A STUDY OF THE EFFECT OF IMMEDIATE VIDEOTAPE FEEDBACK ON NURSES' INTERPERSONAL SKILL

BY

KATHLEEN KERR McINTOSH

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APPROVAL

Name: Kathleen Kerr McIntosh

Degree: Master of Arts (Education)

Title of Thesis: A Study of the Effect of Immediate Videotape Feedback on Nurses' Interpersonal Skill

Examining Committee:

Chairman: T.J. Mallinson

Don Coates
Senior Supervisor

Dan Birch

Maurice Halperin
External Examiner
Professor
Simon Fraser University, Burnaby 2, B.C.

Date Approved: Mar. 27/72

ABSTRACT

Nurses persist in preserving many rituals which began in the era of Florence Nightingale; added to these rituals is a traditional preoccupation with technical procedures which tend to supercede the nurse's concern with the patient as a person. The nursing profession faces the need to change the focus of nursing care toward developing the nurse's interpersonal skills so that she may relate effectively to patients. The nurse/educator in her role as supervisor of nurse-patient interactions can help to promote this change.

This study examines the effect of immediate video feedback on the interpersonal skills of nurses. Interpersonal skill was measured by two criteria: (1) a set of specific behavioral responses, developed by Parsons, and (2) the set of core dimensional behaviors of Carkhuff and Berensen; that is, four qualities which exemplify therapeutic interactions: empathy, respect, genuineness and concreteness.

Recent literature suggests videotape feedback is a potentially powerful agent for changing behavior, but that: (1) the use of videotape feedback is relatively untested; (2) there is little experimental work on testing the theoretical models of effectiveness; (3) videotape feedback should be accompanied by supervision to achieve the greatest effect; (4) new conceptualizations of the change process are needed to understand the use of interventions such as videotape feedback; (5) First hand reports of people's experiences should be examined to develop theory concerning the use of videotape feedback.

This study was conducted at a local hospital, in a twelve week period of time. The nurses who took part in this study were enrolled in a course in Human Behavior at a local university. Two groups of five subjects were selected on the basis of availability. The clinical experience in this course was supervised practice in developing interpersonal skill with patients. Supervision included defining of goals, use of a role model, and use of process recordings. An experienced videotape technician filmed the interview between nurse and client for three separate half hour sessions. A trained videotape behavioral analyst assisted the investigator in rating the tapes.

Four hypotheses were tested. Hypothesis 1 - All students will improve in interpersonal skill in a situation which is supervised, independent of the effect of videotaped feedback. Response ratings tend to support this hypothesis but core dimensions ratings fail to support it. Carkhuff and Truax have demonstrated that the personal qualities of the core dimensions may be acquired even by untrained subjects, but over a longer period. The effects of extended training remain to be investigated.

Hypothesis 2 - Students who have immediate videotaped feedback of their interviews with patients will show more improvement than the students in the control group. Both response ratings and core dimension ratings fail to support this hypothesis.

Hypothesis 3 - Improvement in the set of specific responses will be accompanied by improvement in the core dimensions. Ratings failed to support this hypothesis. Neither group showed improvement in the measurements of the core dimensions although both groups improved in

the response scale. Thus improvement in specific responses is more readily attained, but need not be accompanied by the more slowly acquired changes in personal qualities.

Hypothesis 4 - The experience of receiving videotaped feedback in the clinical practice period will have a negative effect on the nurse initially and a positive effect later. This is supported by narrative evidence provided by the investigator.

While data presented failed to support additional effects for immediate videotape feedback, the treatment as a whole effected change in nurses' interpersonal skills as reflected in response ratings. Furthermore, nurses perceived immediate videotape feedback as productive and attributed attitude and behavior change to it. Further investigations must deal with two possible limitations of this study; the short treatment time and the need for continual refinement of instruments.

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CHAPTER I

INTRODUCTION

Background to the Problem

In the past several decades, nursing leaders have been aware of the need to change the focus of nursing care. The traditional preoccupation with technical procedures has tended to supercede the nurse's concern with the patient as a person. Patient care has focused primarily on bodily functions and patients frequently have become secondary to the operation of the hospital system. Recently, nursing educators have placed emphasis on the development of therapeutic communication combined with technical skills.

There are, however, a number of factors which hinder change in nurses' behavior. Nurses employed in North American hospitals continue to perform many rituals which began in the era of Florence Nightingale. These rituals perpetuate a conformity of behavior which ensures cleanliness, order, and obedience. The ceremonial early morning bathing of patients is one example of such behavior. In addition to many unexamined routines, other time-consuming duties have reduced the nurse's involvement in direct patient care. Technical procedures such as the administration of intravenous therapy, previously the physician's responsibility, have been taken over by the nurse. The increasing complexity of hospital management has placed a burden of administrative

responsibility upon the nurse and has resulted in increased routine paper work. Only recently, have clerks been hired to relieve nurses of a small fraction of this technical work.

Nurses have an internal resistance to departure from their traditional role. Four-fifths (18) of the nursing profession is composed of graduates of three-year hospital training, who have become indoctrinated in routines and procedures designated as nurses' work. In their training period student nurses are used for service at the same time as they are "learning". The cycle of conformity is perpetuated by the traditional nurse who also functions as a role model for both university and two-year diploma nursing students.

Students are unclear about the direction in which they must develop if they are to be capable of forming therapeutic relationships. Historically, nursing education has been concerned primarily with the teaching of practical procedures which require the development of technical skills. Until recently very little attention has been given to the interpersonal skill of the nurse. Rather the focus of teaching communication has been on information-gathering techniques, designed to learn about the patient in order to better meet his needs. This process has proven necessary, but it is an extension of procedure-based education and is not concerned with developing the humane qualities of the nurse. Research on the helping relationship suggests the importance of developing the nurse's sensitivity to understand what are therapeutic attitudes, so that she is less concerned with developing techniques, specific responses or diagnostic labeling. (48) The interaction between the nurse and a patient is foremost a relation-

ship between two human beings, the patient being the more vulnerable at least in the beginning of the relationship. Thus, in order to understand how she needs to change to be more constructive, it is essential that a nurse be aware of her own behavior in relation to the patient. It cannot be over stressed that self-awareness is inherent in a change in nursing practice which focuses on the personal interactions between nurses and patients. The factors mentioned previously which hinder change in nurses' behavior have become institutionalized and are difficult to eliminate. Therefore, if nursing practice is to change in the direction of therapeutic relationships, then nurse-educators must guide nurses in developing interpersonal skills.

Statement of the Problem

The nursing profession faces the need to change the focus of nursing care towards developing nurses' interpersonal skills, so that they may relate effectively to patients. Nurse educators, in the role of supervisors of nurse-patient interactions, can help to promote this change in the following ways: by defining the goals of nurse-patient interactions and by being available for consultation so that nurses can discuss what is happening between them and their patients, and thus receive guidance and feedback. The supervisor can also serve as a role model to the nurse in either of two ways. The first way is to let the nurse observe her interviewing a patient. The second way is less obvious and must be drawn to the nurse's attention: the nurse-supervisor relationship itself can serve as a model for the nurse's

relationships with patients. The supervisor's ability to show warmth and understanding helps the nurse to understand what is involved in effective interpersonal transactions and gives real meaning to the goal of good nursing practice.

