

EMPATHY IN BACCALAUREATE NURSING STUDENTS  
AND THEIR FACULTY

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## CHAPTER 1

### INTRODUCTION

Nursing is a valued helping profession that is concerned with man's total well-being. This concept of man's wholeness includes his physical well-being, and also his personal meanings and perceptions which he holds about his schema of life experiences. Without an empathic grasp of the patient's state of mind, nursing assessments and patient care are not as conducive to the patient's healing and total well-being as is expected by the nursing profession and by society. Further, an experience of illness or personal crisis increases man's need for empathic understanding and responding from his health care professionals.

Within the educational and academic arena, nursing schools are committed to serve as a preparatory ground for nursing students to learn holistic patient care. This care includes not only the physical care aspects and the technical skills, but also effective interpersonal relating skills.

The key ingredient of interpersonal relating has been shown to be empathy (Rogers, 1957). Therefore,

the development of this skill is imperative for effective nursing care and should be an integral part of nursing education. An exploration of empathy levels of students and their faculty may assist in determining what effects faculty role-modeling of empathy have on student interpersonal skills.

### Problem of Study

The problem of this study was confined to three parts as follows:

1. To determine if graduating baccalaureate nursing students significantly differed on empathy scores from entering baccalaureate nursing students.

- 2 To determine if a significant difference existed between the empathy scores of nursing faculty and nursing students.

3. To determine the effects of sex, age, race, marital status, previous formal empathy training, and major area of interest in nursing on the empathy scores of nursing students.

### Justification of Problem

Nursing has been defined as a significant, therapeutic, and interpersonal process. It is a helping

relationship between nurse and patient with empathy as a necessary component (Kalisch, 1971a; La Monica & Karshmer, 1978; Mansfield, 1973; Peplau, 1952; Speroff, 1956). Research findings have consistently demonstrated the importance of empathy as the most critical ingredient in an effective helping relationship (Carkhuff, 1969; Rogers, 1957; Truax, 1966).

Since empathy is a critical ingredient in a helping relationship, it could be expected that professional nurses are highly empathic people. However, studies indicate that empathic abilities have been found to be lacking among registered nurses (Kalisch, 1971a; Wallston, Cohen, Wallston, Smith & DeVellis, 1978). Jourard (1971) believed that nurses could promote healing by encouraging honest self-disclosure from their patients and by giving empathic acknowledgement to their patients of what has been expressed. However, he emphasized that empathy is usually lacking in nurses whom he described as having rigid interpersonal behavior.

Empathy levels have been found to be low not only in practicing registered nurses, but also in senior baccalaureate nursing students (La Monica &

Karshmer, 1978). The technical and physical care aspects are emphasized within the nursing school curriculum, perhaps to all the exclusion of effective interpersonal relating skills. There is a real danger that the health care field may become so enamored with its advancing technology that the patient's emotional, sociocultural, and developmental functioning will be increasingly ignored. The students may risk learning about the increased technology at the expense of learning how to respond to the emotional needs and the human side of their patients (Anthony & Carkhuff, 1976).

Within the arena of education for professional nurses there is a commitment to graduate baccalaureate students whose exiting knowledge and interpersonal skills enable nursing care of the whole group. Contrary to this commitment, Jourard (1971) asserted that professional training encourages graduates to wear a professional mask, to perform stereotyped roles, and to become dehumanized and be dehumanizing in their patient care. Jourard (1971) stated "growth beyond technical expertise is growth as a person among persons--a rehumanizing process" (p. 178). The student's empathic responding to the patient is an example of growth as a person among persons, and enables nursing care of the whole person.

There are many factors evidenced in research which influence student empathy levels. Some nursing students improved their empathy levels significantly after proceeding through an empathy training program incorporated into the curriculum, confirming that in those students empathy could be learned (Anthony & Carkhuff, 1976; La Monica & Karshmer, 1978; Wallston, et al., 1978; Walstedt, 1968). However, an examination of the objectives of nursing education curricula and the learning experiences they offer indicated little attempt toward specifically improving empathy levels through the student's educational process (Kalisch, 1971b).

Other studies have indicated that a student's increase in empathy is directly related to the faculty member's level of empathic functioning. The higher the empathy modeled by the educator, the greater the improvement in empathy levels attained by the student (Gulanick & Schmeck, 1977; Kalisch, 1971b; La Monica & Karshmer, 1978; Speroff, 1956). Bernard and Huckins (1974) emphasized that educators have no more potent tool than that of providing an example and modeling of the desired behavior to the students.

There is impressive evidence that empathy is a necessary ingredient to an effective interpersonal relationship between nurse and patient, serving to promote care and healing of the whole person. There is also a significant fear today that registered and practicing nurses, and also nursing students, are lacking this vital and necessary component. It has become necessary to look to the educating process, and even to the faculty member, to explore the area of student empathy scores and faculty influences on the empathy scores.

### Theoretical Framework

Social learning theory by Bandura (1969, 1971) provided the theoretical framework for this study. The modeling processes theorized by Bandura explain the role modeling influences nursing faculty members might have on the students' behavior.

New modes of behavior are acquired and existing response patterns are modified through one's observation of another's behavior, and observation of the consequences another experiences from his behavior. Modeling behavior serves as a source of information for the observer. Based on cognitive functioning,

it is central to social learning theory that observers acquire mainly symbolic representations of modeled events rather than specific stimulus-response association (Bandura, 1969, 1971).

There are four interrelated subprocesses included in this modeling formulation. The first involves attention processes. Simply exposing people to modeling influences does not guarantee that they will attend closely to them and accurately perceive the modeling cues. Matching responses in the observer will not be acquired if he does not attend to, recognize, and differentiate observational learning. A person may observe a model's behavior and acquire the matching response in representational form without actually performing the overt response. Often, this acquired response is retained over an extended period of time and not activated into an overt response until attainment of age, social status, and other similar factors at which time the activity is considered appropriate (Bandura, 1971).

Both symbolic verbal coding of observed events and rehearsal activities can increase the observational learning following a modeled pattern, and effectively

strengthen the acquired matching response. In verbal coding, the observers transform the modeling stimuli into easily remembered schemes (images) and readily utilizable verbal symbols. These codes serve as guides for subsequent reproduction of the matching responses (Bandura, 1969, 1971).

Third, motor reproduction processes involve the use of symbolic representations of modeled behavior to guide overt behavior performances. Rather than following an external series of instructions, a matching behavioral response in modeling is brought about by the symbolic representations of the absent external stimuli (Bandura, 1969, 1971).

Reinforcement and motivational processes are a final component. A person may possess the capability to perform a modeled behavior, but negative sanctions or unfavorable incentives inhibit his performance. In this process, reinforcement variables not only influence the overt expression of matching behavior, but can also influence one's selective attention to modeled events. Reinforcement also facilitates retention by activating deliberate coding and rehearsal of modeled behaviors.

Within social learning theory, Bandura (1969, 1971) described three effects resulting from one's observation of modeling behavior. The first is the observer's acquisition of new response patterns. Second, there are inhibitory responses in the observer that may be strengthened or weakened, according to his observation of modeled actions and their consequences to the performer. And, third, there is a response facilitation effect whereby a previously learned behavior in the observer is further facilitated by observing the model's behavior.

Studies have indicated that modeling procedures can be successfully employed to induce changes, or strengthen previously learned behavior in an observer. Modeling can be used advantageously to directly promote effective interpersonal behaviors (Bandura, 1969).

