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The effect of patient-centeredness and gender of professional role models on trainees' mentalization responses. Implications for film-aided education

Katalin Bálint [a,*], Tamás Nagy [b], Márta Csabai [c]

[a] Institute for Cultural Inquiry (ICON) – Media and Performance Studies, Utrecht University, The Netherlands
[b] Doctoral School of Psychology, University of ELTE, Budapest, Hungary
[c] Institute of Psychology, University of Szeged, Szeged, Hungary

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ABSTRACT

Objective: To examine how certain characteristics of film-presented practitioner role-models influence trainees' mentalization.
Methods: In an experimental setting, psychology students watched four film clips presenting a patient–practitioner session; the clips varied in the practitioner's patient-centeredness (positive vs. negative) and gender. Participants commented on the practitioner's thoughts, emotions and intentions through the session. Analysis of 116 comments focused on the effect of patient-centeredness and gender variables on mentalization and judgment utterances.
Results: Negative role-models and female role-models induced higher levels of mentalization compared to positive and male role-models. There was no gender difference in the level of mentalization; however male participants gave more judgmental responses than female participants. The patient-centeredness had a larger effect on mentalization when trainees described the opposite gender role-model.
Conclusion: In a systematic comparison, students' capacity for mentalization differed according to role-models' patient-centeredness and gender, as well as the gender-match of students with role-models.
Practice implications: When working with film-presented role-models, educators should be aware of the differences in the level of mentalization elicited by positive and male role-models, as opposed to negative and female role-models. Educators should also consider the gender-match between trainees and role-models, therefore students should be exposed to both cross- and same-gender role-models.
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1. Introduction

Role-modeling is a key contributing factor to the professional identity formation of health care professionals [1–7]. It has been more increasingly included as an explicit part of the curriculum [8]. Recent studies have shown that students primarily learn from observing and making sense of senior professionals' interactions with patients [9], which helps them to shift the knowledge acquired from training into the medical context and to internalize patient-centered empathic attitude [10–12]. A growing body of literature has shown the effectiveness of role modeling in professional development, yet the literature is mainly descriptive. Our knowledge on the components of the learning process that constitute role modeling is still limited.

Role modeling is social in nature. It incorporates observing, understanding of and learning from the role model's behavior [13]. Central to the experience of trainees is the attempt of making sense of and reflecting on (not just emulating) the observed behavior [14,37]. Trainees need to recognize mental states underlying the observed behavior and evaluate its consequences. Mentalization (or mindreading, theory of mind) has a fundamental role in this process as it enables us to build explanatory models on others behavior in terms of mental states [15–19]. Consequently, role modeling has a strong foundation in mentalization. More advanced mentalization involves an interactional perspective, and an elaborate as well as accurate consideration of how mental states connect to behavior [20,63]. Fonagy et al. [21,56] stress that mentalization is not a trait-like ability, but varies with contextual factors.

* Corresponding author at: Institute for Cultural Inquiry (ICON) – Media and Performance Studies, Utrecht University, Muntstraat 2A, 3512 EV Utrecht, The Netherlands. Tel.: +31 6 344 006 78.
E-mail addresses: k.e.balint@uu.nl, katibalint@gmail.com (K. Bálint).

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1.1. Patient-centered and non-patient centered role-models

Role models provide model behaviors for students, which affect students' attitudes toward patients [22–24]. Patient-centered attitude is one of the most important elements in high quality patient care [25–29], and one of the main characteristics of an exemplary role model [30,31]. Encountering a positive – patient-centered – role-model can be a highly formative experience [32]. Encountering a discordant role-model has also been proven to be critical in professional development [14,33]. Observing a non-patient centered role model can be a highly challenging experience at the early stages of career development: learners experience dissociation, confusion and lack of understanding [34], as well as the sense of losing contact with the teachings of their pre-clinical training [3]. Bombeke et al. [3] suggest that seeing the role model as a person – understanding the internal processes leading to a specific behavior, i.e. mentalization – might be helpful to deal with these negative aspects in the learning environment. It seems that positive and negative models influence the internalizing process of a patient-centered attitude in different ways. However, we have limited knowledge on how students mentalize with negative role-models compared to positive ones. Research exploring the cognitive process evoked by a negative role-model may help to prepare students in handling those ambivalent encounters in real life.

