THE ESSENCE OF NURSES' LIVED EXPERIENCE OF EMPATHY IN NURSE-PATIENT INTERACTIONS

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BY

JOYCE ANN SWEGLE, MSN, RN

DENTON, TEXAS

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TEXAS WOMAN'S UNIVERSITY
DENTON, TEXAS

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Date

To the Dean for Graduate Studies and Research:

I am submitting herewith a dissertation written by

Joyce Ann Swegle, M.S.N., B.S., R.N.

entitled The Essence of Nurses' Lived Experience of Empathy in Nurse-Patient Interactions

I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Nursing.

Helen A. Bush
Major Professor

We have read this dissertation and recommend its acceptance:

Linda Hamm
Marion Anema
Peggy J. Pape

Accepted.
Leslie M Thompson
Dean for Graduate Studies and Research

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ABSTRACT

JOYCE ANN SWEGLE, MSN, RN

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DECEMBER 1989

The domain of this study was stated as: What is the essence of nurses' lived experience of empathy in a nurse-patient interaction? The purpose of the study was to identify the essential structure of empathy and to construct a framework of the lived experience of empathy from the perspective of the nurse empathizer in nurse-patient interactions. The study was conducted using a phenomenological orientation.

The purposive sample for the study consisted of five registered nurses who could identify an empathic nurse-patient interaction which they had participated in. The participants also demonstrated an ability and willingness to express themselves in the manner necessary for the study.

Interviews were used to obtain the participants' experiences of empathy in nurse-patient interactions. These descriptions were analyzed using Colaizzi's (1978)

method. The study elicited the following essential structure of empathy:

1. Empathy is a passive and active process in which a nurse imaginatively assumes the role of an identified other.

2. An awareness of the imagined experience provides a framework for nursing intervention.

3. The nurse becomes involved with the patient and his family through repeated interactions.

4. Involvement is contingent upon the length of contact and realized through a mutual responsiveness between the nurse and identified other.

5. Alternative perceptions, decisions, and actions are interjected.

6. The nurse inspires hope in the patient and his family.

7. The nurse becomes cognizant after interaction with the patient or family member of his level of coping as well as her own.

8. Measures are taken to support and facilitate coping for all parties involved.

9. Barriers to empathy development are related to factors which decrease time for involvement and inadequate or ineffective coping skills.

10. Empathy is distinguished by the nurse's belief that her interventions made a difference for the patient.

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CHAPTER I

INTRODUCTION

Empathy has been identified as an important variable in achieving positive outcomes in nurse-patient relationships. The concept of empathy is introduced in the early stages of nursing education as a necessary condition for a therapeutic relationship.

Burgess (1981) stated that in a self-examination of a nurse's responses and behavior, assessment should be conducted regarding the nurse's empathy for the patient. In addition, empathy has been identified in the literature as one component of the art of nursing. The distinction among four fundamental patterns of knowing in nursing was formulated by Carper (1978). She identified one of these fundamental patterns as esthetic knowing. Empathy was defined as a means of gaining knowledge of another person and classified as a mode in the esthetic pattern of knowing. Carper emphasized that the greater the nurse's skill in perceiving and empathizing with others, the greater her understanding will be of alternate modes of perceiving reality. This, in turn, should make available a larger repertoire of choices in providing nursing care that is effective.

Others, including Leininger (1981) and Watson (1979), viewed caring as the essential component of nursing. Watson (1979) described several core factors which are intrinsic to the actual nurse-patient process that produces therapeutic results in the person being served. One of the carative factors she described was the development of a helping-trust relationship. A subconcept of this relationship is empathy. Watson viewed empathy as an interpersonal condition that facilitates growth and produces positive patient outcomes.

While the concept of empathy is held in high esteem in nursing, few attempts have been made to investigate it. Kalisch (1971) reported an experiment in which she attempted to enhance the empathic ability of nursing students. Verbal and nonverbal behaviors that were instrumental in communicating empathy in the nurse-patient relationship were identified by Mansfield (1973). In a study by Forsyth (1977) empathic ability levels of the nurses were assessed and compared with both client perceptions of nurse empathy and demographic variables. In another study empathy was identified as a concept central to the development of biculturalism in graduate nurses (Kramer & Schmalenberg, 1977).

These studies have provided a rather disjointed array of information about isolated aspects of empathy. There has been no attempt to describe the lived experience of empathy by empathizers. It has become progressively clear that traditional hypothetico-deductive methodology has limited ability to formulate complete theory and explain phenomena in nursing practice in relevant terms (Mullen & Reynolds, 1978; Swanson & Chenitz, 1982). Consideration must be given to a systematic means of studying everyday experience as it relates to nursing practice settings. This must be accomplished in a manner that does not compartmentalize the complex and diversified information which gives clues to the nature of human behavior which it attempts to understand.

Phenomenological methodology has been embraced as an alternative to the thus far traditional quantitative methods utilized in nursing (Davis, 1978; Ludemann, 1979; Oiler, 1982; Omery, 1983). The sought after outcomes of qualitative techniques are to describe, document, and understand unknown phenomena. By examining the data that have heretofore been tossed aside as biased, non-scientific, or subjective, it is felt that many of the "truths" in nursing may be discovered (Leininger, 1984).

Domain of Study

The domain of the study was centered in one question: What is the essence of nurses' lived experience of empathy in a nurse-patient interaction?

Purpose of the Study

The purpose of the study was to identify the essential structure of empathy and to construct a framework of the lived experience of empathy from the perspective of the nurse empathizer in nurse-patient interactions.

Justification for the Study

Nurses are in a unique position to undertake the responsibility of helping by maintaining humane and individualistic concern for people and their health problems. A necessary element of this helping relationship is empathy. It is essential that nurses be able to demonstrate an ability to empathize with those seeking their help.

Nurses are in agreement regarding the need for empathy in nursing care. Nursing textbooks present empathy as a valuable tool of the nurse. A number of authors contend that without empathy, there is no basis for helping. What is lacking is a research-based definition or description of

empathy, either in the nursing texts or in the writings of the other helping disciplines.

The definitions which exist are presented in Table 1 to show the reader the various major ideas.

Table 1

Definitions of Empathy from 1948 to 1978

Author and year	Definition
Reik (1948)	third ear
Dymond (1949)	one individual accurately predicts the attitude of another
C. Rogers (1957)	effective communication in a supportive way
Buber (1958)	one person's feelings glide into an object
Katz (1963)	visualizing and apprehending the feelings of others
Carkhuff (1969)	crawling inside another person's skin and seeing the world through that person's eyes
Zderad (1969)	knowing another person and grasping his view of reality
Stein (1970)	an inner participation in a foreign experience
Carper (1978)	gaining knowledge of another person

The researcher's review of available literature resulted in locating 24 studies which used samples of practicing nurses or nursing students and examined empathy. Table 2 shows the 24 researchers and very briefly gives the major thrust of each study. While the studies tested nurses on level of empathy or correlated empathy with another variable, no study defined or described empathy. One study, Mansfield (1973), delineated nurses' behaviors which were believed to be related to empathy.

Table 2

Research Conducted on Empathy in Nurses from 1961 to 1986

Author and year	Findings
Truax (1961)	(1) accurate empathy results in improvement in the patient's status, (2) nurses have low empathy scores
Duff and Hollingshead (1968)	Seventy percent of nurses showed no evidence of empathy
Peitchinis (1972)	Nurses demonstrate low levels of empathy, but are trying to rectify problem
Kalisch (1971)	Nursing students could be taught to be empathic

(table continues)

Author and year	Findings
Mansfield (1973)	Behaviors related to empathy are: (1) introduction to patient, (2) head and body position, (3) verbal behavior, (4) response to non-verbal cues, (5) facial expressions, (6) mirror images
LaMonica (1976)	Nurses demonstrated low levels of empathy
Hurwitz (1976)	Empathy increased when nurse selected her own patients and determined the amount of patient care she would assume
Sparling (1976)	Psychiatric nurses were significantly more empathic than medical-surgical nurses
LaMonica (1976)	A significant difference was found in the means of posttest scores between treatment to increase empathy and control groups of nurses
Forsyth (1977)	(1) nurses demonstrated moderate to high levels of empathy, (2) 98% of patients rated nurses as high in empathy when Hogan scale showed only 50% as having high empathic ability, (3) as length of nursing practice increased, empathy decreased, (4) client's perception of nurse empathy had no predictive value for determining nurse empathic ability

(table continues)

Author and year	Findings
Kramer and Schmalenberg (1977)	(1) found differences in ranking of goals identified by newly graduated nurses and the ranking of those same goals by their supervisors, (2) speculated that predictive empathy by both graduate nurses and their supervisors would result in increased job satisfaction
Layton (1979)	Nursing students' empathy scores were raised if rehearsal was used
Sowell (1979)	As years of nursing practice increased, empathy decreased
Williams (1979)	Self-concept scores of elderly were increased when cared for by empathic nurses
Ebbs (1980)	No significant difference was found between critical care nurses and medical-surgical nurses using Hogan's scale
Thiesen (1981)	Nursing students did not raise empathy scores as a result of the nursing program
I. Rogers (1982)	A moderate correlation was found between nursing student self-reported and patient-reported empathy ratings
Auvenshine (1982)	No difference found in beginning and graduating nursing students on empathy scores

(table continues)

Author and year	Findings
Follstaedt (1983)	No relationship was found between nurse's non-verbal behavior and patient's perception of nurse empathy
Harris (1983)	No relationship was found between job satisfaction and empathic level in nurses
Brunt (1983)	(1) intensive care nurses did not have lower scores on empathy than nurses who did not work in a hi-tech environment, (2) empathy and technology were not negatively correlated
Tyner (1985)	No difference was found in patient perception of nurse empathy on the basis of socioeconomic status
Lockett (1985)	No relationship existed between self-concept and empathy in nursing students
Semands (1986)	(1) no differences were found in two groups of nurses in empathy level as a result of a training program to increase empathy, (2) no difference in patient satisfaction was found in the two groups of nurses on empathy

In conjunction with the studies reported above, the researcher carefully examined the instruments used to measure empathy. While statistically derived coefficients indicated acceptable levels of reliability for the

instruments, validity testing of the instruments as a group is not reported. Table 3 displays significant aspects of the instruments.

Table 3

Development of Instrumentation for Measurement of Empathy from 1949 to 1983

Researcher	Instrument	Sample	Reliability
Dymond 1949	Rating Test correlated with empathy on the TAT	53 students (10 used to correlate with TAT)	Test-retest .60
Truax (1961)	Accurate Empathy Scale (AES) Based on C. Rogers (1951) therapeutic concepts. Instrument has been modified by: Bergin & Solomon (1963) Reddy (1969) Carkhuff (1969) Kalisch (1971)	384 taped segments from therapy sessions of 4 patients	Inter-rater .87
Barrett-Lennard (1962)	Barrett-Lennard Relationship Inventory. Based on C. Rogers (1951) conditions of therapy	42 clients 40 therapists	Split-half client .82-.93, therapist .88-.90

(table continues)

Researcher	Instrument	Sample	Reliability
			Taylor Manifest Anxiety Scale and Q adjustment used to demonstrate construct validity
Hogan (1969)	Hogan Empathy Scale Concepts determined through use of Q-sort. High and low sub-groups were compared with CPI, MMPI, and IPAR	100 military officers, 45 research scientists, 66 student engineers	Test-retest .84, split-half .71
Kalisch (1971)	Nurse-Patient Empathic Functioning Scale. Based on Accurate Empathy Scale (Truax, 1961), modified by Hurwitz (1976).	No study reported	No study reported
LaMonica (1981)	Empathy Construct Rating Scale (ECRS). Factor analysis determined instrument measures: well-developed empathy and lack of empathy.	103 nursing graduate students	Alpha Form A .97, split-half .89. Alpha Form B .98, split-half .96

Empathy has been commonly identified as an important variable in dealing successfully with patients. The researcher's review of the literature and clinical years of experience support the conclusion that while nurses believe empathy is important, they are unable to define or describe it. A research method which can assist in defining and describing empathy is the phenomenological method. Using this approach, nurses are given the opportunity to clarify a concept such as empathy which possesses an abstract nature. By identifying the essential structure of empathy, nurses may be able to diagnose the presence or absence of empathy in themselves. Equally as important, nurse educators may be able to teach nursing students how to become empathic or to increase a level of empathy.

Research Assumptions

Research assumptions for the study were as follows:

1. Participants are capable of identifying and communicating their experiences of empathy.

2. Statements in the interview guide elicited accurate descriptions of nurse empathy.

Research Questions

The research questions for the study were as follows:

1. Please describe a nurse-patient interaction in which you were empathic. Describe the situation fully.

2. Describe the meaning the interaction had for you.

Definition of Terms

1. Essence--essential structures and essential relationships developed by a study of concrete examples supplied by experience (Spiegelberg, 1975).

2. Lived experience--recalled reports of self-defined incidents which were lived through and the meanings which the participants attached to these experiences (Keen, 1975).

3. Lived experience of empathy--recalled reports of self-defined incidents of empathy which were lived through and the meaning which the study participants attached to these experiences.

4. Nurse--registered nurse, regardless of educational preparation, female, 25-50 years of age, with a minimum of 2 years of post-graduation nursing experience.

5. Nurse-patient interaction--a process of perception and communication between person (nurse) and person (patient), represented by verbal and nonverbal behaviors that are goal-directed (King, 1981).

Limitations

The findings described are limited by the population chosen for the study. The findings may not be generalizable to other age groups, other helpers, or different settings or communities. Finally, the study is based on information obtained by self-reporting techniques of interview responses and introspective narration.

Summary

Nursing is a helping profession. Empathy is thought to be a necessary condition for effective helping to occur. The domain of the study is to describe the concept of empathy from the perspective of nurse empathizers. The purpose is to identify the essential structure of empathy and to construct a framework for the concept from the perspective of the empathizer in a nurse-patient interaction.

CHAPTER II

REVIEW OF THE LITERATURE

The review of the literature deals first with the nature of empathy from a philosophical standpoint. Also included is theory from the social sciences and research conducted in those fields. The conceptualization of empathy in nursing literature is presented. Investigations of empathy carried out in nursing are included. Finally, methods of operationalizing empathy are presented.

The Nature of Empathy

The concept of empathy has proven to be an elusive one for both philosophical and psychological concern. The behaviorists attempted to understand man solely through his behavior. The clinicians assumed that others could be understood by the use of systematic self-observation. In contrast, "the behaviorist sees empathy as the source of all error; the clinician, as the source of all truth" (Smith, 1966, p. 101).

A totally intrapsychic empathic process was elaborated by Reik (1948). The four phased process of identification, incorporation, reverberation, and, finally, detachment culminated in the objective analysis of the feelings of

another. Reik (1948) also referred to the instinctive ability to discern unspoken messages from others as "listening with the third ear" (p. 144). He observed that students are often taught to observe only what is presented to their conscious perception to the exclusion of seemingly insignificant signs which are much richer and finer. Reik (1948) felt that this ability to capture the meaning in the asides was a skill that could be demonstrated, but not taught.

> It can be demonstrated that the analyst, like his patient, knows things without knowing that he knows them. The voice that speaks in him, speaks low, but he who listens with a third ear hears also what is expressed almost noiselessly, what is said "pianissimo". (Reik, 1948, p. 147)

Reik (1948) also asserted that the third ear could be turned inward. In this way it provides an organ of hearing for the voices from within and allows one to be aware of what is inside oneself.

Katz (1963) regarded empathy as a basic human endowment and described it as a natural tendency; or a form of imitative instinct. He postulated that man is born to understand and that the capacity for visualizing and apprehending the feelings of other men is a part of his biological inheritance. He viewed empathy as an imaginative and intuitive part of human nature.