Social learning theory is applicable to this study in that Bandura (1971) emphasized learning to be fostered by real-life models, as well as models presented in verbal or pictorial form. It was surprising to Bandura that traditional accounts of learning contained little mention of the modeling processes. Because nursing students have the opportunity to learn by example when

observing their faculty actually caring for patients in the realistic clinical setting as well as the more abstract classroom setting, much opportunity exists for role modeling by the nursing faculty to their students. Role modeling may account for influences that faculty may have on students' empathic functioning.

### Assumptions

The following assumptions were made in this study:

1. Empathy is a desirable attribute in a professional nurse, and is important for holistic nursing care.
2. Empathy can be modeled and measured.
3. Both full-time and part-time faculty members function as role models of professional nursing, whether positively or negatively, to their nursing students.
4. Modeling behavior of high levels of empathy promotes effective interpersonal relationships.
5. Because both groups of entering and graduating baccalaureate nursing students are in the same educational program and exposed to similar variables, they are considered like groups for the purpose of this study.

### Hypotheses

The three hypotheses concerning the empathy levels of nursing students and faculty were operationally defined and stated as follows:

1. Graduating baccalaureate nursing students have no significant differences in empathy scores than entering baccalaureate nursing students as measured by the Hogan Empathy Scale.

2. Nursing faculty evidence no significant differences in empathy scores than baccalaureate nursing students as measured by the Hogan Empathy Scale.

3. The demographic variables of sex, age, race, marital status, previous formal empathy training, and major area of interest in nursing have no significant effect on empathy scores of the nursing students as measured by the Hogan Empathy Scale.

### Definition of Terms

The following terms are defined according to their meaning and usage in this study:

1. Empathy--the "intellectual or imaginative apprehension of another's condition or state of mind without actually experiencing that person's feelings" (Hogan, 1969, p. 308). Rogers (1957) defined empathy

as the "ability to sense the client's private world as if it were your own but without ever losing the 'as if' quality" (p. 99). The empathy score is a relative measure of empathy as measured by the Hogan Empathy Scale.

2. Entering nursing students--those baccalaureate students who have not yet completed 20 units of nursing courses within the nursing department.

3. Graduating nursing students--those baccalaureate students who are classified as seniors, and are in their last semester of the nursing curriculum prior to their graduation.

4. Faculty--full-time and part-time people who teach baccalaureate nursing students within the department of nursing.

5. Role modeling--behavior of significant others that is observed and imitated, promoting new response patterns, or strengthening or weakening previously learned response pattern (Bandura, 1969).

### Limitations

The following limitations were realized in this study:

1. The Hogan Empathy Scale used in this study was not designed to measure or control all the possible variables that may have influenced the empathy level.

2. The Hogan Empathy Scale was a self-report measure and not a behavioral measure of empathy.

3. The sample of baccalaureate nursing students and the faculty for this study were limited to one small, private, accredited school of nursing in the Western region of the United States.

4. The college is a Christian liberal arts institution that only admits into the college those students who adhere to the Christian philosophy of the school.

5. Because the study was limited to one private college, the sample of faculty was small.

### Summary

The key ingredient of interpersonal relationship has been shown to be empathy. Although empathy is imperative for effective nursing care, research results

have found this quality to be low in both registered nurses and nursing students. An exploration of entering and graduating nursing students' empathy scores, of faculty empathy scores, and of other specific demographic variables that may have influenced the empathy scores was done.

## CHAPTER 2

### REVIEW OF LITERATURE

The research and literature on empathic relationship is extensive and includes many academic areas. This review of literature is not a comprehensive survey of the subject of empathy. For the purposes of this review, empathic relationships will be treated in three general categories: empathy in interpersonal relationships, empathy in education, and empathy in nursing.

#### Empathy in Interpersonal Relationships

Rogers (1951, 1975) was one of the earliest theorists to stress the important role of empathy in interpersonal relationships. He conceptualized this process as entering into another person's perceptual world. It was identified as the principal route to understanding helpes and enabling them to feel understood. The practice of empathy involves being sensitive to others, and understanding the fear, or rage or confusion, or loneliness, or vulnerability, or whatever else the person is experiencing. The helper sets aside personal views and values to enter into the

other person's world or his internal frame of reference, and appreciate what his experience feels like to him (Rogers, 1975).

The helper makes an active effort to put himself into this internal world of the helpee without losing his own identity or objectivity. He thinks "with" rather than "for" or "about" the helpee. The word empathy is derived from the German word "einführung" meaning "feeling into". A helper "feels into" the helpee's feelings and experiences as they are being related. The manifestation of empathy is relayed through the helper's ability to perceive what is going on in the helpee's feelings and to communicate this perception clearly to the helpee (Brammer, 1973). The helpee then feels helped because he feels worthwhile as a human being, feels accepted and understood by another human being. He is therefore permitted to be his true self and to explore his true concerns and experiences. Deeper feelings become understood as well as the superficial feelings and perceptions (Okun, 1976).

Building on the Rogerian model, extensive research by Rogers (1975), Carkhuff & Bereson (1967), and others has led to the general acceptance among interpersonal

theorists and helping skills trainers (Carkhuff & Anthony, 1979; Egan, 1970, 1975; Eisenberg & Delaney, 1977; Gazda, Asbury, Balzer, Childers, Desselle & Walter, 1973; Johnson, 1972; Okun, 1976; Truax & Carkhuff, 1967) of the central importance and influence of empathy in interpersonal relationships. High degrees of empathy by a helper have been found to increase a helpee's understanding of himself and facilitate growth. Low empathy by the helper has been found to be related to a slight worsening or deterioration in the helpee (Carkhuff, 1969; Kalisch, 1971a; La Monica & Karshmer, 1978; Rogers, 1961, 1975; Spilken, 1969; Truax, 1966).

Operational definitions of empathy emerged as Carkhuff (1969) developed a 5-point scale to assess helper facilitative dimensions in relation to improvement in the helpee. Level 3 is defined as the minimally facilitative level of empathic functioning. At Level 3, the communication of the helper expresses essentially the same affect and meaning as that expressed by the helpee. Responses of the professional helper below Level 3 detract from those of the client, and communicate significantly less of the helpee's feeling than the helpee

communicated himself. Above Level 3, the responses of the helper are additive and helpful in nature.

There are certain interpersonal skills that one may develop to facilitate an empathic response. This response expresses an understanding of another's world without ever losing the "as if" quality (Rogers, 1951, 1961). These skills are attending, responding, personalizing, and initiating. Attending and responding entail the giving of attention to and responding to another's internal frame of reference and perceptions. There is a communication of caring and warmth, and an understanding of the feelings of another, including a perception of the reason a person feels as he or she does (Carkhuff & Pierce, 1977).

The skill of personalizing enables the helpee to realize what it is about himself that keeps him from attaining a goal. Personalized empathy attempts to enable the helpee to understand where he is in relation to where he would like to be or need to be (Carkhuff & Pierce, 1977).

Initiating facilitates action. It involves defining or operationalizing the helpee's goal and initiating steps of action to reach the desired goal. It also

involves productivity and creativity. A direction and action plan is determined based on the helpee's understanding and knowledge of the problem or desired goal. The helper must focus on both insight and action. Effective action will stem from a real understanding of the helpee's own goal, rather than from random advice. (Carkhuff & Pierce, 1977).

### Empathy in Education

There is very little in the nursing literature that indicates specifically how empathy is assessed and developed in the nursing educational process. Most of the studies have been done in the field of psychology to investigate the effects of modeling on empathy development, and the effects of empathy on enhancing learning.

