Same view but different language

Perceptions of nurse-client interactions

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Abstract - **A video-review procedure was used to compare observations of three groups – nurses, clinicians and lay people – on quality of interactions between nurses and clients with mild ID. First, participants watched a compilation of short video-samples of nurse-client interactions and indicated whether the interaction had "gone well" or "less well". Second, they explained their reasons for these choices. Reviews were audiotaped and transcribed verbatim. Groups described similar reactions to what they saw, but expressed their views in different language. However, nurses and clinicians made more recommendations than lay people about how the nurse-client dyads might improve their interactions. Training/experience might not have as strong an influence on people's perceptions of nurse-client interactions as expected. Use of different language/jargon by different groups to describe the same events, has the potential to create misunderstandings about each other's perspectives and has implications for professional training.**

Keywords: nurses; interactions; clinical experts; lay group; training; perception

I INTRODUCTION

People with intellectual disabilities (ID) depend on the support of others in many aspects of their lives. Good quality interactions between nurses and people with ID are a vital part of this, underpinning effective learning, understanding and social relationships [1]. Nurses often play a key role in the lives of people with ID and, for this reason, much thought and effort goes into promoting good interactions between people with ID and nurses [2, 3]. Yet this assumes that there is a common understanding or perception of what might be a good interaction between nurses and people with ID.

A common finding among studies assessing the nature of interactions between nurses and people with ID is that these interactions tend to be asymmetrical and not tailored to the communication needs of clients. McConkey *et al.* [4] found that nurses tended to use verbal and directive communication strategies and failed to adjust their language to the client's level of understanding. They concluded that nurses could further improve their strategies, for example, by increasing their use of nonverbal signals and using simpler sentences, to engage clients as equal conversation partners. Bradshaw [5] also reported a mismatch between the communication styles of nurses and the communication needs of their clients. Conversational analysis of interactions between nurses and clients in residential homes by Antaki *et al.* [6, 7] and Reuzel *et al.* [8] showed that nurses tended to initiate, lead and direct the conversation. For example, they used language styles that assumed greater degrees of impairment than necessary and there was a lack of encouragement for clients to express their own views regarding daily choices. These studies provide important insights into the nature of interactions between nurses and people with ID. However, the problems identified are not necessarily due to a lack of nurse skills, and may also be due to the difficulties nurses face when trying to find a balance between helping people to express their views and providing guidance [6, 7].

If nurses have to make nuanced judgments

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about how to maintain good communication with people with ID, then one might expect this is something that would develop with experience or training. In turn, this might lead one to ask how nurses perceive interactions with people they support and how they assess whether or not the interactions are going well. Antonsson *et al*. [9] interviewed nurses about their views on their own interactions with clients with ID. Nurses clearly differentiated between successful and unsuccessful interactions and indicated themes they considered important in successful interactions, such as understanding cues and satisfying needs. The immediacy of social interactions requires quick assessments and prompt responses and nurses can provide an 'insider-view' of what they observe and act upon during these encounters, giving insights into this more intuitive type of knowledge. Clients are seen by different practitioners, such as nurses and psychologists, in different contexts and the pooling of their intuitive opinions offers a potentially helpful source of information in efforts to assist and nurses in attaining good quality interactions. How do practitioners recognise whether an interaction has gone well or not and on what criteria do they base their opinions? Perceptions of effectiveness are not so clear in ID and tapping into experienced nurses' intuitive understanding might assist this. However, this begs the question of whether nurses' views of interactions, which people do intuitively in their everyday lives, would be different from those of a lay person. Would video examples of nurse-client interactions be reviewed differently by people who are not trained, or would the essential components be similar?

A useful method that helps to exploit intuitively acquired knowledge is the Burford Reviewing Process (BRP), which has been proven to be effective in tapping into the intuitive knowledge and experience of practitioners, nurses and clients [10, 11]. In this procedure, participants are invited to watch a series of videos in two stages. In the first stage, participants are asked to give their immediate impression about what happened on the tape, by marking the places that catch their attention. They are not asked to talk about their selections during the first stage. In the second stage, participants are invited to review all their selections and describe the events on the video that prompted them. In the BRP it is important that investigators should make no assumptions regarding the responses of participants and should record, but not discuss, their comments. The rapport between the researcher and the observer is a key factor in the review sessions and it is important that the procedure is carried out in a nonjudgmental atmosphere.