Philosopher, Martin Buber (1958) differentiated between the concepts of empathy and inclusion. He viewed empathy as gliding with one's feeling into the dynamic structure of an object. Therefore, a blurring of the position of the two beings resulted. He saw empathy as the exclusion of one man for the sake of the empathized other. Buber (1958) coined the term inclusion. Inclusion consisted of two major elements: a relationship and an event in which one person actively participated and a second person experiences from the standpoint of the other. Inclusion presupposed concreteness or a clinging to one's own distinct identity and provides the basis of the I-Thou relationship.

Phenomenologist, Edith Stein (1970) defined empathy as the taking in of a stimulus where it is integrated and returned as a response. She depicted empathy as an inner participation in a foreign experience. Through a process of phenomenological reduction she concluded that,

> Empathy is not perception, representation nor a neutral positing, but "sui generis." It is an experience of being led by the foreign experience and takes place in three steps: (1) The emergence of the experience, (2) the fulfilling explication, (3) the comprehensive objectification of the explained experience. (Stein, 1970, p. xiv)

The Conceptualization of Empathy in Social Sciences

Empathy may be conceptualized as a clinical use of one's natural empathic capacity. Clinical empathy has been designated as either predictive or interactive. Dymond (1949) conceived of empathy as the ability of one individual to accurately predict the attitude of another. Smith (1966) suggested that the Freudians, non-Freudians, sociologists, and psychologists stress that the perceived similarity to others forms the foundation of our understanding of them. In this vein, empathy becomes the tendency of a perceiver to assume that another person's feelings, thoughts, and behaviors are similar to his own.

The notion of empathy as a clinical tool was pioneered by Rogers (1957). He extended the concept of empathy to include the ability of the therapist to effectively communicate those accurate perceptions in a supportive way to the client.

Rogers (1957) identified empathy as the most important basis of a helping relationship which facilitates growth and described it as follows:

> . . . to sense the client's world as if it were your own, but without ever losing the "as if" quality--that is empathy, and this seems essential to therapy. . . . When the client's world is this clear to the therapist, and he moves about in it freely, then he can both communicate his understanding of which is clearly known to the client and can also voice

> meanings in the client's experience of which the client is scarcely aware. (Rogers, 1957, p. 99)

Carkhuff (1969) emphatically contended that without empathy there is no basis for helping. He described empathy as "crawling inside another person's skin and seeing the world through her eyes" (Carkhuff, 1977, p. 65).

Berenson and Carkhuff (1967) suggested that empathy occurred in five levels rather than as an all-or-none characteristic. At the first level the helper's responses detract significantly from the helpee's experience. At the second level the helper is responding to expressed feelings but does so in a manner which subtracts from the affect being communicated by the helpee. Level three is the point where both affect and content expressed by the helper and the helpee are interchangeable. This is designated as a minimal level for achieving growth or change. At both levels four and five the helper is adding significantly to the helpee's expressed feelings by going beyond what the helpee was able to express.

Berenson and Carkhuff (1967) also proposed that empathy occurred in stages within the helping process. At the first stage the helpee and helper content and affect are interchangeable. This is frequently demonstrated by reflection. It provides information about the helpee's internal frame of reference or representational system.

The second stage could be identified when the helper moves beyond what is being expressed and his responses become additive in nature. This allows the helpee to increase self-understanding. The third stage emphasized action. This stage would be reached when it was no longer necessary for the helper to explicitly verbalize or demonstrate an understanding of the helpee.

Truax (1966) compared the level of therapist offered accurate empathy in four psychoneurotic patients who showed clear improvement on a variety of personality tests with four who showed marked deterioration. Therapy sessions were taped for both groups. Trained judges evaluated 384 2-minute segments using the Accurate Empathy Scale. He found that patients who demonstrated improvement were exposed to psychotherapists who consistently offered high levels of accurate empathy.

A similar study was conducted with 14 hospitalized schizophrenics. Four-minute tape recorded segments were selected from every fifth interview. Naive raters used the Accurate Empathy Scale to quantify therapist offered accurate empathy. Comparisons were made between the mean level of therapist accurate empathy and personality and behavioral change in the patient. The correlation was significant at .77 ($p < .01$) (Truax, 1963). Similar

findings were also reported with a sample of outpatient schizophrenics (Truax, 1966).

The empathy scores of various professionals have been studied (Truax, Altman, & Millis, 1974). A sample of 112 registered nurses' empathy scores was compared to scores from 10 other occupational groups. The registered nurses were found to have low empathy scores. The only group that was less empathic was manufacturing plant supervisors. Similar findings have been reported in nursing research in this area (Duff & Hollingshead, 1968; LaMonica et al., 1976; Peitchinis, 1972).

Duff and Hollingshead (1968) interviewed medical-surgical nurses in a large teaching hospital. They reported that only a small proportion of the nursing staff knew anything about the attitudes of the patients toward their medical problems. They also reported that 70% of the nurses showed no evidence of empathy to the patients.

A thorough investigation of the available literature on the therapeutic effectiveness of counseling by nursing personnel revealed that nurses demonstrate low levels of empathy (Peitchinis, 1972). However, she noted that nurses were recognizing this lack of effectiveness and beginning to take steps to rectify the problem. Despite this

observation, more recent studies continue to reveal that nurses demonstrate low levels of empathic functioning (LaMonica et al., 1976). Twenty-four nurses were tested using the Carkhuff Index of Communication. The initial group mean was reported between a score of 1 and 2. A score of 3 on a 4-point scale represents the minimal level for accurate empathy to exist.

The Conceptualization of Empathy in Nursing

The willingness to listen and understand has long been touted as a special function of the nursing profession. The nurse was seen as someone who cares and who creates a helping atmosphere which facilitates healing, in old and new theories alike (Henderson, 1966; Leininger, 1978; Nightingale, 1946).

Zderad (1969) considered empathy as a means of knowing another person and of grasping his view of reality. She contended that empathy is a therapeutic tool which we use to reach our stated goals of "treating the whole person" or "recognizing each individual as unique" (Zderad, 1970, p. 49). She made the distinction between three separate dimensions of empathy. She viewed empathy as a psychologic process--an experiencing of oneness with another. The second dimension was seen as a physiologic response--

mirroring or motor mimicry. The final dimension was one of social feeling--from Adlerian psychology--meaning to "see with the eyes of another, to hear with the ears of anothers, to feel with the heart of another." She noted, ". . . the phenomena always involves a dynamic relationship between an empathizing subject and an empathized other" (Zderad, 1970, p. 49).

The distinction among four fundamental patterns of knowing in nursing was formulated by Carper (1978). She identified one of these fundamental patterns as esthetic knowing. This involves an active transformation of patient behavior into a perception of an expressed need. She classified empathy as a means of gaining knowledge of another person and as a mode in the esthetic pattern of knowing.

Empathy in Nursing Education

Several studies have been conducted on empathy in nursing education. These studies either examine methods of teaching empathy to nursing students, or measure the effect of nursing education on levels of nursing students' empathy.

Kalisch (1971) experimented in the development of empathy in nursing students. Two experimental and two control groups of 12 and 13 first-year students in an

associate degree program served as the sample. Empathy training and control classes were conducted within the context of an already existing nursing course. The experimental treatment involved didactic training, role-play, experiential training, and a role model of empathy. The control group received lectures and discussions on human behavior.

Treatment effects were evaluated by a one-way analysis of variance of change scores from pretest to the posttest on the: Accurate Empathy Scale; Barrett-Lennard Relationship Inventory, helper and helpee forms; predictive accuracy test with a classmate; Empathy Test (asks respondent to rank types of music and magazines in order of preference for selected groups of people); and clinical instructor evaluations of student empathy. Kalisch (1971) reported significant improvement in change scores on interactive empathy for the treatment group. These improvements were also maintained by the treatment groups on a 6-week follow-up test. The experimental group viewed themselves as more empathic while control group self-assessment did not change.

Patients did not perceive the treatment group participants as being more empathic. However, students who had received empathy training scored significantly higher

on a test of predictive empathy with patients. Yet predictive empathy with a classmate or generalized other did not change significantly. Finally, instructors evaluated students in the experimental group as significantly more empathic than their control group counterparts.

Layton (1978) compared the effectiveness of different modeling conditions in teaching empathy to 56 junior and senior nursing students. Five groups were created: modeling, modeling-labeling, modeling-rehearsal, modeling-labeling-rehearsal, and control group. She predicted that each added treatment would enhance the performance of the group. The treatment groups were shown videotaped vignettes. At the end, the participants were asked to complete an audiotaped interview with a trained, simulated client.

Empathy was measured in three ways. Audiotapes were evaluated using the Carkhuff Empathic Understanding in Interpersonal Processes Scale. Simulated clients completed the Barrett-Lennard Relationship Inventory. Participants completed an investigator developed parallel forms Empathy Test I and II, given respectively in a repeated measures design. Data analysis was carried out by multivariate analysis of variance. The experimental treatment was found

to have little, if any, effect. Only those groups which contained rehearsal as a component performed better than the control group.

The level of empathy in students entering and graduating from one baccalaureate nursing program and their faculty empathy level was examined by Thiesen (1981). Hogan Empathy Scale scores were analyzed for a group of 31 entering students, a group of 52 graduating students, and 13 faculty members. She found no significant differences in empathic functioning between the two student groups. The faculty members were reported to have significantly higher levels of empathy than the students in the study. Student demographic variables of sex, age, race, marital status, previous formal empathy training, and nursing interest area had no significant influence on empathy scores.

In another study, I. Rogers (1982) obtained an empathy rating on a cross section of baccalaureate nursing students using the LaMonica Empathy Construct Rating Scale (ECRS). She also investigated variation in empathy levels during different years of undergraduate study, tested the relationship between self-reported and patient reported empathy rating, as well as empathy rating and grade point average. The student sample consisted of baccalaureate

nursing students from two programs and included 55 sophomores, 34 juniors, and 46 seniors. The patient sample was comprised of 103 participants.

I. Rogers (1982) reported an overall mean empathy rating of 175.4 from a possible range of +252 to -252. The overall rating by patients was 188.7. Analysis of variance failed to demonstrate a statistically significant difference between classes. There were, however, significant differences between programs. A moderate correlation between self-reported and patient reported empathy ratings was noted. The study failed to demonstrate a relationship between empathy and grade point average.

Auvenshine (1982) attempted to identify selected factors related to the development of empathy as a component of human sensitivity in 207 baccalaureate nursing students. Correlations were used to determine the relationship between scores of the LaMonica Empathy Construct Rating Scale and time spent in a clinical learning environment. The scores were also correlated with the student perception of the clinical as either patient centered or task oriented. One-way analysis of variance was used to compare within and between groups of students across seven nursing programs. Unpaired *t*-tests were used

to compare beginning students with those near graduation, and those in private with those in public nursing programs.

The investigator was unable to demonstrate a significant relationship between time spent in the clinical experience and student empathy levels. The study showed that 2% of the variance was shared by amount of empathy and the degree to which students perceived that clinical experience as patient centered. There was no significant difference in empathy levels in beginning and graduating nursing students, nor in students from private and public institutions.

Lockett (1985) utilized a descriptive correlational design to study the relationship between self-concept and level of empathy in 34 second year associate degree nursing students. The variables were measured using the Tennessee Self-Concept Scale and the LaMonica Empathy Construct Rating Scale, respectively. Lockett (1985) rejected the research hypothesis that a positive relationship exists between self-concept and the student's level of empathic functioning.

Empathy in Nursing Practice

Many studies involving empathy within the clinical arena have been reported. Some studies examined nurse behaviors which were felt to demonstrate empathy. Other

studies have compared nurse empathy with patient perception of empathy. Still others have explored the relationship of nurse empathy and setting.

Mansfield (1973) studied verbal and non-verbal behaviors which facilitate empathic communication on initial interaction between a psychiatric nurse and a psychiatric patient. An experienced psychiatric nurse served as the single nurse participant. Initial interactions with six chronic schizophrenic patients, 33-52 years of age, were videotaped. Segments of the videotapes were judged by trained raters using the Accurate Empathy Scale (Truax, 1961). Those segments, in which there was high interrater reliability for nurse empathy scoring, were used to delineate specific verbal and non-verbal nurse behaviors. Several behaviors were consistent throughout and were grouped as: introduction to the patient; head and body position, verbal behaviors; response to non-verbal cues; facial expressions; voice tones; and, finally, mirror images.

Follstaedt (1982) considered whether certain non-verbal behaviors by the nurse had a positive effect on 29 preoperative patients' perception of nurse empathy. The non-verbal behaviors that were manipulated included forward trunk lean, eye contact, distance, and body orientation.

The researcher was unable to demonstrate a relationship between the nurse's exhibited non-verbal behavior and the patient's perception of nurse empathy as measured by the Barrett-Lennard Relationship Inventory.

Hurwitz (1976) studied empathy and its relationship to nurse-patient assignments. Four groups of seven nurse-patient dyads were studied. The groups were selected according to whether the nurse was working in a primary or secondary role and then further delineated by patient assignment or choice. Each dyad was audiotaped and a segment of each audiotape was coded according to a modification of the Kalisch Nurse-Patient Empathic Functioning Scale. Hurwitz (1976) determined that the level of empathy communicated to patients increased with an increased freedom by caregivers to select the patients with whom they worked. She also found increased empathy when caregivers were allowed to determine the amount of patient care they would assume.

The predictive relationship between empathic ability and selected demographic variables was investigated by Forsythe (1977). In addition, she examined the relationship between empathic ability of nurses and client perception of nurse empathy. Seventy nurses and 70 patients were sampled. The baseline empathy rating of the

nurses was obtained by using the Hogan Empathy Scale. Contrary to previous studies, the nurses in this sample demonstrated moderate to high levels of empathy.

The relationship between nurse empathy and client perception of nurse empathy was evaluated using the Barrett-Lennard Relationship Inventory. The inventory was completed on the basis of at least three interactions with a particular nurse. Ninety-eight percent of the patients in the study saw their nurses as highly empathic while nurses' scores on the Hogan Empathy Scale showed only 50% of them having high empathic ability.

Forsythe (1977) utilized a stepwise multilinear regression model to examine the predictive relationship between empathy and: age, marital status, parenthood, education, length of practice, and area of practice. She found a progressive increase in mean empathy scores by level of education. The difference in scores obtained by baccalaureate nurses was significantly higher than those obtained by diploma nurses. The empathy score obtained by associate degree nurses was higher than that obtained by diploma nurses, but the difference was not significant. The difference between associate degree and baccalaureate nurses was not reported. A negative correlation was noted between empathy level and length of practice. Yet, head

nurses obtained higher empathy scores than staff nurses. The investigator indicated some puzzlement at this finding since head nurses have likely practiced longer than staff nurses.

Forsythe (1977) was unable to report significant findings in relationship to age, length of practice, marital status, parenthood, level of practice, or area of practice. The client's perception of nurse empathy also did not have any predictive ability for determining nurse empathic ability.

An investigation of the variability in empathy of nurses in relation to a single variable, number of years in practice, was reported by Sowell (1979). In the study, the Helpee Stimulus Expressions: an Index of Discrimination (Carkhuff, 1969) was completed by 30 nurses whose practice spanned from 1 to 53 years. The investigator found that, as the number of years from first licensure increased, the level of empathy decreased.

Kramer and Schmalenburg (1977) speculated that empathy was a major factor in helping newly graduated nurses to adapt more readily to the work environment. They accepted that empathy is increased by common cultural and subcultural backgrounds and also by being able to consider multiple possibilities of meaning simultaneously. The

researchers proposed that the first job provided an opportunity for nurses to become competent in both a school and work subculture. The first job also provided an opportunity to develop new definitions for assessment, process, intervention, and responsibility in the work force. They hypothesized that this bicultural outlook provided the basis for the development of empathy between supervisory staff and the graduate nurse. Kramer and Schmalenburg (1977) surmised that bicultural nurses would be able to combat burnout in the workplace and experience less job dissatisfaction than their non-bicultural counterparts.