An investigation in Lexington, Kentucky explored the relationship between a teacher's empathic understanding of the students and their cognitive gains as measured by achievement tests. The study was based on Rogers' (1961) hypothesis that empathy is a necessary ingredient of every learning situation. The subjects were 120 third grade students who received pretesting and posttesting throughout 1 academic year. The procedure

also involved an audio tape recording of the teacher's performance in the classroom, and an assessment of the tapes for the teacher's level of empathy using the Truax (1966) scales. The results of this study revealed that the students' cognitive gains were positively and significantly related to the teacher's level of empathy (Aspy, 1975). This supported Rogers' (1961) hypothesis about the necessity of empathy in learning situations.

In addition, Aspy (1975) briefly stated that results compiled from many of his studies and others in past years and repeated in a wide variety of settings supported the necessity of empathy, and the low levels in all professions with whom he has worked (doctors, lawyers, prisoners, prison guards, and others). Aspy concluded that society is functioning at rather low levels of empathy, which reveals the urgency for developing empathy training programs in the helping professions.

Research has shown that the communication of empathy is heavily dependent on the non-verbal message (Tepper & Haase, 1978). High quality verbal empathic messages were demonstrated to be undermined by contradictory and inconsistent non-verbal cues. In a study of the

counseling process, Tepper and Haase (1978) concluded that the non-verbal cues played a combination role in determining whether or not a message was really significant.

The contributions of modeling and verbal instructions to the empathy training of counselors were investigated by Perry (1975). The study was based on previous studies supporting the necessity of empathy and the effectiveness of role modeling. The voluntary subjects consisted of 68 clergymen from various religious denominations. A factorial design incorporating two instruction conditions (instructions, no instructions) and three modeling conditions (high empathy model, low empathy model, or no empathy model) were utilized. In Phase I the subjects wrote their responses to a taped session with a client. The main effect of high empathy modeling on the subjects was significant ( $F(2,60) = 3.46, p < .05$ ) while the main effect of instructions was not significant. In Phase II, the subjects conducted an interview with a client-actor to determine generalization of the instruction or modeling. There was no significant differences between the groups although the main effect of modeling approached significance ( $F(2, 60) = 2.61, p < .10$ ). The results of the study indicated that one's

empathic responses can be positively influenced through the use of high empathy modeling. Didactic information about empathy or instructions on how to be empathic had no effect on the empathic responses of the subjects. The subjects who heard a high empathy model increased in their empathy, while subjects who heard a low empathy model decreased in their empathy, and subjects who heard no model remained the same.

Perry (1975) concluded that the teacher's instruction had no effect at all when compared with the effects of modeling. The educators must model behavior consistent with what they are teaching, and what behavior they desire to see in the students. These results support the conclusion by Tepper and Haase (1978) that a dominant role is played by non-verbal cues in the interaction.

The purpose of a study by Dowling and Frantz (1975) was to examine the relationship between imitative learning and the quality of an interpersonal relationship. It was hypothesized that the nurturant and empathic relationship of a model would enhance the observer's imitative learning. The study was based on the theories of Bandura and Mowrer (cited in Dowling & Frantz, 1975) that suggests imitative learning to be promoted by a facilitative

relationship. The 72 subjects of the study were enrolled in summer classes at a community college, and ranged in age from 18 to 42 years. The subjects were assigned randomly to 10 discussion groups, with 8 groups being experimental and 2 groups being the controls. Two counselors were assigned to the groups. Facilitativeness, the independent variable, was measured in terms of empathy and respect, using a tool developed by Carkhuff and Berenson (1967). The results supported the hypothesis, indicating that when the counselors offered high levels of empathy and respect, the subjects imitated significantly ( $F(4, 62) = 14.93, p < .01$ ) more of these facilitative conditions modeled by the counselors than they did when the counselors offered low levels of empathy and respect. These findings persisted over at least a 3-week time interval. An implication suggested that a counselor serves as a model in every counseling relationship, for better or for worse.

#### Empathy in Nursing

There is little in the nursing literature about the levels of empathy in nurses, and the maintenance of empathy in nursing practice. The literature is also limited on information about how or when empathy is

learned, and how it is developed and specifically incorporated into the nursing curriculum.

A study of 39 employed female registered nurses from a medium-sized, urban, acute and chronic care hospital indicated that all of the nurses tested possessed an extremely low level of empathy. Carkhuff's (1969) Index of Communication was the tool utilized to obtain the objective measures. All of the participating nurses were educated in either a diploma or an associate degree program, and ranged in age between 21-45 years. Of the 24 nurses who were pretested for empathy level, all scored less than 2.0 on Carkhuff's scale, in which a 3.0 level had been established as minimum for helpers to possess. The nurses were divided into experimental or control groups. A human relations staff developmental program was then given to the experimental group, incorporating both didactic and experiential learning to increase the empathic responses. Results of Kruskal-Wallis' one-way analysis of variance showed the training program to have significantly raised the empathy levels of the subjects in the experimental group ( $p < .001$ ). However, only three of the subjects reached a minimal level of empathy, according to Carkhuff's (1969) Index of

communication, upon completion of their training program. The average scores were at the mid-point between hurting another person and only partially responding to superficially expressed feelings. A conclusion drawn from the findings was that more training was needed to enable all the subjects (registered nurses) to obtain an empathy level that would facilitate effective helping (La Monica, Carew, Winder, Haase, & Blanchard, 1976).

Truax (1974) studied the empathy scores of a sample of 112 registered nurses and compared them with the empathy scores of others from 10 other occupational groups. The registered nurses were found to have low empathy scores. The only group who was less empathic than the nurses were manufacturing plant supervisors.

Forsyth (1979) studied the interpersonal functioning of nurses by conducting exploratory research of empathy in nurse-client interactions. The study was designed to test for significant differences in empathic ability in relation to age, marital and parental status, level of education, length of practice, level of practice, and areas of practice of nurses. Seventy nurses from two midwestern hospitals volunteered to be subjects. More than half of the subjects were more than 30 years of age,

married, not parents, diploma prepared, and working staff nurses. The Hogan Empathy Scale and Barrett-Lennard Relationship Inventory were utilized. Both descriptive and multiple regression analytical statistical procedures were utilized in interpreting the data. Pertinent findings from the study were that baccalaureate nurses in the study obtained significantly higher levels of empathy than diploma nurses ( $p < .05$ ). No significant differences were found between empathic ability and age; marital and parental status; and length, level, and area of practice. Older nurses (50-59 years of age) scored lowest on empathy scores, and the 30-39 year old subjects scored highest. Also, the most recent graduates had the highest empathy scores. However, the variation of empathy scores by age and length of practice were not statistically significant. Married subjects and parents also tended to achieve higher empathy scores, although there was still no statistical significance. Medical, surgical, orthopedic, and psychiatric nurses all scored similarly. Forsyth (1979) concluded that there is a need in nursing practice for high levels of empathy, and a concurrent system for cultivating, nurturing, and rewarding empathic ability.

The degree of person-centeredness in professional nurses was investigated by Wallston, et al. (1978). Indications from the findings were that the nurses were performing between the levels of 0 to 1, where level 0 indicated that the nurses did not elicit information but gave information, and level 1 where the information was elicited but the patients' responses were limited by the nurses. In a study with two phases, the 49 nurse subjects were divided into two groups and were asked to offer a helpful response to simulated patient recordings. The first group received no intervention in between Phase I and Phase II of their responses. The second group received a 450-word intervention designed to enhance the helpfulness of their responses after completing Phase I and just prior to Phase II of their responses. The nurses who received the intervention showed significant ( $t = 4.96$ ,  $df = 19$ ,  $p < .001$ ) improvement in the degree of person-centeredness scores, as compared to the group who did not receive the intervention. The brief training facilitated improvement in the helpful responses of the nurses to the simulated patients. The results support the suggestion that professional nurses may be very low in

empathy, but with empathy training could improve their ability for empathic responding and effective interpersonal relationships.