The close personal supervision and feedback described above has frequently been supplemented by the use of written process recordings. The nurse writes down, for the supervisor's scrutiny and reaction, the content of the nurse-patient transaction including non-verbal as well as verbal behaviour and the feelings she experiences in the encounter. A further development followed use of audiotape records for review and supervision.

A new method of supervision will be examined in this study, feedback via the videotape recorder followed by discussion with the supervisor. This method of supervision is relatively untried and the responses one may expect from videotape feedback are uncertain. Although, as Wilmer says, "In no other way is it possible to demonstrate objectively the difference between what we say we do and what we actually do", (58, 123) the effect of videotape feedback is not known. Does the feedback have any impact? and if so, what is the nature of the impact? and how can it be utilized by the supervisor and nurse in a formative manner?

To answer some of these questions this thesis examines the effect of videotape feedback on nurses' acquisition of interpersonal skills.

CHAPTER II

REVIEW OF LITERATURE

The relevant literature was reviewed in search of a theoretical frame of reference for the study of changes in interpersonal relationship skills, to clarify conceptualizations concerning feedback, and to examine the use of the videotape as a method of giving feedback on performance. The literature review will be discussed under the following headings: Communication in Interpersonal Relationships, The Videotape and Nursing Education, Therapeutic Communication, Guided Self-Analysis System and Interaction as a Teaching Aide, The Videotape used for Interpersonal Process Recall.

Communication in Interpersonal Relationships

Despite the evidence that human beings have an inherent ability to communicate with each other and need to do so, it is clear that man's communication skill in a purportedly therapeutic context is far from perfect. "The levels of human nourishment available to the person at a crisis point are grossly inadequate. Most environments cannot sustain such a person." (20,5) The literature stresses the need for those of us who would be counselors to examine our present beliefs and practices and to consider new ways to direct our efforts. (20)

Direct and honest communication between two people is not possible if one or the other tries to incorporate himself into a role. (20,12)

According to Carkhuff and Berenson, "If counselors and psychotherapists functioned in real life the way most of them do in the therapeutic hour they would be patients". (20,7) Kagan and Krathwohl indicate the need for the therapist to become totally sensitive to himself in relation to the client as opposed to performing a stereotyped set of behaviors. (36) Their findings are as follows: "... That one of man's basic interpersonal drives is toward sensory stimulation, stimulation of all of his sensory mechanisms, and that man is the best, the most complete potential source of sensory stimulation for his fellow man". (36, 62-63) They believe "... that the ability to understand the total communication of another may be basic to normal functioning and that distortions in understanding serve special needs". (36,57) In an initial relationship between a counselor and client, each person is often wrapped up in himself and fearful of how the other perceives him; this situation provokes each of the persons involved to resort to behavior that preserves their own self-esteem, sometimes without concern for the other.

Kagan and Krathwohl elaborate on the concept of distortion in interpersonal relationships. (36,58) In a relationship between a client and counselor, distortions in communications are based mainly on the mutual fear of rejection. The client frequently comes to the sessions with a set of expectations of how the other will see him and behave towards him, and constantly seeks evidence to support this belief. If the client withholds feelings or facts it may be read by the counselor as client hostility, as an attempt to belittle the work of the counselor. The counselor trainee in addition has a tendency to be self-

conscious about his role as a counselor and not to be able to hear what the client is saying. Client communication to counselor may also be blocked because of false clues given by the client, or for that matter by the counselor; in other words people have the ability to fake what they do not feel. Counselors often miss the real message in the communication when the client uses metaphors.

The findings of Kagan and Krathwohl have a direct relevance for nurse-patient relationships. In addition to the barriers to therapeutic communication described by these authors, the traditional roles of "nurse" and "patient" present further difficulties. While the patient's dependency is sometimes necessary, it is frequently reinforced in a context of submission and conformity to demands. Meyer suggests that the more a nurse becomes oriented to the performance of techniques and procedures, the less she is inclined to be tender and compassionate towards the patient. (41)

Nuckolls describes what she believes to be inherent in interpersonal relationship skill in nursing and how it can be taught. (44) "Compassion, the basis of nursing's heritage and professional image, constitutes one of nursing's greatest strengths. It provides an entree to the patient and a unique opportunity to help. It seems important that students of nursing learn to use their compassion effectively so that both what they say and what they are become conscious parts of therapy. In other words, tenderness is more than interviewing technique, or interpersonal relating, or intuitive caring alone. A synthesis of knowledge and feeling, it can be taught if the student is given the opportunity to see it practised." (44, 2691)

Nuckolls seems to believe that observation of an expert instructor as a role model will enable a student to learn to perform adequately in an interpersonal situation "... every student can then learn from a life master". (44,2691)

A more rational approach to helping a student develop interpersonal relationship skill is for the teacher to guide the student's interaction with a patient. Bruner states "... It is not so much that the teacher provides a model to imitate. Rather, it is that the teacher can become a part of the student's internal dialogue..." (13,124)

The Videotape and Nursing Education

Nursing education has made little use of videotape feedback as a teaching adjunct. However, videotape recordings have been used to demonstrate procedures, lessons, and interviews. (44,31) It is only within the last four to five years that television has been used in nursing education to any great extent in the United States, although educational television was introduced about twenty years ago. The extent of the use of television in nursing education is difficult to assess; in 1967 approximately 11 percent of the junior college programs and 1.4 percent of the diploma and baccalaureate degree programs used television. (4,31)

Anderson reports that television is being used in a number of ways. Television instruction is used as part of a class, part of a course or a total course. Live television is used for observation of patients, of group processes, and of some learning situations in the clinical areas, or for transmission of instruction by a lecturer. (4,31)

She mentions briefly that, "... communication skills are taught via TV and videotape through a combination of more formal instruction, videotaped role-playing with subsequent playback for critique, and self confrontation via videotape of individual or group interaction. (4,31)

Muecke studied the use of videotape recordings in clinical psychiatric nursing instruction. (42) She reports that videotapes of nurse-patient interaction give more complete and accurate information than written process studies and audio tapes, the usual methods of assessing such interaction. She advocates that when students are video-taped near the beginning and again at the end of the academic quarter, they are more motivated to improve their performance. The student has time to reflect upon, and to practice modification of her behavior. Viewing the second videotape then confirms her change in behavior.

Muecke reports that student evaluation of videotape recording as a learning tool was favorable although the observations were not controlled. Though the students were initially anxious about exposing themselves, Muecke points out that, "This anxiety may attest to the strength of video-taping as a means to provoke self-awareness". (42,205) In spite of this statement she recommends that it is "... useful to concentrate more on patient rather than student behavior on camera in order to alleviate student anxiety during tape playback, and to provide more patient data for the student and her peers to consider in group viewing of the tape". (42,203) From the meagreness of these videotape studies, it is not overstating the situation to conclude that

nursing educators have yet to seriously begin their exploitation of videotape facilities.