1.2. Gender aspects of role-modeling

The gender of the observed person has a major impact on perceptions, and consequently, gender aspects also modulate the learning process of role-modeling [35,36]. For example, the practitioner's gender influences the perceived level of empathic communication [37] and competence [38], as well as patients' satisfaction [39,40]. In line with this several studies have examined the effect of gender match in role-modeling [41–44] and in social learning [45]. A study has suggested that same-sex and cross-sex role-models have different effects on students' perception, however the role-model's gender was found to affect females more than males [46]. Overall, gender aspects have an impact on role-modeling, yet our knowledge is quite limited on the nature of the effect on the learning process.

1.3. Film-presented role models

Film-aided education uses the potential of observational learning and role modeling. Screening and discussing educational videos about patient–practitioner interactions is an effective way to foster patient-centered attitude in undergraduate learning [47–53]. Communication studies have argued that same mentalization processes are activated when watching a real life or a mediatized interaction [54]. However, there has been very little research on how pedagogically relevant features of film-presented role models shape the learning process.

This study aims at examining the influence on trainees' mentalization of (1) the patient-centeredness of the role model, (2) the gender of role model; and (3) the gender of the trainee. The purpose is to identify the facilitating and hindering factors of mentalization. The outcomes of this study may inform us about influential factors of role modeling, and enrich pedagogical considerations on film-aided education in health care.

2. Methods

2.1. Participants

Twenty-nine university students (mean age = 23.6 years, SD = 2.76, range between 22 and 33 years; 15 female) participated in the study. The sample was recruited via university seminars and e-mail lists. All students were enrolled in graduate clinical and counseling psychology programs at two universities in Hungary. The study followed the ethical rules established by the Ethical Committee of Psychology of the Hungarian Academy of Sciences. Participation in the study was voluntary, anonymous and no incentives were provided.

2.2. Material

2.2.1. Interview questions

We collected mentalization responses in a semi-structured interview with the following questions: *What is happening to the practitioner at this moment? How would you describe his/her inner state? (. . .) Could you please tell me more about it?*

2.2.2. The Interpersonal Reactivity Index (IRI)

To examine the validity of the qualitative measure of mentalization, self-reported empathic ability was assessed with the 28-item Interpersonal Reactivity Index (IRI) [55] that consists of four subscales: fantasy scale, perspective taking, empathic concern, and personal distress. It employs a 5-point Likert scale where 0 was "not at all" and 4 was "completely agree". Substantial test–retest and internal reliabilities were reported [52]. In the present study the scale showed good internal consistency (αs = .78–.83).

2.3. Procedure

This study employed a mixed design with gender and patient-centeredness of the practitioner role model as within subject variables and gender of the participant as a between subject variable. We employed a content analytic method and checked its convergent validity with self-reported empathy.

Participants took part in an individual research session that lasted approximately 70 min. Participants read and signed an informed consent form. Participants watched four short film scenes. Each scene was presented twice. Before the first viewing, the participants were instructed to focus on their emotional reactions to the practitioner. Responses were collected during the second viewing. Before the second viewing, the participants were told to focus on the practitioner and to pause the film when they perceive that something important is happening in the scene. Following a standard protocol whenever the participant stopped the video the interviewer posed the abovementioned interview questions. This method is a modified version of Dziobek et al.'s [57] film-based assessment of mindreading. To reduce order bias the film presentation order was randomized across participants. Responses were recorded and transcribed later. The research sessions were conducted by trained assistants who were not familiar with the research hypotheses. Self-reported empathy was assessed at the end of the session.

2.4. Films scenes

Four film scenes were chosen from interactive tutorial software [58]. The film scenes showed counseling sessions that lasted 4–5 min each. The dialogs were written by clinical psychologists, and performed by professional actors. The four scenes formed two sets of pairs. In the joint scenes the same interaction was presented in the same cinematographic setting, with the same actors: scenes 1 and 2 depicted a female practitioner with a male patient with panic disorder symptoms, scenes 3 and 4 depicted a male practitioner with a female patient with chronic headache. Scene 1 and scene 3 presented a non-patient centered negative role-model. Scene 2 and scene 4 presented a positive role-model whose communication was

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