The relationship between job satisfaction and empathic functioning of nurses was formally examined by Harris (1983). Thirty-nine medical-surgical nurses completed the Hogan Empathy Scale and the Brayfield-Rothe Index of Job Satisfaction. Correlational techniques failed to reveal a significant relationship between the two variables.

Williams (1979) discovered that the aged subjects exposed to nurses who offered high levels of empathy increased their self-concept scores, while the elderly exposed to low empathizing nurses decreased their self-concept scores. She utilized a sample of 73 elderly people who had been residing in nursing homes and residential

homes for at least 1 year. Two nurse therapists were selected to participate as group leaders. One had high rated interactions on the Accurate Empathy Scale, while the other had extremely low interactions rated on the same scale. Subjects in both treatment groups and a control group were given the Tennessee Self-Concept Scale as a pretest and posttest. Videotapes of group therapy sessions were rated by trained psychiatric nurses.

Tyner (1985) suggested that there would be a significant difference in scores of middle and lower socioeconomic subjects who responded to empathy items of the Barrett-Lennard Relationship Inventory. Socioeconomic status was determined by use of the Hollingshead Two Factor Index of Social Position. Fifty-two medical and surgical patients were asked to answer questions on the inventory in relation to a nurse who had been assigned their care for 3 consecutive days. A test for independent samples was employed to analyze the data. The findings did not support that there was a difference in patient perception of nurse empathy on the basis of socioeconomic status.

Sparling (1976) predicted that the empathic abilities of nurses working in a psychiatric setting would differ from those working in a non-psychiatric setting. Fifty-seven nurses, 29 from a psychiatric unit and 28 from a

medical-surgical unit, completed the Carkhuff Helpee Stimulus Expression: an Index of Discrimination. A t-test comparison of the two mean scores showed that the nurses on the psychiatric unit were significantly more empathic than their medical-surgical counterparts. This finding contradicted the previous report by Forsythe (1977), that empathy was not related to nor predictable from the area of practice.

The influence of science and technology, as well as specialization, has been emphasized by Carper (1979). She indicated that the gains made in the empirical realm have been inversely accompanied by a diminished ability to care. The relationship between technology and empathy has been investigated in two studies (Brunt, 1983; Ebbs, 1980).

Ebbs (1980) studied empathy of critical care and medical-surgical nurses. She looked at the relationship between nurse empathy of levels and age, education and length of practice. The sample was comprised of 50 nurses, 25 from each specified area. Each participant completed the Hogan Empathy Scale. The group means were compared by using a t-test. No significant difference was identified. A multiple linear regression was used to see if demographic data could be used to predict empathy scores. A predictive relationship between age and length of practice with

empathy scores was established. However, no predictive relationship existed between education and empathy in the study. These findings are contrary to those reported earlier by Forsythe (1977).

Brunt (1983) predicted a significant negative correlation between empathy and technology. He hypothesized that nurses working in an intensive care setting would score lower on empathy than nurses employed in a less technological environment. Fifty-four registered nurses who worked in coronary care, cardiac rehabilitation, surgical cardiac intensive care, and cardiac surgery rehabilitation completed the Hogan Empathy Scale and an investigator developed Perceived Technology Scale.

Brunt (1983) found a significant difference in the nurses' scores on the Perceived Technology Scale among the four units. The following descending order in technology was noted: SICU > CCU > cardiac surgery rehabilitation > cardiac rehabilitation. The prediction that nurses working in intensive care units would have lower scores was not supported. The prediction that empathy and technology would be negatively correlated was also refuted.

Empathy in Continuing Education

A few studies have evaluated the effectiveness of staff development programs in increasing the empathic functioning of practicing nurses. A variety of program formats has been utilized.

LaMonica et al. (1976) evaluated the effectiveness of a staff development program in human relations in increasing empathy in registered nurses. The sample consisted of 39 nurses, 24 of whom were identified as low empathizers based on a pretest with the Carkhuff Index of Communication. The 24 low empathizing nurses were divided into two groups. Group one received the pretest, staff development program, and posttest. The second group received only the pretest and posttest. The remaining nurses were placed in a third group to control for test-retest effects and time. The researchers did not find a significant relationship between pretest scores in the treatment group and the first control group. Using a Kruskal-Wallis one-way analysis of variance, the researchers found a significant difference in means of posttest scores between the treatment group and both control groups. There was no difference in posttest control group means.

Semands (1986) used a two group pretest-posttest experimental design to evaluate the effect of guest relations training on nurse empathy and patient satisfaction. The sample consisted of 47 nurses, 23 were in the experimental group and 24 comprised the control group. The experimental group received an 8-hour guest relations training program. All subjects were pretested and posttested with the Hogan Empathy Scale. Data were collected from 254 patients using the Risser Patient Satisfaction Inventory. The investigator was unable to demonstrate a significant change in pretest-posttest empathy scores for the treatment group using a two-way analysis of variance. Using the same statistical technique, Semands was unable to demonstrate a significant difference between treatment and control groups.

The Measurement of Empathy

The precise measurement of empathy has presented problems. Many different ways of operationalizing empathy are presented in the literature, but none has emerged as the best means of measurement. Instruments that purport to measure empathy fall into three general categories: self-rated scales, judge-rated scales, and client rating instruments.

A researcher's choice of a tool would be dependent upon the chosen methodology and also the intent to measure predictive or interactive empathy. The following measurement devices were those most frequently discussed and utilized in the literature reviewed. The instruments are representative of each of the categories of instruments.

The very first empathy scale reported in the literature was developed by Dymond (1949) to measure predictive empathy. The instrument was utilized as a classroom exercise. The test is made up of four parts, each containing the same six traits: self-confidence, superior-inferior, selfish-unselfish, friendly-unfriendly, leader-follower, and sense of humor. Part one asks the respondent to rate himself on a 5-point scale on each of the six characteristics. In part two, another individual is rated on the same traits. The third part ask the respondent to rate another individual as he believes the other person would rate himself. Finally, the subject rates himself as he believes the other person would rate him. The results from a pair of respondents' ratings of each other are compared.

Ten subjects from the original 53 participants, representing the 5 most and 5 least empathic, were asked to

take the Thematic Apperception Test (TAT). The subjects identified as high empathizers on the Dymond (1949) test were also rated as highly empathic on the TAT. Four of the five low empathizers demonstrated low empathy on the TAT. The fifth low empathizer was rated high on the TAT. Test-retest reliability was reported as .60.

Truax (1961) devised the Accurate Empathy Scale (AES) to measure one of the central therapeutic ingredients identified by Rogers (1951). The scale is highly inferential and crude in construction. Truax and Carkhuff (1967) stated that the scale represented a beginning attempt to operationalize the concept of accurate empathy. The scale is composed of nine stages which describe therapist behavior. The behaviors range from "therapist seems completely unaware of even the most conspicuous of the client's feelings" to "therapist in this stage unerringly responds to the client's full range of feelings in their exact intensity" (Truax & Carkhuff, 1967, p. 47). The scale was designed for use with live observation or tape recording of individual counseling. The interrater reliability for this judge-rated scale was reported to be .87.

No estimates of validity are reported. Truax and Carkhuff (1967) relied on the face validity of the tool.

The concept measured by the tool was significantly related to client therapeutic outcomes and believed to constitute a central therapeutic ingredient (Truax, 1963).

The Accurate Empathy Scale (1961) has been utilized extensively. Many modifications have been spawned from the original scale (Bergin & Solomon, 1963; Carkhuff, 1969; Kalisch, 1971; Reddy, 1969).

The Barrett-Lennard Relationship Inventory (1962) consists of 92 multiple choice items. The items were developed from the theoretical description of conditions of therapy (Rogers, 1951). The items measure four variables: level of regard, empathic understanding, congruence, and unconditionality of regard. In its original form, a fifth variable, willingness to know, was also measured. This variable was deleted, but the rationale for the decision was not made clear. Parallel forms were developed for both client and therapist testing.

The respondent is asked to rate his feeling about his therapist's response to him. The choices range from -3 rating to a +3 rating on each question. The items are arranged so that each fifth item represents the same variable. Positively stated and negatively stated items are randomly arranged.

Content validation was carried out by having experienced judges classify each item as a positive or negative indicator of a concept. The strength of the indicator was also identified. The internal consistency was assessed by the split-half method. Clients' coefficients for subscales ranged from .82 to .93 (N = 42). Therapist coefficients for subscales ranged from .88 to .96 (N = 40). Test-retest reliability coefficients were .84 to .90. Construct validity was demonstrated by high scores on the inventory by both clients' and therapists' scores being significantly related to change scores on the Taylor Manifest Anxiety Scale and a Q-adjustment score.

A 64-item empathy scale was developed by Hogan (1969) and is used to measure interactive empathy. Q-sort description of an empathic man was used to develop a conception of the behavioral connotations of empathy. From these data the empathy criterion was constructed. Trained observers collected data from 100 military officers, 45 research scientists, and 66 student engineers. The descriptions of each individual were correlated with the empathy criterion. The ratings ranged from -.58 to +.68. An item analysis of the subjects' responses on a 100-item Q-sort was performed. Responses of high and low subgroups were compared with the California Psychological Inventory

(CPI), the Minnesota Multiphasic Personality Inventory (MMPI), and a pool of items from the University of California's Institute of Personality Assessment and Research (IPAR). Sixty-four items were selected, 32 scored true and 32 scored false. Thirty-one items were selected from the CPI, 25 from the MMPI, and the remaining 8 from the IPAR test pool. Hogan (1969) noted that 17 of the items selected failed to attain statistical significance, but were retained because of their relevant content.

The correlation between the scale and the empathy ratings in the sample used for its development was .62. However, in an independent sample of medical school applicants, the correlation fell to .39. Test-retest reliability was reported as .84. Split-half reliability yielded a coefficient of .71.

A Nurse-Patient Empathic Functioning Scale was reported in the nursing literature (Kalisch, 1973). This instrument was largely based on the Accurate Empathy Scale (Truax, 1961). There were no studies reported using this particular scale. However, one study reported the use of an investigator developed version or modification of this scale (Hurwitz, 1976).

LaMonica (1981) reported the development of the Empathy Construct Rating Scale (ECRS). The ECRS is an

84-item test that deals with a person's feelings or actions toward another person. The respondent reads each statement and decides the degree to which the statement is like or unlike his perception of himself, his nurse, or his associate. Response options range from -3 (extremely unlike) to +3 (extremely like).

Fifty graduate students of psychology and nursing were asked to write five statements that describe behaviors of people who exhibit well-developed empathy and five statements which describe behaviors of people who lack empathy. Expert judges then rated the statements using a Likert-type scale as being representative of behaviors that totally lack empathy to behavior that represented extremely well developed empathy. Any item rated as unclear indicators by the judges was deleted. From the pool of items left, a 100 item instrument was developed. Reliability was determined by having students rate the most empathic person they knew and the least empathic person they knew. The coefficient alpha was .97 and .98, respectively. The split-half coefficient was .89 and .96, respectively.

Two procedures were used to estimate construct validity of the instrument. The multitrait-multimethod approach was utilized in conjunction with traits from

several other psychological inventories. The characteristics of the factor analysis of the data suggested that empathy does not share variance with any other factor evaluated. A factor analysis of the ECRS was carried out. Based on data collected by the two techniques, an 84-item instrument was developed.

Two factors are measured by ECRS: well-developed empathy and lack of empathy. The scale has discriminant validity when used as a self-report or as a rating scale by a client (LaMonica, 1981).

Kurtz and Grummon (1972) studied the different approaches to the measurement of therapist empathy and their relationship to therapy outcomes. They maintained that client perceived empathy was the best predictor of client outcome, with tape judged empathy being less related to client outcomes and self-rated empathy as being particularly suspect.

Gagan (1983) noted that tools utilizing self-ratings carry a potential for inherent bias. She pointed out that self reporting relies on a cognitive understanding or cognitive appreciation of empathy and does not attempt to measure empathic ability in operation. Judged scales also preclude direct experiencing of the communication process and depend upon accurate interrater reliability. Gagan

(1983) evaluated the Barrett-Lennard Relationship Inventory (1962) within the context of the nurse-patient relationship. She documented the need for further explanation about the specific meaning of questions within that relationship. She reported that patients felt that the questions were too difficult to answer and that their exposure to a given nurse did not provide them with enough information to make sound judgements.

Summary

Numerous studies have been conducted to assess the level of empathic ability in nursing subjects. Attempts have also been made to increase the empathic functioning of both practicing nurses and nursing students. Researchers have endeavored to demographically describe the empathic nurse. These attempts have resulted in contradictory findings (Forsythe, 1977; Sowell, 1979; Sparling, 1977). Nurse behaviors, which are identified as indicators of empathy in one study, are found to have no significant relationship to patient perception of nurse empathy in other study (Follstaedt, 1982; Mansfield, 1973). The inverse relationship between empathy and technology that was speculated to exist (Carper, 1979) was not found in formal studies (Brunt, 1983; Ebbs, 1980). The direct relationship between job satisfaction and empathy that was

hypothesized by Kramer and Schmalenburg (1977) was refuted by a study of these two variables (Harris, 1983).

Nursing definitions of empathy have been borrowed from the theoretical works in psychology and counseling. Nursing studies have utilized instruments developed by these related disciplines to measure empathy within a counseling setting. In light of the confusing and contradictory results reported in the nursing literature, the researcher asks if empathy within a nurse-patient relationship is the same as that encountered in other therapeutic relationships. Subsequently, the expedience of the decision to use instruments developed in other therapeutic disciplines must also be questioned.

CHAPTER III

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

The Phenomenological Movement originated in Europe in the late 1800s. The figure central to the development of the phenomenological approach was Edmund Husserl. He has been attributed with being the founder of this philosophy. The Phenomenological Movement developed in response to an identified need to answer questions unanswerable by the scientific methods prevalent in that time period. Husserl developed a radical conviction that knowledge was to be found in the consciousness of the knowing subject (Spiegelberg, 1982; Valle & King, 1978).

Husserl aspired to achieve freedom from presupposition. He accomplished this by eliminating presuppositions which had not been thoroughly examined (Spiegelberg, 1982).

Husserl's work included an investigation of the intentionality of consciousness and phenomenological intuiting. His work evolved into a study of the essential structures of the acts and contents of consciousness--the intuitive grasping of essences of phenomena. He developed the concept of phenomenological reduction. He conceived of

this occurring in two stages: (a) reduction from facts to general essences (eidetic reduction), and (b) the phenomenological reduction in which phenomena are freed of everything except that which is absolutely given (Spiegelberg, 1982).

The existential-phenomenological psychologists referred to this process as bracketing (Valle & King, 1978). The bracketing process provided for control of investigator bias. In order to see lived-experience, a researcher must suspend what he thinks he knows about the experience and allow the data to prevail. Merleau-Ponty (1962) viewed bracketing as a matter of peeling away layers of interpretations. He viewed bracketing as a never-ending attempt to move beyond the natural world to a phenomenal realm. He remarked that the "most important lesson that reduction teaches us is the impossibility of a complete reduction" (Merleau-Ponty, 1962, p. xiv).

The development of the theme of Lebenswelt or the world of lived-experience is attributed to Husserl. However, this concept went virtually unnoticed until it was introduced several years after Husserl's death by Merleau-Ponty (Spiegelberg, 1982).

Husserl's work served as a catalyst for the development of phenomenological studies in the field of

psychology and sociology. Social scientists recognized that human behavior could not be adequately explained by the scientific philosophy and techniques of the positivists that had overwhelmed the development of science in the latter half of the 19th century. Human experience was excluded from the experimental model because it is neither observable nor quantifiable (Valle & King, 1978).

