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Do Brazilian Immigrant Caregivers' Acculturation Preferences Predict the Quality of Their Relationship with Child Primary Health Care Professionals?

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Abstract

Several studies on immigrants' health-related vulnerabilities have been focused on various determinants of their access to health care services. However, little is known about acculturation processes as determinants of immigrants' health-related behaviors, including their attitudes towards Child Primary Care (CPC) after they enter health services. Therefore, this study aimed to test two conceptual models, hypothesizing: (1) the predictive role of Brazilian immigrant caregivers' meta-perceptions about Portuguese acculturation preferences on their satisfaction with health-care professionals via trust in physicians and (2) the moderating effect of immigrants' own acculturation preferences on such relationships. The data used for this study was part of a bigger database collected in a previous study and included 123 Brazilian immigrant caregivers of children aged between 2- and 6-years old. The database included participants' answers on measures assessing immigrants': 1) own and perceived acculturation preferences (Acculturation Measure); 2) satisfaction with CPC care (EUROPEP) and trust in physician (Trust in Physician Scale); 3) demographic information. Immigrants' meta-perceptions about Portuguese acculturation preferences towards contact predicted their satisfaction with care via trust in physician, whereas no results were found for the culture maintenance dimension. Moderated mediation analyses showed a borderline direct effect of meta-perceptions about Portuguese acculturation preferences towards contact on satisfaction with nursing care but only among immigrants with high levels of own preferences towards contact with the host culture. These results provide innovative theoretical and empirical contributions to the fields of acculturation processes and primary health care and may contribute to the development of intercultural competency among health professionals.

Keywords: Child Primary Care, doctor-patient relationship, acculturation preferences, immigrant caregivers

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Resumo

Estudos anteriores centraram-se nos determinantes de acesso dos imigrantes aos serviços de saúde. Mas pouco se sabe sobre o processo de aculturação como um fator determinante para os comportamentos de saúde dos imigrantes, incluindo sobre a influência que tem nas suas atitudes relativamente aos serviços de Vigilância de Saúde Infantil (VSI). Assim, este estudo pretende testar dois modelos concetuais, hipótese: 1) o papel preditor das metaperceções de imigrantes brasileiros acerca das preferências de aculturação portuguesas na satisfação com os profissionais de saúde, mediado pela confiança nesses profissionais; 2) o efeito moderador das preferências de aculturação dos próprios imigrantes nessa relação de mediação. Os dados utilizados pertencem a uma base de dados de um projeto mais amplo, que incluiu 123 cuidadores imigrantes brasileiros. O protocolo utilizado avaliou os imigrantes: preferências de aculturação próprias e percebidas; a satisfação com os serviços de VSI e a confiança nos médicos; informação demográfica. As meta-perceções sobre as preferências de aculturação portuguesas em relação ao contacto com os imigrantes predizem a satisfação destes últimos com os serviços de saúde, por meio da confiança nos médicos. As análises de mediação moderada mostraram ainda um efeito borderline das meta-perceções sobre as preferências de aculturação de contato na satisfação com os cuidados de enfermagem, entre os imigrantes com elevada preferência por contacto com a cultura de acolhimento. Estes resultados providenciam contribuições inovadoras a nível teórico e empírico para na área dos processos de aculturação, no âmbito dos cuidados de saúde primários, e nas competências interculturais dos profissionais de saúde.

Palavras-chave: Vigilância de Saúde Infantil, relação médico-paciente, preferências de aculturação, cuidadores imigrantes

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Chapter I – Introduction

1.1 The General Context

According to the United Nations, in 2019 there were nearly 272 million immigrants worldwide, representing 3.5% of the world's population, and over 30% lived in Europe (UN, 2019). In the case of Portugal, although this country is traditionally known for its emigration, in 2017 the number of immigrants reached over 440 thousand or 4.14% of the country's population (SEF, 2017). The largest immigrant group in Portugal are Brazilians, who represent 24.3% of the immigrant population followed by Ukrainians (12.2%) and Cape-Verdeans (11.7%). Also, it should be noted that children aged between 0 and 15 years old represent 2.6% of the immigrant population (Gonçalves & Moleiro, 2012).

As several studies show, immigrant children are at increased risk for health problems, as they are more vulnerable to respiratory infections, poor nutrition, dental problems (e.g., Barak et al., 2010; Machado et al., 2009). Some of these problems may be early detected and prevented by Child Primary Care services (henceforward CPC). Since children's health depends on their caregivers, the perception of caregivers about their children's healthcare is crucial, as it may influence their non/adherence to CPC health promotion recommendations, use of preventive care (Calvo & Hawkins, 2015). So far, studies on health-related vulnerabilities of immigrants have mostly been focused on various determinants of their access to health care services (e.g., legal status, educational level, language skills) (Derose, Escarce & Lurie, 2007; Fernandes & Miguel, 2009; Kalich, Heinemann, & Ghahari, 2016). However, less is known about the determinants of immigrants' health-related behaviors, including their attitudes towards CPC once they enter health services. There is some evidence that the nature of doctor-patient relationship may be associated with immigrants' health related behaviors and consequently, their children's health outcomes (Paternotte, van Dulmen, van der Lee, Scherpbier & Scheele, 2015; Taylor, La Greca, Valenzuela, Hsin & Delamater, 2016), but studies in this domains are still scarce. Therefore, the general aim of this thesis was to address this empirical gap by expanding the understanding about the core elements determining the nature of doctor-patient relationship and the factors impacting it. The target group of this study will be Brazilian immigrants, as they represent the largest immigrant group in Portugal.

This introduction will start with the clarification of why immigrants and their children are a vulnerable group regarding health, followed by the contextualization of CPC services,

their main functions and importance of their health recommendations in reducing healthcare disparities and improving health outcomes for immigrant children in particular. Afterwards, it will focus on the core dimensions of the nature of doctor-patient relationship and the main factors influencing them. Then, it will analyse the relationship between acculturation processes and doctor-patient relationship, as some recent evidences (Whittal & Lippke, 2016; Whittal, Hanke & Lippke, 2017) suggest that acculturation processes may impact immigrants' perceived quality of care and consequently their perceived adherence to health recommendations. Finally, drawing upon a bidimensional model of acculturation and an interactionist approach, two conceptual models on the role of Brazilian caregivers' acculturation preferences on their perceived quality of CPC care will be hypothesized.

1.2 Health-Related Vulnerabilities of Immigrants

Various studies have been conducted about immigrants' health-related issues and their vulnerabiltities. Some studies have found that immigrants tend to have better health than the native-born population (Nielsen & Karsnik, 2010; Becerra, Androff, Messing, Castillo & Cimino, 2015). This phenomenon is widely recognised as the "healthy migrant effect", probably explained by the selection prior migration, *i.e*. the immigrants have better health profiles to be able to migrate (Nielsen & Karsnik, 2010; Renzaho, 2007). For example, Derose, Escarce, and Lurie (2007) found that young immigrants in the U.S. who come primarily for work tend to have better health outcomes, including lower mortality rates, than the native-born population. Researchers explain this phenomenon by the so-called "positive health selection" (Hamilton, 2015, p. 355) as well as by immigrants' healthier habits in their countries of origin (e.g., less smoking or being less obese) (Derose, Escarce, & Lurie, 2007; Nielsen & Karsnik, 2010).

However, studies revealed that immigrants' health needs more attention due to their so-called "health acculturation", where their health tends to deteriorate over time (Sime, 2014). This happens as a result of changes in their identities, values, behaviors, including tendency to adopt unhealthy habits while living in an unhealthy environment, caused by their prolonged contact with the majority culture (Derose, Escarce, & Lurie, 2007; Fox, Thayer, & Wadhwa, 2017; Hamilton, 2015). Since the flows of migration are currently heterogeneous worldwide and especially in Europe, some immigrants might not experience any radical change, whereas the others experience a totally different environment with different culture, language, food, climate and thus, their immune system may be affected and impact their health in a negative way (Fernandes & Miguel, 2009).

Also, the adaptation to a new culture, the process of leaving families, facing legal problems, adopting a new language, may cause an acculturation stress (*i.e.*, stress caused by cultural adaptation demands), which may lead to an increase of negative health outcomes (Becerra, Androff, Messing, Castillo, & Cimino, 2015; Barnett, Carballo, Haour-Knipe, Houdry, Jones, & Laukamm-Josten 2009; Chun, Balls Organista, & Marin,2003; Derose, Escarce, & Lurie, 2007). Negatively affected psychological health may lead to higher rates of drug addiction and alcoholism among immigrants, which increases their health-related vulnerability (Carta et al., 2005).

There is an evidence suggesting that immigrants usually engage with health services less frequently than the majority population (Sime, 2014). One of the reasons for that is poor access to healthcare services, which may also be considered as one of the indicators of immigrants' health-related vulnerability (Fernandes & Miguel, 2009; Derose, Escarce, & Lurie, 2007). There are many reasons limiting immigrants' access to healthcare services. In international context such determinants as immigrants' legal status, educational level, language skills, type of occupation and level of income, may impact their access to health services (Derose, Escarce, & Lurie, 2007; Fernandes & Miguel, 2009; Who.int, 2018). For example, the differential conditions and risks that might be faced by various profiles of immigrants may put them into higher or lower vulnerable positions (e.g., the unskilled labor migrants working in such risky sectors as construction or agriculture) (Bäckström, 2014). And, if in addition to this they are in an irregular situation, they tend not to seek access to health services because of fear of deportation, which leads to an increase of their health-related vulnerability (Barnett, Carballo, Haour-Knipe, Houdry, Jones, & Laukamm-Josten, 2009; Fernandes & Miguel, 2009; Who.int, 2018). Also, same researchers have found that due to limited financial resources, many immigrants cannot afford health insurance (which is required in some countries, e.g. U.S.). As a consequence, they are not able to access medical consultations and/or buy necessary medicines.

Within the Portuguese context, access to healthcare varies amongst immigrants. A scope of studies point that legal status, length of stay in the country, lack of knowledge of Portuguese law by both immigrants and health professionals, immigrants' nationality, language barriers directly impact their access to healthcare (Bäckström, 2014; Dias, Severo, & Barros, 2008; Fernandes & Miguel, 2009). For example, Brazilian immigrants in Portugal are facing greater difficulties in accessing health services as compared to representatives of other nationalities (e.g. Cape-Verdean, Angolan, Ukrainian). This happens due to hostile attitudes, discrimination, prejudice, and lack of information about "*a bilateral social security agreement*

between Brazil and Portugal" perceived by the staff of the public health services (Bäckström, 2014, p.88). Also, there are migrants in Portugal who managed to get their residence permit via family reunification process, and in most cases, they face difficulties in getting their health cards and thus, access the health services (Bäckström, 2014). In case of immigrant children, despite Portugal being one of the countries that explicitly entitles migrant children, irrespective of their legal status, to have access to health services, some health centers refuse to admit them, requiring payment of high fees (Bäckström, 2014; Who.int, 2018).
Thus, although, there are contradictory evidence regarding the health of immigrants and their families, the majority of the findings support the allegation that this group is vulnerable in most cases. Therefore, this study aims to explore the factors impacting immigrants' readiness to engage in health promoting activities. There is very little research that has involved immigrants' families with children (Sime, 2014). Therefore, this work will focus on the factors impacting immigrants' engagement with Child Primary Care (CPC), as these services play an essential role in detecting and minimizing some of their health-related vulnerabilities.