Therapeutic Communication

Carl Rogers was one of the first to write that accurate empathy, non-possessive warmth, and genuineness were the main qualities necessary for therapeutic interpersonal relationship skill. (50) If the therapist offers these conditions he is able to help people change for the better. (56) Thus the training in therapeutic communication is concerned with the development of sensitivity in understanding what therapeutic attitudes are, rather than developing techniques, specific responses, diagnostic labeling, or even identifying presumed personality dynamics in the client. (48)

Carkhuff and Berensen (20,5) developed a conceptual scheme for therapeutic communication which operationally defines the facilitative qualities described earlier by Rogers. The core dimensions of this scale necessary to improve functioning in all interpersonal relationships are as follows: Empathy describes the therapist's ability to understand the client on a moment to moment basis and to understand himself in relation to the client. Genuineness is the therapist's ability to be authentic, congruent, and non-defensive. The therapist is honest with himself and with the client. Respect involves the therapist's commitment, his effort to understand, and his spontanaeity. Concreteness implies specificity of expression and keeping the other directly aware of the situation in hand. Accurate feedback can directly influence the client to attend specifically to problem areas

and emotional conflicts.

If the therapist provides a high level of these four facilitative dimensions, the client's experience of isolation and hopelessness is relieved. The client feels freer to explore anxiety-laden material, and as he expresses himself the reduction of anxiety serves to reinforce his ability to explore himself. In other words, if the therapist offers a high level of these facilitative conditions, a reciprocally positive affect is elicited in the client. (20,5)

Research evidence of Carkhuff and Truax shows that enhancement of the described facilitative dimensions can be learned. In one instance it was found possible to raise the level of lay persons to a level not significantly different from expert therapists. Teaching was done in the context of demonstrating what was to be learned. (21)

Kagan and Krathwohl suggest that the relationship between the supervisor and the trainee is similar to a counseling relationship and that the supervisory process in learning to relate effectively was important. They report that the supervisor trainee discussions were helpful in securing trainee learning. (36,91) Truax, Carkhuff, and Douds suggest that the observation of a role model who rates high in the use of the facilitative core dimensions described earlier, helps the trainee to identify with the elements of effective counselling. (56)

Guided Self-Analysis System and Interaction Analysis

The Guided Self-Analysis System for Professional Development (G.S.A.) is a technique by which a teacher may analyse his behavior in the classroom via videotape playback of his classroom interaction. (46)

The G.S.A. has several programs of sequenced interaction codes, the most frequently used one being the Inquiry Program which consists of six schedules or codes. Each schedule is a carefully written guide operationally defining the behaviors to be analysed.

Birch reported that when student teachers are given information regarding the coding methods used in interaction analysis of the G.S.A. Teaching for Inquiry program, this information alone does not have a significant effect on their teaching behavior in the classroom. However, when the process is combined with practice in coding their own behavior, there is a significant improvement in their teaching behavior. (11) The teacher reviews his actual behavior while focusing on methods conducive to successful teaching. The effect of this self-analysis "... is to induce cognitive dissonance in the teacher's mind through revealing a 'gap' between the actual reality of his teaching and his professional definitions of what good teaching is". (46,7)

The G.S.A. is designed to provide a model for change if the cognitive dissonance is responded to (11,7) that is, if the person perceiving his behavior as not congruent with his self-image is willing to try and change, the G.S.A. is designed to assist him. However, other reactions to dissonant discoveries are possible; they may be denied, or may be rationalized away as being compatible with the person's usual behavior. (23)

The G.S.A. Schedule 8 describes four operationally defined response patterns of teachers which promote or inhibit students' thinking and student teacher interaction. The four responses are: closing, rewarding, sustaining and extending. The first two categories

tend to inhibit student thinking and student-teacher interaction. Sustaining responses maintain the students' thinking, extending responses raise the level of student thinking and both of the latter two responses tend to encourage student teacher interaction. (46, 3-15)

One may extrapolate from the behavior of the teacher in the process of change in the classroom situation (46,8) to the behavior of the nurse in an interpersonal relationship with a patient by focusing on the same set of operationally defined behaviors. As the teacher permits the students to talk more there is a new atmosphere in the classroom. A frequent result is less teacher-dominated conversation and more pupil interaction and initiative. During this time the teacher must develop new teaching strategies in order to be comfortable and thus productive in the changed atmosphere. Similarly, as the nurse relinquishes her control of the direction of the interview, the patient may verbalize what is important to him. The principle described above is that good teaching provides a framework for students to develop ability to think and analyse their behavior. This principle is also relevant to nurse/patient interaction. According to Murray "... the main purpose of any nursing interview is to provide the patient with an opportunity to learn something about himself so that he may identify his health needs and decide if and how he wants to meet them. This opportunity is offered by the nurse through her responses to the patient". (43,69-70)

The Videotape Recorder as a Teaching Aide

Wilmer indicates that videotaping could become a revolutionary method in teaching and learning the art of therapist-patient relationships. (58) The major focus of the teaching process is the videotape

replay followed by discussion to facilitate cue discrimination, perception, and to analyse the behavior and to make decisions for modifying and/or changing behavior. He suggests that a ten-minute replay of an interview should occur immediately after the taping and that the replay should be followed by a fifteen-minute discussion period. (58,125) The painful hindsight of the replay causes anxiety to both therapist and patient and acts as a lever for discussion. Geertsma and Reivich indicate that the use of videotape feedback for supervision and teaching of student psychotherapists should supplement but not replace the use of progress notes. (27)

Wilmer's findings in the use of the videotape recorder as an adjunct in supervising psychiatric students are as follows: The videotape feedback provides not only self-confrontation but also living learning. "The effectiveness of this method is limited more by the psychiatrist's anxieties, fantasies and defenses than by those of the patient". (58,123) The camera magnifies certain characteristics of the participant's self image and attitudes about having been observed. He calls these characteristics their "under-ritualized" acts. (58,123) Inexperienced therapists may use the videotape as leverage "against" patients, that is to ignore their own behavior and to focus solely on the reacting patients. It is apparent that supervision is important when videotape replay is used as a teaching aide.

Feedback Via the Videotape Recorder

The use of the videotape recorder for instructional feedback is relatively new and a variety of investigators into this field have chosen

different terms to describe and examine similar processes. The common element in these studies is the primary concern with a particular psychological process, a self-image experience. (25,193)

According to Geertsma, the term "self-cognition" is most accurate; "self" focuses on the attending and considering person while "cognition" describes a process operating through sensory channels and concerning a perceiving self. Geertsma states that "self cognition should relate to such processes as cognitive balance, learning and self-conception" (...) "self-cognition is a natural process that occurs within everyone. It is internally mediated by many processes. When external means of affecting self-cognition are employed, then the term externally mediated self-cognition seems appropriate". (25,194) It is believed that the process of externally mediated self-cognition is potentially a powerful technique in behavior modification even though the effects of the process are not totally understood. (25,196) However, Geertsma and Reivich caution that "videotape self-viewing per se is not likely to effect an optimal therapeutic response and that clinicians using videotape for treatment purposes should be prepared to take an active role in relating patients to significant aspects in the playback action". (26,41)

According to Holzman, past experiments show that people tend to respond with their own style of "defense" when threatened by self confrontation. (33,203) The word defense is a label given to many kinds of behavior. The term defending is clearly defined by Bruner as a strategy, the objective of which is to avoid or escape the problems which we believe cannot be solved without disturbing our way of living;

conversely, coping with a problem respects the needs of the problem while still respecting our integrity. "Given the human condition, neither coping nor defending is found often in its pure form." (14,129) Werner Wolff (1930's) found that judgements of self-production involving people's impressions of their own voices, gaits, profiles, hands, and hand writing were generally more favorable than comments of others. Wolff reported these results as a defensive retreat from reality. Huntley (1940), in an experiment with similar results, explained the subject's behavior as based on the wish to preserve and enhance his self-esteem. Enstein (1955) found that subjects judged themselves more favorably than others did. Frenkl-Brunswick (1939) compared a number of self descriptions with descriptions of actual behavior by others and discovered that people misconstrued their evaluations most in the areas where their weaknesses were most apparent to others. (33,199) However, Holzman reports that self-confrontation by the videotape recorder has been found valuable in achieving objectivity towards oneself and in fostering a change in the participant's behavior. Nevertheless, he points out that most reports describe a theoretical rationale for the use of the videotape recorder, but that "there are no reports of experimental tests of a theory". (33,198) In other words, Holzman is implying that there is need for controlled studies to test these assumptions.