Colaizzi (1978) summarized the phenomenological assumptions regarding experience as follows:

> Experience is (a) objectively real for myself and others, (b) not an internal state but a mode of presence to the world, (c) a mode of world presence that is significant, and (d) as existentially significant, it is a legitimate and necessary content for understanding human psychology. (p. 52)

The philosophy of phenomenology that was conceived by Husserl and developed by both him and his followers formed the foundation of several phenomenological research methodologies (Colaizzi, 1978; Giorgi, 1975; 1979; Van Kaam, 1959).

The influence of the logical positivists has also been felt in nursing. Even after the positivists experienced a declining influence in other fields, nursing still clings to the experimental model as the only means of producing knowledge. Ludeman (1979) contended that nursing's continued fidelity to the scientific method in education and research has placed qualitative methodology in a second

rate position. Support has been given to her stance by Leininger (1984) who stated that master's and doctoral students are almost exclusively exposed to faculty who value the quantitative research methodology. She indicated that these students are often taught that quantitative research is the only way to produce sound scientific data. Leininger (1984) stated qualitative methods were presented as being unscientific. She speculated that because of their descriptive and exploratory nature, qualitative methods are presented to students as producing lower level knowledge than experimental methods.

Within the last few years nursing has recognized the implications of the concepts developed by Husserl and subsequent phenomenologists in the study of human beings (Davis, 1978; Oiler, 1982; Omery, 1983).

Davis (1978) suggested that students who enter doctoral programs in nursing are well versed in a clinical approach which "emphasizes observation, interviews, interaction, and interpersonal relations in an attempt to understand the patient's definition of the situation" (p. 194). She speculated that many of the researchable problems associated with the nursing process would align themselves readily with the concepts of phenomenological inquiry.

Oiler (1982) contended that nursing is concerned with the lived experience of patients. The nurse is concerned with obtaining an accurate view of the reality of the patient's experiences. She asserted that in this sense, phenomenology offered a promising approach for nursing research.

Omery (1983) stated that the scientific method has become restraining. The reductionistic nature of the method which partitions human beings into increasingly smaller bits, has not provided nurses with the information necessary to fit these accumulated bits back together into an integrated whole. This particular position has been supported by others in nursing (Swanson & Chenitz, 1982; Watson, 1981).

Watson (1981) identified that the issues central to early nursing theorists were lost or submerged by the credibility given the Received View including the processes of reductionism, quantification, objectivity, and operationalization. She stressed the need to change the research process in nursing to consider the wholeness of individuals.

Swanson and Chenitz (1982) believed that nursing should be concerned with becoming more sure of things which are already known or discovering the unknown. They

contrasted this with the current research tradition in which investigators are concerned with the precise measurement of variables which exist only in a preconceived notion of reality.

Some critics have referred to the scientific method as a ghost which must be exorcised before nursing can progress (Webster, Jacox, & Baldwin, 1981). However, moderates in the field of nursing research have taken the stance that although quantitative and qualitative methods represent different paradigmatic perspectives, they are not mutually exclusive (Goodwin & Goodwin, 1984). There is a growing number of investigators who are unwilling to let the methodology dictate the phenomena of study but have instead chosen a research style that is consistent with the phenomena.

This contingency approach to the selection of a research tradition allows for the selection of a methodology for its promise of providing answers to the questions of concern. Its ability to do this depends upon the "goodness of fit" between the phenomena and the methodology (Bargagliotti, 1983). In addition, some investigators have advocated the use of a combination of qualitative and quantitative methods in one study. They felt this allowed for a comprehensiveness that neither

approach could achieve alone (Goodwin & Goodwin, 1984; Price & Barrell, 1980).

The research methodology selected for the present study was the qualitative one of phenomenology. The study was concerned with nurses' lived experience of empathy in a nurse-patient interaction. The problem is one of describing the essence of empathy in a situation and attempting to construct a general framework of empathy in nurse-patient interactions from the point of view of the emapthizer or nurse.

Omery (1983) described the phenomenological method as an inductive, descriptive research method. The goal of the method is to "describe the total systematic structure of lived experience, including the meanings that these experiences had for the individuals who participated in them" (p. 50). The characteristics of empathy and the intuitive domain of its existence dictated a phenomenological approach to answer the questions proposed by the study.

Setting

Nurses were interviewed by the investigator to gather data for the present study. The source of the participants was health care agencies which employ registered nurses and referrals from professional associates of the investigator.

The study was carried out in a town in north Texas that has a population of approximately 60,000. The interviews were conducted in an office or in a mutually agreed upon location.

Population and Sample

The population consisted of female registered nurses currently working in health care agencies. They varied from 25-50 years of age. They had practiced as registered nurses for at least 2 years prior to the interview.

The participants were selected by a purposive sampling technique (Kerlinger, 1973; Polit & Hungler, 1983). Voluntary participation was solicited. Nurses were selected because they met the above criteria, demonstrated a willingness to participate in the study, and were willing to have their voices and responses audiotape recorded.

Colaizzi (1978) stated that with phenomenologic methods the motive for selection of a participant should be the person's experience with the phenomenon under investigation, and the person's ability and willingness to express himself in a manner necessary for the design of the study.

Buhler and Massarik (1968) emphasized the centrality of life goals and intentionality through the life course. They viewed life experiences within a complex orientation

to past, present, and future. They believed that psychological growth was prompted by hoping for attainment of future goals and by achieving a sense of fulfillment of life goals. The years included in adulthood (25 years to 50 years of age) were viewed as a time for setting definite goals and striving to achieve them. The age group identified in the sample was selected because they are considered to be within the same developmental stage (Buhler & Massarik, 1968).

Forsythe (1977) found that there was a slight inverse relationship between nurses' empathy level and length of practice; however, this finding was not statistically significant. She also noted that nurses who held head nurse and supervisory positions had greater empathy than staff nurses, even though these positions are frequently obtained after years of practice. She concluded that a predictive relationship did not exist between a nurse's empathy level and her length of practice.

Two years was chosen as a minimum length of practice for the participants in this study. This was considered a minimum time span to have acquired a sufficient breadth of nursing experience and to have experienced empathy in a nurse-patient interaction.

Omery (1983) stated that due to the length of the data collecting interviews and the detail of description, the sample size is generally small. Interviews were conducted until common themes emerged.

Protection of Human Subjects

This study was submitted to the Committee for the Protection of Human Subjects of the Texas Woman's University. Permission was obtained from this committee prior to data collection, as well as Graduate School permission.

The participants were asked to read an explanation of the study. If the nurse volunteered and agreed to participate in the tape recorded interview, the nurse was asked to read and sign a written consent form in accordance with the requirements set forth by the Committee for the Protection of Human Subjects.

The participant's name did not appear on the typewritten transcript. The audiotaped interviews were erased after they were transcribed. All participants were given the opportunity to withdraw from the study at any time before, during, or after data collection without any penalty.

Instruments

Two instruments were used for data collection in the study. The first instrument was a Demographic Data Questionnaire. The questionnaire was designed by the researcher to assure that volunteers met the proposed criteria. The information included age, gender, date of first licensure to practice as a registered nurse, collective length of employment, current employment setting, and job role. The data were also used to describe the sample.

The second instrument utilized was an investigator-developed interview guide. The interview guide was developed to elicit a full description of one's experience of empathy in a nurse-patient interaction as lived by each nurse participant.

The interview method was chosen because it provides a rich source of data. The questions were developed to tap the participant's experience rather than theoretical knowledge of empathy (Colaizzi, 1978).

The same questions were used with each participant as well as the same means of data collection. Clarification was sought by bracketing to maintain the integrity of the participants' experiences. The data obtained from them had face and content validity (Colaizzi, 1978; Eckartsberg,

1971). Validity is understood to be present if the essences describe what is given to the consciousness of the researcher. Reliability exists if one can use the description consistently (Giorgi, 1987).

Data Collection

After agreeing to participate and assuring that the participants had read an explanation of the study and given written consent, they were asked to complete the Demographic Data Questionnaire. The interview was then conducted by the researcher. The interview guide consisted of three open-ended questions which were expected to elicit a full and accurate description of the essence of empathy in one nurse-patient interaction. The researcher sought to describe this phenomenon of human experience in its "fullest breadth and depth" (Spiegelberg, 1965, p. 2).

Data collection with each participant required approximately 30 to 60 minutes. An additional 10 to 15 minutes were required for a follow-up interview to assure the validity of the descriptive analysis.

Treatment of the Data

Following data collection, the audiotaped recordings were transcribed in their entirety. The transcriptions

were then analyzed according to the method proposed by Colaizzi (1978):

1. Read all of the subjects' descriptions (protocol) in order to acquire a feeling for them.

2. Return to each protocol and extract significant statements. These are phrases or sentences that directly pertain to the investigated phenomenon. Repetitive statements found in several protocols can be eliminated. Statements referring to specific points can be transposed into a general formulation.

3. Meanings are formulated. The researcher uses creative insight to move beyond protocol statements to arrive at meanings without severing connection with the original protocols. Colaizzi (1978) stated that this was a precarious task because the formulations "must discover and illuminate those meanings hidden in the various contexts and horizons of the investigated phenomenon" (p. 59).

4. Organize the aggregate formulated meanings into clusters of themes.

    a. The cluster of themes is validated. This is accomplished by referring back to the original protocols. Validity is assured if the cluster of themes contains everything that is accounted for in the original protocols and nothing that isn't implied

or proposed by the original description. If validity is violated then the preceding procedures must be conducted again.

b. Some ambiguity must be tolerated. If discrepancies or contradictions are noted, the researcher "must proceed with the solid conviction that what is logically inexplicable may be existentially real and valid" (Colaizzi, 1978, p. 61).

5. An exhaustive description of the phenomenon is generated from the results.

6. Formulate the exhaustive description of the phenomenon into a statement of identification of its fundamental structure.

7. A final validation is accomplished by returning to the subjects and asking them to compare the descriptive results with their experience. Any additions to or deletions from the descriptions must be worked into the final descriptive product.

Pilot Study

A pilot study was conducted to determine the feasibility of carrying out a study designed to identify the essential structure of empathy and constructing a framework of the lived-experience of empathy from the

perspective of the nurse empathizer in nurse-patient interactions.

Problem Statement

The research problem of the pilot study was: What is the essence of nurses' lived experience of empathy in a nurse-patient interaction?

The purpose of the pilot study was to determine if the lived experiences of empathy from the nurses' perspective could be reached without preconceived perspectives.

Conceptual Orientation

Nurses have been challenged with providing quality nursing care within the context of a helping, nurse-patient relationship. In order to accomplish this, nurses must be able to respond in a constructive manner. It is essential that nurses investigate the recurring phenomena that influence positive patient outcomes. Wiedenbach (1963) declared that,

> Nursing is a helping art--a deliberate blending of thoughts, feelings, and overt actions. It is practiced in relation to an individual who is in need of help, is triggered by a behavioral stimulus from that individual, is rooted in an explicit philosophy and is directed toward fulfillment of a specific purpose. (p. 4)

Watson (1979) conceptualized nursing as the science of caring. She believed that the development of a

helping-trust relationship was closely linked to the promotion and acceptance of the expression of positive and negative feelings. She stated that "helping others . . . may be the ultimate health intervention . . . one that not only prevents illness but also promotes a higher quality of life and a higher level of wellness" (Watson, 1979, p. 304).

Travelbee (1979) contended that empathy was the nurse's most valuable tool in communicating with her patients. The ability to align herself empathically with the patient or "being with" the patient allows the nurse and the patient to accept the unique life experience being shared (Travelbee, 1979).

The review of the literature revealed numerous studies which measured empathy in nurses and nursing students, attempted to correlate empathy to other concepts, and investigated the effect of different methodologies on empathy development. However, these studies were conducted with the assumption that the expression of empathy by a nurse will be the same as that expressed by a counselor or in a counseling situation. The instruments utilized in these studies were developed for use by counselors and cannot be readily applied to the nursing situation.

Additionally, no research has been done to delineate or describe empathy within the confines of nursing.

The conceptual orientation for the pilot study was comprised of a phenomenological approach to the formulation of the essence of the lived experience of empathy from the nurses' self-defined description of empathy. Swanson and Chenitz (1982) stated that qualitative research, by its very nature, is applicable to nursing. Furthermore, the qualitative research approach of phenomenology conceptually is congruent with nurses' clinical approach (Davis, 1973).

Population and Sample

A nonprobability purposive sample of two was selected for inclusion in the study from the general population of registered nurses, age 25-50, who had at least 2 years of post-graduation experience. The nurses came from a general population of registered nurses in north central Texas. Participants were obtained through personal contacts of the researcher. All of the participants were known to the researcher prior to the interview. The following criteria were used to select participants:

1. The participants had to speak and read English.

2. The participants had to be able to provide a personal meaning of empathy and identify at least one

situation in which they perceived themselves to have been empathic.

3. The participants had to indicate a willingness to discuss their empathic experiences.

4. The participants had to be 25-50 years of age.

5. The participants had to have at least 2 years of nursing experience.

All the participants met all the criteria. The participants were 30 to 36 years of age with 4 to 10 years post graduation nursing experience.

Instrument

The interview guide was composed of the following questions:

1. Please describe a nurse-patient interaction in which you were empathic. Describe the situation fully.

3. Describe the meaning that the interaction had for you.

Data Collection

Preliminary Participant Preparation

The Texas Woman's University Human Subjects Review Committee required the researcher to complete these steps to ensure protection of the human rights of the subject.

1. Prior to conducting the pilot study, permission was obtained from the Texas Woman's University Human Rights Committee (Appendix A).

2. Participants were screened for the subject's willingness to describe an empathic experience and the personal meaning for the experience.

3. Written explanation of the purpose, risks and benefits, and the methodology of the study were reviewed by the participants prior to the interview (Appendix B). The researcher answered questions posed by the participants before and after the interview.

4. The participants provided witnessed, written informed consent forms allowing the researcher to conduct the study using a tape recorder (Appendix C).

5. A demographic data sheet (Appendix D) was completed by the participants to collect data on age, gender, and length of practice.

Interview Format

Individual interviews were conducted by the researcher with each participant. The interview was conducted using an open-ended approach. Researcher responses were reflective and clarifying rather than analytical.

The interview sessions took approximately 30 minutes. Participants were given an opportunity to add new content

to the previous descriptions. Both of the participants felt that their descriptions of empathy were complete.

The interview data were transcribed and analyzed. Both of the participants were contacted by the researcher to validate whether the structures from the data were congruent with the participants' perceptions of empathy. Both of the participants concurred with the cluster of themes.

Data Treatment

The design was a descriptive pilot using the Colaizzi (1978) phenomenological methodology. The specific method used was protocol analysis of transcribed tape-recorded interview descriptions of two registered nurses.

Colaizzi's (1978) phenomenological methodology included these steps.

1. Read all the subject's descriptions (protocol) in order to acquire a feeling for them.

2. Return to each protocol and extract significant statements. These are phrases or sentences that directly pertain to the investigated phenomenon. Repetitive statements found in several protocols can be eliminated. Statements referring to specific points can be transposed into a general formulation.

3. Meanings are formulated. The researcher uses creative insight to move beyond protocol statements to arrive at meanings without severing the connection with the original protocols. Colaizzi (1978) stated that this was a precarious task because the formulations "must discover and illuminate those meanings hidden in the various contexts and horizons of the investigated phenomenon" (p. 59).

4. Organize the aggregate formulated meanings into clusters of themes.

a. The cluster of themes is validated. This is accomplished by referring back to the original protocols. Validity is assured if the cluster of themes contains everything that is accounted for in the original protocols and nothing that isn't implied or proposed by the original description. If validity is violated then the preceding procedures must be conducted again.

b. Some ambiguity must be tolerated. If discrepancies or contradictions are noted, the researcher "must proceed with the solid convictions that what is logically inexplicable may be existentially real and valid" (Colaizzi, 1978, p. 61).