1.3 Health-Related Vulnerabilities of Immigrant Children and the Relevance of CPC

Immigrant children can be generally defined as a particularly vulnerable group regarding health, as they are at a predominantly high risk of developing health problems (e.g., obesity, asthma, diabetes, mental health issues), and in their case poor health may have a lasting effect on future health conditions (Case, Fertig, & Paxson, 2005; Schmeer, 2012). Because of some of the health problems appearing in early childhood may be detected and prevented, immigrant children require at least a basic and preventive healthcare (Bäckström, 2014; Fernandes & Miguel, 2009; Who.int, 2018). In this case, CPC services play an essential role in early detecting and preventing the health-related problems, improving health outcomes, reducing healthcare disparities with higher prevalence among immigrants and low-income children (Seid & Stevens, 2005; Starfield, 1996).

In most European countries (including Portugal) CPC is universal and free and provided by the National Health System (NHS) or in some cases private sectors/mixed systems (*i.e.*, interaction between the private and public sectors), and can be defined as the delivery of accessible and integrated healthcare services by healthcare physicians for all children (de Almeida Simões, Augusto, Fronteira, & Hernández-Quevedo, 2017; Seid & Stevens, 2005; van Esso et al., 2010). Additionally, CPC can be considered as the primary source of knowledge and advice for caregivers raising children (Barak et al., 2010; Jenni, 2016).

Preventive care of children is linked to well-child visits and includes general health supervision, immunization schedules, screening examinations, surveillance, health advice and anticipatory guidance (*i.e.*, providing developmentally appropriate, practical information about children regarding their feeding and nutrition, sleeping, injury prevention, language development to their parents) (Combs-Orme, Holden Nixon, & Herrod, 2011; Jenni, 2016). Thus, CPC might play an important role in children's development, their health outcomes not only early in life, but also over their life course (Calvo & Hawkins, 2015; Kuo, Etzel, Chilton, Watson, & Gorski, 2012).

Various studies have been conducted on health-related vulnerabilities of immigrant children with the main focus on the determinants of their access to healthcare services, such as language barriers, low income, lack of awareness (Jokinen-Gordon & Quadagno, 2013; Schmeer, 2012). However, it is also important to consider caregivers' perceptions of the healthcare, as children's health outcomes might depend not only on a periodic monitoring of their development by pediatricians and their recommendations, but also on their caregivers' health-related behaviors (e.g., non/adherence to pediatric regimens, health promoting recommendations, utilization of preventive care) (Brandon, 2004; Calvo & Hawkins, 2015; Jimmy & Jose, 2011; Mourão & Bernardes, 2019). In this case, their likelihood of receiving needed medical care and the degree to which immigrants adhere to physicians' prescriptions and recommendations depends on their perception of, not only their own medical care, but also their children's medical care, which in turn might depend on the experienced patient-provider relationship (Jokinen-Gordon & Quadagno, 2013; Stevens, Shi, & Cooper, 2003). For example, it was found that negative assessments of children's medical care were associated with their unmet medical needs and less frequent reception of preventative care (Jokinen-Gordon & Quadagno, 2013). This in turn may be caused by various factors, such as caregivers' dissatisfaction with care, low socio-economic status, belonginess to a minority group, language barrier (Cox et al., 2012; Jokinen-Gordon & Quadagno, 2013). To understand better how immigrant caregivers' perceptions about healthcare are being shaped, it is important to look into the nature of doctor-patient relationship and the factors influencing it.

1.4 Factors Influencing Doctor-Patient Relationship

When speaking about immigrants' health-related behaviors and their attitudes towards children's medical care, it is important to understand which factors are associated with adults' perceptions of health care (Jokinen-Gordon & Quadagno, 2013). Various studies have found that the interaction between healthcare providers and patients is very important and may have

positive or negative effects on the various health determinants, such as patients' trust towards the healthcare providers, satisfaction with healthcare services, their seek for care, their adherence to prescribed treatments, and, thus, to their health outcomes (Paternotte, van Dulmen, van der Lee, Scherpbier, & Scheele, 2015; Taylor, La Greca, Valenzuela, Hsin, & Delamater, 2016).

Some studies showed that communication with culturally diverse patients may be challenging, because the contact of doctors with immigrants is usually a potential source of low-quality communication, which leads to a reduced quality of care and, thus, to immigrants' poor health outcomes (Paternotte, van Dulmen, van der Lee, Scherpbier, & Scheele, 2015). Various factors may influence the quality of the interaction between doctors and immigrant patients. In this section we will overview some of them, such as language barriers, lack of knowledge and information, discrimination, cultural differences, and acculturation processes (*i.e*. cultural and psychological change occurring as a result of the continuous contact between two or more diverse cultural groups and their individual members) (Berry, 2005; Clough, Lee, & Chae, 2013; Morales et al., 2006; Paternotte, van Dulmen, van der Lee, Scherpbier, & Scheele, 2015; Wiking, Johansson, & Sundquist, 2004).

As it was previously mentioned *poor language ability* may be considered as one of the issues influencing the relationship between a doctor and an immigrant patient (Cook, Kosoko-Lasaki, & O'Brien, 2005). For example, due to language barriers patients might be unable to accurately complete medical forms and understand medical information, which negatively affects doctor-patient relationship and causes mistrust (Becerra, Androff, Messing, Castillo, & Cimino, 2015). Also, language differences between a healthcare professional and an immigrant patient may lead to misunderstanding and miscommunication between them, which, consequently, may cause an incorrect diagnosis and an inappropriate treatment (Renzaho, 2007; Vissman et al., 2011). Language difficulties in communication between physicians and immigrant patients is known as "linguistic discordance", and it is widespread among immigrants of many ethnic origins (Clough, Lee, & Chae, 2013; Traylor, Schmittdiel, Uratsu, Mangione, & Subramanina, 2010). If, on one hand, the linguistic discordance may have a negative effect on the doctor-patient relationship and, thus, lead to lower satisfaction and trust among immigrants (Becerra, Androff, Messing, Castillo, & Cimino, 2015), language concordance, on another hand, tends to foster trust and positive communication, which leads to immigrants' positive health outcomes (Traylor, Schmittdiel, Uratsu, Mangione, & Subramanina, 2010).

Lack of knowledge and information about the healthcare system also leads to unsatisfactory communication outcomes between healthcare professionals and immigrant patients. Several studies showed that patients with different ethnic backgrounds tend not to know how to enter the healthcare system due to their limited knowledge of the host healthcare services (Hultsjö & Hjelm, 2005; Paternotte, van Dulmen, van der Lee, Scherpbier, & Scheele, 2015). Consequently, limited literacy regarding health care services causes patients, for example, to visit a wrong doctor and get an inadequate diagnose and medical mistreatment (Kalich et al., 2015; Paternotte, van Dulmen, van der Lee, Scherpbier, & Scheele, 2015).

Other challenges for a positive communication between a doctor and an immigrant patient are *prejudices and assumptions of healthcare professionals* about ethnic minority patients. In other words, the role of health professionals' intercultural competencies (ICC) (*i.e*. doctor's knowledge and awareness of the cultural differences and his/her own assumptions) is paramount in building a trustworthy relationship with their patients, as it affects the latter's adherence behaviors and health outcomes (Gurung, 2006; Paternotte, van Dulmen, van der Lee, Scherpbier, & Scheele, 2015; Tucker et al., 2011).

There is an evidence suggesting that *experienced discrimination within healthcare services* leads to detrimental consequences for the use and the quality of services, which negatively impacts health outcomes of immigrants (Clough, Lee, & Chae, 2013; Derose, Escarce, & Lurie, 2007). Several studies have found that patients from diverse ethnic and racial backgrounds often report that they experience stigmatization and discrimination in getting healthcare or unfair treatments from health providers, compared to the majority population (Becerra, Androff, Messing, Castillo, & Cimino, 2015; Clough, Lee, & Chae, 2013). This perceived discrimination may be explained as the perception of differential treatment, such as a lack of attention and empathy from the doctors towards immigrant patients, shorter consultation times or a stronger hierarchy (*i.e*. the position of the doctor is perceived by the patient as a position of authority) (Becerra, Androff, Messing, Castillo, & Cimino, 2015; Migge & Gilmartin, 2011; Szapocznik, Scopetta, & King, 1978; Wiking, Saleh‐Stattin, Johansson, & Sundquist, 2009). For example, in the Portuguese context, Brazilian immigrants experience hostile attitudes and feel more discrimination from the National Health Services compared to representatives of other nationalities (e.g. Angolans, Eastern Europeans) or, in the context of the US, Latinos believed that they would get a better healthcare treatment if they would belong to a different racial group (Becerra, Androff, Messing, Castillo, & Cimino, 2015; Bäckström, 2009).

As a result, on the context of the healthcare system, *discrimination* towards immigrants negatively affects their health outcomes in several ways. First, dissatisfaction with healthcare providers and mistrust of the healthcare system overall decreases the seek and the use of medical care in future; second, the minority group members tend to receive more inadequate medical treatment, which means decreased quality of services on the part of healthcare physicians (Clough, Lee, & Chae, 2013; Derose, Escarce, & Lurie, 2007; Schneider, 1986). Consequently, it leads to an increase of vulnerability of immigrants' health conditions. Also, some studies have found that trust is higher when a doctor and a patient are representatives of the same race, ethnicity, and gender (Cook, Kosoko-Lasaki, & O'Brien, 2005; Yong, Lemyre, Farrell, & Young, 2016).

Some studies showed that *differences in beliefs, values, perspectives about illness* between doctors and immigrant patients lead to misunderstandings regarding the healthcare delivery (Kleinman, Eisenberg, & Good, 2006; Paternotte, van Dulmen, van der Lee, Scherpbier, & Scheele, 2015). For example, Chinese immigrants tend to have strong identification with their traditional health beliefs, and, consequently, they are less likely to trust non-Asian healthcare providers (Wiking, Saleh‐Stattin, Johansson, & Sundquist, 2009). This may be explained by the fact that the immigrants may have different etiological understanding of illness and health (e. g. Western versus non-Western medicine) influenced by their religions, values, traditions, which, consequently, shape their ways of identifying the symptoms, cope with diseases, seek for healthcare and adhere the doctors' prescriptions (Gurung, 2006; Kleinman, Eisenberg, & Good, 2006).

Studies found that *differences in cultures* may lead to misunderstandings between doctors and patients (even if they speak the same language) due to dissimilarities in their verbal and non-verbal behaviors (Hultsjö & Hjelm, 2005). For example, some patients use religious etiologies to explain their conditions or might behave with more emotions, so it becomes more difficult to assess the seriousness of illness (Hultsjö & Hjelm, 2005; Paternotte, van Dulmen, van der Lee, Scherpbier, & Scheele, 2015; Sheets, Baty, Vázquez, Carey, & Hobson, 2012). Consequently, such conditions might lead to misunderstandings between doctors and patients creating mistrust and dissatisfaction with healthcare services, which may lead to negative health outcomes.