Berger says that videotape replay is a tool which can expand profoundly our understanding of self images and self concepts. "Television magnifies. There is an immediate intimacy and powerful confrontational impact from seeing the closeup of a portion of the face, or of hands anxiously twisting a Kleenex or matches, or of someone

unconsciously taking off and putting on alternately her marriage band while talking about the difficulties in her marriage". (9,55)

Kaswan and Love also write favorably about the value of videotape replay as self confrontation. They state: "The videotape appears to be the most comprehensive form of objective confrontation because it presents information about the self more completely, directly and concretely than other media and also permits easy repeatable verification of information through immediate replay". (37,225) However, these authors are aware of possible shortcomings of this method as indicated by the following statement: "Formulations involving confrontations have been developed within different settings for a variety of purposes and in a multiplicity of conceptual frameworks". New conceptualizations of the change process are required to understand the use of interventions such as videotape feedback. (37,225) The impact of the process of viewing oneself is not certain.

Alger describes two specific events which may be examined by videotape replay; the first is contradictions in communication. He says, "Communication occurs on many levels and is conveyed over many channels, including word content, tonal quality, context, gesture and mannerisms". (2,34) When contradictions occur simultaneously, for example, a scowl accompanying kind words, the stage is set for double bind behavior. The second event, the "second chance" phenomenon, is related to different levels of communication, one of which the client may not be aware. His example is of a man who sat unmovingly when another beside him cried in a group session, but in the videotape playback he began to cry himself saying he was unable to expose his feelings in the original group

session. In a similar group session, Alger reports that the videotape feedback clarified non-verbal rejection and in another case clarified an attempt of a group member to control the group. It may be concluded that perhaps the greatest value of the videotape playback is that the participants have the opportunity of taking more responsibility for themselves. (2)

The Videotape Used for Interpersonal Process Recall

The videotape is also used for Interpersonal Process Recall to facilitate therapy and counselor training. The purpose of Interpersonal Process Recall is to help the patient and the counselor trainee to become more aware of their feelings as they were during the interview, and to understand the content of the interview. Kagan et al describe their findings of Interpersonal Process Recall as used at Michigan State University for more than 5 years. (35)

The role of the recall person is as follows: this person is one who observes the interview between counselor and client; following the interview the counselor leaves and the recall worker and client observe the videotape feedback, either together or separately and then discuss the tape. The function of the recall worker is to keep the patient focused on the feelings and content of the interview, <u>not</u> to establish a relationship with the patient. "Because he limits his clinical function to actively probing the immediate past, the name 'interrogator' was selected to describe his role." (35, 366-367)

Kagan says that some have felt that if the counselor is competent he can serve as the interrogator. Kagan suggests that the counselor

would tend to avoid in recall the same areas he did not attend to in the interview; also that patients have difficulty expressing their feelings about their counselors directly to them.

The major effort in the training of the interrogators is directed towards developing the trainees' sensitivity in recognizing verbal and non-verbal cues. This is done by videotape replay. The trainee is asked to identify places where he would stop the interview for discussion and to explain why he chose to stop at that point.

Bodkin reports that at the Mental Research Institute in Palo Alto, California, videotape is used in training family therapists. (17) The videotape is used early in therapy and it is used overtly. The playback follows immediately after the taping of the interview. The family therapy trainee, the supervisor, and sometimes the family are present in this supervisory process.

Bodkin finds that patterns of response are made apparent by videotape replay. For example, when thirty-four trainees underwent a five-minute self-presentation for supervisory purposes, one of the participants appeared to act her role, as opposed to being herself. She was given a paradoxical instruction to behave naturally. After an initial resistance to change, she was able to form a new pattern of behavior in therapy sessions which could be confirmed by the videotape recorder.

Bodkin indicates that it is important to observe each person's reaction to seeing himself in interaction with others. He asks members of families to write down answers to the following questions immediately following the videotape feedback, but before the discussion of same.

"(1) What did you learn about yourself from watching the replay?

(2) What did you learn about anyone else in the family?

(3) What did you learn about how you interact or relate to one another in terms of the whole family functioning together?" (12,260)

He suggests that first hand reports of people's experiences should be examined to develop theory concerning the use of videotape feedback.

Summary

What can we glean from the reports presented above? Primarily, there is a need for those of us who would be counselors to examine present practices and plan for change. Carkhuff and Berensen have developed a conceptual scheme for therapeutic communication which they call the core dimensions, and we will use this term hereafter. The core dimensions stress the therapist's ability to have a sensitive understanding of what therapeutic attitudes are, and not to diagnose or label. If the therapist can be empathetic, genuine, concrete and respectful of others, he is able to help promote change for the better.

Literature suggests videotape feedback is a potentially powerful agent for changing behavior, but that: (1) the use of videotape feedback is relatively untested; (2) there is little experimental work on testing the theoretical models of effectiveness; (3) videotape feedback should be accompanied by supervision to achieve the greatest effect; (4) new conceptualizations of the change process are needed to understand the use of interventions such as videotape feedback; (5) first hand reports of people's experiences should be examined to develop theory concerning the use of videotape feedback.

CHAPTER III

METHOD OF STUDY

The purpose of this study was to examine the effect of immediate video feedback on the interpersonal skills of nurses. Interpersonal skill was measured by two criteria: (1) a set of specific behavioral responses, developed by Parsons (47), and described below, and (2) the set of core dimensions of Carkhuff and Berensen, described in Appendix A.

The following hypotheses were tested:

(1) All students will improve in interpersonal skill in a situation which is supervised, independent of the effect of videotape feedback.

(2) Students who have immediate videotaped feedback of their interviews with patients will show more improvement than the students in the control group.

(3) Improvement in the set of specific responses will be accompanied by improvement in the core dimensions.

(4) The experience of receiving videotaped feedback in the clinical practice period will have a negative effect on the nurse initially and a positive effect later.

Definition of Terms

The specific set of behavioral responses by the student to the client were delineated as follows:

(a) Closure: a response by the student which has the effect of cutting off the other's current line of thinking. Closing responses terminate or sharply reduce the other's current level (complexity) of thinking.

(b) Verbal Reward: a response by the nurse that indicates to the other that his remark has merit. Such responses do not elicit further client talk and depict a judgement on the part of the nurse.

(c) Sustaining: a response which maintains the client's level of thinking. Sustaining responses invite the other to talk more about his ideas without raising the level of thinking required.