Results

The interview of the two subjects' lived experience of empathy provided voluminous and meaningful data. Each participant had the opportunity to choose her own situation and share the meaning she attached to that experience. The assumption that nurses could identify and communicate their experiences of empathy was met, as was the assumption that the research questions would elicit accurate descriptions of the concept of empathy.

Validity and Reliability

Validity was established following completion of data analysis by presenting the conclusions developed from the first four steps of data analysis to each of the research participants who verified that the cluster of themes represented their lived experiences with empathy. All data were analyzed using the Colaizzi (1978) methodology.

A listing of significant statements that were extracted from the transcribed text of the interviews are presented in Table 4.

Table 4

Significant Statements Extracted from Interviews

1. It wasn't until later that I really became involved with him.
2. Always had him.
3. His neuro status was improving, and you just like grasp at it.
4. He became more of a person.
5. At that point he became a retrospective individual.
6. It was like you could feel the joy in that.
7. You get so excited and you'd get angry when someone took care of that patient that did not do as good of a job.
8. That was going to make a difference.
9. I became real involved with his family.
10. It's just like that you could really feel with him because you were that close and because you kind of had that quiet time, sometimes.
11. But when you became that close to a patient, you made the time then or you would make it sometime later, you know.
12. The anger that I felt was just unreal.
13. It felt like a part of me had left.
14. I really missed him.
15. I shared a lot of my heart with him and the family and became real involved with them.
16. We put ourselves into that situation.

(table continues)

17. What if that was my brother?

18. What if that was my family member?

19. If I was in that situation, I would want someone to care . . . to give everything to me as a patient.

20. Putting myself in that situation makes me feel more for that patient.

21. Build up that rapport with the family, to have the continuing . . . see the progress and defeats.

22. Short-term patients, they don't have this much to give back either.

23. You get real attached.

24. You are not just the person taking care of them, you are actually a human being.

25. You have a name and a place in their lives during their time of need.

26. I think if you can give someone a little part of yourself and make them feel good or make them feel cared about.

27. She was a very sad situation.

28. Just sitting with this woman and spending time with her.

29. She seemed to respond to just another person caring and taking the time to sit.

30. The more someone would do that, the more she would kind of get out of her rut, stay out of her room more, and actually maybe become involved a little bit with the other patients.

31. Just the look of fear on their faces.

32. Was quite emotional to me.

(table continues)

33. Spending time with these people.

34. Just spending time with the family.

35. The joy in their faces that he was going to be okay.

36. His mother was just obviously, just very hysterical.

37. As I would have been as a mother also.

38. I spent some time with her trying to help her realize.

39. We talked at some length.

40. I felt a sense of empathy at that time, you know, as a mother.

41. I was able to do a little bit more than just taking the blood pressure.

42. As a person, one human being to another.

43. Maybe make a difference.

44. They felt that they were at the end of their ropes or that they couldn't see how they were going to go on from the situations they were in.

45. Just to spend a little time, talk to them, teach them a little bit about what was going on.

46. Maybe it made a little difference in their lives.

47. They want to share something with you.

48. Just being there for them.

49. It's a good feeling.

50. Was very rewarding.

From the significant statements that were extracted from the transcriptions of the interviews, a cluster of

themes was synthesized. Table 5 represents the cluster of themes that was derived from the interviews.

Table 5

Cluster of Themes

1. Role-taking
   a. One discovers aspects of another's feelings by imaginatively assuming another's role.
   b. Self-vulnerability is imagined in given situations.
   c. Shared experiences promote intimacy.
2. Opportunity for involvement
   a. One must make a time commitment.
   b. One must be willing to invest emotionally with the client.
   c. Mutual responsiveness allows for bonding or attachment to occur.
3. Appreciation of the human condition.
   a. One acknowledges the human condition on an emotional level.
   b. Concern for another's well-being is demonstrated.
4. Rewards
   a. One believes that individual involvement made a difference.
   b. Belief is affirmed by identification of positive emotions at closure.

CHAPTER IV

ANALYSIS OF DATA

This chapter presents a description of the sample and findings of the study. The findings are described according to each step of data analysis and include a description of significant statements, formulated meanings, themes, and a description of the essential components of empathy in nurse-patient interactions. The chapter concludes with a summary of the findings.

Description of the Sample

The sample of participants who agreed to participate and whose protocols were analyzed consisted of five registered nurses between 27 and 37 years of age. The sample was a purposive sample identified by the researcher for meeting criteria for inclusion in the study.

Of the five participants, all were Caucasian females. Three were baccalaureate graduates, one held an associate degree in nursing, and one was a diploma graduate. The participants had practiced as registered nurses for 4 to 10 years following licensures. Table 6 describes the demographic data for each participant whose interaction was used throughout the analysis.

Table 6

Description of Sample by Demographic Variables

Age	Gender	Licensed	Length of employment
30	female	1978	10 years
36	female	1984	4 years
33	female	1980	9 years
37	female	1980	8 years
27	female	1984	5 years

N = 5.

Findings

Situation of Empathy

Participants were allowed to describe any interaction which they felt represented an empathic interaction between nurse and patient. Only two participants chose to describe interactions from their current job role and setting. One participant from an ambulatory care setting chose to describe more than one brief interaction. The general themes of the interactions for the five protocols were:

1. Seven-year-old male being treated in an emergency room for acute exacerbation of asthma.

2. Twenty-four-year-old male automobile accident victim being care for in ICU, post-operative craniotomy with multiple complications.

3. An elderly male with a known diagnosis of cancer being treated in an emergency room after becoming unresponsive.

4. Twelve-year-old male, newly diagnosed as having a malignant brain tumor, being cared for in a progressive care unit.

5. Three-year-old in pediatric intensive care unit suffering from multiple metabolic problems including juvenile diabetes, liver failure, and hepatitis A.

6. Intoxicated 16-year-old being treated in an emergency room following an automobile accident.

Extraction of Significant Statements

The tape recordings were listened to repeatedly in order to get a feel for the interactions described. The recordings were then transcribed. Transcripts were read several times at intervals to allow for comprehension of data. Significant statements were highlighted, coded, and numbered. These statements consisted of phrases, complete sentences, or small groups of sentences. Repetitive statements were eliminated.

Formulated Meanings

Each extracted significant statement was utilized to formulate a meaning. Formulated meanings were then referred back to the original protocol to assure that the connection with the original protocol was not severed. Formulated meanings were developed from the context of the statements in the protocol. Examples of significant statements and formulated meanings from each protocol are listed in Table 7.

Table 7

Examples of Significant Statements and Formulated Meanings

Examples from M:	
SS:	Initially, his technical needs took up more of my time.
FM:	Technical needs can be a priority involving a lot of the nurse's time.
SS:	Just, I guess, putting myself in that situation makes me feel more for that patient.
FM:	Imagining herself in the patient situation promotes a common ground closeness with the patient.
Examples from P:	
SS:	After we got the situation a little bit more under control, we got mom back in to let her touch him and see that, yes indeed, he was alive, but was not by any means out of danger at that point.

(table continues)

FM: The nurse responded to the mother's need to be close and touch her son.

SS: This hit home quite a bit with her. The fact that she had been spending all this volunteer time, you know, working with young people involved with alcohol and drugs and you know, here is her son lying on this stretcher so drunk that he could hardly breathe for himself and it was quite a shock to her.

FM: The nurse recognized the compromising situation the mom found herself in.

Examples from R:

SS: I always try to remind myself that even though as an ICU nurse we supposedly get hardened and distance ourselves from things, that here is this child dying.

FM: The nurse recognizes that the death of the child has an impact on her.

SS: Sometimes it's hard, particularly when you're thrown into a situation and you haven't known this patient or the family.

FM: It is difficult to lead in situation when you have not had an opportunity to develop a relationship with the patient or the family.

Examples from W:

SS: I guess that's why I feel closer to those kids and close to those parents. Because I know what it's like. It's not fun having a sick kid.

FM: The nurse identifies with the role of the parent of a chronically ill child.

SS: They are just frightened because there is nothing they can do. It's beyond their control.

FM: The nurse identified the patient's powerlessness in controlling the situation.

(table continues)

Examples from Y:

SS: I stayed there for about 20 minutes and did the initial listening and trying to talk them down out of the anger.

FM: The nurse made herself available to the family.

SS: They had a 12-year-old. I have a 7-year-old. And, I can imagine how that would feel if it were my child.

FM: The nurse imagines the feeling she would experience had this happened to her child.

Theme Clusters

The formulated meanings were then organized so that clusters of themes and theme categories emerged that were common to all protocols. The theme clusters which emerged fell into seven categories including role-taking, appreciation of the human condition, involvement, advocacy, coping, barriers, and rewards. The categories and cluster of themes are presented in Table 8.

Table 8

Categories of Themes and Theme Clusters

Theme Category 1: Role-taking
--Theme cluster 1A: Imaginatively Assuming Another's Role (Table 9)
--Theme cluster 1B: Nurse Actions Guided by Role-taking (Table 10)

(table continues)

Theme Category 2: Appreciation of the Human Condition (Table 11)

Theme Category 3: Involvement
- -- Theme cluster 3A: Availability (Table 12)
- -- Theme cluster 3B: Emotional Investment (Table 13)
- -- Theme cluster 3C: Mutual Responsiveness (Table 14)

Theme Category 4: Advocacy
- -- Theme cluster 4A: Advocates with Other Health Care Workers (Table 15)
- -- Theme cluster 4B: Identifies Options and Alternatives (Table 16)
- -- Theme cluster 4C: Instills Hope (Table 17)

Theme Category 5: Coping
- -- Theme cluster 5A: Patient and Family Coping (Table 18)
- -- Theme cluster 5B: Nurse Coping (Table 19)

Theme Category 6: Barriers
- -- Theme cluster 6A: Priorities (Table 20)
- -- Theme cluster 6B: Ineffective Nurse Coping Skills (Table 21)

Theme Category 7: Rewards
- -- Theme cluster 7A: Belief that Nurse Made a Difference (Table 22)
- -- Theme cluster 7B: Belief Affirmed by Self and Others (Table 23)

The Role-taking Theme

Characteristics of the role-taking theme which emerged in the scenarios included discovery of another's feelings by imaginatively assuming another's role, imagined self-vulnerability in given situations, and promotion of intimacy through shared experienced (Table 9). The role-taking focused on the surrounding support system as well as

the patient. All of the participants related a role-taking experience with family members which promoted empathic nursing intervention. This aspect took on particular importance when the patient was unresponsive or had limited communication capability.

Table 9

Theme Cluster 1A: Imaginatively Assuming Another's Role

The nurse imagines herself in the patient situation:
-- We put ourselves into that situation.
-- You think if I was in that situation, I would want someone to care.
-- Putting myself in that situation makes me feel more for that patient.
-- It is easy for me to identify with people because I just put myself into their shoes.
The nurse imagines herself in the family situation:
-- What if that was my brother? What if that was my family member?
-- He was a few years younger than me, the age that could have been my brother or my boyfriend.
-- To look at it from their point of view.
-- I can imagine how that would feel if that was my child.
The nurse has a similar experience as patient or family:
-- I guess that's why I feel closer to those kids and close to those parents because I know what it's like.
-- I feel closer to them because I have wheezed a couple of times myself.
The nurse experiences a sense of vulnerability:
-- As a mother, you know, it was unfortunate that something like this would happen to your child.
-- As I would have been as a mother also, knowing that here is my son.
-- They had a 12 year old. I have a 7 year old.

In addition this role-taking was acted upon by the nurse. The cognitive model of the patient or family experience held by the nurse served to direct the nurse's intervention. The imagined role provided a framework for intervention guided by dignity and respect for the individual (Table 10).

Table 10

Theme Cluster 1B: Nursing Actions Guided by Role-Taking

Nurse views patient as valued being:
-- I think you need to have a humanistic approach and you need to treat every one of those patients like they were your dad.
-- You know, with the same courtesy and same respect that you would like someone to give to someone that you loved.
Value of humanness directs nursing intervention:
-- We got mom back in to let her touch him and see that, yes indeed, he was alive, but was not by any means out of danger at that point.
-- To be as helpful and as supportive as I can be.
-- I would want someone to care--to give everything to me as a patient.

Appreciation of the Human Condition Theme

The characteristics of the appreciation of the human condition theme which emerged in the transcribed protocols included patient and family experiences. The nurse identified and labeled the patient experience, feeling, or response. The same process was carried out with family

members, either individually or collectively, as they dealt with the health care situation described. Table 11 describes the characteristics of the appreciation of the human condition theme.

Table 11

Theme Cluster 2: Appreciation of the Human Condition

The nurse identifies and labels the patient's feeling, experience, and response:
-- I know how they are feeling and I know what a frightening feeling it is.
-- He had the frightened look and it is frightening.
-- There is nothing they can do. It's beyond their control.
-- She was very sad.
-- The little boy immediately burst into tears and ran into the bathroom, shut the door, and wouldn't come out.
-- The little boy was very fearful.
-- To him surgery meant losing his hair and somebody cutting his head open and it really scared him.
The nurse identifies and labels the family's feelings, experiences, and responses:
-- Every time he had a setback, you know having to deal with that, because I mean they would just be so devastated.
-- Just the joy on their faces.
-- Just the look of fear on their faces--this is it--daddy is going this time.
-- The mother was just obviously, just very hysterical.
-- Here is her son lying on this stretcher so drunk that he could hardly breathe for himself and it was quite a shock to her.
-- He was extremely angry.
-- Here is this child dying and here is this family.
-- You have to keep bringing yourself back to where they are at.
-- The parents were devastated. They were just in shock.

(table continues)

-- They were very angry and very hostile.
-- Everyone had been very secretive and had not explained things.

The Involvement Theme

The theme of involvement emerged throughout all protocols. Involvement was characterized in three ways. The first of these was through availability. The nurse made a commitment to spend time with the patient. She was available to talk with the patient and to develop a close relationship with him. This availability was also extended to the family, either individually or collectively. An effort was made to address the family or significant others' emotional needs and to develop a rapport with them. The nurse's availability was reinforced by her words and actions (Table 12).

In addition, involvement was characterized and enhanced by continuity of nurse contact with the patient and his family. The greater opportunity for exposure to one another, either at a single time or sequentially over several times, greatly increased the nurse's involvement (Table 13).

Table 12

Theme Cluster 3A: Availability

Nurse spends time with the patient:
-- I mean I felt bad for him and you think of him as a patient, but it wasn't until later that I really became involved with him.
-- I took care of him, you know, always had him.
-- You made the time then or you would make it sometime later.
-- It's just like that you could really feel with him because you were that close and because you kind of had that quiet time sometimes.
-- Just sitting with this woman and just spending time with her.
-- Giving them someone they know is going to be there.
Nurse spends time with the family:
-- I became very involved with his family.
-- I don't think she will do that again because I spent enough time with her (mom).
-- I did give them some place where they could get hold of me if they wanted to ask me more questions, or if they needed help.
-- I had time to look after their emotional needs that particular day.
-- Made sure they could reach me.
-- Then I spent some time with her (mom).
-- We talked at some length.

Table 13

Theme Cluster 3B: Continuity

Continuity of assignment:
-- He had a specific nurse per shift that primarily took care of him.
-- He pretty much had primary nurses.

(table continues)

Single nurse-patient exposure:
- -- If (he) had been in there for a week and left, I mean you still feel sorry for him, you still take care of him, but you don't get that involved.
- -- By the time they start feeling better, they are transferred out. So you don't have that time.
- -- The turnover is so fast and that sometimes say if the patient doesn't die within your time or whatever, when you go back the next day, the patient may not be there. You never really have a chance to resolve with the patient or the family.
- -- I always remember ones (patients) that I have taken care of for a long period of time.
- -- Then he left to go to rehab. It felt like a part of me had left.
- -- I really missed him.

Repeated nurse-patient exposure:
- -- They come back, you know, a lot of times you saw them 6 months out of the year.