Also, several studies revealed the impact *of acculturation* on the trust level of immigrants towards the healthcare physician and their satisfaction with healthcare quality (Han & Lee, 2016; Yong, Lemyre, Farrell, & Young, 2016). For example, it was found that immigrants' higher level of acculturation (*i.e*. higher use and preference of the host society's

language at work, home, with friends; higher preference for the host society's language in media; higher preference for representatives of the host society in social relations) predicts higher level of trust towards healthcare physicians, which in turn leads to a higher level of satisfaction with the care (Cook, Kosoko-Lasaki, & O'Brien, 2005; Hong et.al, 2018). Also, such proxy measures of acculturation as length of stay in the country and language fluency are significant predictors of immigrants' trust level in healthcare system and satisfaction with physicians (e.g., Han & Lee, 2016; Hong et.al, 2018).

The literature reviewed above shows that trust between immigrants and healthcare providers (Fernandes & Miguel, 2009; Tarn et. al, 2005) and immigrants' satisfaction with healthcare (Han & Lee, 2016) are core elements determining the nature of doctor-patient relationship, which may indirectly impact the health outcomes of the latter. Some previous studies have found a positive association between Brazilian caregivers' satisfaction with Portuguese CPC and their adherence to paid vaccines for their children, as well as to CPC recommendations regarding children's psychomotor development (Mourão, 2019). Also, among all the factors influencing the relationship between immigrant patients and health professionals, there is a lack of research testing the mechanisms of acculturation affecting such relationships (Abraído-Lanza, Armbrister, Flórez, & Aguirre, 2006). Therefore, this study aimed to bridge this gap by investigating the impact of acculturation processes on trust in physicians and satisfaction with care as the main dimensions of the doctor-patient relationship. Since there is wide-ranging variations of conceptions and operationalizations of the term acculturation in existing studies, there is a confusion and incoherence in the field of acculturation and health research (Hunt, Schneider, & Comer, 2004; Lopez-Class, Castro, & Ramirez, 2011; Fox, Thayer, & Wadhwa, 2017). Therefore, it is important to look deeper into the concept of acculturation and find the most relevant one for this study.

1.5 The Socio-Psychological Framework of Acculturation

1.5.1 Acculturation Models Overview

There are many psychological approaches to acculturation (Schwartz, Unger, Zamboanga, & Szapocznik, 2010), however, it is important to understand that all instruments measuring acculturation refer to a process of cultural and psychological change which results from a contact between two or more different cultures (Hunt, Schneider, & Comer, 2004; Mills, Fox, Gholizadeh, Klonoff, & Malcarne, 2017; Thomson & Hoffman-Goetz, 2009).

Initially, acculturation was conceptualized as a unidimensional process of changes in terms of losses in one cultural orientation and gains in another one, that is, assimilation (or

not) of values, beliefs, behaviors, or attitudes of the host society by the minority group (Abraído-Lanza, Armbrister, Flórez, & Aguirre, 2006; Mills, Fox, Gholizadeh, Klonoff, & Malcarne, 2017; Thomson & Hoffman-Goetz, 2009). Thus, this perspective assumes that different acculturation dimensions such as values, attitudes, behavior, and self-construal, represent the same underlying dimension without any distinction (Abe-Kim, Okazaki, & Goto, 2001; Miller, 2007). Even nowadays many health researchers prefer to use unidimensional and/or proxy measures (e.g., place of birth, length of residence in the host country, generation status, language) to assess acculturation in their studies (Becerra, Androff, Messing, Castillo, & Cimino, 2015; Fox, Thayer, & Wadhwa, 2017; Mills, Fox, Gholizadeh, Klonoff, & Malcarne, 2017).

However, these measures often fail to capture all important aspects of the concept of acculturation or may capture non-acculturative causes of health issues, as they work as a one-way change process in which immigrants assimilate the new culture (Bourhis, Moïse, Perreault, & Senecal, 1997; Fox, Thayer, & Wadhwa, 2017; Lopez-Class, Castro, & Ramirez, 2011). For example, these perspectives do not take into consideration the possible cultural (mis)matches in health-related practices and beliefs of both minority and majority groups (e.g., Bäckström, 2009; Wiking, Saleh‐Stattin, Johansson, & Sundquist, 2009), which may impact immigrants' health-related behaviors (e.g., physical activities, adherence to advised medical treatment). As a result, these models may not provide an accurate reflection within the context of interpersonal relationships between immigrants and healthcare providers, as they simply neglect complexity of cultural change and adaptation occurring in such dimensions as values, believes, attitudes, and behaviors and do not take into account that the host society also changes by the presence of culturally different immigrants (Bourhis, Moïse, Perreault, & Senecal, 1997; Lopez-Class, Castro, & Ramirez, 2011; Thomson & Hoffman-Goetz, 2009).

Also, studies show that using the unidimensional measures of acculturation, respondents are forced to select between two cultures rejecting the possibility to maintain the culture of origin and adopting the aspects of a new culture (Mills, Fox, Gholizadeh, Klonoff, & Malcarne, 2017). However, several researchers (e.g., Berry, 2005; Te Lindert et al., 2008) state that the acquisition of the host societies culture does not necessarily require the loss of the one's culture, which calls for a bidimensional model of acculturation, which is considered as more superior to the unidimensional acculturation framework (Mills, Fox, Gholizadeh, Klonoff, & Malcarne, 2017).

If a unidimensional model posits a negative correlation between mainstream and heritage dimensions, a bidimensional acculturation framework does not make that zero-sum assumption and considers these two dimensions as independent from each other (Doucerain, Segalowitz, & Ryder, 2017; Mills, Fox, Gholizadeh, Klonoff, & Malcarne, 2017). Berry's bidimensional model of acculturation is the most widely accepted in psychology (Fox, Thayer, & Wadhwa, 2017; Mills, Fox, Gholizadeh, Klonoff, & Malcarne, 2017). A bidimensional model measures two major domains: the extent of the immigrants' preferences to maintain their culture of origin (*i.e.* culture maintenance) and the extent of their preference to immerse into a new culture (*i.e.* desire to contact) (Sam, Jasinskaja-Lahti, Horenczyk, & Vedder, 2013; Thomson & Hoffman-Goetz, 2009). Moreover, this theoretical model predicts the adaptation outcomes for the immigrant groups in terms of acculturative stress, physical and mental health, depending on that if the prevailing societal climate is compatible with its component groups' acculturation preferences (Berry, 1997; Brown & Zagefka, 2011).

To the best of our knowledge, there is no research about how acculturation preferences of Brazilian caregivers (one of the largest immigrant group in Portugal) impact their trust level in Portuguese doctors and satisfaction with Portuguese health care as the determinants of doctor-patient relationship (Neto, Oliveira, & Neto, 2017). Considering that acculturation is not a process which one group experiences in isolation, but it is essentially an intergroup phenomenon, the acculturation preferences of both, minority and majority groups should be considered (Brown & Zagefka, 2011). Therefore, in this study the role of acculturation preferences will be investigated within the framework of bidimensional and intergroup perspectives (*i.e.*, the interplay between host society and immigrant group acculturation preferences) (Bourhis, Moïse, Perreault, & Senecal, 1997).

1.5.2 Conceptualization of Acculturation Preferences

As it was mentioned above, according to Berry's bidimensional model, acculturation preferences should be considered towards contact (*i.e.*, to what extent immigrants prefer to immerse into a new culture) and culture maintenance (*i.e.*, to what extent immigrants prefer to maintain their culture of origin) (Berry, 1997; Sam, Jasinskaja-Lahti, Horenczyk, & Vedder, 2013; Thomson & Hoffman-Goetz, 2009). According to Sam and Berry (2010), to understand immigrants' acculturation process it is important to understand the nature of the contact between two cultures, that is, if the contact relationship is based on domination of one culture or on hostility or on mutual respect. Moreover, the contact impacts the psychological processes of individuals of both cultures and might lead to simple changes in behavior (e.g.,

eating habits, dressing) and cause acculturative stress (*i.e.*, stress caused by cultural adaptation demands), which may lead to an increase of negative health outcomes (e.g., obesity, anxiety, depression) (Becerra, Androff, Messing, Castillo, & Cimino, 2015; Barnett, Carballo, Haour-Knipe, Houdry, Jones, & Laukamm-Josten 2009; Chun, Balls Organista, & Marin,2003; Derose, Escarce, & Lurie, 2007; Sam & Berry, 2010).

Culture maintenance is another dimension occurring within the acculturation processes (Berry, 1997). Ward and Szabo (2019) found that heritage culture maintenance was associated with stronger support of familism (*i.e.*, needs of the family are more important than the individual), which indirectly affected the psychological outcomes and health behaviors of immigrant adolescents. That is, heritage culture maintenance may impact health outcomes of immigrants' families via family functioning. For example, Schwartz et al. (2016) found that inconsistency in heritage culture maintenance among Hispanic adolescents in the US predicts the characterization of their family relationships, which in turn might be associated with either positive or negative (e.g., alcohol misuse, depression) outcomes. That is, the increase of support of host culture's values by adolescents may bring advantages for immigrant families (e.g., medical appointments) as long as the heritage culture is retained (Berry's integration), whereas the loss of one's culture (Berry's assimilation) leads to family conflict and disengagement, and, thus, to negative outcomes for adolescents (Schwartz et.al., 2013, 2016; Ward & Szabo, 2019).

Combining both dimensions of acculturation (*i.e.*, contact and culture maintenance) and considering them as attitudinal dimensions, Berry (1997, 2005) identified four possible acculturation strategies: integration, assimilation, separation, and marginalization. In this case, the integration strategy means high immigrants' preference for maintaining their original cultural identity and being interested in interacting with the host community members at the same time, which can be consequently associated with positive psychological outcomes (Zagefka & Brown, 2002). Assimilation reflects low preferences for maintaining the culture of origin and high engagement with the host culture. Separation describes individuals who have high preferences for maintaining their heritage culture and low desire to contact the host society. And marginalization reflects the minimal engagement or rejection of individuals in both, maintaining the culture of origin and having relations with host culture members. If the integration strategy is considered as the most successful in relation with positive adaptation, marginalization, on the contrary, is considered the least successful (Berry, 1997).

1.5.3 Acculturation as an Intergroup Process

Some researchers (e.g., Penn, Kar, Kramer, Skinner, & Zambrana, 1995; Schouten & Meeuwesen, 2005) found that culture and ethnicity may be a barrier in establishing a trustworthy and satisfying relationship between doctor and patient. One of the explanations may be cultural values of immigrants contrasting with health physicians' prescriptions (Erger & Marelich, 2004; Schouten & Meeuwesen, 2005). Taking into consideration that the majority of healthcare services involve physicians from the majority host groups and patients from immigrant minority groups, their relationships should be viewed from a perspective of intergroup contact. This means that there might be a sort of cultural (mis)match in health-related practices and beliefs of both minority and majority groups (e.g., Bäckström, 2009; Wiking, Saleh‐Stattin, Johansson, & Sundquist, 2009), which may impact immigrants' health-related outcomes (e.g., obesity, dental caries, mental health issues).