A thorough search of the literature by Kalisch (1971a) revealed few studies in which an attempt was made to increase empathy, and that none of the studies utilized nursing students or graduate nurses as subjects. Based on research indicating empathic abilities to be lacking among the helper professionals in the helping fields (Carkhuff & Berenson, 1967), Kalisch (1971a) developed and studied a short-term experience designed to increase empathy among nursing students. The sample consisted of 49 students of an associate degree program who were randomly assigned to experimental and control groups. In the experimental groups, empathy training was given that included didactic training, role-playing, experiential training, and a role-model empathy. The control groups received lectures and discussions on human behavior. Five various tools measuring interactive, self-evaluative, patient evaluative, predictive, and rating scale aspects of empathy were administered to the subjects. A one-way analysis of variance and t-tests were employed for interpretation of the data.

Results of the study (Kalisch, 1971a) showed that subjects in the empathy training program improved significantly ( $F(1, 47) = 7.20, p < .01$ ) on posttests of interactive empathy, a self-evaluation of empathy, a clinical instructor evaluation of empathy, and a test of predictive empathy with a patient. Gains were maintained by the experimental subjects on interactive empathy at a 6-week follow-up test ( $F(1, 43) = 7.26, p < .01$ ). An important conclusion was that there is a need for an empathy training program to be incorporated into nursing educational curricula.

The results obtained by Kalisch (1971a) are supported by similar results obtained by La Monica and Karshmer (1978). Although it is commonly believed that nursing students learn empathy and effective interpersonal skills during their psychiatric didactic and clinical nursing experiences, research by La Monica and Karshmer (1978) did not support this statement. Senior baccalaureate nursing students in their last semester were tested immediately prior to and just following their psychiatric nursing experience. On both pretesting and posttesting, all the students scored low on their empathy levels, indicating that they had not acquired the

facilitative skills of effective listening, attending, and verbal responses. It was only after a didactic and experiential empathy training program that the students significantly ( $p < .01$ ) improved their empathy levels, confirming that in those students empathy could be learned. A conclusion of the study was that a small effort by nursing educators and nursing administrators would result in an increase of empathy levels of students and practicing nurses, thereby facilitating better patient care.

As stated previously, the skills of attending, responding, personalizing, and initiating may facilitate an empathic response (Carkhuff & Pierce, 1977). These skills involve open and warm communication or disclosure. Jourard (1971) suggested that a healthy relationship thrives on open and candid communication and interpersonal interaction. This phenomenon of open communication was termed self-disclosure. Empathy entails listening and attending to the verbal disclosure of another persons. A patient who is verbally disclosing is making himself known to his nurses and physicians.

M. Johnson (1980) studied the interpersonal relationships between nurses and clients/patients,

identifying improvement of patient care. For several years, she conducted both formal and informal interviews with junior and senior nursing students, graduate students, and practicing staff nurses to assess the amount of self-disclosure between nurse and patient. The practicing nurses responded that they often did not have time to listen to patients, and that other care activities were considered more important than talking with the patients. In addition, the nurses stated that they did not have the interpersonal skills to relate with patients, gave no assistance to helping patients deal with personal problems, and that they felt safer in discouraging self-disclosure from their patients.

The junior and senior nursing students reported that they usually tried to encourage patient self-disclosure when they had time to listen. The students felt less confident about their role in reciprocating personal self-disclosure, and perceived such an opportunity as occurring infrequently in their nurse-patient relationships. The majority of the graduate students responded that they frequently self-disclosed, and encouraged disclosure from the patients. The disclosed

information was used to individualize the nursing care for the patient (M. Johnson, 1980).

As a result of the data from the formal and informal interviews, M. Johnson (1980) then studied the reciprocal disclosure occurring between nurses and patients on medical, surgical, psychiatric, and critical care units in a large urban hospital. The subjects were 70 nurses who completed a questionnaire and 68 patients who were interviewed.

The findings indicated low levels of self-disclosure occurring between the nurse and patient in all of the units. Statistically, a mean of 60.00 meant full disclosure compared with a mean of 00.00 indicating no self-disclosure. On the medical unit the nurses' mean level of self-disclosure to patients was 3.50. On the surgical unit and critical care units, the nurses' mean level of self-disclosure was 8.89 and 7.81, respectively. The low level of psychiatric nurses' mean level of self-disclosure to patients was 7.59, which was interesting to note since psychiatric nursing therapy is primarily verbal. These findings indicate a need for both nurses and clients to be assisted in learning how to have more effective interpersonal relationships with one another (M. Johnson, 1980).

In a study by Packard, Schwebel, and Ganey (1979) concerns of 19 final semester baccalaureate nursing students were studied by obtaining data from 10 taped group meetings throughout a 16-week semester. The data were collected and categorized according to task-, self-, or client-related concerns, with a rating reliability of .90. An important finding was the low frequency of client-related concerns offered by the students.

To overlook the key role that empathy plays in the realm of nursing is to deny nursing's basic premise--human interpersonal caring and nourishment (Peplau, 1952). This same interhuman element is described by Anderson (1979) to be the most meaningful factor of every nursing event. Nursing is practiced in a shallow manner if the nurse is concerned only with the menial care and tasks to be done. Two nurses may be at the bedside helping each other with the care of a patient, but they actually exclude the patient as a person. Little eye contact with the patient occurs, conversation is usually between the nurses, and although they efficiently perform their tasks, the patient becomes an object of manipulation. Therefore, if nurses are to perpetuate healthiness and well-being in relation to

health care, much more emphasis needs to be placed on nurses learning more about human interpersonal relationships.

Ludemann (1968) explained that the empathic process in the nurse enhances the ability to identify patient needs and individualize the nursing care plans to meet these needs. It can also be utilized to discover the meaning of a patient's non-verbal communication, and to understand the personal meanings and perceptions the illness holds for the patient.

#### Summary

It has been well documented that empathy is given critical importance to the role it plays in effective interpersonal relationships. Research over the years strongly identified a high degree of empathy to possibly be the most potent, and certainly one of the most potent, factors in a helping relationship that facilitates growth and healing. Little attempt has been made in nursing to study this important element. There is a need to incorporate an assessment of student empathy and a training program for development of empathy into the nursing education processes. Results of the few studies investigating empathy in nursing

shared some consistent findings. Both nursing students and practicing nurses were low in empathy, below effective facilitating levels, but improved in empathy after participating in an empathy training program. It has also been consistently shown in the literature that empathic modeling is important to the learning of empathy.

## CHAPTER 3

### PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

A descriptive and correlational study was conducted using self-report questionnaires as the method of obtaining the data. The primary purpose of this study was to look at differences in empathy scores of entering and graduating baccalaureate students, and nursing college faculty. The criteria for the descriptive and correlational design (Polit & Hungler, 1978) were met in that there was no direct manipulation of the independent variables, and no attempt to state cause-effect relationships. The study was conducted after the variables had occurred in a natural course of events. A normal distribution and equal variances were assumed and parametric statistics were employed.

#### Setting

Data were collected for this study at a private Christian liberal arts college, in the Western United States, with an approximate enrollment of 2,500 students, approximately 200 of whom were nursing students. The nursing department of the college offers a fully

accredited nursing curriculum based on a stress/adaptation model. The nursing department prepares the students for a Bachelor of Science degree conferred upon graduation and a career in professional nursing.