Affects nurse's relationship with family:
- -- You don't have the chance (with short-term patients) to build up that rapport with the family.

Furthermore, the involvement theme was depicted by a mutual responsiveness. Nurse responsiveness which included open, honest communication to both patient and family was identified as essential. Feedback obtained from the patient and family was important to developing a close relationship (Table 14).

Table 14

Theme Cluster 3C: Mutual Responsiveness

Nurse communication:

-- I would talk to him, you know when even though I'd see he didn't want to respond that much or whatever. I'd talk to him while I was giving his bath.
-- Communication was carried out to the fullest degree.
-- Being sure to touch them and ask them how they feel.
-- I was able to do a little bit more than just taking the blood pressure or putting in the IV or giving the medication, but that you know, as a person, one human being to another.
-- I hugged them.
-- Mostly I listened.
-- I stayed there for about 20 minutes and did the initial listening and trying to talk them down out of the anger.
-- Mostly I told them that I cared.
-- I decided that I needed to deal with it myself and I went back and talked to them.
-- After I talked with them some, they got the little boy out of the room, and then I talked with him also.

Patient and family responsiveness:

-- She seemed to respond to just another person caring and taking the time to sit and have some sort of interaction with her.
-- It seemed like the more someone would do that (interact with her), the more she would get out of her rut.
-- They want to share something with you.

Advocacy Themes

The role of the nurse as an advocate for the patient was derived as a major theme from the protocols. The nurse acted on behalf of the patient and family. The advocacy might have occurred directly with other health care workers

or alternatively be accomplished by a mobilization of resources which facilitated patient or family outcomes. Sometimes the nurse demonstrated a protectiveness of the patient's well-being (Table 15).

Table 15

Theme Cluster 4A: Advocates with Other Health Care Workers

Direct advocacy:
- -- I'm used to going in when a doctor talks to family and patient simply to explain any questions they have, prompt them to ask questions they voiced to me earlier.
- -- All I know is that I asked him (physician) to come back to talk with them more and he refused.
- -- I think nurses have to pick up the pieces and they have to fill in the gaps (left by others) and be kind of a liaison.

Protective of patient well-being:
- -- You get so angry when someone took care of that patient that didn't do as good of a job.
- -- The anger I felt (toward the other nurse) was just unreal.
- -- I was angry because the nurse should know even if the doctor didn't order an x-ray. You always do an x-ray if you put a central line in.

Mobilizes resources:
- -- I involved the social worker and the chaplain. Provide them with resources that are available.
- -- We got the rocking chair in so the mother could hold the child as the child died.
- -- Staff will go to great lengths to emotionally support a family.

Table 16 describes methods employed by the nurse to broaden the patient and family view of available options. The sharing of information or teaching was a major component of this theme cluster. However, the nurse also provided assistance with priority setting and allowed the patient and family autonomy in decision-making. Furthermore, the nurse also looked at options for herself and was flexible in her interpretation of rules and regulations.

Lastly, the nurse instilled hope into situations which were physically and emotionally ravaging for both the patient and the family. Pointing out progress, even though slight, finding positive aspects, and supporting family ties even in bleak situations were methods used to inspire others (Table 17).

Table 16

Theme Cluster 4B: Identification of Options and Alternatives

Sharing information:
-- Drew a picture of the skull and explained about intracranial pressure and what the tumor could be--that it could be malignant or nonmalignant and that they wouldn't really know for sure until they did a biopsy.
-- I teach one parent how to take care of their kid and save them from putting that child in that kind of situation.

(table continues)

-- You can teach them (family) how to take care of a patient.
-- Teach them a little bit about what's going on or explain some things to them.
-- A lot of teaching with his family.
-- I spent some time just trying to explain that they shave a small area.
-- A lot of my time was spent giving him some information.

Priorities:
-- Wasn't necessarily the end of the world, that he was going to be okay and there was something that could be worked through at a later date--the issue as far as the alcohol.
-- She could kind of understand a little bit about what was going on and what needed to go on from there.

Decision-making:
-- I gave them (parents) the names of two neurosurgeons.
-- There was nothing wrong with getting a second and third opinion.
-- That was their right and certainly was the safest thing to do.

Flexibility:
-- I'm not into rules and regulations.
-- We asked her if she wanted to do that (hold the child) gave her a choice in how she wanted things to go.

Table 17

Theme Cluster 4C: Hope

Instilling hope for the patient:
-- His neuro status was improving and you just like grasp at it.
-- We would encourage them to bring him tapes of his little girl talking to him.
-- They would just be so devastated that you would have to be positive (for the patient).

(table continues)

-- So you always had hopes for him.
-- Experiences they (family) were having were maybe not quite so earth shattering, that there was some hope.

Coping Themes

Coping emerged as a major theme from the transcribed protocols. The situations portrayed both patient and family coping. The nurse assessed the level of coping and utilized interventions designed to ease distress and facilitate coping for patient and family alike. Effective coping was often facilitated by helping the family reframe their perceptions (Table 18).

In addition, methods of coping utilized by the nurse were described. Nurse coping was characterized by realizing that emotionally charged situations have an impact on her. In order to function effectively she must develop skills at processing her emotions. She must also receive support and reinforcement from others in the setting to remain empathic. It is essential that the nurse be able to achieve a balance between personal boundaries and emotional distance from those she cares for. Table 19 represents the theme clusters derived from the protocols regarding nurse coping.

Table 18

Theme Cluster 5A: Patient and Family Coping

Assessment of coping:
- -- I could see that they were having a lot of problems with this (diagnosis).
- -- Mother seemed pretty appropriate--tearful (at loss of child).
- -- The dad was appropriately crying and grieving. Earlier he had been angry.

Intervention directed at achieving effective coping:
- -- Helping her work through the crisis situation at the moment.
- -- Working with her through the anger she was feeling at me initially.
- -- She was more in control of herself and calmer and able to kind of get a hold on the situation.
- -- (With the child's death imminent), the most important thing to me was support the family and getting the family through the crisis.
- -- I opened the door and asked him (grandfather) if he wanted to come visit. He just wanted to see the child.
- -- Doing the most caring things that I could think of to help them grieve through and make this an easy transition for them.

Changing perceptions:
- -- The things weren't necessarily, even though they felt they were at the end of their ropes or that they couldn't see how they were going to go on from the situations they were in.
- -- Helping them feel as good as they could about the situation (child's death) and to work through it.
- -- They will remember that experience as more pleasurable than as traumatic as it could have been.

Table 19

Theme Cluster 5B: Methods of Nurse Coping

Self-awareness:
- -- The staff tries to be in touch with their feelings so that they can provide better care for the patient.
- -- For my own mental health and for the family I have to work through (my feelings).

Use of support systems:
- -- That type of interaction (empathic) is very much encouraged. Staff will go to great lengths to emotionally support a family.
- -- It (colleague support) had a lot of meaning for me and this is one reason I have stayed in this ICU so long.

Recognition of personal boundaries:
- -- You have to be able to--when you're working in a situation to somehow be able to detach yourself from that.
- -- You have to sort of put up some sort of almost detachment.
- -- To have that little bit of detachment or uninvolvement in order to be able to go from one situation to the other. If not, you go crazy.
- -- In one day I may have two patients die and if I don't distance myself from that somewhat, I would be a basket case.

Closure:
- -- You have to be able to let go and you have to be able to let go very quickly in order to go on.
- -- That was a nice feeling, too, to be able to stay. If I had left at 3 o'clock, then I would have missed so much of the resolution.
- -- I would have been left hanging because I had all these feelings.
- -- I started cleaning the body. That's usually my time when I can sort of grieve through what's gone on, think about it, and work through it.

Barrier Themes

Throughout the protocols the nurses described what they considered to be barriers to empathy in nurse-patient interactions. In certain situations empathy was depicted as having a lower priority than other things. Sometimes this was justified by the patient's condition and other times demanded by the workplace. Life-threatening priorities might supersede empathic interaction or technical procedures take precedence over involvement. Most of the nurses indicated that there was a lack of emphasis and reinforcement for being empathic in the work setting.

Lack of exposure to the patient and family was also cited as a characteristic barrier to empathy. In areas of high patient turnover such as an ambulatory care setting or in high acuity areas where patients are transferred quickly or die, there is limited opportunity for interaction. Environmental constraints also compound the lack of continuity by affecting staff assignments and workload (Table 20). Lack of effective nurse coping skills also provide a barrier if the nurse is unable to revitalize herself or bring closure to emotionally charged situations (Table 21).

Table 20

Theme Cluster 6A: Priorities

Nursing priorities:
-- His technical needs took up more of my time.
-- There are more life-threatening situations.

External pressures:
-- You're trying to do everything so right because everyone is checking it and doing quality assurance and it's taking away from the time with the patient.

Environmental constraints:
-- On a busy medical-surgical floor, they would not have had the time and attention that I was able to give that day with only four patients.

Lack of exposure:
-- Sometimes it's hard, particularly when you're thrown into a situation and you haven't known this patient or the family.

Table 21

Theme Cluster 6B: Ineffective Nurse Coping Skills

Avoidance:
-- You never really have a chance to resolve with the family or the patient, and you stuff (your feelings). They are not resolved. They come out later in other situations.
-- You get a little hard to protect yourself.
-- It's real easy to stuff. I'll think about it later when I'm alone or whatever, and then maybe you never get around to thinking about it or working through it.

Inexperience:
-- I can remember as a new nurse I was like overwhelmed, you know with these things and really took them home with me.

Reward Themes

This final theme of rewards was characterized by two main foci. First, the nurse can identify tangible ways in which her nursing care made a difference for a patient or his family (Table 22).

Table 22

Theme Cluster 7A: Belief that Nurse Made a Difference

Impact on patient and family:
-- Maybe I got them on the road and through that attack. Anyway, it got mom to understand a little bit.
-- This was the first time that she (mom) understood what it was. She understood that this was going to happen and that she could control it (exacerbation).
-- I mean he would raise one finger and it was like you could feel the joy in that you get so excited.
-- Down the road, 6 months from now, that (nursing intervention) was going to made a difference in his being able to come back up to normal function.
-- And maybe that (nurse spending time with patient) made a difference in someone's life at that point.
-- I was able to maybe make a difference, maybe make a bad situation a little easier to deal with or a little easier to look at.
-- Maybe it made a little difference in their lives. It made the situation a little easier for them to go through.
-- The dad was appropriately crying and grieving. Earlier he had been angry, not coping with the situation effectively.
-- The parents went away feeling satisfied with the situation.
-- Made a difference.

Secondly, the nurse experiences a sense of personal satisfaction from her perceived impact on the patient and family. These intrinsic rewards may be characterized as a sense of pride for having done a good job or feeling good about the work performed. The belief that the nurse made a difference may be reinforced by others. Patients, family members, or peers may provide this support during the course of involvement or at the time of closure or they may be assumed by the nurse. Table 23 describes the characteristics of this affirmation by self and others.

Table 23

Theme Cluster 7B: Affirmation of Belief by Self and Others

Intrinsic rewards:
-- I guess that's where (with juvenile asthmatics) I can really make a difference
-- I teach one parent how to take care of their kid. That's where I feel I can make a difference.
-- Just being there for them, it's a good feeling.
-- It was a good feeling--kind of a rewarding feeling that things went okay.
-- It made me feel good that we were able to get through that crisis moment.
-- It was a nice resolution.
-- I felt good about the family.
-- It's the thing that gives me warm fuzzies in nursing.
-- The really most warming part is knowing you have helped this family, connected with them in some way, helped them work through this crisis--this devastating situation that's unfair.

(table continues)

-- I think I shared a lot of my heart with him and the family.

Explicit extrinsic rewards:
-- Those people thanked me that day.
-- They thanked me for being there,
-- Then he shook my hand and told me how he appreciated me.

Assumed extrinsic rewards:
-- I think they appreciated me being there.
-- I think they appreciated having that option.
-- I think it (nurse's presence) made a difference for the family. In making a difference for the family, it made a difference for the child.
-- I feel that I make a difference every day in what I do only everybody doesn't recognize it, and maybe they're not going to thank you but I think I make a difference.

Exhaustive Description of Nurses' Lived Experience of Empathy in Nurse-Patient Interactions

From the theme categories and clusters, the following exhaustive description of nurses' lived experience of empathy was generated.

Role taking

The lived experience of empathy by the nurses in the study involved a role-taking process. This process was initially a passive one in which the nurse imagined herself in another's role. The other person might have been the patient, family member, or significant other. The role assumed was situation and time specific. The role selected

was determined in part by the communication capability of the identified patient. Role-taking by the nurse would also be determined by the nurse's perception of need for intervention. Role-taking with surrounding support system members took on increasing importance as the patient became less responsive and the need for family support became more evident.

As a result of this imaginative experience, the nurse identified vulnerabilities she would face in similar situations. The outcome of this shared experience then formed the foundation of intimacy in the relationship between the nurse and the identified other. A common ground closeness was created. Having experienced the same or similar feeling provided an enhanced awareness and enabled the nurse to understand how the feeling was experienced by the other person. This was also the case with the nurse having experienced a particular role in her life. For example, a nurse-mother could readily imagine the experience of the mother of a 3-year-old child in an intensive care unit.

This role-taking experience by the nurse formed the basis for active nursing interventions. The imaginative process provided a framework for action that was guided by dignity and respect for the individual. The frame of

reference provided by the identified other's role allowed patients and their significant others to be valued by the nurse as human beings. This viewpoint allowed the nurse to be caring, helpful, and supportive. The nursing interventions became a reflection of what the nurse would want provided for her in the same situation.

Appreciation of the Human Condition

The empathic experience which nurses lived through required that the nurse identify and label the patient's feelings. The nurse must be aware of the emotional experience of the patient and be able to relate patient behaviors to these emotional experiences.

The same process is also necessary with significant others. The nurse may recognize and label the individual member's response as well as the collective response of the family as a whole.

Involvement

Nurse's lived experience of empathy was characterized by involvement. Involvement was viewed as an active process. The nurse made an overt or tacit commitment to be available to the patient and his family. The time with the patient might be spent talking, interacting, or just being physically present. A similar experience was reported

regarding interaction with family members. Time spent with patients and their families promoted development or rapport and close relationships. Availability enhanced responsiveness and was frequently reinforced by the nurse.

Involvement was contingent upon continuity of assignment. Continuity was viewed as occurring in a lengthy exposure to a single patient or as repeated exposures to the same patient. Continuity was accomplished by assigning nurses to the same patient or through repeated interactions within a single exposure. This allowed for the resolution of emotionally charged situations due to the working knowledge of individuals involved in the relationship.

Lastly, involvement was characterized by mutual responsiveness. Communication by the nurse to the identified other was essential. Patient and family responsiveness was crucial to developing closeness. Communication could be nonverbal as well as verbal. Listening, verbalizing, hugging, and processing all allow for the recognition of humanness among people.

Advocacy

Within the context of an empathic nurse-patient interaction the nurse assumed a role as an advocate for the patient. Sometimes the nurses advocated on the patient's

behalf with other health care personnel. This could be accomplished by directly approaching other personnel. The nurse also might act in a liaison role to fill in the gaps left by other health care workers. She frequently intervened by mobilizing resources within the health care community to fully meet the patient's needs. The nurse assumed a role that was protective of the patient's well-being.

The nurse was very active in assisting with the identification of options and alternatives available to the patient and his family. Frequently, the nurse shared information with the patient. This sharing of information may have taken the form of patient or family teaching. The provision of information and explanations was goal directed and assisted the patient in setting priorities and making decisions.

The nurse also realized that she had options and alternatives in delivering nursing care. Rigid health care systems were successfully manipulated to provide the flexibility needed to meet patient needs.