For example, some national studies found that Cape Verdean and Brazilian immigrants in Portugal tend to hide from healthcare providers the use of some traditional practices adopted from their country of origin (Bäckström, 2009; Mourão & Bernardes, 2019). This may be explained by the conflict between traditional, folk practices and health professionals' recommendations (Mourão & Bernardes, 2019). Moreover, this may happen due to a perceived lack of sensitivity and cultural understanding by healthcare providers or perceived experiences of prejudice and discrimination on health services (Bäckström, 2009; Cook, Kosoko-Lasaki, & O'Brien, 2005). That is, it can be assumed that there might be a certain level of bias, discrimination and prejudice against minority groups maintaining folk-medical practices (despite high levels of integration) widely used in their cultures of origin, which leads to perceived discrimination, and, consequently, creates mistrust between doctors and immigrant patients. Such mistrust may eventually undermine the latter's willingness to accept and/or adhere to the prescribed treatments and continue seeking the professional healthcare in future (Dovidio, Love, Schellhaas, & Hewstone, 2017; Landrine & Klonoff, 2004; Mourão & Bernardes, 2019; Zagefka et al., 2014).

Thus, the combination of acculturation attitudes held by the minority and the majority group member within their interaction impact their interpersonal and intergroup relational outcomes (e.g., in regards to immigrants, the quality of patient-physician interaction may be associated with the global satisfaction with healthcare) (Bourhis, Moise, Perreault, & Senecal, 1997; Piontkowski, Rohmann, & Florack, 2002; Saha, Arbelaez, & Cooper, 2003). Based on this, the acculturation attitudes of just one group might not be the best predictor of harmonious or conflictual intergroup relations, but instead the fit between both groups'

preferences (Brown & Zagefka, 2011). It means that, since the host society is also a part of a dynamic interactionist process, its acculturation preferences should be also considered (Brown & Zagefka, 2011; Whittal & Rosenberg, 2015).

Also, the interactionist process may involve changes in both minority and majority groups' expectations, including three relational outcomes: consensual (*i.e.*, a shared understanding), problematic (*i.e.*, neither conflict nor understanding in opinions) and conflictual (*i.e.*, direct conflict in opinions), depending on the combination of acculturation preferences of representatives of both groups (in this case, local doctors and immigrant patients) (Bourhis, Moise, Perreault, & Senecal, 1997; Kazarian & Evans, 2001; Whittal & Rosenberg, 2015). Therefore, the fit (*i.e.*, concordance (match) or discordance (mismatch)) between minority groups' and the host society's acculturation preferences on this domain may predict the quality of intergroup relations (Bourhis, Moise, Perreault, & Senecal, 1997; Brown & Zagefka, 2011; Piontkowski, Rohmann, & Florack, 2002).

However, according to Brown and Zagefka (2011, p. 147), in this case the metacognition (*i.e.*, "what one group perceives the other to want") of one group may impact their own acculturation preferences and intergroup attitudes, and thus, may be more relevant. Their main findings show that if immigrants perceived that the majority members desired contact, the greater was their own preference for contact. The same association between the meta-perceptions of culture maintenance and own acculturation preferences towards culture maintenance was found. Moreover, Piontkowski, Rohmann, and Florack (2002) argued that the fit between the perception of what the other group wants and immigrants' own acculturation preferences is a better predictor of intergroup outcomes than the fit between real acculturation attitudes of both groups. Findings of both, Brown and Zagefka (2011) and Piontkowski, Rohmann, & Florack (2002) show that the lower fit between own desired acculturation preferences and the perceived other's acculturation preferences are associated with worse intergroup outcomes (e.g., acculturative stress, discrimination).

The most recent studies by Whittal and colleagues (2016, 2017) investigated the relationship between acculturation preferences of immigrants and their health-related behaviors based on bidimensional and interactionist frameworks. Their main results showed that immigrants' acculturation preferences relate to their perceived quality of care and perceived medical advice adherence via perceived doctors' expectations. These findings confirm that acculturation preferences are an important element in a doctor-patient relationship, as patients' acculturation attitudes are significantly associated with the perceived doctors' expectations about patients' acculturation preferences, and thus, may be a key

motivator in their health behaviors and the potential health related outcomes (Whittal, Hanke, & Lippke, 2017; Whittal & Lippke, 2016). For example, it was found that integration acculturation preferences of immigrants were positively related to their perception of acceptance by doctors their heritage culture maintenance, which led to a higher perceived quality of care and medical advice adherence. Marginalization acculturation preferences of immigrants, on the contrary, were negatively associated with their perception of acceptance by doctors their cultural values and practices, which led to lower perceived quality of care and lower medical advice adherence (Whittal, Hanke, & Lippke, 2017; Whittal & Lippke, 2016).

1.6 Research Question and Hypotheses

To date, most studies conducted in the area of acculturation and health, tested the influence of acculturation preferences on health behaviors such as, for example, healthy lifestyles and adherence to prescribed treatment. Important findings were presented in Mourão and Bernardes (2019) research, showing that mismatches in practices and beliefs in infant care between immigrant caregivers and doctors may cause conflict, which negatively impacts treatment adherence. Such circumstances may involve the lower level of integration preferences among immigrants which leads to high levels of mistrust in medical professionals and, consequently, lower level of satisfaction with medical care (Aruguete & Roberts, 2002; Cook, Kosoko-Lasaki, & O'Brien, 2005; Mourão & Bernardes 2019). Also, some researchers (e.g., Mills, Fox, Gholizadeh, Klonoff, & Malcarne, 2017) investigated the impact of acculturation on perceived healthcare and health outcomes (e.g., higher rates of disease).

We already know that the fit between the meta-perception and own acculturation preferences towards contact and culture maintenance is important in predicting the intergroup relations (Brown & Zagefka, 2002). Also, the most recent study (Whittal & Lippke, 2016) tested acculturation preferences of immigrants and perceived quality of care. However, based on the theory and literature presented in this area, we have found a gap in research investigating the impact of immigrant patients' perceived acculturation preferences on the quality of doctor-patient relationship, namely, on trust in physicians and satisfaction with care. Therefore, we find it important to understand how the immigrants' meta-perceptions about contact and culture maintenance affect the quality of doctor-patient interaction. Also, it is important to investigate the effect of immigrants' own acculturation preferences towards both dimensions on the impact of immigrants' meta-perceptions about contact and culture maintenance on the quality of doctor-patient relationship. That is, how they affect the level of trust in physicians and, consequently, satisfaction with health care, as this might impact the

health-related behaviors of immigrants, and their health outcomes (e.g., Ferguson & Candib, 2002). The target group of this research will be Brazilian immigrants, since they are the largest foreign community in Portugal (119.363 persons registered in 2010), being more discriminated compared to other nationalities, which makes them extremely vulnerable (Bäckström, 2014; Neto, Oliveira & Neto, 2017). Drawing upon the previous conceptual background, the present study proposed to test two hypotheses:

Hypothesis 1: Brazilian immigrants' meta-perceptions about Portuguese acculturation preferences towards contact and culture maintenance will predict satisfaction with medical and nursing care, and this relationship will be mediated by trust in physicians (Fig. 1).

Hypothesis 2: Brazilian immigrants' own acculturation preferences towards contact and culture maintenance will moderate the effect of immigrants' meta-perception about acculturation preferences of Portuguese on satisfaction with care (medical and nursing) via trust in physician (Fig. 2).

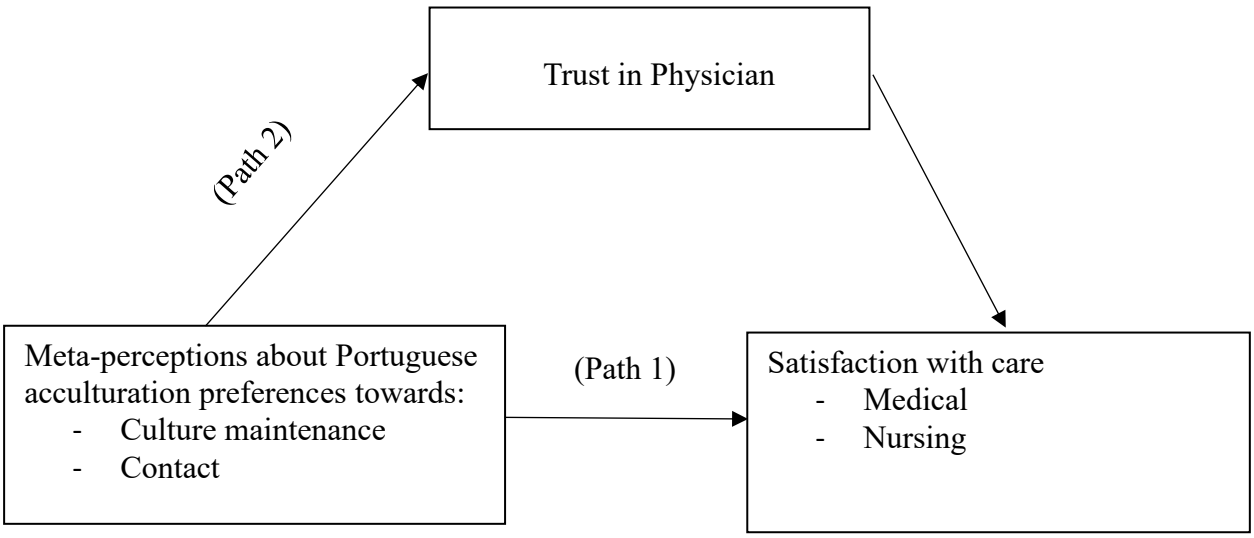

Figure 1. The Mediating Role of Trust in Physician in the Relationship Between Meta-Perceptions about Portuguese Acculturation Preferences and Immigrants' Satisfaction with Care

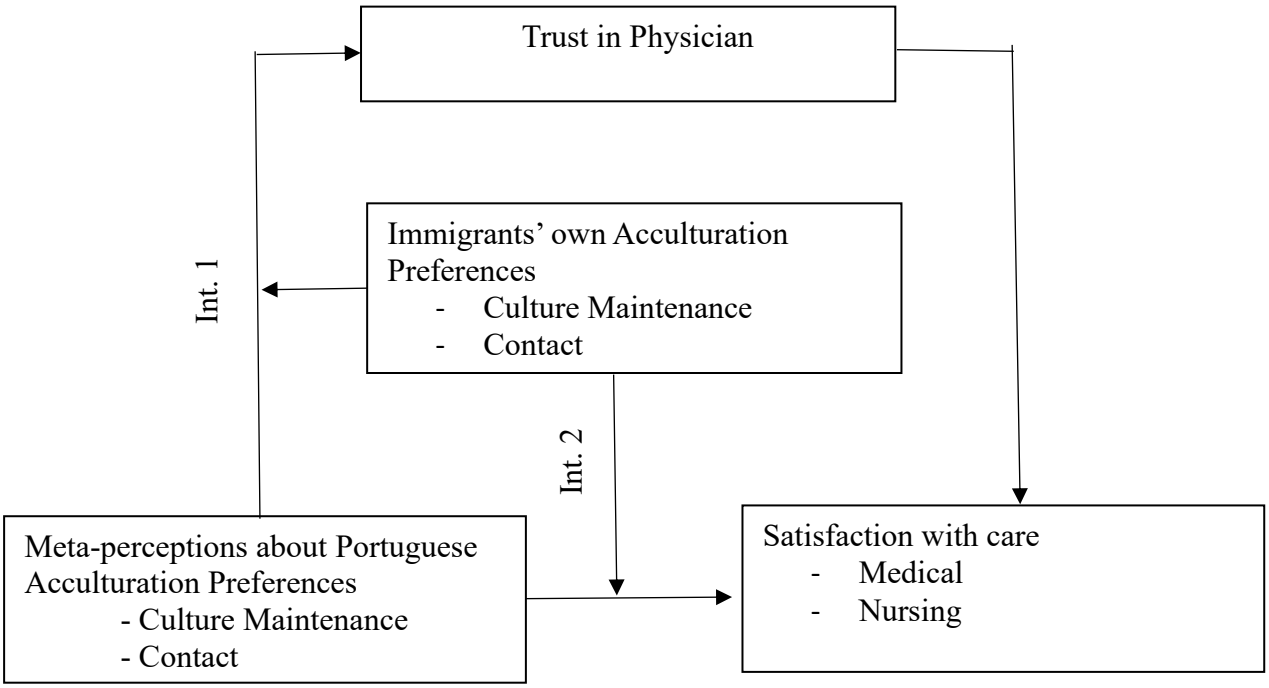

Figure 2. The Interaction Effect of Immigrants' Own Acculturation Preference by Meta-Perception about Portuguese Acculturation Preferences on Satisfaction with Care through Trust in Physician