Using an adapted version of the BRP to review videotaped nurse-client interactions, the present study set out to compare the views of three different groups of participants, 1) nurses, who had daily experience with people with ID, 2) clinicians, who had extended training and counselling experience with people with ID, and 3) lay participants, who had no experience in the field of ID or related care. The aim of the present study was not to identify the factors contributing to successful communication exchanges. Rather, we aimed to investigate how different groups of people view interactions between nurses and people with ID.

II MATERIALS AND METHODS

Participants

Eighty-four participants were invited to review the videos. Participants were divided into three groups (28 in each group): nurses, clinicians and a group of lay people.

Nurses (Ns). All participants in this group (21 women, 7 men) were working as nurse in residential homes and daycare centres for people with ID and cared for at least one client with severe forms of challenging behavior. The severity of the challenging behavior was based on the Dutch Protocol Severity of Challenging Behavior (CB). In this protocol nurses and therapists rate the frequencies and impact of different, particular forms of CB (e.g., screaming, hitting others, throwing objects), resulting in an overall indication of CB severity). Working experience ranged from 1 to 22 years (Mdn = 8, M = 9.1, SD = 5.7) and median age was 35 years (SD = 11.3, M = 36.7, range 19 – 56). Their clients' chronological ages ranged between 15 and 50 years. All nurses were familiar with clinical diagnoses of clients, e.g. autism, ADHD, personality disorders and attachment disorders.

Clinicians (CL). This group (23 women, 5 men) included clinical psychologists, case managers and behavior therapists with a related academic degree. All clinicians worked for the Dutch Centre for Consultation and Expertise, which provides specialised advice on clients with ID and challenging behavior to Dutch healthcare institutions. Working experience ranged from 8 to 37 years (Mdn = 21.0, M = 22.0, SD = 7.4) and median age was 50 years (M = 48.2, SD = 6.0, range 36 – 59).

Lay group (LG). Participants in this group (16 women, 12 men) had no experience of working with people who have ID. Occupations varied considerably (e.g. mailman, architect, painter, project manager in the building industry) and education levels ranged from vocational training to University master's degree. The median age in this group was 31.5 years (M = 35.5, SD = 12.8, range 20 – 59).

Nurse-client pairs. 20 Nurse-client pairs from Amarant, an institute for people with ID in the Southern Netherlands, participated in the

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videotaping of daily interactions. Amarant also funded the research. Ten nurses had more than 7 years' working experience and ten had less than 2 years' working experience. Both sets had an equal number of male and female nurses, a random distribution of nurse age and a random distribution of client age. Borderline, mild and moderate IQ scores of clients were derived from WISC-RN and Kaufman Intelligence Test assessments. Where no IQ scores were available, psychologists estimated the participants' level of functioning based on Vineland Adaptive Behaviour Scale scores. Five clients had IQ levels between 60 and 85, nine clients were communicating verbally with IQ levels between 45 and 60, and six clients had IQ levels below 45. The presence of psychiatric or other diagnoses of developmental disabilities was based on a review of case notes.

Preparation of videotapes

Informed consent and ethical considerations. The Psychology Ethics Review Board at Tilburg University has confirmed the authors that the present study was not subject to the Dutch Medical Research Involving Human Subjects Act, and therefore ethics approval was not mandatory. The Board of Directors of the health-care organisation where the study took place were also fully informed about the study and had no ethical objections.

Nurses working at Amarant were informed about the project and recruited by their manager. All nurse volunteers were asked for their permission to show the videotapes to the three participant groups in the study. Clients, or clients' parents, were similarly informed and asked to give consent for the clients to be videotaped. Clients with IQ levels between 60 and 85 gave permission for videotaping by themselves. These clients who were communicating verbally with IQ levels between 45 and 60 were asked to give their permission to be filmed, with their nurse acting as a witness. Their parents were asked for permission. Finally, the parents of clients with IQ levels below 45 were asked for permission with regard to the filming.

