The Interpretive Research Group as an Alternative to the Interpersonal Process Recording

By: Mona M. Shattell, Beverly Hogan, and Alison Ray Hernandez

***Note: Figures may be missing from this format of the document**

Abstract:
In the spirit of trying something new, we abandoned the traditional interpersonal process recording for an entirely new way to teach students about communication-an interpretive research group. We propose the interpretive research group as a strategy for teaching communication and analysis that encourages active student-faculty participation, provides for more egalitarian student-teacher relationships, and creates a liberating learning environment.

Article:
If You've Always Done It That Way, It's Probably Wrong.
                              ~Charles F. Kettering

Charles F. Kettering (1876-1958), the author of our opening quote, was one of the great innovators. Because of Kettering's inventions, we start our cars with the simple turn of a key (instead of a hand crank), we have Freon for refrigeration and air conditioning, and we have the option of automatic transmissions in automobiles. Kettering believed in change, in trying to do things differently, even if the new way was not yet perfect. In the spirit of trying something new, we have abandoned the traditional interpersonal process recording for a new way of teaching students about communication-the interpretive research group.

Interpersonal Process Recording
Psychotherapy Education
The date of first use of the interpersonal process recording is not known; however, taped and transcribed student-client interviews were used as early as the 1920s and 1930s to train psychotherapists.[1] In the 1940s and 1950s, the Rogerian school of psychotherapy recognized that students needed to practice and learn specific interviewing skills,[2,3] and the transcribed interview was seen as an objective way to instruct and evaluate student behavior.[1] These process recordings were generally remembered by students and mentors because they tended to be laborious yet produced profound insights.[4]

Nursing Education
The interpersonal process recording first appeared in the nursing literature in 1955 in an article by Bernice Hudson, who described "the nursing process record" as "a fairly new teaching device which holds considerable promise in nursing."[5(p224)] The process record is a student's written verbatim account of as much as the student can remember of a student-patient interaction. The

student talks with a patient for an unspecified period of time, moves to a quiet area away from the patient to take notes on the interaction, and then later, more formally documents and analyzes the interaction. Hudson's nursing process record had consisted of 3 components: (1) the conversation between student nurse and patient, (2) the student's comments, and (3) the instructor's comments. The purpose of the process record was to "help the student develop her [sic] skill to meet people's needs, and to accomplish this in a short time. This device also helps her to recognize clues which will guide her to meet her patients' needs better-to listen, to study what she did, and to figure out how the thing she did 'worked'."5[(p224)]

Hudson noted that, "The instructor and students have a conference after both have studied the process record individually. Insight, understanding, and possible action are the results they hope to get."5[(p224)] Similarly, Nehren and Batey 6 noted that "in individual conferences with the instructor, the student is given the opportunity, which she [sic] needs, to express verbally the interaction that has occurred between herself and her patient. In reliving the interaction, she again analyzes the total communication process. Through guided discussion, she is assisted to grow from her independent analysis of the interaction toward insights and approaches to interaction beyond her previous awareness."6[(p71)] Nehren and Batey 6 thought that early learning about interpersonal communication must be guided by the instructor and posited that "a learner's continued growth in interpersonal relationship skills is dependent [emphasis added] upon the supervision that she [sic] receives in the use of the process recording."6[(p70)]

Faculty in graduate programs in psychiatric/mental health nursing may still provide this type of clinical supervision, but in our experience, supervision is no longer provided to undergraduate students. Faculty members who use the process recording as a teaching strategy tend only to write comments and provide a grade for the assignment, without the formal conference, discussion, and active learning that occur in formal clinical supervisory sessions. The face-to-face, in-depth analysis by student and teacher was probably the most valuable part of the experience, and in our view, its loss greatly reduces the value of the exercise.

Changes in healthcare delivery have also decreased the effectiveness of the interpersonal process recording. One such change is in the ability to audiotape student-patient interactions. Seeing a video or listening to a recording of an interaction with a client 7 has long been used as a way to improve communication skills.

In the current healthcare climate, however, recordings are prohibited, leaving students to rely on memory alone. Yet, human memory tends to fill in memory gaps with information that seems to fit.8 This is well known among experts in psychology, law, and criminal justice.9,10 It is difficult for students to hone in-depth interactions with psychiatric patients. The anxiety of knowing that verbatim recall is expected is added to the anxiety on talking with patients. Furthermore, issues of social desirability may result in confabulation: Students may write what they think the teacher wants to hear, portraying themselves in a favorable light and providing absolutely no basis on which to evaluate communication skills. Nurse educators may say, "Well, they still learn because they have to think about what would be appropriate communication." However, encouraging the construction of interactions offers a lesson in fabricating data, an unethical and potentially dangerous practice.