Finally, the nurse instilled hope for the patient and family. The interjection of hope was accomplished in a number of ways. Sometimes the nurse was able to provide information which allowed the family to change their

perception of the hopelessness of the patient's situation. Pointing out the positives and the progress made by patients, regardless of how slight, was helpful in maintaining hope for the patient. Encouraging the family members to continue to include the patient in family activities also demonstrated that the situations were not completely hopeless.

Coping

An essential component of empathy was coping. The nurse took an active role in facilitating patient and family coping. Effective coping became an outcome which the nurse used to gauge her effectiveness. Empathy was a tool she used to change perceptions, ease distress, and reframe perceptions so that the situation could be worked through.

Coping was also seen as crucial for the nurse. The nurse must be able to process her own emotions and resolve them. She must have enough self-awareness to recognize that patient care situations have an impact on her. The nurse may utilize support systems available to her to work through her own feelings.

In addition, the nurse must recognize her own personal boundaries in order to cope effectively. She must balance

her emotional involvement with her need for emotional protection in stressful situations.

Finally, interactions must be brought to closure. Closure allowed the nurse to go on to other situations. She could function in other situations without being haunted by unresolved emotions.

Barriers

Within the context of the nurse-patient interactions several barriers to empathy were identified. In certain situations empathy was relegated a lower priority than other nursing interventions or skills. Sometimes this was justified by the life-threatening events being experienced by the patient or others under her care. Technical concerns also took precedence over empathy.

The nurses described administrative pressures within the work setting which detracted from the nurse's ability to be empathic or infringed on her allegiance to provide care to the patient. They speculated that the constraints found in some areas would prevent the exposure they had experienced in their empathic interaction. Lack of contact with the patient or the family was cited as a barrier because the nurse lacked a working knowledge of the patient situation.

Ineffective nurse coping skill also provided a barrier to empathic interaction. Avoidance was used as a means of preventing involvement with the patient. It also served as a way to prevent the nurse from dealing with her own emotions.

Rewards

The lived experience of empathy was characterized by the nurse's belief that she made a difference for those for whom she provided care. Sometimes the impact of the empathic interaction on the patient or family could be measured in a tangible manner. Someone who was not coping prior to the nursing interaction may demonstrate effective coping skills. Parents can intervene more effectively with their child's health problem in the future. A look of relief on a family member's face could validate that, in fact, the nurse made a difference.

There are also some intrinsic rewards for the nurse as well. The nurse goes away from situations feeling good about her intervention. Sometimes there is external reinforcement received from others, either colleagues or patients and their families. Even in the absence of explicit extrinsic rewards, the nurse assumes that it exists. The nurse believed that she made a difference.

Essential Structure of Empathy

From the exhaustive description of empathy, the following essential structure was developed:

Empathy is both a passive and an active process. Passively, the nurse imaginatively assumes the role of another person. The nurse becomes aware of the experience of the other person and actively provides interventions on the basis of the imagined experience.

Empathy in nurse-patient interactions is characterized by involvement with the patient and his family. The nurse's involvement is contingent upon the length of contact. Involvement is realized by a mutual responsiveness and communication between the nurse and patient or his family.

The nurse advocates on behalf of the patient with other health care workers. She creatively offers options and alternatives which allows for priority setting and decision-making. Finally, the nurse inspires hope in patients and their families.

The nurse is cognizant of coping methods used by patients and their families, as well as her own coping strategies. She utilizes interventions to ease distress and facilitate coping in others. The nurse also recognizes

the impact of emotional situations on her and seeks appropriate support for herself.

Conversely, when factors which enhance empathy are absent barriers to empathy development are created. Lack of time for involvement is a major barrier, regardless of the cause. Inadequate or ineffective coping skills resulted in another barrier.

Empathy is also distinguished by a feeling that the nurse made a difference for the patient. This difference might be measured by some tangible patient outcome or through the nurse's system of internal or external reinforcement.

Summary of Findings

From the analysis of the five protocols of empathy as experienced by nurses, significant statements were extracted and meanings were formulated. The data were organized into 7 theme categories and 15 theme clusters. An exhaustive description of empathy was identified and the essential structure of empathy was derived. The following findings represent the essential structure of empathy:

1. Empathy is a passive and active process in which a nurse imaginatively assumes the role of an identified other.

2. An awareness of the imagined experience provides a framework for nursing intervention.

3. The nurse becomes involved with the patient and his family through repeated interactions.

4. Involvement is contingent upon the length of contact and realized through a mutual responsiveness between the nurse and identified other.

5. Alternative perceptions, decisions, and actions are interjected.

6. The nurse inspires hope in the patient and his family.

7. The nurse becomes cognizant after interaction with the patient or family member of his level of coping as well as her own.

8. Measures are taken to support and facilitate coping for all parties involved.

9. Barriers to empathy development are related to factors which decrease time for involvement and inadequate or ineffective coping skills.

10. Empathy is distinguished by the nurse's belief that her interventions made a difference for the patient.

CHAPTER V

SUMMARY OF THE STUDY

A summary of the study is included in this final chapter. Following the summary is a discussion of the findings and a discussion of the conclusions and implications of the study. The chapter concludes with recommendations for further study.

Summary

The domain of this study was stated as: What is the essence of nurses' lived experience of empathy in a nurse-patient interaction? The purpose of the study was to identify the essential structure of empathy and to construct a framework of the lived experience of empathy from the perspective of the nurse empathizer in nurse-patient interactions. The study was conducted using a phenomenological orientation.

The purposive sample for the study consisted of five registered nurses who could identify an empathic nurse-patient interaction which they had participated in. The participants also demonstrated an ability and willingness to express themselves in the manner necessary for the study.

Interviews were used to obtain the participants' experiences of empathy in nurse-patient interactions. These descriptions were analyzed using Colaizzi's (1978) method. The study elicited the following essential structure of empathy:

1. Empathy is a passive and active process in which a nurse imaginatively assumes the role of an identified other.

2. An awareness of the imagined experience provides a framework for nursing intervention.

3. The nurse becomes involved with the patient and his family through repeated interactions.

4. Involvement is contingent upon the length of contact and realized through a mutual responsiveness between the nurse and identified other.

5. Alternative perceptions, decisions, and actions are interjected.

6. The nurse inspires hope in the patient and his family.

7. The nurse becomes cognizant after interaction with the patient or family member of his level of coping as well as her own.

8. Measures are taken to support and facilitate coping for all parties involved.

9. Barriers to empathy development are related to factors which decrease time for involvement and inadequate or ineffective coping skills.

10. Empathy is distinguished by the nurse's belief that her interventions made a difference for the patient.

Discussion of Findings

The discussion of findings analyzes the conceptualizations of empathy identified in Chapter II in relation the exhaustive description and essential structure of empathy derived from this study.

Philosophical Basis of Empathy

Philosophers have defined empathy as a totally intrapsychic experience, inner participation in a foreign experience, or as a natural instinct. As the description of nurses' lived experiences of empathy unfolded, these definitions seemed to hold limited utility. The participants described a process of imaginatively participating in another's experience. However, at this point the resemblance faded. The nurses described empathy as a very active process which went beyond the mere imagined experience, yet used it as a guidepost. The differences could perhaps be explained by the practice-oriented nature of nursing.

Empathy in Social Science

Empathy, as it was described in this study, goes well beyond the concept of predictive empathy and more closely resembles interactive empathy as it was described by Rogers (1957). Certainly, similarities could be readily identified between Rogers' (1957) "as if" quality and the imagined role-taking reported by nurses in this study. This is also true of Carkhuff's (1969) description as "crawling inside another's skin and seeing the world through her eyes."

Additionally, communication and responsiveness played an important role in the lived experience of empathy. The nurse was able to "voice meanings" in the experience of the client of which he was unaware. Undoubtedly, this occurred when situations were reframed or perceptions changed as described in the protocols. Many times, however, the nurse was able to go beyond voicing meanings and demonstrated through her actions alternate methods of dealing with experiences.

The conceptualization of the client in social science studies bears a marked contrast to the recipient of empathy as it was described by the nurses' experiences. In the social sciences, the client is an individual involved in a one-to-one relationship with a helper. Within the nursing

arena, the concept of client becomes less clear-cut. Although there is one identified client, he exists in the midst of significant others. At any given time, the situation may demand that the nurse function empathically with the patient as well as the significant others.

Furthermore, social science studies identified empathy by isolated verbal responses by helpers. The description of empathy described by the nurses in the study included not only verbal responses, but action oriented interventions as well. The goals of social science and nursing varied dramatically. Both were goal oriented, however, social science assumed patient improvement was possible, while in nursing this goal was recognized as not always achievable. When it is acknowledged that the patient cannot improve, alternate goals are developed, such as adapting to a handicap, dying a peaceful death, or acceptance by others of life changes.

Empathy in Nursing

Nursing literature abounds with studies conducted using a hypothetico-deductive orientation to measure the relationship between empathy and numerous variables in practice and education. The conceptualization of empathy found in these studies closely resembles that found in the social sciences. There has been some conjecture about the

occurrence of empathy in the nurse-patient relationship, but the speculation is heavily influenced by the writing of social scientists (Carper, 1978; Zderad, 1970). While it is difficult to analyze findings from previous studies in relation to the current study with precision, similarities and areas of contrast are noted.

Kalisch (1971) and Layton (1978) examined the effect of different teaching methods on empathy development in nursing students. Although a variety of methods was used, only those in which students took an active part, i.e., role-play, experiential training, rehearsal, or viewing another's role-modeling, were effective. In the present study, participants described empathy as an active intervention process which was guided by the more passive imaginative elements.

Mansfield (1973) identified nurse verbal and nonverbal behaviors which facilitated empathic nurse-patient communication. None of the behaviors with the exception of verbal responsiveness was identified by the participants in the current study. The nonverbal behaviors reported by Mansfield (1973), such as facial expression and head and body position, were minute in comparison to the actions elicited by nurses' descriptions.

Carper (1979) speculated that technology had a negative influence on the empathic ability of nurses. The relationship between technology and empathy has been formally examined in two studies (Brunt, 1983; Ebbs, 1980). Both of these investigations hypothesized that a difference in nurse empathy could be related to the difference in technology found in the area of practice. However, in both cases this was not confirmed by the results of the study.

Technology was described as a barrier to empathy in the current study when it detracted from the time available for involvement. Available time seemed to be a more crucial component than technology. From a practical standpoint, patients cared for in highly technical environments frequently have nurses more readily available to them. Nurse patient ratios in less technical settings tend to be substantially higher, thereby limiting the nursing time available to each individual. Taking into consideration actual contact time, the effect of technology might fade.

Measurement of Empathy

Several devices to measure empathy were reported in the literature. These instruments fall into three general categories: self-rated scales, judge-rated scales, and client-rating instruments. The inherent problems

associated with self-rated scales have been noted previously and are not discussed in this section (Gagan, 1983; Kurtz & Grummon, 1972).

Judge-rated scales, such as the Accurate Empathy Scale (Truax, 1961), were typically designed to be used with direct observation or tape recordings. Many nursing studies which used judge-rated instruments relied on audiotapes as the primary source of data. This practice results in a preponderance of emphasis on verbal responses rather than on the total experience of empathy. In light of the current study, only a very small portion of the experience of empathy, as it was described, would be revealed by the use of such an instrument.

Gagan (1983) noted the difficulties in using client rating instruments in nursing practice. The problems of limited exposure and understanding questions, within the context of the nurse-patient relationship, are supported in relation to the current findings. These problems are compounded by the inability to clearly delineate the recipient of empathy in nursing interactions. Reliance on instruments of this type to measure empathy detracts significantly from the total empathic experience as described in the present study.

Conclusions and Implications

The following conclusions and implications were derived from this study:

1. Empathy is a process by which a nurse comes to know another's experiences. It is an interpersonal process between a nurse and an empathized other. The nurse is readily identifiable because of her professional role. However, the empathized other is determined by the situation and by the communication capability of the identified patient.

2. Empathy occurs within the context of a relationship and is realized through mutual responsiveness. The relationship develops with repeated interactions over time.

3. The subjective experiences of the empathized other are shared with the nurse. The nurse recognizes herself in the experience of others. As a result she develops more self-awareness.

4. The experiences of the nurse are shared with the empathized other. This occurs in relation to the imagined experience. The nurse integrates her perception of the patient experience with her professional experiences. This integration forms the basis for the interventions which she shares with the empathized others. In this way, empathy

may be conceptualized as an active process extending beyond the current notion of verbal responsiveness.

5. Both participants are changed. The empathized other may gain new perceptions, learn new behaviors, or make decisions. The nurse becomes more self-aware, able to share more because of her involvement with that person, and experiences an increase in self-esteem.

Recommendations for Further Study

Based on the conclusions and implications, the following are recommended for further study:

1. Time was an important component of the nurse's experience of empathy. It is recommended that future studies be conducted to evaluate the perception of time and its effect on availability. How is time perceived in short-term or intense nurse-patient relationships? Is time perceived as actual contact time versus available time or as absolute contact time?

2. The experience of the empathized other would add another viewpoint to the concept of empathy. Particularly in light of the interpersonal aspect of empathy, a more complete understanding of the process could be achieved.

3. Relationships with others besides the identified patient were a significant finding in this study. Further investigation regarding the experience of empathy by

significant others is recommended. Does this experience have an effect on patient outcome?

4. The active aspect of empathy was emphasized. Are some actions perceived as more empathic by the patient or family?

5. The relationship between coping and empathy needs further study. Factors which affect coping methods by both the nurse and patient should be examined.

6. Study of the relationship between hope and empathy as they are experienced by the patient and the family is recommended.

REFERENCES

Auvenshine, M. A. (1982). A descriptive survey of factors related to the development of elements of human sensitivity in baccalaureate nursing students. Dissertation Abstracts International, 43, 1433B. (University Microfilms No. 82-18060).

Bargagliotti, L. A. (1983). The scientific method and phenomenology: Toward their peaceful coexistence in nursing. Western Journal of Nursing Research, 5, 409-411.

Barrett-Lennard, G. T. (1967). Dimensions of therapist response as causal factors in therapeutic change. Psychological Monographs, 76 (43, whole No. 562).

Berenson, B. G., & Carkhuff, R. R. (1977). Beyond counseling and therapy (2nd ed.). New York: Holt, Rinehart & Winston.

Bergin, A. E., & Solomon, S. (1963, September.). Personality and performance correlates of empathic understanding in psychotherapy. Paper presented at American Pscyhological Association, Philadelphia, PA.

Brunt, J. H. (1985). An exploration of the relationship between nurses' empathy and technology. Nursing Administration Quarterly, 9, 69-78.

Buber, M. (1958). I and thou (R. Smith, Trans.). New York: Scribner.

Buhler, C., & Massarik, R. (1968). The course of human life: A study of goals in the humanistic perspective. New York: Springer.

Burgess, A. W. (1981). Psychiatric nursing in the hospital and the community (3rd ed.). Englewood Cliffs, NJ: Prentice-Hall.

Carkhuff, R. R. (1969). Helping and human relations (Vol. 2). New York: Holt, Rinehart & Winston.

Carkhuff, R. R. (1977). The art of helping III (3rd ed.). Amherst, MA: Human Development Press.

Carkhuff, R. R., & Truax, C. B. (1967). Toward effective counseling and psychotherapy: Training and practice. Chicago: Aldine Publishing.

Carper, B. A. (1978). Fundamental patterns of knowing in nursing. Advances in Nursing Science, 1, 13-23.

Carper, B. A. (1979). The ethics of caring. Advances in Nursing Science, 1, 11-19.

Colaizzi, P. (1978). Psychological research as the phenomenologist views it. In R. Valle & M. King (Eds.), Existential-phenomenological alternatives for psychology (pp. 48-71). New York: Oxford University Press.

Davis, A. (1978). The phenomenological approach in nursing research. In N. Chaska (Ed.), The nursing profession: Views through the mist (pp. 186-196). New York: McGraw-Hill.

Duff, R. S., & Hollingshead, A. B. (1968). Sickness and society. New York: Harper & Row Publishers.