Video recording. The interactions between nurses and clients were recorded over a three-month period. To help the nurses and clients habituate to the camera, the researcher taped nurses and clients on five different days. No instructions were given to the nurses and clients about how they should interact or what they should talk about. Instead, the aim was to capture typical interactions between nurses and clients.

Selection of video samples. A one-minute sample of the interactions was selected for each of the 20 nurse-client pairs, from the final taping session. To reduce possible bias, the samples showed the first minute of tape in which both nurse and client were continuously visible.

Review compilation. The final selection consisted of twenty one-minute sections of videotaped interactions of nurse-client pairs. Each pair was shown only once and samples were separated by a short display of blank tape.

Review Procedure

Reviews were conducted at a quiet location preferred by the participant (e.g., at home or at their office). Each review session lasted between 60 and 90 minutes (90 minutes was felt to be the maximum that could be asked of participants during their working day). All participants were given a standard explanation of what was going to happen before the review procedure started. The rapport between the researcher and the observer was a key factor in the review sessions, as participants are considered to respond especially well in a relaxed, informal atmosphere (Burford *et al.* 2003). Before beginning the reviews the participants were assured that they would not be judged on how well they performed, but that they were valued as informants with needed expertise.

Reviews were divided into two phases. During the first phase, the participant watched the compilation of video samples on a laptop. Normally in the BRP there are no interruptions in viewing during the first phase. In this study, the researcher stopped the tape after each sample and asked the participant whether he or she thought the interaction had "gone well" or "less well"[1]. If participants had difficulty in deciding, the researcher asked them, once only, just to try and make a choice. In the few cases where this happened, participants were able to come to a decision. Other than this, no discussion took place during this phase.

During the second phase, the researcher replayed the compilation, stopping the tape after each sample and asking the participant to explain in his or her own words why he or she thought that the interaction had gone well/less well. The researcher did not engage in discussion about the samples or ask extra questions, to avoid influencing the participant's responses. After giving his or her explanations, the participant was asked if he or she could identify specific events and behaviors on the tape that might add further clarification. All reviews were audiotaped and transcribed verbatim.

Procedural Reliability for Video Reviews

Eight master's students in psychology were trained to conduct the video reviews. One of the authors was present for 25% of their reviews, to observe whether they correctly followed the procedure. The author did not interrupt or engage during the procedure. Mean agreement was 96.2% (*SD* = 5.0) between the scheduled steps of the review procedure and the observed procedures,

[1] Nearest translation possible from Dutch.

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indicating a high procedural reliability.

Data Analysis

The immediate impressions of the three groups (NS, CL, LG) obtained during phase one were compared using Chi Square.

To prepare for analysis of phase two data, the transcripts from the video reviews of all 20 video samples were first divided into clauses according to basic grammatical sentence constructions (i.e., subject, adjunct, subordinate clauses, and enumerations). Through a process of content analysis the clauses were assigned to the three main categories of descriptors that emerged from the participants' responses – Behavior, Feelings, and Recommendations. Inter-rater reliability was conducted using 20% of the transcripts. Cohen's kappa was .91 [12]. Quantitative analyses compared NS, CL and LG distribution patterns of these categories using MANOVA and independent *t* tests.

III RESULTS

Phase one: comparing immediate impressions of nurse-client interactions

The first phase of the video reviews obtained the immediate impressions of the three groups on whether the nurse-client interactions had 'gone well' or 'less well'. Agreement between the groups was assessed by using Chi Square analyses for the three groups of participants' responses on all 20 video samples. Table 1 shows that the Chi-square analyses failed to be significant for 13 of the 20 samples (Table 1). This suggests that the immediate impressions of the NS, CL and LG groups were similar for two-thirds of the video samples.

Phase two: comparing participants' explanations of their immediate impressions

Emergence of categories

Three main categories of i) Behavior, ii) Feelings and iii) Recommendations emerged from the participants' explanations, with Behavior as the predominant category.