Fifty years after it was first introduced in nursing, we still assign the interpersonal process recording envisioned by Hudson,[5] Nehren and Batey,[6] and Peplau,[11] although in a diminished version. No research has shown that the process recording actually produces the desired effects-ability to communicate and to analyze verbal interactions. One study of nursing students' interpersonal skills actually showed an inverse relationship between good interpersonal skills and time in nursing school.[12] The more nursing education the students had, the worse their communication skills became. The interpretive research group is an alternative to the interpersonal process recording.

The Interpretive Research Group as a Teaching Strategy
Background
The first author (Shattell) was exposed to an interpretive research group during her doctoral studies at the University of Tennessee, Knoxville. The interdisciplinary group was led by Drs Sandra Thomas (nursing) and Howard Pollio (psychology) and met once a week throughout the calendar year. Graduate and undergraduate students and faculty from a wide variety of departments attended. Students and faculty from nursing, psychology, education, romance languages, and sports management were the regular attendees in the group. Each week, they participated in a line-by-line interpretive analysis of a transcript from one of the various studies that the group members were conducting, including patients' experience soliciting nursing care,[13] African American male athletes' experience of racism in sports,[14] and women's experience of child-birth-associated anger.[15]

When the first 2 authors (Shattell and Hogan) began working on a study of medical-surgical patients' experience of the hospital environment, they replicated the research group and noted the potential utility of the data analysis process for undergraduate students in a psychiatric/mental health nursing course. Shattell and Hogan believed that similar skills are developed for both interpreting research interviews and for analyzing verbal nurse-patient interactions.

We pilot tested the strategy with a small group of undergraduate students and held four 3-hour groups to analyze interview transcripts from the study of medical-surgical patients' experience of the hospital environment.[16] Surprisingly, the students actively contributed and were often quite insightful in their interpretations and discussions of the interview transcripts. After receiving overwhelmingly positive student feedback on the group process, we implemented the interpretive research group as a clinical requirement for our students.

Implementation
Planning
At the beginning of each semester, we describe the interpretive research group method to students during clinical orientation. We schedule as many groups as necessary to allow each student to attend at least 2 group sessions during the semester. Each research group is planned so that it includes students from each of our clinical groups because it is beneficial for students to have an opportunity to get to know each other in the context of the group (and to get to know a teacher who is not their assigned clinical instructor). Both of us gain "psychic income" from the group and therefore, we both almost always attend (although this is not necessary). Also, when both of us are there, students gain an added benefit from observing 2 teachers engage in scholarly dialogue and debate.

Location

The interpretive research group is held at a local coffeehouse in a private room we reserve at the beginning of each semester. During our pilot test of the group, we tried various settings (classroom, conference room, and coffeehouse) and students "voted" the coffeehouse the best site. Students enjoyed the informal atmosphere and "getting away from campus." The coffeehouse environment also broke down the hierarchical power structure inherent in a traditional classroom or on-campus conference room.

Advantages

The interpretive research group has several advantages over the interpersonal process recording in teaching communication skills. The group analyzes the transcripts of interviews with real patients (research participants) conducted by real psychiatric/mental health nurses. The analysis is done in a small-group format with 1 or 2 faculty members who guide the discussions of communication strategies, meanings, and interpretation. In addition, students learn about group process and gain a greater understanding and appreciation of research. The interpretive research group is a liberating environment in which students' opinions and ideas are valued. Through this teaching/learning activity, students discover themselves as collaborators and colleagues with one another and with the faculty.

Professional Practice and Social Justice Issues

Student participation in the group provides opportunities for open student-faculty, student-student, and faculty-faculty discussions of various issues. For example, patient experiences (transcripts) have inspired students to think about and discuss issues such as "How do I maintain the caring attitude that I have today?" and "How do I avoid turning into one of those burned-out nurses I see all the time in clinical?"

Transcripts have also triggered discussions of racism, classism, and homophobia as well as ethical issues and value conflicts. For instance, during one group session, several students reacted strongly to the interviewee's substance abuse problem. Several students made negative comments on people who abuse drugs. One student said "Drug addicts get what they deserve." The instructor (Hogan) then directed the discussion to the students' reactivity and the ways in which patient care is affected by value judgments. Most students acknowledged their need to work on their feelings; however, the student who had been so emphatic about "drug addicts getting what they deserve" reiterated her feelings on the matter, although with less intensity.