Dymond, R. (1949). A scale for measurement of empathic ability. Journal of Consulting Psychology, 13, 127-132.

Ebbs, E. M. (1980). Empathy in critical-care and medical-surgical nurses. Unpublished master's thesis. Texas Woman's University, Denton.

Eckartsberg, R., von (1971). On experiential methodology. In A. Giorgi, W. Fischer, & R. von Eckartsberg, (Eds.), Duquesne studies in phenomenological psychology (Vol. 1, pp. 69-79). Trenton, NJ: Humanities Press.

Follstaedt, R. M. (1982). The effect of nurse's nonverbal behaviors on the patient's perception of empathy. Unpublished master's thesis, University of Louisville, Louisville, KT.

Forsyth, G. L. (1977). Exploration of empathy in nurse-client interaction. Unpublished doctoral dissertation, Texas Woman's University, Denton.

Gagan, J. M. (1983). Methodological notes on empathy. Advances in Nursing Science, 6, 65-72.

Giorgi, A. (1975). An application of phenomenological method in psychology. In A. Giorgi, C. Gischer, & E. Murray (Eds.), Duquesne studies in phenomenological psychology (Vol. 2, pp. 82-103). Trenton, NJ: Humanities Press.

Giorgi, A. (1987, April). Validity and reliability from a phenomenological perspective. Paper presented at the second biannual conference of the International Society for Theoretical Psychology, at Banff, Alberta, Canada.

Goodwin, W. L., & Goodwin, L. D. (1984). Qualitative versus quantitative research or qualitative and quantitative research? Nursing Research, 33, 378-380.

Harris, P. A. (1983). Job satisfaction and empathic level of medical-surgical nurses. Unpublished master's thesis, Texas Woman's University, Denton.

Henderson, V. (1966). The nature of nursing. New York: Macmillan.

Hogan, R. (1962). Development of an empathy scale. Journal of Consulting and Clinical Psychology, 33, 307-316.

Hurwitz, S. B. (1976). Empathy and its relationship to nurse-patient assignments. Unpublished master's thesis, University of Rochester, New York.

Kalisch, B. J. (1971). An experiment in the development of empathy in nursing students. Nursing Research, 20, 202-211.

Kalisch, B. J. (1973). What is empathy? American Journal of Nursing, 73, 1548-1552.

Katz, R. L. (1963). Empathy: Its nature and uses. New York: Free Press.

Keen, E. (1975). A primer in phenomenological psychology. New York: Holt, Rinehart & Winston.

Kerlinger, F. N. (1973). Foundations of behavioral research (2nd ed.). New York: Holt, Rinehart & Winston.

King, I. M. (1981). A theory for nursing. New York: John Wiley & Sons.

Kramer, M., & Schmalenberg, C. (1977). The first job-a proving ground basis for empathy development. Journal of Nursing Administration, 7, 12-20.

Kurtz, R. R., & Grummon, D. L. (1972). Different approaches to the measurement of therapist empathy and their relationship to therapy outcomes. Journal of Consulting and Clinical Psychology, 39, 106-115.

LaMonica, E. L. (1981). Construct validity of an empathy instrument. Research in Nursing and Health, 4, 389-400.

LaMonica, E., Carew, D., Winder, A., Haase, A. M., & Blanchard, K. (1976). Empathy training as the major thrust of a staff development program. Nursing Research, 25, 447-451.

Layton, J. M. (1979). The use of modeling to teach empathy to nursing students. Research in Nursing and Health, 2, 163-176.

Leininger, M. (1978). Futurology of nursing: Goals and challenges for tomorrow. In N. Chaska (Ed.), The nursing profession: Views through the mist (p. 104). New York: McGraw-Hill.

Leininger, M. (1981). Caring: An essential human need. Philadelphia: Charles B. Slack.

Leininger, M. (1984). Qualitative research methods: To document and discover nursing knowledge. Western Journal of Nursing, 6, 151-152.

Lockett, E. K. (1985). Self-concept and level of empathy in associate degree nursing students. Unpublished master's thesis, Texas Woman's University, Denton.

Ludemann, R. (1979). The paradoxical nature of nursing research. Image, 11, 2-8.

Mansfield, E. (1973). Empathy: Concept and identified psychiatric nursing behavior. Nursing Research, 22, 525-530.

Merleau-Ponty, M. (1962). Phenomenology of perception. Trenton, NJ: Humanities Press.

Mullen, P. M., & Reynolds, R. (1978). The potential of grounded theory for health education research: Linking theory to practice. Health Education Monographs, 6, 280-292.

Nightingale, F. (1946). Notes on nursing: What it is and what it is not. New York: Appleton-Century.

Oiler, C. (1982). The phenomenological approach in nursing research. Nursing Research, 31, 178-181.

Omery, A. (1983). Phenomenology: A method for nursing research. Advances in Nursing Science, 5 49-60.

Peitchinis, J. A. (1972). Therapeutic effectiveness of counseling by nursing personnel: Review of the literature. Nursing Research, 21, 133-148.

Polit, D., & Hungler, B. (1983). Nursing research: Principles and methods (2nd ed.). Philadelphia: Lippincott.

Price, D., & Barrell, J. (1980). An experiential approach with quantitative methods: A research paradigm. Journal of Humanistic Psychology, 20, 75-95.

Rawnsley, M. M. (1980). Toward a conceptual base for affective nursing. Nursing Outlook, 28, 244-247.

Reddy, W. B. (1968). The effects of immediate and delayed feedback on the learning of empathy. Unpublished doctoral dissertation, University of Cincinnati, Cincinnati, OH.

Reik, T. (1948). Listening with the third ear. New York: Farrar Straus.

Rogers, C. R. (1951). Client-centered therapy. Boston: Houghton-Mifflin.

Rogers, C. R. (1957). Necessary and sufficient conditions of therapeutic personality change. Journal of Consulting Psychology, 21, 95-103.

Rogers, C. R. (1975). Empathic: An unappreciated way of being. The Counseling Psychologist, 5, 2-9.

Rogers, I. A. (1982). Effects of undergraduate nursing education on empathy. Dissertation Abstracts International, 43, 1436B. (University Microfilms No. 82-23170)

Semands, D. (1986). Empathy and patient satisfaction. Unpublished master's thesis, Texas Woman's University, Denton.

Smith, H. C. (1966). Sensitivity to people. New York: McGraw Hill.

Sowell, J. H. (1979). A study of empathy in relation to years of active nursing practice. Unpublished master's thesis, Case Western Reserve University, Columbus, OH.

Sparling, S. L. (1976). A comparison of empathic abilities of nurses in a psychiatric versus a non-psychiatric setting. Unpublished master's thesis, Case Western Reserve University, Columbus, OH.

Spiegelberg, H. (1965). The phenomenological movement: Vol. 2. The Hague, the Netherlands: Martinus Nijhoff.

Spiegelberg, H. (1975). Doing phenomenology: Essays on and in phenomenology. The Hague, the Netherlands: Martinus Nijhoff.

Spiegelberg, H. (1982). The phenomenological movement: A historical introduction. The Hague, the Netherlands: Martinus Nijhoff.

Stein, E. (1970). On the problem of empathy. The Hague, the Netherlands: Martinus Nijhoff.

Swanson, J. M., & Chenitz, W. C. (1982). Why qualitative research in nursing? Nursing Outlook, 30, 241-245.

Thiesen, E. E. (1981). Empathy in baccalaureate nursing students and their faculty. Unpublished master's thesis, Texas Woman's University, Denton.

Travelbee, J. (1979). Interpersonal aspects of nursing. Philadelphia: F. A. Davis.

Truax, C. B. (1961). A scale for the measurement of accurate empathy. Psychiatric Institute Bulletin. Madison, Wisconsin Psychiatric Institute, University of Wisconsin.

Truax, C. B. (1963). Effective ingredients in psychotherapy: An approach to unraveling the patient-therapist interaction. Journal of Counseling Psychology, 10, 256-263.

Truax, C. B. (1966). Counseling and psychotherapy: Process and outcome. Fayetteville, AR: Rehabilitation Research and Training Center, University of Arkansas.

Truax, C. B., Altman, H., & Millis, W. (1974). Therapeutic relationships provided by various professionals. Journal of Community Psychology, 2, 33-36.

Tyner, R. (1985, June). Elements of empathic care for dying patients and their families. Nursing Clinics of North America, 20, 393-401.

Valle, R., & King, M. (1978). An introduction to existential-phenomenological thought in psychology. In R. Valle & M. King (Eds.): Existential-phenomenological alternatives for psychology (pp. 6-17). New York: Oxford University Press.

Van Kaam, A. L. (1959). Feeling of being understood. Journal of Individual Psychology, 15, 69.

Van Kaam, A. (1966). Existential foundations of psychology: Vol. 3. Pittsburgh: Duquesne University Press.

Watson, J. (1979). Nursing: The philosophy and science of caring. Boston: Little, Brown, and Co.

Watson, J. (1981). Nursing's scientific quest. Nursing Outlook, 29, 413-416.

Webster, G., Jacox, A., & Baldwin, B. (1981). Nursing theory and the ghost of the received view. In H. Grace & McCloskey (Eds.), Current issues in nursing (pp. 26-35). Scranton, PA: Blackwell Scientific Publications.

Wiedenbach, E. (1963). The helping art of nursing. American Journal of Nursing, 63, 54-57.

Williams, C. L. (1979). Nurse therapist high empathy and nurse therapist low empathy during therapeutic group work as factors in changing the self-concept of the institutionalized aged. Dissertation Abstracts International, 40, 3095B-3096B. (University Microfilms No. 80-01353

Zderad, L. T. (1969). Empathic nursing. Nursing Clinics of North America, 4, 655-662.

Zderad, L. T. (1970). Empathy: From cliche to construct. In C. Norris (Ed.), Proceedings of the third nursing theory conference (pp. 46-75). Kansas City: Department of Nursing Education, University of Kansas Medical Center.

APPENDIX A

Permission to Conduct Study

TEXAS WOMAN'S UNIVERSITY
Box 22939, TWU Station
RESEARCH AND GRANTS ADMINISTRATION
DENTON, TEXAS 76204

HUMAN SUBJECTS REVIEW COMMITTEE

Name of Investigator: Joyce Ann Swegle Center: Denton

Address: 1616 May Date: 11-4-86

Denton, Texas 76201

Dear Ms. Swegle:

Your study entitled Promoting Empathetic Communication in Nursing Students

has been reviewed by a committee of the Human Subjects Review Committee and it appears to meet our requirements in regard to protection of the individual's rights.

Please be reminded that both the University and the Department of Health, Education, and Welfare regulations typically require that signatures indicating informed consent be obtained from all human subjects in your studies. These are to be filed with the Human Subjects Review Committee. Any exception to this requirement is noted below. Furthermore, according to DHEW regulations, another review by the Committee is required if your project changes.

Any special provisions pertaining to your study are noted below:

_____ Add to informed consent form: No medical service or compensation is provided to subjects by the University as a result of injury from participation in research.

_____ Add to informed consent form: I UNDERSTAND THAT THE RETURN OF MY QUESTIONNAIRE CONSTITUTES MY INFORMED CONSENT TO ACT AS A SUBJECT IN THIS RESEARCH.

_____ The filing of signatures of subjects with the Human Subjects Review Committee is not required.

_____ Other:

__XX__ No special provisions apply.

cc: Graduate School
Project Director
Director of School or
Chairman of Department

Sincerely,

Chairman, Human Subjects
Review Committee

TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON
THE GRADUATE SCHOOL
P.O. Box 22479, Denton, Texas 76204 817/898-3400, 800-338-5255

February 13, 1989

Ms. Joyce Ann Swegle
1616 May
Denton, TX 76201

Dear Ms. Swegle:

I have received and approved the Prospectus for your research project. Best wishes to you in the research and writing of your project.

Sincerely yours,

Leslie M Thompson

Leslie M. Thompson
Dean for Graduate Studies
and Research

dl

cc Dr. Helen Bush
Dr. Anne Gudmundsen

APPENDIX B

Explanation of Study

EXPLANATION OF STUDY

As a doctoral student at Texas Woman's University, College of Nursing, I am studying the development of empathic communication in nurses. Empathy is a concept that is important to the helping relationship which nurses must foster with their patients.

As a participant in this study, you will be asked to complete a personal information sheet. This will probably require 3-5 minutes. These will be coded in a manner to protect anonymity. You will also be asked to answer some questions about your own communication skills and how you think that you acquired them. Your responses to these questions will be audiotaped. This activity will require approximately 30-60 minutes. The tapes will be erased at the conclusion of the study.

As you participate, you will have the opportunity to learn more about your own communication. You may become more aware of your own thoughts, feelings, and behaviors. Such increased awareness can be experienced as pleasant, uncomfortable, or a mixture of both. You do have the right to withdraw from the study at any time. I am willing to answer your questions about participation.

As a participant in this study, you may receive the results of the study by printing your address on the 3 x 5

card supplied by the investigator. The results will be forwarded to "Occupant" at the address given.

APPENDIX C

Consent Forms

TEXAS WOMAN'S UNIVERSITY
HUMAN SUBJECTS REVIEW COMMITTEE

CONSENT FORM A (Written presentation to subject)

Consent to Act as a Subject for Research and Investigation:

The following information is to be read to or read by the subject. One copy of this form, signed and witnessed, must be given to each subject. A second copy must be retained by the investigator for filing with the Chairman of the Human Subjects Review Committee. A third copy may be made for the investigator's files.

1. I hereby authorize _____
(name of person(s) who will perform procedure(s) or investigation(s)
to perform the following procedure(s) or investigation(s): (describe in detail)

2. The procedure or investigation listed in Paragraph 1 has been explained to me by _____
(name)

3. (a) I understand that the procedures or investigations described in Paragraph 1 involve the following possible risks or discomforts: (describe in detail)

(b) I understand that the procedures and investigations described in Paragraph 1 have the following potential benefits to myself and/or others:

3. (c) I understand that--No medical service or compensation is provided to subjects by the university as a result of injury from participation in research.

4. An offer to answer all of my questions regarding the study has been made. If alternative procedures are more advantageous to me, they have been explained. A description of the possible attendant discomfort and risks reasonably expected have been discussed with me. I understand that I may terminate my participation in the study at any time.

_____ _____
Subject's Signature Date

If the subject is a minor, or otherwise unable to sign, complete the following:

Subject is a minor (age _____), or is unable to sign because:

Signatures (one required)

_____ _____
Father Date

_____ _____
Mother Date

_____ _____
Guardian Date

_____ _____
Witness (one required) Date

CONSENT FORM C (to be used in addition to Form A and when voices or images are to be recorded)

TEXAS WOMAN'S UNIVERSITY

We, the undersigned, do hereby consent to the recording of our voices and/or images by _____, acting on this date under the authority of the Texas Woman's University. We understand that the material recorded today may be made available for educational, informational, and/or research purposes; and we do hereby consent to such use.

We hereby release the Texas Woman's University and the undersigned party, acting under the authority of Texas Woman's University, from any and all claims arising out of such taking, recording, reproducing, publishing, transmitting, or exhibiting as is authorized by the Texas Woman's University.

SIGNATURES OF PARTICIPANTS*

_____
Date

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

The above consent form was read, discussed, and signed in my presence. In my opinion, the person signing said consent form did so freely and with full knowledge and understanding of its contents.

_____	_____
Authorized representative of the Texas Woman's University	Date

*Guardian or nearest relative must sign if participant is minor.

APPENDIX D

Instruments

Demographic Data Questionnaire

Age:_____

Gender:_____

Date of first licensure as an RN:_____

Collective length of employment:_____

Current employment setting:_____

Current job role:_____

Interview Questions

1. Please describe a nurse-patient interaction in which you were empathic. Describe the situation fully.

2. Describe the meaning that the interaction had for you.