Behavior. This category referred to the behaviors of clients and nurses. It contained two sub-categories, (1) Exact Behavior, (2) General Behavior (Table 2). Exact Behavior contained comments referring to specific, clearly described forms of behavior of nurses and / or clients on the videotape, for example, 'the client is sitting on his chair'. In contrast, comments in General Behavior were more general and multi-interpretable, for example, 'This nurse is enthusiastic'. Cohen's kappa for the behavior category was 0.70 [12].

TABLE 1. OVERVIEW OF χ^2, *dfs* AND *p* VALUES FOR EACH VIDEO SAMPLE

Video sample	χ^2	*df*	*p*
1	6.37	2	0.04
2	2.35	2	0.31
3	10.12	2	0.01
4	1.04	2	0.60
5	2.52	2	0.28
6	.63	2	0.73
7	5.40	2	0.07
8	1.17	2	0.56
9	9.91	2	0.01
10	8.62	2	0.01
11	4.70	2	0.10
12	1.51	2	0.47
13	2.50	2	0.29
14	.96	2	0.62
15	9.23	2	0.01
16	.05	2	0.98
17	6.43	2	0.04
18	13.34	2	0.001
19	.24	2	0.89
20	.77	2	0.68

TABLE 2. EXAMPLES OF BEHAVIOR

Exact Behavior: "They sit next to each other on the bench" "The nurse asks: what do you want to know?" "Made a joke by saying: don't take my finger" "The boy was smiling" "That man was eating his sandwich" "He stroke her arm"
General Behavior: "His body posture is relaxed" "The nurse helped the client" "He also calms her down" "Yes, she is very patient" "The nurse is really doing her own things"

Feelings. This category reflected the feelings/evaluations of the participant about the nurse-client interactions. It contained three sub-categories, (1) General Feelings, referring to feelings that were related to the whole situation, (2) Specific Feelings, referring to feelings about particular behaviors of the nurse or client on the videotape, and (3) Interpretations, in which the participant interpreted the feelings of the nurse or client. Table 3 shows examples of these sub-categories. Cohen's kappa for the Feelings category was 0.70 [12].

Recommendations. In this category the participants recommended how the nurse should behave or handle a situation. This included comments like "The nurse should communicate more clearly by pointing to the object", or "The nurse should knock on the door before he goes in". Cohen's kappa in this recommendations category was 0.76 [12].

Redundant comments. Comments that were unclear or extraneous to the research question were assigned to this category and excluded from further analysis. Examples in this category are: "I think that the dog belongs to the client", or "I cannot further clarify this, this is it". Cohen's kappa in this

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TABLE 3. EXAMPLES OF FEELINGS/ EVALUATION

General Feelings: "Beautiful video fragment" "Just a warm expression" "I think, this interaction is quite okay" "I really don't like this"
Specific Feelings: "I really like the way she is helping instead of just giving the instructions" "That man is doing a good job" "The way she is behaving makes me agitated"
Interpretations: "That client doesn't like it anymore" "In fact, she wants him to go away" "He is really feeling comfortable" "I think she liked it"

category was 0.73 [12]. A small number of comments by participants in the NS and CL groups were clinical, for example, referring to a client's autistic behavior. These comments accounted for no more than 0.3% of all explanations and were excluded from further analysis.

Comparing explanations of immediate impressions between groups

The nature of the groups' explanations about the vignettes were compared using a 3 (Group: NS vs. CL vs. LG) x 3 (Nature of explanations: Behavior vs. Feelings vs. Recommendations) MANOVA on the mean proportions of occurrence across all 20 video samples. The variable 'nature of explanations' was treated as a within-subjects variable (repeated measure) and 'group' as a between-subjects variable. There was an interaction effect between 'nature of explanations' and 'group', $F(4, 162) = 2.81$ $p = .03$), indicating that there were differences between groups in the nature of explanations they provided.