Chapter II - Methods

2.1 Study Design, Procedure, and Data Collection

This is a cross-sectional quantitative study. The data used for this study was part of a bigger database collected in a previous study (Mourão, 2019), which was approved by the Institutional Review Board of ISCTE-IUL. Participants were contacted at key-institutions (e.g., kindergartens) and immigrant groups in social networks (e.g., Facebook, blogs) and invited to participate in a study about well-child visits. Also, a "snowball" sampling strategy was used for the data collection. The sample included parents who were Brazilian immigrants in Portugal with children aged between 2 and 6 years old. The selection criterion was justified by the age range when child well-visits occur more frequently, and by the country of origin of the target group for this research.

The Boards of institutions provided their formal consent to participate in the research. Participants were provided informed consents, which included the information about the objectives of the study, their voluntary participation, the confidentiality, and anonymity of the data, which they signed and submitted before starting to fill the questionnaires out. The data collection protocol was available in both, electronic (using Qualtrics software) and paper formats, to ensure a more heterogeneous group of participants and include immigrant parents who potentially did not have access to the internet. This protocol was individually filled out by the child's caregiver who used to go more often to CPC services. To compensate the participation in the study, respondents were offered the possibility of participating in a lottery (six 25€ vouchers were randomly allotted). For the data collected online, participants were provided the same information as the ones who filled the paper format questionnaire. In this case, participants' proceeding with the questionnaire and thus, participation in the study, was considered as their agreement with informed consent.

2.2 Participants

One hundred and twenty-three Brazilian immigrant caregivers with Brazilian nationality participated in this study. Most participants were women (n=117), who were going for child health services appointments more often. Participants' age ranged between 23 and 48 years old (M = 35.2, SD = 5.4) and the majority (70.2%) identified themselves as Brazilian nationals, whereas the rest of the participants regardless of holding Brazilian nationality, identified themselves as Portuguese with Brazilian origin (13.2%), Portuguese (5%), or both, Brazilian and Portuguese (7.4%). Participants had between 1 and 4 children, aged between the 2 and 6 years old (M = 3.9, SD = 1.4). They had completed on average 13.1 years of

education (SD = 5.6), and most were employed (54.5%). Most participants had specialized (34.2%) and intermediary (34.2%) professions (e.g., administrates, salespersons, hairdressers, etc.) and a monthly household income ranging between 500€ - 1000€ (33.3%), 1000€ -1500€ (34.2%) and more than 2000€ (16.7%). Approximately half of the respondents lived in Portugal for more than 5 years (52.8%) and around the same number reported having legalization in process or temporary resident permission (52.4%). Most of the families included both parents with immigrant status (71.9%). Most of participants (73%) reported using the public health services. Detailed sample characteristics are presented in Table 1.

Table 1. Participants' Socio-Demographic Characteristics

Variables	Descriptive
Parenthood	
Mother	117 (95.1%)
Father	6 (4.9%)
Age	
Mean (SD)	35.2 (5.4)
Minimum-Maximum	23-48
Group Identification	
Brazilian	85 (70.2%)
Portuguese with Brazilian origin	16 (13.2%)
Portuguese	6 (5%)
Brazilian and Portuguese	9 (7.4%)
Other	5 (4.1%)
Number of Children	
Mean (SD)	1.6 (0.8)
Minimum-Maximum	1-4
Child's Age	
Mean (SD)	3.9 (1.4)
Minimum-Maximum	2-6
Participant's Education (Years of School)	
Mean (SD)	13.1 (5.6)
Minimum-Maximum	1-35
Participant's Work Status	

Employed	66 (54.5%)
Unemployed	55 (45.5%)
Participant's Profession	
Specialized	39 (34.2%)
Intermediary level	39 (34.2%)
Less/nonspecialized	36 (31.6%)
Monthly Household Income	
<500€	4 (3.3%)
500€-1000€	40 (33.3%)
1000€-1500€	41 (34.2%)
1500€-2000€	15 (12.5%)
>2000€	20 (16.7%)
Time in Portugal	
⩽5 years	58 (47.2%)
>5 years	65 (52.8%)
Participant's Situation in Portugal	
Legalization in process or temporary resident permission	54 (52.4%)
Permanent resident permission or Portuguese citizenship	49 (47.6%)
Parent's Immigration Status	
Both immigrants (Brazilian)	87 (71.9%)
Brazilian immigrant and Portuguese	28 (23.1%)
Brazilian immigrant and other	6 (5%)
CPC Services	
Public (health care centre, family health unit, hospital)	84 (73%)
Private (pediatrician, clinic, hospital)	31 (27%)

2.3 Measures

Acculturation Measure: Own and Outgroup Acculturation Preferences. The items developed by Brown & Zagefka (2002) and translated into Portuguese by França & Guerra (2015), were used to measure participants' own acculturation preferences as well as their perceptions of the outgroup's acculturation preferences (*i.e.*, meta-perceptions). Acculturation

preferences were measured in two dimensions, the desire for culture maintenance and contact. All items were measured in 5-point Likert scale from 1 (*totally disagree*) to 5 (*totally agree*).

To confirm a good fit of the scale to data, a CFA was performed in a previous study (Mourão, 2019), and a four-factor model confirmed. Participants' own preference towards culture maintenance was measured by three items (e.g., "*I think it is important that Brazilians in Portugal maintain their own culture*") and preference towards contact with host society was assessed by two items (e.g., "*I think that it is important that Brazilians in Portugal have Portuguese friends*"). In the present sample, these scores presented reasonable to good internal consistency indices (α = .688 and r_{sb} = .776, respectively).

The outgroup acculturation preference towards culture maintenance was measured by three items (e.g., "*I believe that the Portuguese do not mind that Brazilians maintain their way of living*") and the outgroup acculturation preference towards contact with Brazilian immigrants was assessed with two items (e.g., "*I believe that the Portuguese find it important that Brazilians also spend time with Portuguese people*"). In the present sample, these measures showed good internal consistency indices (α = .897 and r_{sb} = .919, respectively). The scores were calculated by averaging their respective items, the higher the scores the higher the own and outgroup acculturation preferences.

The Trust in Physician Scale (TPS). The eleven items developed by Anderson and Dedrick (1990) and validated by Pereira, Pedras, and Machado (2013) in a sample of Portuguese type 2 diabetics and their partners, were used to measure the trust of Brazilian caregivers in Portuguese physicians (e.g., "*I trust the doctor so much that I always try to follow his/her advice*"; "*I sometimes distrust the doctor's opinion and would like a second one*"). All items were answered using a 5-point Likert scale format ranging from 1 (*strongly disagree*) to 5 (*strongly agree*).

The results of CFA performed in a previous research (Mourão, 2019) were used supporting the one factor model but excluding three items presenting low loading values (*i.e.*, *"I doubt that the doctor really cares about my child as a person"; "I feel the doctor does not do everything he/she should for my child's medical care"; "I sometimes worry that the doctor may not keep the information we discuss totally private"*).

One negative statement was reverse scored (*i.e.*, *"I sometimes distrust the doctor's opinion and would like a second one"*), and the final composite variable was calculated by the sum of participants' answers, ranging from 8 to 40. Higher scores represented higher level of trust in the physician. The internal consistency of the scale measuring the trust in physician was very good (α = .874; 8 items).

The European Task Force on Patient Evaluation of General Practice Care (EUROPEP). To evaluate the satisfaction with primary healthcare, the EUROPEP questionnaire is widely used (Wensing et al., 2000). For the present study, the Portuguese version of the EUROPEP adapted by Roque, Veloso, and Ferreira (2016) with the subscales of satisfaction with medical and nursing care was used.

Eighteen items were used to measure participants' satisfaction with children's family doctor's/pediatrician's technical care (e.g., "*Explanation about medication, treatments, and tests prescribed*") and doctor-patient relationship (e.g., "*Interest shown by your child's situation*"), and three items were used to access Brazilian caregivers' satisfaction with the health care centre/clinic in relation to nursing care (e.g., "*Time devoted to you by the nursing staff*"). All items were answered using a 5-point Likert scale format ranging from 1 (*bad*) to 5 (*excellent*). Also, participants were given a possibility of choosing the answer "not applicable" for each statement.

A CFA performed for a previous work was used (Mourão, 2019), supporting the two-factor model and all items loaded significantly on the corresponding factor ($p < 0.001$), but only with a modest fit to the data in some fit indices ($\chi 2$ (188) = 522.161, $p < 0.001$; $\chi 2/df$ = 2.78; CFI = 0.87; TLI = 0.84; PCFI = 0.71; PNFI = 0.66; RMSEA = 0.12; Hair et al., 2010; Hu & Bentler, 1999; Kline, 2011; Maroco, 2010; Schreiber et al., 2006).

The internal consistency of the satisfaction with medical care and nursing care scales was very good (α= .967 and .857, respectively). The values of each factor were calculated by a weighted sum, excluding the "not applicable" answers. To compute a composite variable for EUROPEP scores were converted from a scale ranging from 1 (bad) to 5 (excellent) to a scale ranging from 0% to 100%, the higher the scores the higher the satisfaction with care.

2.4 Data analysis

First, using the IBM-SPSS 26.0 (Statistical Package for Social Sciences) we analyzed the descriptive statistics of the sample. Six participants were excluded from the initial pool of data because despite their Brazilian nationality they identified themselves as Portuguese. Since Portuguese were considered as an outgroup in this study, we excluded those participants as to minimize result biases.

Second, we used Pearson correlations to explore the associations between all model variables. We have classified the correlations between all the model variables based on the cut offs from Cohen (1992).

Third, using the PROCESS macro (Model 4) in IBM-SPSS 26.0, four mediation models were tested: model 1 to test with the predictive effect of meta-perceptions of Portuguese acculturation preferences towards culture maintenance on satisfaction with medical care via trust in physician, **Fig. 1**, paths 1 and 2); model 2 to test the predictive effect of meta-perceptions of Portuguese acculturation preferences towards contact on satisfaction with medical care via trust in physician, **Fig. 1**, paths 1 and 2); model 3 to test the predictive effect of meta-perceptions of Portuguese acculturation preferences towards culture maintenance on satisfaction with nursing care via trust in physician, **Fig. 1**, paths 1 and 2); model 4 to test the predictive effect of meta-perceptions of Portuguese acculturation preferences on satisfaction with nursing care via trust in physicians, **Fig. 1**, paths 1 and 2). The indirect effects were tested using a bootstrapping approach and considered significant when the CI did not include zero.