The reading of the transcript continued for several minutes, then the instructor noticed that a loquacious student had become quiet, and she held her head down and avoided eye contact with the group members. When the instructor made eye contact with her, the student began to painfully tell her a story. She told the group that her 21-year-old brother was in the hospital in the intensive care unit due to a motor vehicle accident related to drugs and alcohol. She said tearfully that her brother might not survive. She then went on to tell the group to remember that they were not immune to, or isolated from, substance abuse because it could happen to anyone. The students, especially the most reactive of them, apologized and expressed their condolences.

Sadly, the student's brother died a few weeks later. After his death, the student reported that the other students in the class were genuinely supportive of her. The most negatively reactive students from that particular interpretive research group organized the entire class in support of the student. The lessons learned by all who participated in the group that day were not forgotten.

The interpretive research group could be useful in various courses. Students in introductory nursing courses could benefit from learning about communication in the nonthreatening group atmosphere. Beginning nursing students could learn to analyze and interpret transcripts of interviews conducted by experts using appropriate communication. Conversely, the interpretive research group is also appropriate for doctoral students. We have had several doctoral students participate in our group as part of a fieldwork requirement for their qualitative research methods course, to gain hands-on experience working with qualitative data. Doctoral student feedback was positive; students reported that the group "made what I'm learning in class really come alive" and "it made abstract concepts real." An added benefit for undergraduate students was the opportunity to interact with doctoral students, rather than viewing them from afar, if at all, with the thought, "I could never get a PhD."

Disadvantages
Some disadvantages accompany the interpretive research group strategy. One weakness is that the group does not directly evaluate students' actual communication skills. However, student-patient communication can easily and perhaps more effectively and efficiently be evaluated by observing face-to-face student-patient encounters in the clinical setting. Feedback can be given to the student immediately, and the student-patient interaction can be analyzed by the student and faculty member collaboratively.17

Another drawback to the interpretive research group is that it takes substantial faculty time because groups are small and held frequently over the semester. Faculty members may not want to spend the additional time with students that this strategy requires. However, from our experience, analyzing verbatim transcripts with students in a group is much more enjoyable than grading interpersonal process recordings.

Finally, faculty members who are not engaged in qualitative research may not have access to the interview transcripts that are most appropriate for this type of teaching/learning. One way to acquire transcripts for educational use is to incorporate student-to-student audiotaped interview assignments. Students could interview each other regarding some common phenomenon, for example, the student's experience of nursing school or the student's experience of caring. The student interviewer would transcribe the interview for subsequent analysis in the interpretive group. This method of attaining transcripts would also help the faculty member directly evaluate individual students' communication skills and build a "bank" of transcripts which faculty could later draw upon (with student consent).

We believe that the interpretive research group is an excellent way to teach students about communication, analysis, interpretation, research, and human experience in an active, participatory environment that is conducive to open, respectful dialogue. Below, one of our former interpretive research group members (Hernandez) presents the student's perspective.

Student Perspective

When I (Hernandez) signed up for the interpretive research group, I was not sure what to expect, but I was excited about the prospect of earning clinical hours at a coffeehouse. This type of analytical discussion was a new experience for me, and I found it interesting and beneficial. I enjoyed the opportunity to talk openly with my professors and other students about some of the more abstract aspects of patient care, such as therapeutic communication. Although communication techniques had been presented in lecture and in the textbook, I had difficulty conceptualizing what therapeutic communication looked like in practice, particularly because most nurses I had encountered in my clinical rotations did not model this behavior.

We went through the transcripts of interviews with patients, slowly focusing on a few lines at a time. We were taking the time to listen to every word that was said and to understand what the speaker meant. We volunteered our interpretations and were often asked to elaborate and explain our positions. However, the professors were not looking for right or wrong answers. Instead of feeling like we were being quizzed, we felt that the professors were genuinely interested in hearing our ideas. Our ideas were taken seriously. We also looked closely at the communication techniques used in the interviews, observing how the interviewer engaged the patient by asking clarifying questions (eg, what do you mean by x?) and by referring to things the patient had mentioned earlier so the patient would know that the interviewer was really listening.

The transcripts we read were part of a study that focused on understanding the patient's experiences with mental healthcare providers. I found this content very useful. As we recognized recurrent themes in the transcripts, we began to develop a more concrete idea of the important aspects of therapeutic communication. Hearing patients' perspectives on positive and negative experiences with healthcare providers also gave me a stronger sense of how important communication skills are in my role as a nurse.