Independent *t* tests were conducted to identify the origin of the differences. The CL group was found to use more Behavior than the NS group ($t(54) = 2.92$, $p = .005$) and both CL ($t(54) = 3.27$, $p = 0.002$) and NS ($t(54) = 2.64$, $p = 0.01$) used more Recommendations than LG. No other significant differences were found. See Table 4 for the mean scores.

TABLE 4. PROPORTIONS OF EACH SUB-CATEGORY THAT OCCURRED IN THE EXPLANATIONS OF EACH PARTICIPANT GROUP

Descrip-	NS		CL		LG	
tion	*M*	*SD*	*M*	*SD*	*M*	*SD*
Behavior	57.3	10.5	64.1	6.8	60.8	10.2
-General behavior	34.0	8.9	42.0	6.1	37.2	8.6
-Exact behavior	23.2	9.0	21.9	7.5	23.6	10.7
Feelings	21.5	6.0	20.1	4.2	21.5	7.7
-General feelings	12.5	5.2	11.5	3.6	12.5	5.9
-Specific feelings	4.2	2.6	3.9	2.1	3.6	2.3
-Inter-pretation	4.8	3.0	4.7	2.0	5.4	3.9
Recomm-endation	3.0	2.6	3.2	2.4	1.4	1.7

The three groups appeared to have a similar pattern of comments about Behavior, Feelings and Recommendations. To establish whether this was the case, paired-sampled *t* tests were conducted and revealed that the pattern was comparable between the groups (Table 4). Within each group, Behavior was mentioned more frequently than Feelings ($t(27) = 24.13$, $p < 0.001$ (CL); $t(27) = 13.66$, $p < 0.001$ (NS); $t(27) = 13.08$, $p < 0.001$) (LG) and Recommendations ($t(27) = 41.75$, $p < 0.001$ (CL); $t(27) = 24.80$ (NS), $p < 0.001$; $t(27) = 29.93$, $p < 0.001$) (LG), and Feelings occurred more frequently than Recommendations ($t(27) = 17.77$, $p < 0.001$ (CL); $t(27) = 15.51$, $p < 0.001$ (NS); $t(27) = 13.57$, $p < 0.001$) (LF).

Detailed comparison of Behavior

As shown in Table 4, Behavior was the predominant category and so it was subjected to further analysis. Ten randomly selected video sample were used, to gain more detailed information about the aspects of behavior given most emphasis, when participants judged the nurse-client interactions. Through content analysis, the Exact and General Behaviors sub-caregories were further divided into: (1) Physical characteristics, (2) Verbal communication, (3) Activities, (4) Attitude, and (5) Autonomy. In addition, the General Behaviors sub-category also included (6) Atmosphere (e.g., the nurse is behaving in a friendly way) and (7) Connection (e.g., they are making contact with each other). Inter-rater reliability (Cohen's kappa) was 0.90 for Exact Behaviors and 0.89 for General Behaviors [12].

Detailed analyses of Exact Behavior. Table 5 shows a similar pattern of distribution across the participant groups. For each group, the majority of descriptions belonged to Verbal Communication and Physical Characteristics (NS = 81.1%, CL = 80.2%, LG = 80.8%). Table 6 shows that their four most commonly cited codes were also comparable across the three groups. Participants thus not only considered similar aspects of behavior to be relevant, but also used the same language to explain the behaviors they highlighted.

Detailed analyses of General Behavior. For General Behavior, two sub-categories, Verbal Communication and Connection, were the most frequently mentioned (NS= 55.6%, CL= 64.7%, LG= 55.1%), but the four most commonly cited codes within these sub-categories varied between the groups, especially for Connection (Table 8).