#### Population and Sample

The population of this study consisted of approximately 200 baccalaureate nursing students and 11 full-time and 5 part-time faculty. Drawn from this population was a sample of 96 subjects; 31 were entering nursing students, 52 were graduating nursing students, 9 were full-time nursing faculty, and 4 were part-time nursing faculty. Accidental sampling was utilized, meaning that those subjects available at hand became the sample subjects for this study (Kerlinger, 1973).

Three criteria were established for inclusion in this study. First, all subjects were enrolled or employed at the private liberal arts college at which the study was done. Second, only entering or graduating baccalaureate nursing students were sampled, according to their classification and progression in the nursing curriculum, as already defined in this study. Third,

all faculty were employed by the college either full or part-time. Part-time faculty were included because they spent a minimum of 15 hours per week working closely with their students in clinical experiences, often in a one-to-one relationship.

A required class for entering nursing students was attended by the researcher to administer the tool to the entering nursing students who were in attendance in that class. All of the graduating nursing students were sampled during a gathering to practice their graduation ceremony.

The written instructions, consent form, and questionnaires were submitted to each faculty member's personal mailbox. Instructions were given to re-submit the completed questionnaire to a designated box for the researcher.

#### Protection of Human Subjects

Written permission to conduct the study was obtained from the Texas Woman's University Human Research Review Committee (Appendix A), from the graduate school (Appendix B), and the participating agency (Appendix C) prior to its initiation. Subjects were informed of the purpose of the study by means of an oral explanation

provided by the researcher (Appendix D). All subjects consenting to participate in the study signed a consent form stating they understood their involvement including inherent possible risks and benefits, and that they agreed to participate (Appendix E). Signed consent forms were collected before the study began. To protect the privacy, anonymity, and confidentiality of the subjects, they were required not to indicate their names on the tool questionnaires. Numerical coding of the questionnaires was used to match the demographic data with responses to the instrument. The subjects were protected from any possible embarrassment by maintaining the confidentiality of the responses.

### Instruments

Two instruments of measurement were used in this study. The demographic questionnaire (Appendix F) was developed by the researcher. The items--sex, race, marital status, past formal empathy training, and major area of nursing interest--were chosen not only for classification purposes but also to examine the possible correlations of demographic data with the empathy scores.

The Hogan Empathy Scale (Appendix G) was used to measure for an empathy score. The test consists of 39 true/false items. The score assigned an individual consisted of the total number of correct responses. The test originally consisted of 64 items but the 39 item shorter version was later developed. The shorter scale correlates above .90 with the 64-item version (Greif & Hogan, 1973).

Hogan (1969) instituted several analyses using Q-sort descriptions and intercorrelations, based on responses from professional and non-professional people alike. From these analyses, it was inferred that empathy refers to a relatively discrete social phenomenon recognizable by laymen and professionals. These findings served as a justification for the development of the empathy scale and as a basis for its construction.

An empathy criterion was developed. Psychology faculty and graduate students were asked to describe their conceptions of a highly empathic person. Their Q-sort descriptions were intercorrelated resulting in a mean correlation coefficient of .171, and an estimated reliability of their composite at .94 which was significant at the .05 level. Evidence was then gathered for evaluating the empathy ratings which were used to

define highly empathic and non-empathic individuals. An item analysis was conducted to select items for a scale which would discriminate between nominated groups (Hogan, 1969).

A sample of 103 students was chosen to perform another empirical check on the interpersonal meaning of the scale, describing the behavior of high and low empathy scorers. The high scorers were described as pleasant, charming, friendly, dreamy, cheerful, sociable, sentimental, imaginative, discreet, and tactful. The low scorers on the other hand were described as cruel, cold, quarrelsome, hostile, bitter, unemotional, unkind, hard-hearted, argumentative, and opinionated. Thus, high scorers seem to be socially acute and sensitive to nuances in interpersonal behavior. Low scorers, however, seem hostile, cold, and insensitive to the feelings of others.

The empathy scale is closely related to measures of interpersonal effectiveness and social adequacy. An analysis of the scale's inter item correlations suggested three underlying themes: empathic persons are known by a patient and forbearing nature, socially ascendant tendencies, and by liberal and humanistic political and

religious attitudes. Conversely, non-empathic people tend to be withdrawn from others and intolerant, with authoritarian values (Greif & Hogan, 1973).

Reliability and validity studies have shown the Hogan Empathy Scale instrument to be generally positive. The test-retest reliability coefficient of .84 was obtained over a 2-month period with 50 college undergraduates. The KR-21 formula applied to the scores of 100 military officers yielded a coefficient of .71 (Hogan, 1969).

Validity was established by having two junior high school teachers rate the five highest and lowest males and females on social acuity. The empathy scale also discriminated the two groups at the .01 level for the males and at the .05 level for the females. Greif and Hogan (1973) in a review of validity studies on the instrument concluded that there is a "reasonable correspondence between the empathy scale and the theoretical context within which it was developed" (p. 282).

#### Data Collection

The entering nursing students completed the demographic and instrument questionnaires after attending science class. The students were free to leave at the

completion of the class, so those who remained to complete the questionnaires for this study did so on a voluntary basis. Data from the graduating students were obtained at a different time in the same classroom. The graduating students were gathered to plan for their graduation ceremony.

The questionnaires were distributed to all the students and instructions were given in written form. The measures were a demographic questionnaire and a paper and pencil self-report on empathy by a circled true or false response. Upon completion of the questionnaires, the subjects returned them to a box placed in the front of the classroom. Faculty was treated likewise, except the instruments were submitted to their mailboxes, and upon completion were submitted back to the box supplied by the researcher.

Total data collected from students and faculty made for 102 subjects. Responses from six student subjects were withheld from statistical analysis due to incomplete answers on the demographic or the instrument questionnaires.

All questionnaires were scored by hand by the researcher using a key provided by Hogan (1969). The

demographic variables and the empathy score were transferred to computer cards for statistical treatment.

#### Treatment of Data

The demographic data was first tabulated then frequency distributions and percentages were computed. The subjects were then placed into naturally occurring groups according to their class standing or faculty status. The means of the empathy scores of the entering and graduating nursing students were compared using a t-test. The faculty were then compared with all the nursing students on their empathy scores using the analysis of variance statistical test. All demographic variables of sex, age, race, marital status, previous formal empathy training, and reported interest area in nursing were compared with the empathy scores for both the nursing students and faculty and the nursing students only. A one-way analysis of variance was utilized to determine significant differences between groups, and to determine the effects of sex, age, race, marital status, previous formal empathy training, and reported interest areas in nursing on empathy scores. The analysis of variance is a parametric procedure and was utilized to test the significance of differences between the means

of the groups in the study (Polit & Hungler, 1978). For all statistical comparisons, .05 was utilized as the level of significance.

## CHAPTER 4

### ANALYSIS OF DATA

The following discussion is a description of the sample based on the demographic data. An explanation of the findings of the study and a discussion of the hypotheses follows.

#### Description of Sample

The sample of student subjects, all female, was divided into two general groups according to their progression through the nursing program. There were 31 entering baccalaureate students and 52 graduating baccalaureate students.

The sample of baccalaureate nursing faculty, also all female, consisted of nine full-time and four part-time faculty. Rationale for including part-time faculty was that they instructed within student clinical experiences where much small group or one-to-one interaction took place.

The range of ages of the subjects was as follows: 15 subjects were 19 years of age or less; 10 subjects were 20 years of age; 10 subjects were 21 years of age;

20 subjects were 22 years of age; 16 subjects were 23 years of age; 25 subjects were 24 years of age or more.

