important variable that I should have operationalized in a specific way by excluding it from the mental status examination or history taking and relating it more to PCC (e.g. information giving, information verifying, information receiving, shared decision making, and socio-emotional variables). The majority of the participants marked receiving some kind of communication skill training (e.g., closed-ended item) but some open-ended items may indicate that these professionals were referring to their training on interviewing patients, a narrower view of patient-centered communication. Although the current study did not analyze these open-ended responses, future analyses will include coding procedures that might reveal more about the types of communication training these professionals received and used in their practice. Ultimately, more studies are needed that explore the type of communication training MPHs receive in India and how/if these principles diverge and converge with what the literature suggests are "best practices" in western cultures.

Operationalizing variables was a challenge. Selecting appropriate measurements that were not from a psychological perspective required time and effort. Future studies might incorporate different scales for emotion management. For example, although emotion regulation and the PANAS (positive and negative affect scale) are reliable and valid measures, conceptually, participants could have reported on their emotional wellbeing, not just the frequency of positive and negative emotions they experienced at work.

Sampling and recruitment procedures were comprehensive but could be enhanced. The professional body that a majority of Indian psychiatrists are associated with (Indian Psychiatric Society) has membership charges. Hence, the psychiatrists were recruited from a publicly available, not regularly updated, list with many nonfunctioning emails. This contributed to the uneven and small sample size of psychiatrists in the study. Additional sample lists and recruitment efforts could be made so comparisons could be made in analyses, if appropriate.

Although the above research processes could be improved in this study, the current study has some important findings that add to the mental health communication literature. It highlights the importance of information giving in the mental health context and indicates that Indian mental health professionals are applying this communication skill in their practice irrespective of communication training. Additionally, it predicts that more information receiving leads to less negative emotions as MHPs perform their work. It emphasizes how using an empathetic communication approach can help MHPs use adaptive emotion management strategies. These findings could be important in assisting those developing more robust communication skills training programs for MHPs. These findings highlight the importance of having a standardized communication skill training curriculum for the MHP in the entire country. Training could focus on socioemotional behaviors like empathy, adaptive emotion management for professionals, and channeling these strategies toward reducing their own stress. These assets might also address the gap between the patient-provider ratio and the lack of knowledge related to mental illness among the Indian population that causes burnout among MHPs. Additionally, this is the first step for developing support for MHPs. By acknowledging their stress and burnout, this training could normalize MHP's experiences and create space for mental health professional's validation and emotional wellbeing. Incorporating this training into the current curriculum for MHPs could be a

low-cost strategy that might enhance MHPs efficacy in diagnosis and treatment, while not requiring significant resource allocations. More comprehensive training might also encourage Indian MHPs to expand their PCC-related behaviors with patients and families in mental health contexts, enhancing patient awareness, participation in medical conversations, and reducing stress and burnout among MHPs.

This thesis is one of the few studies that have focused on Indian clinical psychologists and communication. In general, existing research mostly focuses on the psychiatrist's approach from a medical perspective. It remains important to gather insights on how clinical psychologists apply these skills in a therapeutic way and what challenges they face. This research is a stepping stone in understanding the challenges clinical psychologists face while executing PCC. Future research could investigate communication processes in clinical psychologist/client interactions from both the clinical psychologists' and clients' points of view.

Lastly, this study was completed during the coronavirus pandemic which changed the way diagnosis and treatment were implemented. Given the challenges of everyday living for the participants and the researcher, the replication of this study could be challenging; however, these findings remain meaningful in understanding the experiences of MHP's communication and their own emotion management, especially during a global pandemic.

This work is relevant to academic and practitioner audiences. The goal is to submit a manuscript based on this thesis for the National Communication Association Conference in 2023. Possible publication outlets are *Health Communication*, *Journal of Health Communication*, and *Communication Quarterly*.