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TABLE 5. PROPORTIONS OF EXACT-BEHAVIOR SUBTYPES FOR EACH PARTICIPANT GROUP

	NS	CL	LG
Verbal communication	59.9	59.9	61.4
Physical characteristics	21.2	20.3	19.2
Attitude	9.1	10.6	11.2
Activities	7.1	7.2	5.2
Autonomy	2.8	2.0	3.0

TABLE 6. FOUR MOST COMMONLY CITED BEHAVIOR CODES IN THE SUB-CATEGORIES OF VERBAL COMMUNI-CATION AND PHYSICAL CHARACTERISTICS

Verbal Communication						
	NS		CL		LG	
#	Code	%	Code	%	Code	%
1	Quote	42.1	Quote	39.3	Quote	33.7
2	Say	26.7	Say	25.3	Say	27.4
3	Ask	22.5	Ask	21.8	Ask	27.4
4	Answer	5.8	Answer	8.7	Answer	8.1
Physical Characteristics						
#	NS		CL		LG	
1	Look at	30.9	Look at	52.8	Look at	41.7
2	Stand	22.8	Laugh	19.3	Stand	19.8
3	Sit	20.3	Sit	13.7	Sit	18.8
4	Laugh	9.8	Stand	11.2	Laugh	15.6

Data were collected in the Netherlands and video reviews were conducted in Dutch. Table 6 shows the best fitting translations. It should be borne in mind that category labels and descriptions cannot be translated exactly into English (Table footnote).

TABLE 7. PROPORTIONS OF SUB-CATEGORIES FOR GENERAL BEHAVIOR FOR EACH PARTICIPANT GROUP

	NS	CL	LG
Connection	27.4	41.5	28.4
Verbal communication	28.2	23.2	26.7
Attitude	15.0	10.4	19.2
Physical characteristics	12.3	11.4	10.4
Atmosphere	9.1	6.3	2.8
Autonomy	5.3	2.5	6.6
Activities	2.8	4.7	6.0

Verbal communication and Connection were salient for all three groups, but when the groups had to describe the behaviors, their use of language diverged. Clinicians for example talked in terms of *adapting* and *joining in*, whereas lay individuals used words such as *helping* and *communicating.*

IV DISCUSSION

This study compared the views of three groups, Nurses, Clinicians and a Lay Group with no background experience of people with intellectual disabilities, about their judgments and perceptions of nurse-client interactions. Their immediate impressions about the videotaped nurse-client

TABLE 8. FOUR MOST COMMONLY CITED GENERAL BEHAVIOR CODES IN THE SUB-CATEGORIES OF CONNECTION AND VERBAL COMMUNI-CATION

Connection						
	NS		CL		LG	
#	Code	%	Code	%	Code	%
1	Know e/other	13.9	Adapt	10.4	React	16.6
2	Make contact	10.1	Join in	9.7	Help	9.9
3	React	9.1	Make contact	9.7	Comm-unicate	9.9
4	Take over	7.5	React	8.6	Focus on	7.2
Verbal communication						
#	NS	CL			LG	
1	Say	51.0	Speak	45.7	Say	65.9
2	Clarify	20.3	Ask	15.7	Ask	10.0
3	Ask	12.5	Inform	7.3	Clarify	7.1
4	Explain	4.7	Clarify	5.3	Explain	4.1

Data were collected in the Netherlands and video reviews were conducted in Dutch. Table 8 shows the best fitting translations. It should be borne in mind that category labels and descriptions cannot be translated exactly into English (Table footnote).

interactions they reviewed appeared to be similar. Moreover, the explanations given by participants for their immediate impressions were also comparable. Participants from the different groups described similar behaviors and feelings about what they saw, but used different language. Apart from the difference in language, the general agreement between the groups suggests that training and experience might not have as strong an influence on people's perceptions of nurse-client interactions as might have been expected.

Interpreting inter-personal interactions is an essential life skill, the building blocks of which are likely to be hard wired [13]. According to Lim, Plucker and Im [14], people share implicit theories about aspects of behavior, including inter-personal interactions. It was noteworthy that participants used feelings to explain about 20% of their judgments (i.e., NS = 21.5%; CL = 20.1%, LG = 21.5%). Thus, irrespective of their expertise, the participants may have been relying on intuitive judgments that they were sometimes unable to explain. For example, participants sometimes reported that they 'just felt' that something in the interaction did not 'feel right', even though they could not make these feelings more explicit.