Of the total sample, 75 subjects were Caucasian. The remaining subjects included: 4 Asian, 2 Spanish, 1 Black, and 1 multi-racial.

The marital status of the subjects consisted of 79 single and 17 married subjects. There were no separated or divorced subjects in the sample.

The subjects were questioned as to previous formal empathy training, although a definition was not provided. Only 11 subjects responded positively to having previous empathy training, while 85 subjects had never had such training.

Nursing was divided into four broad categories to determine major interest areas. The interest areas of the total sample of subjects were as follows: 42 subjects preferred pediatric/maternal nursing, equaling 43.8%; 35 subjects preferred medical/surgical nursing, equaling 36.5%; 5 subjects preferred psychiatric nursing, equaling 5.2%; and the remaining 14 subjects preferred other areas of nursing, equaling 14.6%.

### Findings

The first null hypothesis stated that there would be no significant difference in empathy scores between entering and graduating baccalaureate nursing students as measured by the Hogan Empathy Scale. A t-test between the means of the entering and graduating nursing students' empathy scores indicated no significant difference between the groups (t = .60, df = .69, p = <.05).

The first hypothesis was supported. The inference for this sample is that progression through the nursing program may not negatively effect students' empathy levels, although it may also not contribute to improving their empathic and interpersonal helping skills.

The second hypothesis stated in the null was that there would be no significant difference in empathy and the nursing faculty as measured by the Hogan Empathy Scale. A one-way analysis of variance of the empathy scores showed the faculty to have significantly higher empathy scores (F (1, 93) = 3.96, p = .0496) than the nursing students. The second null hypothesis was rejected. The inference for this sample may be explained by Bandura (1971) in that the acquired empathic response of the students may be retained over an extended period

of time. It often is not activated into an overt response until attainment of age, social status, and other similar factors at which time the activity is considered appropriate.

The third null hypothesis stated that the demographic variables of sex, age, race, marital status, previous formal empathy training and major area of interest in nursing would have no significant effect on empathy scores of the nursing students as measured by the Hogan Empathy Scale. A one-way analysis of variance was done to determine significant differences between groups on the following demographic variables:

1. All subjects were female so no analysis was run.
2. There were no significant ( $F(4, 89) = 1.14$ ,  $p = .3479$ ) differences between age groups although there was a progressive increase in mean scores on the empathy scale as age increased.
3. There was no significant ( $F(4, 90) = 1.36$ ,  $p = .2529$ ) differences between racial groupings of the subjects.
4. There were no significant ( $F(1, 93) = 1.12$ ,  $p = .2923$ ) differences between single and married

subjects although married subjects had a higher mean score than the single subjects.

5. There were no significant ( $F(1, 93) = 3.59$ ,  $p = .0614$ ) differences between subjects who reported previous formal empathy training and those who reported having had no previous formal empathy training. Although not significant, a strong trend was evident toward higher empathy scores for those subjects who reported previous formal empathy training.

6. There were no significant ( $F(3, 91) = .34$ ,  $p = .7940$ ) differences between reported interest areas in nursing.

A trend of higher empathy scores was noted in those subjects who reported previous empathy training. The lack of statistical significance may have been due to a small sample.

#### Summary of Findings

The following findings are summarized:

1. The sample consisted of 31 entering baccalaureate nursing students, 52 graduating baccalaureate nursing students, 9 full-time baccalaureate nursing faculty, and 4 part-time baccalaureate nursing faculty.

2. There were no significant differences in empathy scores between entering and graduating baccalaureate nursing students.

3. Baccalaureate nursing faculty had significantly higher empathy scores than the baccalaureate entering and graduating nursing students.

4. The demographic variables of sex, age, racial status, marital status, previous formal empathy training, and nursing interest areas had no significant influence on empathy scores.

## CHAPTER 5

### SUMMARY OF THE STUDY

This chapter presents a summary of the study and a discussion of findings. Conclusions and implications from the study are shown. Recommendations for further study are stated.

#### Summary

This study was conducted to determine if baccalaureate entering and graduating students and their nursing faculty differed on empathy scores. The demographic variables of sex, age, race, marital status, previous formal empathy training, and major areas of interest in nursing were examined for their possible influence on empathy scores.

The theoretical framework for the study was Bandura's (1969, 1971) social learning theory. He theorized modeling processes that explain role modeling influences nursing faculty members may have on the students' behavior.

The particular behavior pertinent to this study was empathy, measured as a score by the Hogan Empathy Scale. The instrument was administered to baccalaureate nursing

students and their faculty at a liberal arts college in the Western area of the United States. The 96 subjects were divided into groups of entering and graduating students and nursing faculty members. The statistical interpretation of the data was done by a t-test and a one-way analysis of variance.

The findings of the study were as follows:

1. There were no significant differences in empathy scores between entering and graduating baccalaureate nursing students.
2. Baccalaureate nursing faculty had significantly higher empathy scores than the baccalaureate entering and graduating nursing students.
3. The demographic variables of sex, age, racial status, marital status, previous formal empathy training, and nursing interest areas had no significant influence on empathy scores.

#### Discussion of Findings

The first null hypothesis predicted that graduating nursing students would not differ significantly in empathy scores from entering nursing students. The findings supported the hypothesis that no significant differences existed between the groups. This supports past research

(La Monica & Karshmer, 1978) that empathy levels were low in senior baccalaureate nursing students, even after their psychiatric nursing experience. Empathy levels of graduating nursing students in this study were not lower than the entering students, thus indicating that progression through the nursing program may not negatively affect the students' empathy levels. But more importantly, entering nursing students are just as empathic as graduating students, indicating that students may not have improved throughout their course of studies.

The second null hypothesis stated that the nursing faculty would not differ significantly in empathy scores from the nursing students. This hypothesis was not supported; the nursing faculty scored significantly higher in empathy than the students. The faculty possessed greater empathy skills than the students and could provide empathic role models. As Bandura (1971) has indicated, modeling is always taking place in instructing situations but this modeling appeared not to contribute to greater empathy on the part of the students. The interaction with the faculty members during their 3-year nursing program did not appear to contribute to improvement in the empathy scores of the

graduating students over the entering students' empathy scores.

Past research has indicated that the higher the empathy modeled by the faculty member, the greater the improvement in empathy levels attained by the students (Dowling & Frantz, 1975; Perry, 1975). The lack of this improvement taking place in this study may be due to a number of factors, as follows:

1. The Hogan Empathy Scale measured self-report scores of empathy, which may not be an accurate reflection of actual empathic behavior.

2. A study by Perry (1975) found teaching and instructions had no effect at all when compared with the effects of modeling. He concluded that the teacher's instruction without the modeling of the desired behavior to the students is ineffective. The faculty in this study may in fact not be modeling empathic behavior. Or possibly, there is verbal instruction given in nursing education without enough attention to modeling, non-verbal cues, rehearsal activities, role-playing, and reinforcement.

3. Since the Hogan Empathy Scale provides no norms of what constitutes high or low levels of empathy,

possibly the faculty modeled low levels of empathy even though their scores were higher than the students.

4. As previous studies have shown (Kalisch, 1971a; La Monica, et al., 1976) empathy training may necessitate a training program in empathy to be effective. The normal interactions of student-faculty may not be adequate for improving the interpersonal and empathic skills of nursing students.

The third hypothesis predicted that demographic variables would have no significant effects on empathy scores. None of the demographic variables of sex, race, age, marital status, previous formal empathy training, and area of interest in nursing had a significant influence on empathy scores. Although not statistically significant, there was a strong trend toward higher empathy scores in those subjects reporting previous empathy training. The lack of significance is interesting in light of the fact that there is much support in the literature that empathy training is directly related to significant increases in the empathy levels of the trainees (Kalisch, 1971; La Monica & Karshmer, 1978). The possible reasons for this lack of significance could be the small number of subjects who reported

having had empathy training, or the lack of an adequate definition of what constitutes empathy training given to the subjects.