(d) Extending: a response which raises the level (complexity) of client thinking. Extending responses invite the pupil to continue talking and also raise the level of thinking required.

(e) Negative non-verbal: a response which is incongruent with the conversation at hand; for example, if the nurse laughs when the client says, "I am afraid I may die" or "they don't tell me anything".

(f) Positive non-verbal: a response which enhances the conversation at hand; for example, if the nurse nods her head to show that she is listening to the client.

Improvement in the measurement of responses was defined as a lesser number of closing and rewarding verbal responses and negative non-verbal responses and an increase in the number of sustaining and

extending responses. Improvement in the core dimensions was as defined in Appendix A.

Subjects

The nurses who took part in this study were being supervised in their development of interpersonal skill with patients. Supervision included defining of goals, use of a role model and use of process recordings. Two groups of five subjects were selected from a class of twenty nursing students enrolled in a course in Human Behavior at a local University. The members were all graduate registered nurses in the degree program of the School of Nursing. The groups were controlled in terms of work experience and age of the nurses. In both groups there were two subjects between forty and fifty years of age and three subjects between twenty-five and thirty-five. The study was conducted at one hospital in two consecutive six week periods.

Design of the Study

The hypotheses were tested as follows: The dependent variable (the students' interpersonal skill) was measured by two criteria: (1) a set of specific behavioral responses (defined earlier), and (2) the core dimensions of interpersonal skill (defined in Appendix A). The independent variable (the use of the videotape recorder for immediate feedback) was used to provoke change in the dependent variable.

The set of specific responses can be measured accurately according to results obtained by Birch's study. (11) The measurement of the Core Dimensions "present many limitations, most obviously a high degree of subjectivity on the part of the raters or judges. This subjectivity

could not be avoided even if it were undesirable". (20,5) However, the importance of the qualities it measures justifies its use. (21,333)

A trained videotape technician recorded the interview between nurse and client for three separate half hour sessions. A trained videotape behavioral analyst assisted the investigator in measuring the data.

Equipment

The videotape technician used a Sony AV 3600 Videotape machine and a Sony monitor (11 inch). Written permission of each patient and each doctor was obtained on special forms. See Appendix B.

Procedure

To test the hypotheses both groups of five students were individually videotaped for three one-half hour sessions while they were interviewing patients.

The experimental group was given immediate feedback by the videotape recorder, and their interpersonal skill was rated by the investigator and a trained behavioral analyst who used the two sets of measurements described earlier. The control group did not view the videotaped recordings of their interviews, but they were rated as described above.

The investigator collected data in ten minute behavior unit observations on each student at each interview. This provided a total of thirty minutes of behavior observation for each student in the three sessions. The use of a limited behavior sample is based on the assumption that the sample will be representative of the subjects

behavior in that setting, that in a given setting behavior tends to be patterned and that those patterns tend to recur. Insofar as the behavior sample is not representative, differences will be non-systematic, and therefore randomly distributed across subjects. Under ideal laboratory conditions, it would be desirable to obtain a more extensive sampling of subjects' behavior. This study however, was conducted under field conditions which made it impossible to obtain more than three videotaped interviews from each subject.

Preparation for Study

Initially the subjects involved in this study expressed a great deal of anxiety about the course requirements and the use of the videotape. They said they had come to University to learn "something new" and they were reluctant to spend time with patients that focused on their ability to show interpersonal skill. They repeatedly stated that they did not understand what was expected of them and they questioned how they could be evaluated. At the beginning of their clinical practice many were afraid and some were angry. Even though the students had volunteered to be videotaped, they expressed concern at being scrutinized. The instructor and the investigator spent considerable time listening to the students explore their anxiety. It was interesting that after they had been videotaped, they said how lucky they felt to have had the experience.

The chief of medical staff in one of the two hospitals used for the course refused to allow the videotape recorder to be used. In the other hospital the chief of staff was receptive to the use of the

videotape recorder and personally helpful by allowing his patients, if they agreed, to be videotaped without a telephone call to him in each instance.

As mentioned previously, it was necessary for the investigator to seek written permission from each doctor and each patient chosen by the nurses for interviewing and videotape recording of the interviews. Many doctors appeared interested in the experiment and the investigator spent considerable time discussing nurse/patient interviewing with them. Only one doctor openly opposed any "interference", as he saw it. The investigator also sought the patient's consent to being involved in the study. In some instances the doctors actually encouraged their patients to become involved in the study.

Many of the patients were apprehensive about being videotaped. Their responses to the investigator's request revealed conflicting attitudes. However, most of the patients were so eager to have "someone to talk to" that they agreed to be videotaped; but many expressed concern about what was expected of them and some stated "I have nothing to talk about".

It was necessary for the head nurse to agree that the patients chosen were suitable for videotaped interviewing. The nursing staff assisted the investigator in patient selection, although many were skeptical of the purpose of the interview. In time the staff nurses did express interest in the videotaping, and the investigator arranged for a few of the nurses to be videotaped and discussed the experience with them. In one instance a taping was shown to the head nurse groups.

The investigator considered that it was worthwhile to spend

time with the nursing staff in response to their curiosity. In this way interest in interpersonal communication was fostered, and hopefully the staff gained something from the experience which would be reflected in their contact with patients and students.

CHAPTER IV

RESULTS AND DISCUSSION

The data were collected on two scales by two non-participant observers. One scale measured four specific verbal responses as well as the positive and negative non-verbal responses of the students and the other scale measured the core dimensions of interpersonal skill.

The data will be presented and analysed as follows:

(1) On tables indicating the above measurements from the experimental and control groups in three sessions.

(2) Narrative explanation of numerical data appearing on the tables.

(3) Discussion of results and factors influencing results.

Presentation of Data

Table 1 shows the number of responses each subject gave during the periods measured by the observers. The numbers in the table represent the mean of the two observers' data. The mean scores of the two groups on each of the six responses in three sessions are also shown. For both groups there was an increase in the number of sustaining and extending responses, and a decrease in the number of closing and rewarding responses, between the first and the third sessions. The data obtained at the first session represents the base line measurement of responses for each of the groups. In the experimental group, responses were measured to obtain a base line before application of the feedback treatment.

Table 1

Number of Responses of Students of Three Interview Sessions for First Ten Minutes

Session 1

	Control Group						Experimental Group					
Student	A	B	C	D	E	Mean	F	G	H	I	J	Mean
closing	2	16	7	19	10	10.8	5	30	5	10	9	11.8
rewarding	-	3	2	1	1	1.4	-	3	1	-	2	1.2
extending	8	-	8	3	6	5.0	7	4	9	9	12	8.2
sustaining	2	-	2	-	-	0.8	1	-	-	2	-	.6
+non-verbal	6	1	10	1	2	4.0	13	3	9	6	10	8.2
-non-verbal	-	-	-	-	-	0.0	2	1	2	3	2	2.0

Session II

	Control Group						Experimental Group					
Student	A	B	C	D	E	Mean	F	G	H	I	J	Mean
closing	6	19	13	12	18	13.6	10	12	11	3	4	8.0
rewarding	-	1	1	1	3	1.2	1	3	4	-	-	1.6
extending	1	3	1	-	4	1.8	3	9	5	8	9	6.8
sustaining	9	-	-	-	5	2.8	-	-	-	-	3	0.6
+non-verbal	3	4	5	1	2	3.0	3	7	12	7	15	8.8
-non-verbal	-	-	-	-	1	0.2	-	-	2	-	3	1.0