When the professionals and lay people did provide explanations for their judgments, they based their judgments on similar aspects of observed behavior. This adds further credence to the notion that common elements of the interactions were salient to all three groups of the participants. Romney, Weller and Batchelder [15] and D'Andrade [16], suggest that shared cultural understandings can lead to common interpretations of behavior. Yet, if this was the key factor then one

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might have also expected the respondents to use a shared language to describe what they saw, whereas the professionals and lay people sometimes described what they saw in different terms. Table 8 shows that the three groups focused on the same aspects of behavior (i.e., verbal communication and connection) but use different language to describe what they saw. In the case of clinicians, this reflected their professional language or jargon.

A second difference in the responses of the three groups was that nurses and clinicians made more recommendations than lay people about how the nurse-client dyads could improve their interactions in the future. Professionals seemed to think more about the implications of what they had seen. This is likely to be a result of their training and experience, through which they consider it part of their job to translate their observations into useful suggestions for change. For example, in one of the video samples, the client was constantly moving and looking around while talking to his nurse. The nurse did not speak about this with his client. One of the NS group suggested that the nurse should have said to his client: "Please, look at me for a moment". Another participant in the CL group also commented on this sample that: "This client is not looking at his nurse. You cannot 'reach' this client with words only, you know." Although training may have a positive influence on how professionals use their observations, the fact that they may use different language to describe the same events could be a barrier to clear communication. Training needs to emphasise the importance of communicating recommendations and action plans in clear language that fosters a shared understanding of human processes with clients and their families, and also with each other.

Clear communication is especially pertinent to work with people who have intellectual disabilities, where a multi-disciplinary approach is commonly taken to help with difficulties they may face. During multi-disciplinary meetings it is important that different professionals, care workers, family members and individuals with intellectual disabilities, do not misinterpret each other's terminology and mistakenly assume differences in perspectives.

There are a number of possible limitations to this study that need to be considered. The video samples of client nurse interaction were very short, and the limited nature of the exchanges might have focused the three groups' attention towards common factors when making their judgments. If the participants had observed longer extracts there might have been greater variance in how the three groups judged the interactions and the aspects of the interactions that they focused on. However, even if this proved to be the case, the fact that the three groups used different language to describe common factors remains of interest.

The finding that the professional groups produced more recommendations than the lay group should also be treated with some caution. This may have been an artefact of the review procedure, and given the professional groups' backgrounds and training they may have believed they were expected to provide suggestions for improvement. Even though lay people may not have thought it was part of their role to provide recommendations, they might have proved perfectly capable of doing so if asked.

Finally, the classification system used in the present study might have been a weakness, and resulted in potentially informative data from the participants' open responses being lost. However, these data remain available and can be used for future qualitative analyses. It would be interesting to find out whether more subtle differences in the judgments and perceptions of the three groups of participants emerged from a qualitative analysis.

Future research could address the methodological issues raised above, and investigate if longer extracts of interactions would yield a different pattern of results and what recommendations lay people would make if asked. Another development of the approach would be to ask individuals with intellectual disabilities themselves and their relatives to carry out video reviews. A study by Burford and Jahoda [10] showed that clients with mild intellectual disabilities are able to participate in the BRP. Recent studies involving clients and relatives have found that the characteristics of nurses they value most concern their ability to communicate and form relationships [17, 18]. This raises the question as to whether individuals with intellectual disabilities themselves would focus on the same features as nurses and lay people when judging whether interactions had "gone well" or "less well" and whether nurses, nurses and people with intellectual disabilities share similar views.

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REFERENCES

1. R. P. Hastings, and B. Remington B, "Staff behaviour and its implications for people with learning disabilities and challenging behaviours," Br. J. Clin. Psychol., vol 33, pp. 423-438, 1994.
2. R. Forrester-Jones, J. Carpenter, P. Coolen-Schrijner, P. Cambridge, A. Tate, J. Beecham, et al., "The social networks of people with intellectual disability living in the community