The married subjects in this study had a higher mean empathy score than the single subjects. Findings by Forsyth (1979) also showed a tendency for married subjects to achieve a higher empathy scores, but the differences were not statistically significant.

The area of interest in nursing reported by the subjects made no difference in empathy scores. Graduating students who had psychiatric experiences in their course of studies, and those who especially preferred psychiatric nursing still had similar empathy scores as the entering students prior to any psychiatric nursing experiences. This data supports previous studies (Forsyth, 1979; Johnson, M., 1980; Kalisch, 1971a; La Monica & Karshmer, 1978).

### Conclusions and Implications

The following conclusions and implications were identified:

1. Bandura (1969, 1971) identified four inter-related sub-processes included in the modeling/imitative learning process; attention processes, verbal explanation

and rehearsal activities, actual modeling of the instructions given, and reinforcement and motivational processes. Perhaps the students were exposed to higher empathic faculty, but did not attend to, recognize, or accurately perceive the modeling cues. The students also need both verbal explanation, rehearsal, and immediate feedback. Reinforcement also influences the students selective attention to the modeled events. It is then important for nursing faculty to give the verbal instruction on empathy, provide rehearsal and role-playing opportunities, identify the empathy modeling behavior in themselves to the students, and provide reinforcement. Such reinforcement includes trying to place students in clinical agencies where empathy and effective interpersonal relationships between nurse/patient are highly valued and modeled. Graduating students may have shown no improvement in empathy over the entering students because they were not encouraged to rehearse or role-play empathic interaction or were not consciously made aware of the empathic modeling in the faculty, or in the staff of the clinical agencies.

2. Studies documenting low empathic functioning in nurses suggests that nursing students have difficulty

finding high empathic models. This supports the need for empathy training programs developed in nursing curriculums. Forsyth (1979), La Monica and Karshmer (1978), Kalisch (1971a), and M. Johnson (1980) have also documented this need.

3. Neither the area of interest in nursing, nor the psychiatric nursing experience in the students' course of studies influenced a change in empathy scores from the scores of the entering students. The psychiatric nursing experience in the students' course of studies influenced a change in empathy scores from the scores of the entering students. The psychiatric learning experiences in nursing programs may not adequately foster the empathic development of the nursing students.

4. Empathy scores obtained from a self-report questionnaire may not be an accurate reflection of the actual empathic behavior.

5. Based on a trend toward higher empathy scores in the older subjects, and Bandura's (1969, 1971), social learning theory, older students may be more socially or developmentally open to learning empathic behavior as modeled by high empathic role models.

### Recommendations for Further Study

Future research to study empathy in nursing is necessary and recommended. However, the study of empathy in nursing is beset by a number of re-occurring problems. First, there is a lack of agreement among researchers regarding the appropriate tools for measuring empathy. It is difficult to compare studies where different measures of empathy were utilized. Second, there is a lack of normative levels established for the testing instruments. Thus, comparison between groups or longitudinal studies is difficult. Also, without normative levels it is impossible to state what constitutes high or low empathy levels.

In view of these problems, the following recommendations are suggested:

1. To establish normative levels with the Hogan Empathy Scale of self-reported measures of empathy, other studies are needed that consist of a larger and a more heterogeneous sample.

2. A study of empathy scores of baccalaureate students who major in nursing needs to be compared with students' empathy scores from other majors. This would also allow a comparison between students of various helping professions.

4. A longitudinal study measuring pretraining and posttraining empathy development is recommended.

5. Follow-up studies to evaluate retention of learned empathy is recommended.

6. A persons' self-reported empathic scores should be compared with another's perception of that empathy. More specifically, a study could compare a faculty member's self-report empathy score with the students' perception of empathic behavior in that faculty member. Or, the staff nurse's self-report empathy score could be compared with the patients' perception of the nurse's empathic behavior.

7. A study designed to determine if a significant relationship exists between empathy scores and marital or parental status is recommended. Research has shown a trend toward higher empathy scores in married and parent subjects than in single subjects.

## APPENDIX A

## TEXAS WOMAN'S UNIVERSITY

## Human Research Committee

Name of Investigator: Elaine E. Macdonald Center: Dallas  
Address: 3006 Steven Date: 10/4/79  
Irving, Texas 75062  
\_\_\_\_\_

Dear Ms. Macdonald:

Your study entitled Empathy in Baccalaureate Nursing Students and their Faculty has been reviewed by a committee of the Human Research 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 require that written consents must be obtained from all human subjects in your studies. These forms must be kept on file by you.

Furthermore, should your project change, another review by the Committee is required, according to DHEW regulations.

Sincerely,



Chairman, Human Research  
Review Committee

at Dallas.

## APPENDIX B

TEXAS WOMAN'S UNIVERSITY

DENTON, TEXAS 76204

THE GRADUATE SCHOOL


October 27, 1980

Miss Elaine Elizabeth Macdonald Thiesen  
3006 Steven  
Irving, Texas 75062

Dear Miss Thiesen:

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,

  
Robert S. Pawlowski  
Provost

RP:dl

cc Dr. Helen Bush  
Dr. Anne Gudmundsen  
Graduate Office

## APPENDIX C

TEXAS WOMAN'S UNIVERSITY  
COLLEGE OF NURSING  
DENTON, TEXAS 76204

DALLAS INWOOD CENTER  
1810 INWOOD ROAD  
DALLAS, TEXAS 75235

DALLAS PRESBYTERIAN CENTER  
8194 WALNUT HILL LANE  
DALLAS, TEXAS 75231

HOUSTON CENTER  
1130 M.D. ANDERSON BLVD.  
HOUSTON, TEXAS 77025

AGENCY PERMISSION FOR CONDUCTING STUDY\*

THE Siola College

GRANTS TO Elaine E. Thiesen

a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem.

The problem of this study is to determine if nursing students are low in empathy, and what within the pre-nursing period may affect the empathy levels of the nursing students.

The conditions mutually agreed upon are as follows:

1. The agency (may) ~~(may not)~~ be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) ~~(may not)~~ be identified in the final report.
3. The agency (wants) ~~(does not want)~~ a conference with the student when the report is completed.
4. The agency is (willing) ~~(unwilling)~~ to allow the completed report to be circulated through interlibrary loan.
5. Other \_\_\_\_\_

Date: May 26, 1980

Ac 103 Frick

Signature of Agency Personnel

Elaine E. Thiesen

Signature of Student

Helen A. Bush Ph.D. R.N.  
Signature of Faculty Advisor

\* Fill out and sign three copies to be distributed as follows: Original - Student;  
First copy - agency; Second copy - TWU College of Nursing.

## APPENDIX D

Oral Presentation to Students

My name is Elaine Thiesen and I am a graduate student at Texas Woman's University. As partial requirement for my Master's degree, I am required to write a thesis and would appreciate your voluntary participation.

This is a study of interpersonal attitudes of nursing students and nursing faculty. You will be asked to complete a questionnaire by giving a written response of "true" or "false." There are no right or wrong answers and you are asked to respond as truthfully as you can to the questionnaire.

Prior to completion of the questionnaire, you will be asked to complete the demographic data sheet requesting such information as age, sex, marital status, student classification, RN licensure information, and major specialty information. You will be given as much time as you need, but it is estimated that this will take approximately 5-10 minutes of your time.