Session III

	Control Group						Experimental Group					
Student	A	B	C	D	E	Mean	F	G	H	I	J	Mean
closing	3	11	5	2	6	5.4	5	11	8	5	3	6.4
rewarding	4	-	4	-	1	1.8	-	2	2	-	1	1.0
extending	2	3	1	11	7	4.8	6	17	13	15	10	10.2
sustaining	11	-	9	1	7	5.6	-	-	-	-	2	0.4
+non-verbal	6	3	2	-	1	2.4	9	10	9	3	7	7.6
-non-verbal	-	-	-	-	-	0.0	-	-	-	-	1	0.7

Table 2

The Core Dimensions

Measurement of Interpersonal Relationship Skill (See Appendix A) of Students for First Ten Minutes of Three Interview Sessions

Student	Control Group						Experimental Group					
	A	B	C	D	E	Mean	F	G	H	I	J	Mean
Session I												
Empathy	3	1	2.5	1	3	2.1	2	2	2.5	1.5	1.5	1.9
Respect	2.5	2	2.5	2	3	2.4	2.5	2	2.5	1	2	2
Genuineness	4	1	3	2	3	2.6	2	2	3	1.5	2.5	2.2
Concreteness	2	1	2	1	2	1.6	2	1	2.5	1.5	1.5	1.7
Session II												
Empathy	2	1	2.5	1	2.5	1.8	1	1.5	2	1.5	2.5	1.7
Respect	2.5	1.5	2.5	2	2	2.1	1	2	2	2	2.5	1.9
Genuineness	2	1	3	2	2.5	2.1	1	1.5	2.25	2.5	2.75	2
Concreteness	3	1	2	1	2	1.8	1	1.5	1.25	2	2.5	1.65
Session III												
Empathy	3	1	2.5	1.5	2	2	1.5	1	1	2	2	1.5
Respect	3	1	2.5	2	2	2.1	2	1.5	1	2	3	1.9
Genuineness	3	1	2.5	1.5	1.5	1.9	1	2.5	1	2.5	2.75	1.85
Concreteness	2.5	1	2.5	1	2	1.8	1.5	2	1	2	2.5	1.8

Table 2 shows the mean score of the observers' rating of the core dimensions for each subject. The items were rated on a scale from zero to 5. The mean scores at the two groups on each of the four core dimensions is also shown. The data obtained at the first session represents base line behavior for each of the groups. In the experimental group responses were measured to obtain a base line before application of the feedback treatment. For both groups totals for each of the dimensions at the three sessions indicate little or no change.

The data presented on Table 1 shows that in the first session each group had nearly the same number of closing and rewarding responses, but that individual differences in closing responses varied: the range in the control group was 2-19 and in the experimental group it was 5-30. Also, in the first session individual difference in the experimental group were greater than in the control group, one individual having three times as many closing responses as the person with the next nighest number of closing responses. Between the first and second sessions there was a marked difference between the two groups in the number of closing responses; the experimental group showed a sharp drop in number, about one-third, while the control group showed an increase of nearly one-quarter. This can be partly accounted for by the single drop in the number of closing responses by one individual in the experimental group. The number of sustaining and extending responses combined was greater in the experimental group in the first session, the base line. In the second session there was a slight decrease in the numbers of sustaining and extending responses for both groups. However, in the third session the group totals were nearly equal and showed an increase of about

one-half for the control group and one-third for the experimental group.

The experimental group consistently had a much larger number of positive non-verbal responses in each of the three sessions. They also had a slightly larger number of negative non-verbal responses in each session but these numbers decreased each session.

Individual differences were remarkable in two instances: one by a member in the control group who lowered her closing responses from 19 in the first session to 6 in the third session and increased her total of extending and sustaining responses from 3 to 12; and one by a member in the experimental group who lowered her closing responses from 30 to 11 and raised her total extending and sustaining responses from 4 to 17.

Measurement of the core dimensions for both groups of students in each of the three sessions showed a low total for each item, and no change in either group between the first and the second, or the second and the third sessions. The individual differences in each session varied only slightly. In the control group no subject improved in her score. In the experimental group two subjects showed a slight increase and two subjects showed a slight decrease in their scores. Computer results did not show any significant differences between the groups and therefore, are not shown.

The reliability of the results obtained through measurement of the core dimensions is questionable due to several factors. The shortness of the course, the lack of practice, and the inconsistency of patient contact are believed to be be deterrents to the subjects'

improvement in the core dimensions. There was little opportunity between interviews for subjects to modify their behavior following feedback. The small number of observation periods as well as the known subjectivity of the measurement scale used also must be considered as factors affecting reliability.

Conclusions

It may be concluded from analysis of this data that hypothesis 1 - namely, all students will improve in interpersonal skill in a situation which is supervised, independent of the effect of videotaped feedback - may be accepted on the results of the measurements of the response scale and rejected on the results of the measurements of the core dimensions scale. There is research evidence that the personal qualities of the core dimensions may be acquired even by lay people at a level comparable to that of qualified expert therapists in a 100 hour period. (21) Thus, it may be proposed that a longer period of time to learn and practice may have produced more positive results.

Hypothesis 2 - students who have immediate videotaped feedback of their interviews with patients will show more improvement than the students in the control group - must be rejected by the results on both scales. On the response scale the students in the control group rated the same as the students in the experimental group in the third session. Since the initial scores of the control group were lower than those of the experimental group, the control group increased their scores to a greater degree than did the experimental group. The results on the response scale may be partly explained by the fact that both groups of

students were receiving feedback from their process study recordings. Results of the measurements of the core dimensions showed that while neither group improved, neither group became worse.

Hypothesis 3 - improvement in the set of specific responses will be accompanied by improvement in the core dimensions - must be rejected. Neither group showed improvement in the measurements of the core dimensions although both groups improved in the response scale. Thus, it may be proposed that the acquisition of interpersonal skill required to improve in the measurement of specific responses need not be accompanied by the more slowly acquired changes in personal qualities.

Hypothesis 4 - the experience of receiving videotaped feedback in the clinical practice period will have a negative effect on the nurse initially and a positive effect later - may be accepted on the basis of observations of the instructor and the investigator. The nurses who received immediate feedback showed a great deal of anxiety over their initial interview. They were worried before the interview, about "What to say to the patient?", "How long do I have to talk?", "Will you tell me when it's over?". During the initial feedback period they sought approval from the instructor and expressed relief that "the ordeal was over". By the time of the third interview, the subjects were more relaxed and showed pride in having had the experience. The students in the control group, who were videotaped but did not have feedback, were more anxious before the first interview than the last. They knew they were not going to see their videotapes until the course ended and coped with this situation. Thus, it may be conjectured that the students in the experimental groups had a rewarding experience, and the students in

the control group were able to cope because of the strength of the supervisory process.