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12 Years after resettlement from long-stay hospitals," J. Appl. Res. Intellect. Disabil., vol 19, pp 285-295, 2006.
3. J. Robertson, E. Emerson, N. Gregory, C. Hatton, S. Kessissoglou, A. Hallam, and C. Linehan C. "Social networks of people with mental retardation in residential settings," Mental Retardation, vol 39, pp. 201-214, 2001.
4. R. Mcconkey, I. Morris, and & M. Purcell, "Communications between staff and adults with intellectual disabilities in naturally occurring settings". J. Intellect Disabil Res, vol 43, pp. 194-205, 1999. doi: 10.1046/j.1365-2788.1999.00191.x
5. J. Bradshaw, "Complexity of staff communication and reported level of understanding skills in adults with intellectual disability," J. of Intellect Disabil Res, vol 45, pp. 233-243, 2001. doi: 10.1046/j.1365-2788.2001.00318.x
6. C. Antaki, W. M. L. Finlay, and C. Walton, "Conversational shaping: Staff members' solicitation of talk from people with an intellectual impairment," Qual Health Res, vol 17, pp. 1403-1414, 2007a. doi: 10.1177/1049732307308950
7. C. Antaki, W. M. L. Finlay, and C. Walton, "The staff are your friends: Intellectually disabled identities in official discourse and interactional practice," Brit J. Soc Psychol, vol 46, pp. 1-18, 2007b. doi: 10.1348/014466606x94437
8. E. Reuzel, P. Embregts, A. Bosman, M. Van Nieuwenhuijzen, and A. Jahoda, "Interactional patterns between staff and clients with borderline to mild intellectual disabilities," J Intellect Disabil Res, vol 57, pp. 53-66, 2012.
9. H. Antonsson, U. H. Graneheim, M. Lundström, and S. Åström, "Caregivers' reflections on their interactions with adult people with learning disabilities," J Psychiatr Ment Health Nurs, vol 15, pp. 484-491, 2008. doi: 10.1111/j.1365-2850.2008.01259.x
10. B. Burford, and A. Jahoda, "Do video reviews of therapy sessions help people with mild intellectual disabilities describe their perceptions of cognitive behaviour therapy?" J Intellect Disabil Res, vol 56, pp. 179-190, 2012.
11. B. Burford, A. Kerr, and H. Macleod, "Nurse recognition of early deviation in development in home videos of infants with Rett disorder," J Intellect Disabil Res, vol 47, pp. 588-596, 2003.
12. J. Cohen, "Statistical power analysis for the behavioral sciences," Hillsdale, NJ: Erlbaum, 1988.
13. C. Trevarthen, "Action and emotion in development of cultural intelligence: Why infants have feelings like ours," In J. Nadel & D. Muir (Eds.). Emotional Development. Oxford: Oxford University Press, 2005.
14. W. Lim, J. A. Plucker, and K. Im, "We are more alike than we think we are: Implicit theories of intelligence with a Korean sample," Intelligence, vol 30, pp. 185-208, 2002.
15. A. K. Romney, S. C. Weller, & W. H. Batchelder, "Culture as consensus: A theory of culture and informant accuracy," American Anthropologist, vol 88, pp. 313-338, 1986.
16. R. G. D'andrade, "The cultural part of cognition". Cognitive Science, vol 5, pp. 179-195, 1981.
17. E. Roeleveld, P. Embregts, M. Hendriks, and K. Van Den Bogaard K, "See me as a human being! Necessary competences for care staff according to people with intellectual disabilities," [Zie mij als mens! Noodzakelijke competenties voor begeleiders volgens mensen met een verstandelijke beperking], Orthopedagogiek: Onderzoek en Praktijk, vol 50, pp. 195-207, 2011.
18. J. Van Der Meer, P. Embregts, L. Hendriks, and J. Sohier, "There is someone in the center, who needs a liveable life. What do parents of people with severe intellectual disabilities and severe challenging behaviour consider important regarding the care staff?" [Er is iemand in het midden die een leefbaal leven moet hebben. Wat vinden ouders van mensen met een ernstige verstandelijke beperking en ernstige gedragsproblemen belangrijk in een begeleider?]. In: P. Embregts, and L. Hendriks, (eds.) Menslievende professionalisering in de zorg voor mensen met een verstandelijke beperking. Aansluiten bij cliënten en hun ouders. Arnhem: HAN University Press, 2011.

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