Finally, also using the PROCESS macro (Model 8) in IBM-SPSS 26.0, we conducted moderated mediation analyses, using immigrants' own acculturation preferences towards culture maintenance and contact as moderators, respectively (**Fig. 2**). To interpret the moderated mediation, we examined the significance of the B estimates (unstandardized coefficients) of the indirect effects at different levels of the moderators (*i.e.*, +1SD, Mean, -1SD) and the statistical significance of the index of moderated-mediation (IMM). Both procedures were tested using a bootstrapping approach. The coefficients (*i.e.*, B estimates and index of moderated mediation) were considered significant when the CI did not include zero.

Chapter III - Results

3.1 Descriptive statistics

As presented in Table 2, Brazilian caregivers reported high satisfaction levels with medical and nursing care, although their trust in the physician was only moderate. Participants showed a moderate to high preference towards culture maintenance, but also a rather high preference towards contact with the host society. Participants perceived that the Portuguese show moderate preferences towards Brazilians' culture maintenance, and moderate to high preferences towards contact with Brazilians.

Table 2. Descriptive Statistics and Distribution of All Model Variables

Variables (Range)	Min	Max	Mean	SD
Predictors				
Meta-perception of culture maintenance (1-5)	1	5	3.15	0.96
Meta-perception of contact (1-5)	1	5	3.59	0.90
Mediator				
Trust in physician (8-40)	8	39	26.74	5.88
Moderators				
Own acculturation preferences towards culture maintenance (1-5)	1.33	5	3.55	0.79
Own acculturation preferences towards contact (1-5)	2	5	4.31	0.73
Outcomes				
Satisfaction with medical care (0-100)	1.92	100	73.13	23.62
Satisfaction with nursing care (0-100)	0	100	75.61	23.35

Table 3 presents the correlations among all variables in the study. The relationship between trust in physician and satisfaction with medical care was strong, positive and

significant, the relationship between trust in physician and satisfaction with nursing care was moderate and positive. This means that the higher the trust in physician the higher the immigrants' satisfaction with care. As for acculturation preferences, there was a moderate positive correlation between perceived Portuguese preferences (meta-perceptions) and immigrants' own preferences towards culture maintenance. A similar pattern was found between perceived Portuguese preferences (meta-perception) and immigrants' own preferences towards contact. This means that the more immigrants perceive that Portuguese accept their maintenance of heritage culture, the higher will be their own preference in maintaining it, and the more immigrants believe that Portuguese prefer to have contact with them, the higher will be their own preference towards contact. The correlation between perceived Portuguese preferences towards contact and trust in physician was relatively low and positive, which means that the more immigrants perceive that Portuguese prefere to have contact with them, the higher their trust in physician.

Table 3. Pearson Correlations Between All Model Variables

Variables	1.	2.	3.	4.	5.	6.	7.
Predictors							
1. Meta-perception of culturae maintenance	-----						
2. Meta-perception of contact	.314**	-----					
Mediator							
3. Trust in physician	.166	.190*	-----				
Moderators							
4. Own acculturation preference towards culture maintenance	.258**	.094	.020	-----			
5. Own acculturation preference towards contact	.042	.307**	.081	.201*	-----		
Outcomes							

6. Satisfaction with medical care	-.013	.046	.721**	.100	-.024	-----	
7. Satisfaction with nursing care	.144	.155	.353**	.061	-.005	.564**	-----

Note. *$p \leq 0.05$ ** $p \leq 0.01$ *** $p \leq 0.001$

3.2 The relationship between meta-perceptions about Portuguese acculturation preferences and immigrants' satisfaction with care: the mediating role of trust in physician

Table 4 presents the results of the four mediational models, where meta-perception about Portuguese acculturation preferences towards culture maintenance and contact were the predictors, respectively, trust in physician was the mediator, and satisfaction with medical and nursing care were the outcome variables.

Table 4. The Relationship Between Meta-Perceptions about Portuguese Acculturation Preferences and Immigrants' Satisfaction with Care: Simple Mediation Models

Outcome (O) Satisfaction with care	**Predictors (P)** Meta-perceptions about Portuguese acculturation preferences	**Mediators (M)**	**Effect of P on M (a)**	**Effect of M on O (b)**	**Direct effect (c')**	**Indirect effect ab**	**95%CI**	**Total effects (c)**
Medical	Culture maintenance (model 1)	Trust in Physician	1.01	3.03***	-3.36*	3.05	-.32 to 6.95	-.31
					$R^2 = .55$***			$R^2 = .0002$
	Contact (model 2)		1.18*	3.00***	-2.33	**3.53**	.12 to 7.63	1.20
					$R^2 = .54$***			$R^2 = .0021$
Nursing	Culture maintenance (model 3)		.90	1.36***	2.26	1.23	-.31 to 3.68	3.49
					$R^2 = .14$***			$R^2 = .0209$

Contact (model 4)	1.23*	1.35***	2.31	**1.66** 4.28	.02 to	3.96
			$R^2 = .14^{***}$			$R^2 = .024$

Note. $^{***}p \leq 0.001$, $^{**}p \leq 0.01$, $^{*}p \leq 0.05$

As shown in Table 4, overall, the more immigrants trust Portuguese doctors, the higher their satisfaction with medical and nursing care. In model 1 results indicated that the meta-perception about Portuguese acculturation preferences towards culture maintenance showed a borderline effect on trust in physician (B = 1.01, SE = .57, *p = .08*), which means that there is a possible tendency of a higher trust in Portuguese doctors if Brazilian immigrants perceive that Portuguese accept their heritage culture maintenance. However, immigrants who perceived that Portuguese have higher levels of acceptance of their heritage culture showed lower levels of satisfaction with medical care, and this direct effect was statistically significant. Thus, we see what MacKinnon, Krull, and Lockwood (2000) refer to as 'inconsistent mediation' *i.e.*, mediated, and direct effects have opposite signs. In this case the direct and indirect effects of relatively similar sizes and opposite signs may explain a nonzero, but at the same time nonsignificant total effect (B = -.31, SE = 2.33, *p = .89*). Still, the indirect effect was not statistically significant, which means that the association between immigrants' meta-perception about Portuguese acculturation preferences towards culture maintenance and their satisfaction with medical care was not mediated by trust in physician.

Model 3 did not show any statistically significant results regarding the effects of immigrants' meta-perception of culture maintenance on physician trust or their satisfaction with nursing care.

In models 2 and 4 results indicated that meta-perception about Portuguese acculturation preferences towards contact significantly predicted trust in physician, which means that there is a higher trust in Portuguese doctors if Brazilian immigrants perceive that Portuguese are open for contact. In both models, the indirect coefficient was statistically significant and the direct effect of meta-perception about Portuguese acculturation preferences towards contact on satisfaction with both medical and nursing care was nonsignificant. In other words, the relationship between meta-perception of contact and satisfaction with care, was fully mediated by trust in physician. Overall, these mediation models accounted for approximately 54% of the variance of satisfaction with medical care ($F_{(2.110)} = 63.68$, $p \leq .001$) and 14 % of the variance with nursing care ($F_{(2.106)} = 8.44$, $p \leq .001$).

3.3 Moderating effects of immigrants' own acculturation preferences on the mediating role of trust in physician

Own acculturation preferences towards culture maintenance and contact were included as moderators in the previously tested models, as to test the moderated mediation models presented in Figure 2. The results indicated that immigrants' own acculturation preferences towards culture maintenance and contact were not significant moderators of any of the (in)direct effects of meta-perception about Portuguese acculturation preferences on satisfaction with medical and nursing care independently and via trust in physicians (Table 5, 6). This means that the change in immigrants' own acculturation preferences did not impact the strength of the effect of immigrants' meta-perceptions about Portuguese acculturation preferences on their satisfaction with health care independently and via trust in physicians. However, a borderline effect was found in the direct effect of meta-perceptions about Portuguese acculturation preferences towards contact on satisfaction with nursing care moderated by immigrants' own acculturation preferences towards contact. That is, meta-perceptions significantly predicts satisfactions with nursing care but only for those immigrants with high acculturation preference towards contact – the more they perceive that Portuguese are open for contact, the more they are satisfied with nursing care (B = 5.787, SE = 2.96, $p = .053$) (Table 5). There is no significant association between acculturation preferences and satisfaction with nursing for immigrants with low to moderate preferences for contact (B = -2.569, SE = 3.76, $p = .49$) (Table 5).

Table 5. Conditional Direct Effects of Meta-Perceptions About Portuguese Acculturation Preferences and Dependence on Satisfaction with Care at Three Levels of Immigrants' Own Acculturation Preferences

Outcome: Satisfaction with care	**Own acculturation preferences towards culture maintenance**			**Own acculturation preferences towards contact**		
	Low	Moderate	High	Low	Moderate	High
Medical						
Direct effect of meta-perception of culture maintenance independently from trust in physician	-2.940	-3.069	-3.199	-----	-----	-----

Direct effect of meta-perception of contact independently from trust in physician	-----	-----	-----	-4.587	-2.360	-.295
Nursing						
Direct effect of meta-perception of culture maintenance independently from trust in physician	4.677	1.675	-1.326	-----	-----	-----
Direct effect of meta-perception of contact independently from trust in physician	-----	-----	-----	-2.569	1.662	**5.787**

Note. Low, moderate, and high values correspond to unstandardized regression coefficients.

Table 6. Conditional Indirect Effects of Meta-Perceptions about Portuguese Acculturation Preferences and Dependence on Satisfaction with Care at Three Levels of Immigrants' Own Acculturation Preferences

Outcome: Satisfaction with care	**Own acculturation preferences towards culture maintenance**				**Own acculturation preferences towards contact**			
	IMM	Low	Moderate	High	IMM	Low	Moderate	High
Medical								
Indirect effect of meta-perception of culture maintenance through trust in physician	1.111	2.590	3.470	4.350	-----	-----	-----	-----
Indirect effect of meta-perception	-----	-----	-----	-----	.305	3.135	3.359	3.567

of contact through trust in physician								
Nursing								
Indirect effect of meta-perception of culture maintenance through trust in physician	.513	1.095	1.495	1.895	-----	-----	-----	-----
Indirect effect of meta-perception of contact through trust in physician	-----	-----	-----	-----	.161	1.464	1.582	1.698

Note. Low, moderate, and high values correspond to unstandardized regression coefficients. IMM, index of moderated mediation

Chapter IV - Discussion

4.1 The Role of Acculturation Preferences on the Quality of CPC Doctor-Patient Relationship

This study generally aimed to investigate the impact of Brazilian immigrant caregivers' meta-perceptions about contact and culture maintenance on the quality of CPC doctor-patient relationship. More specifically, this study aimed to test the conceptual models presented in Figures 1 & 2. Thus, this study investigated whether Brazilian immigrants' meta-perceptions about Portuguese acculturation preferences towards contact and culture would predict their satisfaction with CPC care via their trust in physician (Figure 1), and the moderating effect of their own acculturation preferences on these relationships (Figure 2).