Discussion

Today, nurses report less time for the interpersonal aspects of care and often find themselves taking a very task-oriented approach to care. Patients are dissatisfied with the lack of interpersonal connection and frequently report feeling that clinicians are not listening to them [16,18,19] even in psychiatric nursing, nurses report spending less time interacting with patients in settings where this is a primary goal.[20]

As practice environments change, nurse educators need to use the most effective educational methods. The interpretive research group takes the most significant elements of the interpersonal process recording-open faculty-student discussion and analysis of actual transcripts of audiotaped interviews-and uses them as a forum for teaching/learning about interpersonal communication. The interviewer is an expert in interpersonal communication and can guide students through the analysis. At the same time, students learn that teachers are not infallible. Students offer suggestions and feedback on the teacher's communication techniques, which is empowering for students who have been taught that teachers are "information disseminators"[21] and students are "empty receptacles."[22]

Conclusion

Interpretive research groups are small-8 to 10 students and 1 to 2 faculty members, and the groups offer a safe place for students to openly discuss values and issues as they arise. Students learn about group process and get excited about research. At the very least, they learn that they do not "hate research" after their experience with actual data. The research group is an energizing teaching/learning strategy for students and faculty alike.

Many learning activities and written assignments are required of students because they are conventional. Remember Kettering's words: "If you've always done it that way, it's probably wrong." The interpretive research group is a new way to teach communication and analysis that encourages active student-faculty participation, provides for more egalitarian student-teacher relationships, and creates a liberating learning environment.

References
1. Neuman KM, Friedman BD. Process recordings: fine-tuning an old instrument. JSoc Work Educ. 1997;33:237-243.
2. Covner J. Studies in phonographic recordings of verbal material. 1. The use of phonographic recordings in counseling practice and research. J Consult Psychol. 1942;6:105-113.
3. Rogers C. The use of electronically recorded interviews in improving psychotherapeutic techniques. Am J Orthopsychiatry. 1942;12:429-434.
4. Fox R, Gutheil I. Process recording: a means for conceptualizing and evaluating practice. J Teach Soc Work. 2000;20:39-55.
5. Hudson BC. The nursing process record. Nurs Outlook. April 1955;3:224-226.
6. Nehren JG, Batey MV. The process recording. Nurs Forum. 1963;2:65-73.
7. Sloan G. Audio recording nurse-patient interactions. Nurs Stand. April 2003;17:33-37.
8. Bartlett CF. Remembering (1932). Cambridge: Cambridge University Press; 1967.
9. Gonsalves B, Paller KA. Mistaken memories: remembering events that never happened. Neuroscientist. October 2002;8(5):391-395.
10. Loftus E. Our changeable memories: legal and practical implications. Nat Rev Neurosci. March 2003;4(3):231-234.
11. Peplau H. Talking with patients. Am J Nurs. July 1960;7:964-966.
12. Harrison T, Pistolessi T, Stephen T. Assessing nurses' communication: a cross-sectional study. West J Nurs Res. 1989;11:75-91.
13. Shattell M. "Nurse bait:" strategies hospitalized patients use to entice nurses within the context of the nurse-patient relationship. Issues Ment Health Nurs. 2005;26:205-223.
14. Lawrence SM. An examination of the African-American male athlete's experience of race in sport. Sociol Sport Online [serial online]. 2004;7. Available at: http://physed.otago.ac.nz/sosol/v7i1/v7i1.html .
15. Mozingo JN, Davis MW, Thomas SP, Droppleman PG. "I felt violated:" women's experience of childbirth associated anger. MCN Am J Matern Child Nurs. November-December 2002;27(6):342-348.

16. Shattell MM, Hogan B, Thomas SP. It's the people that make the environment good or bad: the patient's experience of the acute care hospital environment. J Am Assoc Crit Care Nurs Adv Pract Acute Crit Care. 2005;16:159-169.

17. Baker J, Pelto C, Wittman E. An alternative to process recording. Nurs Outlook. February 1976;24:115-118.

18. Shattell MM. "Eventually it'll be over:" the dialectic between confinement and freedom in the phenomenal world of the hospitalized patient. In: Thomas SP, Pollio H, eds. Listening to Patients: A Phenomenological Approach to Nursing Research and Practice. New York, NY: Springer; 2002:214-236.

19. Thomas SP, Shattell MM, Martin T. What's therapeutic about the therapeutic milieu? Arch Psychiatr Nurs. 2002;16:99-107.

20. Cleary M, Edwards C. "Something always comes up:" nurse-patient interaction in an acute psychiatric setting. J Psychiatr Ment Health Nurs. December 1999;6:469-477.

21. Hall J. Dispelling desperation in nursing education. Nurs Outlook. 2004;52:147-154.

22. Freire P. Pedagogy of the Oppressed. New York, NY: WW Norton & Co; 1971.