Your name will in no way be connected to the questionnaire or the demographic data sheet and your anonymity will be maintained.

Explanation to Faculty

My name is Elaine Thiesen and I am a graduate student at Texas Woman's University. As partial requirement for my Master's degree, I am required to write a thesis and would appreciate your voluntary participation.

This is a study of interpersonal attitudes of nursing students and nursing faculty. You will be asked to complete a questionnaire by giving a written response of "true" or "false." There are no right or wrong answers and you are asked to respond as truthfully as you can to the questionnaire.

Prior to completion of the questionnaire, you will be asked to complete the demographic data sheet. Both the questionnaire and the demographic data sheet will be placed in your mailboxes on campus. It is estimated that completion of the two forms will only take 5-10 minutes of your time.

Please be assured that your name will in no way be connected to the questionnaire or the demographic data sheet and your complete anonymity will be maintained at all times.

Thank you for your participation.

## APPENDIX E

## Consent Form

TEXAS WOMAN'S UNIVERSITY  
COLLEGE OF NURSING

(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 Elaine Thiesen  
(Name of person(s) who will perform  
procedure(s) or investigation(s))

to perform the following procedure(s) or investigation(s). (Describe in detail):

This is a study of interpersonal attitudes of nursing students and nursing faculty. In order to obtain more information about interpersonal attitudes of nurses, you will be asked to complete a questionnaire by giving a written response of true or false. The questionnaire scale will provide information about your interpersonal nursing attitude. There are no right or wrong answers. You will be asked to respond as truthfully as you can to the questionnaire.

Prior to completion of the questionnaire you will be asked to complete a data sheet requesting the following information: age, sex, marital status, student classification, RN licensure information, we well as major specialty area.

You will be given as much time as you need to complete the questionnaire. It is estimated that you will need approximately 5-10 minutes.

Your name will in no way be connected to the questionnaire and your anonymity will be maintained.

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

(Form A--Continuation)

3. (a) I understand that the procedures or investigations described in Paragraph 1 involve the following possible risks or discomforts:  
(Describe in detail):
- (1) It will take a period of time to read and complete the questionnaire.
  - (2) Although measures have been taken to control data, an improper release of the data may occur.
- (b) I understand that the procedures and investigations described in Paragraph 1 have the following potential benefits to myself and/or others:
- (1) Information yielded from this study may have implications in planning nursing curriculum within schools of nursing.
  - (2) Interpersonal attitudes of nursing students and faculty may be influenced and/or improved during their nursing school or teaching experience.
  - (3) Patient care may ultimately be influenced and/or improved.
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. I understand that I may terminate my participation in the study at any time.

---

Subject's Signature

---

Date

## APPENDIX F

Demographic Data Questionnaire

## 1. Sex

- (a) \_\_\_\_\_ Male  
(b) \_\_\_\_\_ Female

## 2. Age

- (a) \_\_\_\_\_ 19 years  
(b) \_\_\_\_\_ 20 years  
(c) \_\_\_\_\_ 21 years  
(d) \_\_\_\_\_ 22 years  
(e) \_\_\_\_\_ 23 years  
(f) \_\_\_\_\_ 24 years or more

## 3. Race

- (a) \_\_\_\_\_ Caucasian  
(b) \_\_\_\_\_ Black  
(c) \_\_\_\_\_ Asian  
(d) \_\_\_\_\_ Spanish  
(e) \_\_\_\_\_ Other

## 4. Marital Status

- (a) \_\_\_\_\_ Married  
(b) \_\_\_\_\_ Single  
(c) \_\_\_\_\_ Divorced or Separated

## 5. Class of this Year

- (a) \_\_\_\_\_ Freshman  
(b) \_\_\_\_\_ Sophomore  
(c) \_\_\_\_\_ Junior  
(d) \_\_\_\_\_ Senior  
(e) \_\_\_\_\_ Not Applicable

6. Faculty
- (a) \_\_\_\_\_ Yes
- (b) \_\_\_\_\_ No
7. Have you ever had any previous formal empathy training:
- (a) \_\_\_\_\_ Yes
- (b) \_\_\_\_\_ No
8. What is your major type of nursing experience?  
Please only check one answer.
- (a) \_\_\_\_\_ Critical Care
- (b) \_\_\_\_\_ Floor Nursing
- (c) \_\_\_\_\_ Convalescent Home
- (d) \_\_\_\_\_ Other
9. What is your major area of interest in nursing?
- (a) \_\_\_\_\_ Medical-Surgical
- (b) \_\_\_\_\_ Pediatric-Maternal
- (c) \_\_\_\_\_ Psychiatric
- (d) \_\_\_\_\_ Other
10. Faculty
- (a) \_\_\_\_\_ Full-time
- (b) \_\_\_\_\_ Part-time

## APPENDIX G

Hogan Empathy Scale

Directions: This booklet contains a series of statements. Read each one, decide how you feel about it, and then mark your answer on the left. If you agree with a statement, or feel that it is true about you, answer TRUE. If you disagree with a statement, or feel that it is not true about you, answer FALSE. Answer all questions.

1.    T    F    A person needs to "show off" a little now and then.
2.    T    F    I usually take an active part in the entertainment at parties.
3.    T    F    I like to have a place for everything and everything in its place.
4.    T    F    I feel sure there is only one true religion.
5.    T    F    I am afraid of deep water.
6.    T    F    I have at one time or another tried my hand at writing poetry.
7.    T    F    I prefer a shower to a tub bath.
8.    T    F    It bothers me when something unexpected interrupts my daily routine.
9.    T    F    It is hard for me just to sit still and relax.
10.   T    F    I always try to consider the other fellow's feelings before I do something.
11.   T    F    I don't like to work on a problem unless there is a possibility of coming out with a clear-cut and unambiguous answer.
12.   T    F    I can remember "playing sick" to get out of something.
13.   T    F    I like to keep people guessing what I'm going to do next.

14. T F Before I do something I try to consider how my friends will react to it.
15. T F I like to talk before groups of people.
16. T F My parents were very strict and stern with me.
17. T F Sometimes I rather enjoy going against the rules and doing things I'm not supposed to.
18. T F I think I would like to belong to a singing club.
19. T F I usually don't like to talk much unless I am with people I know well.
20. T F I think I am usually a leader in my group.
21. T F I must admit I often try to get my own way regardless of what others may want.
22. T F I liked "Alice in Wonderland" by Lewis Carroll.
23. T F I don't really care whether people like me or dislike me.
24. T F Clever, sarcastic people make me feel very uncomfortable.
25. T F I have a natural talent for influencing people.
26. T F The trouble with many people is that they don't take things seriously enough.
27. T F Only a fool would try to change our American way of life.
28. T F Most of the arguments or quarrels I get into are over matters of principle.
29. T F I would like the job of a foreign correspondent for a newspaper.
30. T F People today have forgotten how to feel properly ashamed of themselves.

31. T F When a man is with a woman he is usually thinking about things related to her sex.
32. T F I frequently undertake more than I can accomplish.
33. T F I enjoy the company of strong willed people.
34. T F Disobedience to the government is never justified.
35. T F I have a pretty clear idea of what I would try to impart to my students if I were a teacher.
36. T F I am usually rather short-tempered with people who come around and bother me with foolish questions.
37. T F It is the duty of a citizen to support his country, right or wrong.
38. T F I have seen some things so sad that I almost felt like crying.
39. T F As a rule I have little difficulty in "putting myself into other people's shoes."

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Oral permission received for use of this instrument from Dr. Robert Hogan and Dr. H. G. Gough on April 27, 1979.

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