First, contrary to our expectations, meta-perceptions about Portuguese acculturation preferences did not predict neither satisfaction with CPC medical nor nursing care in the dimension of culture maintenance via trust in physician. Still, findings showed a tendency for a positive association between perceived acceptance of Brazilian heritage culture by the Portuguese and immigrants' trust in physicians, which in turn was associated with a higher level of satisfaction with medical care. These results partially supported H1 and are in line with studies demonstrating the importance of immigrants' perceptions that the doctors accept if the immigrants desire to maintain their heritage culture for a good doctor-patient relationship, higher perceived quality of care and better adherence to recommendations (Cook, Kosoko-Lasaki, & O'Brien, 2005; Whittal, Hanke, & Lippke, 2017).

As expected, a high perceived preference of Portuguese towards contact with Brazilian immigrant caregivers was associated with a higher level of trust in physician, which in turn accounted for a higher satisfaction with both, medical and nursing care. These findings support our mediational hypothesis in the dimension of contact (H1). Being in line with previous studies, these findings confirm that immigrant caregivers' perceived expectations about the physicians' acculturation preferences towards contact play an important role in shaping the doctor-patient relationship and increase their perceived quality of care (Whittal, Hanke, & Lippke, 2017; Whittal & Lippke, 2016). That is, if immigrants perceive that Portuguese are open for a contact with them, they may positively perceive their relationship with physicians, which may lead to a higher trust in health care providers and consequently to a higher satisfaction with care (Sam & Berry, 2010).

As we see testing H1, results were significant for the contact dimension but not for the culture maintenance dimension. Zagefka and colleagues (2007) found that perceived immigrant acculturation preferences towards intercultural contact were negatively associated

with the host society's prejudice, whereas perceived immigrant preferences for culture maintenance were not. At the same time, based on the reviewed literature, prejudice creates mistrust between doctors and immigrant patients (Dovidio, Love, Schellhaas, & Hewstone, 2017; Landrine & Klonoff, 2004). Thus, it can be assumed that immigrants' meta-perceptions about Portuguese acculturation preferences towards culture maintenance did not show a significant association with satisfaction with care via trust in physician because, perhaps, there is no association between perceived Portuguese preferences for culture maintenance and perceived prejudice, which was not measured. This argument, however, is yet to be tested.

Also, the fact that the findings did not show any association between meta-perceptions about Portuguese acculturation preferences and satisfaction with nursing care via trust in physician in culture maintenance dimension and a weaker association, compared to the satisfaction with medical care, in the contact dimension, may be explained by the fact that nurses in Portugal do not possess wide clinical autonomy like in some other European countries (Dussault, Temido, & Craveiro, 2015). This means that patients usually have more communication regarding their children's health problems and treatments with doctors and pediatricians rather than with nurses, which makes the perception of acculturation preferences of Portuguese towards heritage culture maintenance by Brazilian immigrants more important for the satisfaction with medical care. Also, the mediating mechanism (trust) was more focused on the relationship with physicians instead of nurses, which may also have accounted for the weaker associations with the satisfaction with nursing care.

Our second aim was to investigate whether immigrants' own acculturation preferences towards culture maintenance and contact moderated the effects of immigrants' meta-perceptions about Portuguese acculturation preferences towards culture maintenance and contact, respectively, on satisfaction with care through their trust in physician. To our best knowledge, this study was the first considering the doctor-patient relationship as trust in doctors and satisfaction with care in relation to own and perceived acculturation preferences in two dimensions separately. Surprisingly, immigrants' own acculturation preferences did not moderate any of the (in)direct effects of immigrants' perceived acculturation preferences of Portuguese on satisfaction with medical and nursing care via trust in physician, which contradicted our H2. Perhaps, in the specific context of the doctor-patient relationship as an intergroup outcome, the measurement of perceived and own acculturation preferences in two dimensions separately was not the most adequate indicator of the complex interpersonal relationship established with health providers. A future study could aim to explore the perceived and own acculturation strategies (*i.e.*, integration, assimilation, separation,

marginalization) and their fit (*i.e.*, the attitude discrepancy) in association with doctor-patient relationship (*i.e.*, trust in physician and satisfaction with care).

Still, the direct effect of meta-perceptions about Portuguese acculturation preferences towards contact on satisfaction with nursing care was moderated by immigrants' own acculturation preferences for contact. Our findings showed that satisfaction with nursing care was higher when the meta-perceptions of contact agree with immigrants' own preferences for contact. These results partially supported studies suggesting that the interrelation between immigrants' own acculturation preferences and the perceptions of what the other group wants predicts the intergroup outcomes, particularly the quality of doctor-patient relationship (Piontkowski, Rohmann, & Florack, 2002; Whittal & Lippke, 2016). Again, we can observe these findings for the dimension of contact but not for the dimension of maintenance. Perhaps, the contact dimension is a better predictor of satisfaction with health care by tapping immigrants' intentions to form relationships with the host society members, whereas culture maintenance is related to people's attitudes towards their cultural practices and could predict other psychological processes (Berry, 1997).

Also, the bivariate tests showed positive and significant correlation between perceived Portuguese preferences (meta-perceptions) and immigrants' own preferences towards culture maintenance, same as between perceived Portuguese preferences (meta-perception) and immigrants' own preferences towards contact, which are in line with previous studies (Brown & Zagefka, 2011; Piontkowski, Rohmann, & Florack 2002). These results are in line with findings of Brown and Zagefka (2011) that the perceived preference for contact by the host society group is associated with the greater preference among the immigrant group as well, same association is related to the dimension of culture maintenance.

Certainly, there are many other factors that could moderate the impact of meta-perception about acculturation preferences on doctor-patient relationship. Whereas this research has looked specifically at one factor (immigrants' own acculturation preferences), which has potential to be improved, it is important to keep in mind other factors that may occur during this dynamic process, such as perceived discrimination, perceived social support, prejudice (Mourão & Bernardes, 2019; Whittal & Lippke, 2016). Still, our results support the relevance of acculturation processes in accounting for the relationship between immigrant patients and doctors representing host society, going beyond the use of unidimensional and/or proxy measures of acculturation (Mills, Fox, Gholizadeh, Klonoff, & Malcarne, 2017; Thomson & Hoffman-Goetz, 2009).

4.2 Limitations and implications for future research

Some limitations should be pointed out to this study. First of all, immigrants' own acculturation preferences as their metacognitions were assessed by a general measure of acculturation, which does not focus on more particular domains such as health-related behaviors (e.g., meta-perceptions about Portuguese acceptance of Brazilian immigrants to maintain (or not) their heritage cultural practices related to child care). This may eventually account for the fact that our hypotheses were supported only partially, and weak associations were found between acculturation preferences and doctor-patient relationship. Therefore, an acculturation measure might need to be more specific to the health context, as immigrants' acculturation preferences vary across different domains (Arends-Tóth & Van de Vijver, 2004; Schwartz & Unger, 2017).

Secondly, some limitations can be related to the sampling procedures. This research was exploratory, therefore cross-sectional secondary data was used to draw main conclusions. However, we suggest collecting longitudinal data on this topic to find out more solid causal relationships. Moreover, although the sample size was sufficient for the analyses conducted, due to the strict selection criterion we had to delete some participants, though for stronger and more robust statistical tests and results, larger samples would be needed. Also, most participants were mothers, which potentially could give a certain direction to results and limit our knowledge about the acculturation preferences and doctor-patient relationship of male caregivers. Moreover, since the sample was formed by Brazilian immigrants in Portugal, as they are the biggest and more discriminated group compared to other nationalities, the results may not be generalized to other immigrant groups (Bäckström, 2014; Neto, Oliveira, & Neto, 2017).

Regardless of the above-mentioned limitations, the present study has a relevant theoretical and practical implications. From a theoretical point of view, this research identifies the predictive role of immigrants' perceived acculturation preferences based on Berry's bidimensional model on the doctor-patient relationship. To the best of our knowledge, this is the first study which investigated not only the impact of perceived acculturation preferences for contact and culture maintenance on doctor-patient relationship, but also the effect of own acculturation preferences on that impact. Previous studies considered acculturation strategies (*i.e.*, combination of contact and culture maintenance dimensions) related to immigrants' heath behaviors and outcomes, whereas this study considered the association between these two dimensions and doctor-patient relationship separately, which makes it a theoretical contribution to the literature on immigrants' acculturation and health. The evidence provided

points towards acculturation processes as a potentially influential factor in the doctor-patient relationship through a complex process including immigrants' own and perceived acculturation preferences and satisfaction with care via trust in physician. These factors may relate (in)directly to immigrants' health related behaviors, therefore, this study may be considered as an empirical contribution to the literature on immigrants' health. Future studies should test the produced hypotheses with stronger analytic methods in different countries and different areas in medicine.

From a practical point of view, the identification of the determinants of doctor-patients relationship that are relevant for immigrant caregivers and the influence of their perceived and own acculturation preferences on these determinants is important as it could contribute to the development of intercultural sensitivity and competency of CPC professionals for possible immigrants' health behaviours and health outcomes (Cook, Kosoko-Lasaki, & O'Brien, 2005; Fernandes & Miguel, 2009; Torres & Rollock, 2007; Whittal & Rosenberg, 2015). Intercultural competency of health professionals, in turn, is essential in building a trustworthy relationship with their patients as it affects the latter's health related behaviours and health outcomes (Gurung, 2006; Paternotte, van Dulmen, van der Lee, Scherpbier, & Scheele, 2015; Tucker et al., 2011). And, based on this study, we can conclude that the contact dimension of acculturation may be more suitable target of intervention to improve doctor-patient relationship than the culture maintenance dimension. Thus, overall, this study provides some important initial steps to improve the understanding of why immigrants and their children show poorer health (Case, Fertig, & Paxson, 2005; Fernandes & Miguel, 2009; Schmeer, 2012), lower perceived quality of care (Whittal & Rosenberg, 2015) and poorer adherence to medical recommendations (Mourão & Bernardes, 2019; Tucker et al., 2011) than the host society.

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Appendix A – Data Collection Protocol

INSTRUÇÕES E CONSENTIMENTO INFORMADO

O Centro de Investigação e Intervenção Social do ISCTE-Instituto Universitário de Lisboa está a realizar um **estudo sobre as consultas de rotina das criancas**, que acontecem habitualmente nos Centros de Saúde/Unidades de Saúde Familiar (USF) ou em serviços de saúde privados (ex. pediatras particulares). Pretende conhecer a **experiência que famílias imigrantes Brasileiras em Portugal têm nessas consultas**. O estudo faz parte de um projeto de Doutoramento em Psicologia, financiado pela Fundação para Ciência e Tecnologia (FCT; SFRH/BD/96783/2013).

Convidamos os **pais ou mães de origem Brasileira, com filhos(as) com idades entre os 2 e os 6 anos**, a preencherem o questionário que se segue e que durará cerca de 20 minutos. O questionário deverá ser preenchido por aquele que vai mais vezes com a criança às consultas de rotina (pai ou mãe). Caso tenha **mais do que um(a) filho(a) com a idade indicada**, por favor, **responda em relacão ao seu(a) filho(a) mais velho(a)**.