Other Evidence of Change

There were several factors which had a direct influence on the behavior of subjects in their interpersonal relationships. Initially, students in both groups were assigned to a patient for the purpose of developing a relationship. As part of the course they were required to tape record interviews which they subsequently analysed in writing. The analysis included the words spoken, the behavior expressed, and the subject's feeling at the time. The instructor read these process studies and wrote comments on them. In this way the students received feedback which could have influenced their subsequent behavior in the videotaped interviews; for instance, the nurses' frequent use of closing statements in the initial interviews was glaring and these decreased in both groups in the videotaped sessions.

Both groups of students participated in classroom discussion three hours weekly and in individual discussion with the instructor for one hour weekly. The groups were not held at the same time, one group's experience was six weeks before the other, but the experimental group was first and this meant that the instructor had six weeks practice with the experimental group before she worked with the control group.

The students expressed concern about their interviews being videotaped. Initially, they were anxious about "being watched" by the expert videotape technician, and the students in both groups tended to adopt rigid body posture. Their concerns decreased somewhat as they became aware that the technician was totally involved in filming the

interview, and their posture became more relaxed. However, the technician's expertise in focusing the camera on particular mannerisms became apparent to the experimental group when they viewed the replay. Consequently, in subsequent sessions, these students seemed to be attempting to control such behavior, for example, ring twisting.

During the replay the subjects pointed out their obvious ineffective behavior but were less likely to comment on strengths. However, they were also quick to rationalize or later deny much of their behavior that was unacceptable to them.

The nurses unanimously voiced their opinion that "it was good for them to see themselves on videotape". This raises the question of whether or not the attitudes of the instructor or the investigator influenced the nurses' opinions to any great extent. It was the expressed belief of both the instructor and the investigator that the experience would be rewarding for the nurses.

Some of the nurses had had no previous learning experience focusing on Interpersonal Relationships between nurse and patient, so that the course itself, in addition to the use of the videotape recorder, was threatening. As mentioned earlier, traditional nursing education has focused on techniques, often to the exclusion of attitudes and feelings between patient and nurse; and the nurses in both groups had all been graduated for more than six years. Also two nurses in both groups had been graduated for twelve or more years. Most of the nurses were aware that in their initial interviews, at least, they were uncomfortable "just sitting and talking to a patient"; they were used to "doing something" for the patient.

The course was short and concentrated, given in a six week period during which time the students were concurrently enrolled in one other intensive course. This heavy programme did not allow the nurses much time to absorb new ideas or to test and examine their attempts to change their behavior. They were required to spend thirty hours in the six-week period interviewing a patient. However, the short stay of the patients, usually about five days, limited the number of contacts a nurse could have with any one patient. Therefore, it was difficult for her to develop a relationship beyond a superficial level.

The investigator was aware that the personal lives of the subjects affected their capacity to become involved in interpersonal relationships. For example, one nurse experienced the event of a death in her family and stated that she was unable to communicate effectively with her patient. She said, however, that she learned from the experience the pathos of being unable to become involved with another.

The investigator proposes that circumstances beyond the control of the study may have influenced the results. It is suggested that feedback given by the process recordings aided the control group in improving their scores on the response scale. While the control group had far lower scores than the experimental group in the second session, the scores for both groups in the third session were nearly equal. During the interim between the second and third videotaped interviews, both groups received feedback steadily from their process recordings. The fact that the experimental group had their experience in the first six-week period created an advantage for the control group in terms of the instructor's increased expertise in guidance of the latter group.

The fact that the course in human behavior was compressed into a six-week period, and that the clinical experience was in a short-stay patient unit, are considered to be limiting factors in the study. Together with the pressure of other intensive courses and, in some instances, personal difficulties, the time available to students to reflect on videotape feedback, to become more objective, and to work on modifying their behavior between interviews was limited. The lack of continuity of contact with one patient restricted the student's opportunity to build on a previous relationship.

The literature reviewed suggested that the experience of being videotaped and receiving feedback produces anxiety in the participants. Such a reaction was observed in the study subjects. Their anxiety was compounded by their immersion in course material that was a departure from the traditional nursing education to which they were accustomed. Since no student in either group had practiced nursing for a period less than five years, the confrontation with behavior that was considered to be less than helpful to patients was presumably threatening to the nurse's image of herself as a competent practitioner. Feelings aroused by such confrontation possibly accounted for the strong tendency to rationalize or deny ineffective behavior. It may be conjectured that the low scores on the core dimensions scale were influenced by the anxiety of the subjects in an unfamiliar situation which threatened their self-esteem.

As a result of this study, the investigator concurs with a number of views expressed in the literature. The realistic feedback of the videotape confronts the subject with his exact behavior, and therefore induces cognitive dissonance that requires accommodation. The ability

of subjects to be objective and to focus on their own behavior varied and the need to preserve self-esteem was evident.

Despite the fact that none of the hypotheses of this study could be accepted, there was evidence of a different kind to suggest the value of using videotape feedback in developing human relationship skills. Toward the end of the study, the students in the experimental group focused more on their own interviewing behavior in discussion and rationalized unacceptable behavior less. By the third interview, most of the students seemed less preoccupied with themselves and were able to attend more to the patients. Many patients commented that they benefitted from the experience. As the study progressed, the students were more relaxed and most stated that the experience was valuable in that they were able to see themselves as they actually performed. Some indicated that they intended to use videotape recordings in teaching students in the future.

CHAPTER V

RECOMMENDATIONS FOR FURTHER STUDY

Earlier in this thesis it was noted that nurses are unclear concerning the ways in which they must develop if they are to be capable of forming therapeutic relationships. But literature reviewed in this study gives a theoretical framework for the helping relationships that generally is not yet well-studied, and in particular, not utilized by nurse-educators. To be more specific, the following recommendation is immediate from the discussion in the preceding chapters:

(1) That in schools of nursing continuous focus be placed on developing in students (and educators) the personal qualities, the core dimensions, of interpersonal skill.

There are indications that with regard to interpersonal transactions it is possible to raise the core dimension scores of lay persons to a level not significantly different from those of experts. (21) Under similar conditions it is expected that nurses would also obtain this high level of functioning. It would, therefore, be worthwhile to know whether or not this high standard of competence is retained; and if not, what sort of periodic enhancement techniques are appropriate? The following recommendation is directed at an attempt to exploit this curious phenomenon.

(2) That early in the nursing curriculum the core dimensions of student nurses be tested, augmented as indicated above, and then periodically be re-examined and, where necessary, refreshed through the remainder of the program.

Once a nurse has completed such a program, it would be nearly imperative that this continual reassessment become a largely self-guided procedure. In this direction, research evidence suggests the value of videotaped feedback as giving more complete and accurate information, to both supervisor and trainee, than written process studies and audiotapes which are the usual methods of assessing nurse-patient interactions. (42) Videotape self-viewing provokes self-awareness and has been found valuable in achieving objectivity towards oneself and in fostering a change in the participant's behavior. (42,33) For example, videotaped feedback makes apparent patterns of behavior of the participant, and allows him to practice change and view the modification of his behavior. (17)

Therefore, in relation to the videotape recorder the investigator proposes:

(3) That the videotape recorder be used as a method of giving feedback to the student nurse early in her education, and continued throughout, for learning interpersonal as well as manual skills.

(4) That the videotape be used as a method of giving feedback to practicing graduate nurses and nurse educators.

Of course, it is paramount that measurement of improvement in a nurse's skill be examined from the point of view of what is best for the patient. The ultimate evidence that the nurse is effective is that the patient benefits. This is the key goal in patient care and is often obscured by nurses' efforts to improve themselves.