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APPENDICES

Table 1. Descriptive Statistics

Variable	Mean	SD	Information Giving (IGD)	Information receiving (IRD)	Information verifying (IVD)	Socioemotional (SED)	Shared decision making (SDM)	Emotion Wellbeing (Positive emotions)	Emotion Wellbeing (Negative emotions)	Emotion regulation-Cognitive reappraisal	Emotion regulation-Emotion suppression
Information Giving (IGD)	5.489	0.617	1	0.489**	0.473**	0.237	0.296*	0.190	-0.169	0.266**	-.058
Information receiving (IRD)	5.424	0.586	0.489**	1	0.790**	0.612**	0.548*	0.263**	-0.460**	0.334**	.042
Information verifying (IVD)	5.494	0.531	0.473**	0.790**	1	0.586**	0.421*	0.218*	-0.435**	0.283**	-.009
Socioemotional (SED)	5.602	0.470	0.273*	0.612**	0.586**	1	0.454*	0.167	-0.267**	0.351**	.093
Shared decision making (SDM)	5.040	0.790	0.296**	0.548**	0.421**	0.454**	1	0.174	-.264**	0.229*	-.021
Emotion Wellbeing (Positive emotions)	3.734	0.609	0.190	0.263**	0.218*	0.167	0.174	1	-.338**	.101	-.057
Emotion Wellbeing (Negative emotions)	1.694	0.577	-0.169	-0.460*	-0.435*	-0.267*	-0.264*	-0.338**	1	-.145	.183
Emotion regulation-Cognitive reappraisal	4.508	0.961	0.266**	0.334**	0.283**	0.351**	0.229*	0.101	-.148	1	.290**
Emotion regulation-Emotion suppression	3.604	1.278	.058	.042	-0.09	.093	-.021	-.057	0.183	0.290**	1

*indicates $p < .05$ and **indicates $p < .01$.

Table 2. Multiple Regression Analysis Summary for Patient-Centered Communication Predicting Emotion Regulation

Variable	Cognitive Reappraisal			<i>t</i>	95% CI
	B	p	β		
Constant	-0.536	0.656		-0.447	[-2.919, 1.846]
IGD	0.252	0.134	0.162	1.512	[-0.079, 0.583]
IRD	-0.102	0.719	0.133	0.789	[-0.332, 0.769]
IVD	0.219	0.432	-0.056	-0.361	[-0.660, 0.456]
SED	0.525	0.037	0.257	2.114	[0.032, 1.017]
SDM	0.018	0.893	0.015	0.134	[-0.251, 0.287]

Note. $R^2 = 0.165$, $p = 0.003$.

Variable	Emotion Suppression			<i>t</i>	95% CI
	B	p	β		
Constant	3.082	0.077		1.787	[-0.340, 6.504]
IGD	-0.151	0.529	-0.073	-0.631	[-0.627, 0.324]
IRD	0.326	0.416	0.149	0.817	[-0.465, 1.116]
IVD	-0.331	0.415	-0.138	-0.819	[-1.133, 0.471]
SED	0.376	0.294	0.138	1.054	[-0.331, 1.083]
SDM	-0.139	0.477	-0.086	-0.714	[-0.525, 0.247]

Note. $R^2 = 0.026$, $p = 0.743$

Table 3. Multiple Regression Analysis Summary for Patient-Centered Communication Predicting Positive and Negative Emotions at Work

	<i>Positive Emotion</i>				
Variable	B	p	β	<i>t</i>	95% CI
Constant	1.958	0.016		2.442	[0.367, 3.549]
IGD	0.079	0.481	0.080	0.707	[-0.142, 0.300]
IRD	0.201	0.280	0.194	1.087	[-0.166, 0.569]
IVD	0.006	0.973	0.006	0.034	[-0.366, 0.379]
SED	0.013	0.937	0.010	0.079	[-0.316, 0.342]
SDM	0.028	0.755	0.037	0.314	[-0.151, 0.208]

Note. $R^2 = 0.075$, $p = 0.158$.

	<i>Negative Emotion</i>				
Variable	B	p	β	<i>t</i>	95% CI
Constant	4.032	0.000		5.841	[2.662, 5.402]
IGD	0.101	0.294	0.108	1.054	[-0.089, 0.291]
IRD	-0.347	0.032	-0.352	-2.178	[-0.664, -0.031]
IVD	-0.259	0.113	-0.238	-1.600	[-0.580, 0.062]
SED	0.099	0.488	0.081	0.697	[-0.184, 0.383]
SDM	-0.029	0.713	-0.039	-0.369	[-0.183, 0.126]

Note. $R^2 = 0.236$, $p = 0.000$.