Não existem respostas certas nem erradas, e a sua opinião pessoal e sincera é muito importante para nós. Não queremos avaliar os cuidados de saúde que o(a) seu(sua) filho(a) tem recebido, mas sim conhecer a sua experiência nas consultas de rotina das crianças em Portugal. **Não existem riscos** associados à sua participação no estudo e ao responder, a todas ou quase todas as perguntas, habilita-se a ganhar um dos 6 vouchers Sonae de 25€ que serão sorteados.

A sua **participacão** no estudo é **livre e voluntária**: pode escolher participar ou não participar. Se escolher participar, pode interromper a sua participação em qualquer momento, caso sinta vontade de o fazer, e sem ter que se justificar. Os **dados** recolhidos são **anónimos e confidenciais**, e serão utilizados apenas para fins de investigação. As suas respostas não vão ser analisadas individualmente e não permitirão identificá-lo(a).

Caso tenha alguma dúvida e/ou queira fazer algum comentário sobre o estudo poderá **contactar a investigadora Susana Mourão** (email: Susana_Sofia_Mourao@iscte-iul.pt). Muito obrigada, desde já, pela sua participação.

Se tem **mais do que 18 anos** e percebeu as informações apresentadas acima, indique por favor se **aceita participar no estudo**:

- o Sim
- o Não

Nome:_____

Data: _____

Assinatura: _____

1ª PARTE

As perguntas que se seguem são sobre dados familiares e pessoais, e sobre a sua experiência em Portugal.

DADOS SOBRE O SEU(SUA) FILHO(A)

Idade (por favor indique o número de anos)**:** _____anos

Naturalidade da mãe (país onde nasceu)**:** _____

Nacionalidade da mãe: _____

Naturalidade do pai (país onde nasceu)**:** _____

Nacionalidade do pai: _____

Constituição do agregado familiar (pessoas com quem vive)**:**

_____

Rendimento mensal do agregado familiar (pessoas com quem vive)**:**

- o Menos de 500€
- o 500€ a 1000€
- o 1000€ a 1500€
- o 1500€ a 2000€
- o Mais de 2000€

DADOS SOBRE SI

Grau de parentesco com a criança:

- o Mãe
- o Pai

Idade:_____anos

Número de filhos: _____

Escolaridade (por favor indique o número de anos completos)**:**____anos

Profissão: _____

Situação profissional:

- o Empregado(a)
- o Desempregado(a)

Com qual destes grupos mais se identifica (escolha 1 opção)**:**

- o Brasileiros
- o Portugueses de origem brasileira
- o Outro. Qual? _____

Há quanto tempo vive em Portugal?

- o 1 ano ou menos
- o a 3 anos
- o a 5 anos
- o Mais de 5 anos

Qual a sua situação em Portugal?

- o Em processo de legalização
- o Autorização de residência temporária
- o Autorização de residência permanente
- o Nacionalidade portuguesa/dupla nacionalidade
- o Outra. Qual? _____

Quanto concorda com cada uma das seguintes frases?	**Discordo totalmente (1)**	**Discordo (2)**	**Não concordo nem discordo (3)**	**Concordo (4)**	**Concordo totalmente (5)**
1. Eu acho que é importante que os Brasileiros em Portugal mantenham a sua cultura.	1	2	3	4	5
2. Eu acho que os Brasileiros em Portugal devem manter a sua própria religião, linguagem e vestuário.	1	2	3	4	5
3. Eu acho que é importante que os Brasileiros em Portugal mantenham a sua própria forma de vida.	1	2	3	4	5
4. Eu acho que é importante que os Brasileiros em	1	2	3	4	5

Portugal tenham amigos Portugueses.					
5. Eu acho que é importante que os Brasileiros em Portugal também passem algum tempo com os Portugueses.	1	2	3	4	5
6. Acredito que os Portugueses não se importam que os Brasileiros mantenham a sua própria cultura.	1	2	3	4	5
7. Acredito que os Portugueses não se importam que os Brasileiros mantenham a sua religião, linguagem e vestuário.	1	2	3	4	5
8. Acredito que os Portugueses não se importam que os Brasileiros mantenham a sua própria forma de vida.	1	2	3	4	5
9. Acredito que os Portugueses acham que é importante que os Brasileiros tenham amigos Portugueses.	1	2	3	4	5
10. Acredito que os Portugueses acham que é importante que os Brasileiros também passem tempo com os Portugueses.	1	2	3	4	5

2ª PARTE

As perguntas que se seguem são sobre a sua experiência nas consultas de rotina do(a) seu(sua) filho(a). Relembre-se que, caso tenha mais do que um(a) filho(a) com 2 a 6 anos de idade, deverá responder em relação ao(à) que for mais velho(a).

Local das consultas (pode assinalar mais do que 1 opção)**:**

- o Centro de saúde
- o Unidade de saúde familiar (USF)
- o Pediatra/clínica privada
- o Outro. Qual? _____

No caso de ir a mais do que um local, onde vai mais regularmente?

_____

Quantas vezes foi às consultas de rotina desde que o seu(sua) filho(a) nasceu?

_____

Costuma ler os conselhos escritos do livro de saúde infantil do seu filho(a)?

- o Nunca
- o Poucas vezes
- o Às vezes
- o Muitas vezes
- o Sempre

Que avaliação faz do <u>médico de família/pediatra que habitualmente segue o(a) seu(sua) filho(a)</u> em relação a:	 **Excelente (5)**	 **(4)**	 **(3)**	 **(2)**	 **Mau (1)**	**Não se aplica (6)**
1. Fazê-lo sentir que tem tempo durante a consulta.	5	4	3	2	1	6
2. Interesse mostrado pela situação do(a) seu(sua) filho(a).	5	4	3	2	1	6
3. Facilidade com que se sentiu à vontade para lhe contar os problemas do(a) seu(sua) filho(a).	5	4	3	2	1	6

4. Forma como foi envolvido(a) nas decisões sobre os cuidados que o médico prestou ao(à) seu(sua) filho(a).	5	4	3	2	1	6
5. Forma como o médico o(a) ouviu.	5	4	3	2	1	6
6. Confidencialidade da informação sobre o processo do(a) seu(sua) filho(a).	5	4	3	2	1	6
7. Forma como foi prestado alívio rápido dos sintomas do(a) seu(sua) filho(a).	5	4	3	2	1	6
8. Ajuda que recebeu para se sentir suficientemente bem para desempenhar as tarefas diárias do(a) seu(sua) filho(a).	5	4	3	2	1	6
9. Atenção dispensada aos problemas do(a) seu(sua) filho(a).	5	4	3	2	1	6
10. Exame clínico feito pelo médico.	5	4	3	2	1	6
11. Oferta de serviços de prevenção de doenças (por exemplo, rastreio, check-ups e vacinas).	5	4	3	2	1	6
12. Explicação dos objetivos dos exames, dos testes e dos tratamentos.	5	4	3	2	1	6
13. Forma como foi suficientemente informado(a) sobre os sintomas e a doença do(a) seu(sua) filho(a).	5	4	3	2	1	6

Que avaliação faz do <u>médico de família/pediatra que habitualmente segue o(a) seu(sua) filho(a)</u> em relação a:	 **Excelente (5)**	 **(4)**	 **(3)**	 **(2)**	 **Mau (1)**	**Não se aplica (6)**
14. Ajuda que recebeu para enfrentar os problemas emocionais relacionados com o estado de saúde do(a) seu(sua) filho(a).	5	4	3	2	1	6
15. Apoio que recebeu para compreender porque é importante seguir os conselhos do seu médico.	5	4	3	2	1	6
16. Conhecimento sobre o que foi feito e dito em anteriores contactos no centro de saúde/clínica.	5	4	3	2	1	6
17. Preparação sobre o que esperar de especialistas, dos cuidados hospitalares ou outros prestadores de cuidados.	5	4	3	2	1	6
18. A competência, cortesia e carinho do pessoal médico.	5	4	3	2	1	6

Que avaliação faz do <u>local das consultas de rotina do(a) seu(sua) filho(a)</u> em relação a:	 **Excelente (5)**	 **(4)**	 **(3)**	 **(2)**	 **Mau (1)**	**Não se aplica (6)**
19. Tempo que lhe foi dedicado pelo pessoal de enfermagem.	5	4	3	2	1	6
20. Forma como foi contactado(a) para utilizar os serviços de prevenção de doenças fornecidos pelo centro de saúde/clínica.	5	4	3	2	1	6
21. A competência, cortesia e carinho do pessoal de enfermagem.	5	4	3	2	1	6

Quando pensa no médico de família/pediatra que habitualmente segue o(a) seu(sua) filho(a), quanto concorda com cada uma das seguintes frases?	**Discordo totalmente (1)**	**Discordo (2)**	**Não concordo nem discordo (3)**	**Concordo (4)**	**Concordo totalmente (5)**
1. Eu duvido que o médico se interesse realmente pelo(a) meu(minha) filho(a) como pessoa.	1	2	3	4	5
2. Habitualmente, o médico tem em consideração as necessidades do(a) meu(minha) filho(a) e coloca-as em primeiro plano.	1	2	3	4	5
3. Eu confio tanto no médico que tento sempre seguir os seus conselhos.	1	2	3	4	5
4. Se o médico me diz alguma coisa, eu acredito que seja verdade.	1	2	3	4	5
5. Por vezes não confio na opinião do médico e gostaria de uma segunda opinião.	1	2	3	4	5
6. Eu confio nos juízos do médico sobre os cuidados de saúde do(a) meu(minha) filho(a).	1	2	3	4	5
7. Eu sinto que o médico não faz tudo o que está ao seu alcance pelos cuidados médicos do(a) meu(minha) filho(a).	1	2	3	4	5
8. Eu acredito que o médico coloca as necessidades médicas do(a) meu(minha) filho(a) acima de tudo quando está a tratar os seus problemas de	1	2	3	4	5

saúde.					
9. O médico é um especialista em tratar problemas médicos como os do(a) meu(minha) filho(a).	1	2	3	4	5
10. Eu confio que o médico me conte se algum erro foi cometido durante o tratamento do(a) meu(minha) filho(a).	1	2	3	4	5
11. Algumas vezes preocupo-me que o médico não mantenha as informações discutidas nas nossas conversas confidenciais.	1	2	3	4	5

AGRADECIMENTO

Muito obrigada por ter participado neste questionário. Tal como apresentado no início, este estudo pretende **conhecer a experiência de famílias imigrantes Brasileiras em Portugal nas consultas de rotina das crianças** e, mais especificamente, as atitudes dessas famílias face aos conselhos que são dados nas consultas.

Lembramos que pode enviar **email para Susana_Sofia_Mourao@iscte-iul.pt**, caso tenha alguma dúvida ou comentário a fazer, e ainda se quiser receber informação sobre os principais resultados do estudo.

Mais uma vez, muito obrigada pela sua colaboração.

Caso queira participar no **sorteio dos vouchers Sonae**, indique o seu **email abaixo**. Garantimos que só o iremos utilizar para este fim e não vamos associá-lo às respostas do questionário.

Autoriza que esse email seja utilizado para **receber informação sobre outros estudos**:

- ❍ Sim
- ❍ Não