APPENDICES

APPENDIX A

RATING SCALES FOR ASSESSMENT OF INTERPERSONAL FUNCTIONING

RATING SCALES FOR ASSESSMENT OF INTERPERSONAL FUNCTIONING

SCALE 1

Empathic Understanding in Interpersonal Processes

Level 1

The verbal and behavioral expressions of the first person either do not attend to or detract significantly from the verbal and behavioral expressions of the second person(s) in that they communicate significantly less of the second person's feelings than the second person has communicated himself.

Examples: The first person communicates no awareness of even the most obvious, expressed surface feelings of the second person. The first person may be bored or uninterested or simply operating from a preconceived frame of reference which totally excludes that of the other person(s).

Level 2

While the first person responds to the expressed feelings of the second person(s), he does so in such a way that he subtracts noticeable affect from the communications of the second person.

Examples: The first person may communicate some awareness of obvious surface feelings of the second person, but his communications drain off a level of the affect and distort the level of meaning. The first person may communicate his own ideas of what may be going on, but these are not congruent with the expressions of the second person.

Level 3

The expression of the first person in response to the expressed feelings of the second person(s) are essentially interchangeable with those of the second person in that they express essentially the same affect and meaning.

Example: The first person responds with accurate understanding of the surface feelings of the second person but may not respond to or may misinterpret the deeper feelings.

Level 4

The responses of the first person add noticeably to the expressions of the second person(s) in such a way as to express feelings a level deeper than the second person was able to express himself.

Example: The facilitator communicates his understanding of the expressions of the second person at a level deeper than they were expressed, and thus enables the second person to experience and/or express feelings he was unable to express previously.

Level 5

The first person's responses add significantly to the feeling and meaning of the expressions of the second person(s) in such a way as to (1) accurately express feelings levels below what the person himself was able to express or (2) in the event of on-going deep self-exploration on the second person's part, to be fully with him in his deepest moments.

Examples: The facilitator responds with accuracy to all of the person's deeper as well as surface feelings. He is "together" with the second person or "tuned in" on his wavelength. The facilitator and the other person might proceed together to explore previously unexplored areas of human existence.

SCALE 2

The Communication of Respect in Interpersonal Processes

Level 1

The verbal and behavioral expressions of the first person communicate a clear lack of respect (or negative regard) for the second person(s).

> Example: The first person communicates to the second person that the second person's feelings and experiences are not worthy of consideration or that the second person is not able to act constructively. The first person may become the sole focus of evaluation.

Level 2

The first person responds to the second person in such a way as to communicate little respect for the feelings, experiences, and potentials of the second person.

> Example: The first person may respond mechanically or passively or ignore many of the feelings of the second person.

Level 3

The first person communicates a positive respect and concern for the second person's feelings, experiences, and potentials.

> Example: The first person communicates respect and concern for the second person's ability to express himself and to deal constructively with his life situation.

Level 4

The facilitator clearly communicates a very deep respect and concern for the second person.

> Example: The facilitator's responses enables the second person to feel free to be himself and to experience being valued as an individual.

Level 5

The facilitator communicates the very deepest respect for the second person's worth as a person and his potentials as a free individual.

> Example: The facilitator cares very deeply for the human potentials of the second person.

SCALE 3

Facilitative Genuineness in Interpersonal Processes

Level 1

The first person's verbalizations are clearly unrelated to what he is feeling at the moment, or his only genuine responses are negative in regard to the second person(s) and appear to have a totally destructive effect upon the second person.

> Example: The first person may be defensive in his interaction with the second person(s) and this defensiveness may be demonstrated in the content of his words or his voice quality. Where he is defensive he does not employ his reaction as a basis for potentially valuable inquiry into the relationship.

Level 2

The first person's verbalizations are slightly unrelated to what he is feeling at the moment, or when his responses are genuine they are negative in regard to the second person; the first person does not appear to know how to employ his negative reactions constructively as a basis for inquiry into the relationship.

> Example: The first person may respond to the second person(s) in a "professional" manner that has a rehearsed quality or a quality concerning the way a helper "should" respond in that situation.

Level 3

The first person provides no "negative" cues between what he says and what he feels, but he provides no positive cues to indicate a really genuine response to the second person(s).

> Example: The first person may listen and follow the second person(s) but commits nothing more of himself.

Level 4

The facilitator presents some positive cues indicating a genuine response (whether positive or negative) in a nondestructive manner to the second person(s).

> Example: The facilitator's expressions are congruent with his feelings, although he may be somewhat hesitant about expressing them fully.

Level 5

The facilitator is freely and deeply himself in a nonexploitative relationship with the second person(s).

> Example: The facilitator is completely spontaneous in his interaction and open to experiences of all types, both pleasant and hurtful. In the event of hurtful responses the facilitator's comments are employed constructively to open a further area of inquiry for both the facilitator and the second person.

SCALE 4

Personally Relevant Concreteness or Specificity of Expression in Interpersonal Processes

Level 1

The first person leads or allows all discussion with the second person(s) to deal only with vague and anonymous generalities.

> Example: The first person and the second person discuss everything on strictly an abstract and highly intellectual level.

Level 2

The first person frequently leads or allows even discussions of material personally relevant to the second person(s) to be dealt with on a vague and abstract level.

> Example: The first person and the second person may discuss the "real" feelings but they do so at an abstract, intellectualized level.

Level 3

The first person at times enables the second person(s) to discuss personally relevant material in specific and concrete terminology.

> Example: The first person will make it possible for the discussion with the second person(s) to center directly around most things that are personally important to the second person(s), although there will continue to be areas not dealt with concretely and areas in which the second person does not develop fully in specificity.

Level 4

The facilitator is frequently helpful in enabling the second person(s) to fully develop in concrete and specific terms almost all instances of concern.

> Example: The facilitator is able on many occasions to guide the discussion to specific feelings and experiences of personally meaningful material.

Level 5

The facilitator is always helpful in guiding the discussion, so that the second person(s) may discuss fluently, directly, and completely specific feelings and experiences.

> Example: The first person involves the second person in discussion of specific feelings, situations, and events, regardless of their emotional content.

APPENDIX B

CONSENT RE PHOTOGRAPHS, MOTION PICTURES, SOUND RECORDINGS AND TELEVISION

CONSENT RE PHOTOGRAPHS, MOTION PICTURES, SOUND RECORDINGS AND TELEVISION

In the interests of medical science and health sciences education, the members of the staff, employees and agents of the University and persons or corporations authorized by the University, are hereby authorized without payment of any remuneration to the undersigned or myself, to take or cause to be taken, to exhibit or cause to be exhibited, to edit or cause to be edited, including publication in scientific or professional publications and telecasting over open or closed circuit television, for scientific or educational purposes only, such still photographs, motion pictures, sound recordings and live or recorded television pictures of or relating to my

.............................., ...,
(self, son, daughter, etc.) (print name of patient)

before, during and after treatment, as may be approved by the said patient's physician, Dr. ....,
(print name)

Signed at................................this......day of

......................., 19 .

Signed..................................

Address.................................

....

If the patient is under the age of
21, have parents or guardians sign.....................

Witness.............................

Address.............................

....

APPROVED:

Patient's Physician....................

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