

**COLLABORATING IN CARE:  
DEVELOPING A MODEL OF DIALOGIC EMPATHY  
IN NURSING EDUCATION**

by

**KIMBERLEE JEAN TRUDEAU**

A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy. The City University of New York

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**ABSTRACT****COLLABORATING IN CARE:  
DEVELOPING A MODEL OF DIALOGIC EMPATHY  
IN NURSING EDUCATION**

by

Kimberlee Jean Trudeau

Advisor: Professor Colette Daiute

The goal of this exploratory study was to teach nursing students to perceive empathy as a dialogic process versus as a personal characteristic through narrative reflection. This required the development of a dialogic empathy model for nursing education; that is, a model that presents empathy as a reciprocal process shared by the nurse and client within their interactions. Given the increasing cultural diversity between providers and clients in stressful medical situations, awareness of the interaction of the characteristics of oneself and another (i.e., dialogism) could potentially enhance both the efficacy and experience of care.

This study included (a) narrative reflection of nurse-client interactions from various perspectives (based on Discourse Theory) and (b) pre/posttest assessments in a randomized design. I collected data from 44 participants in a first semester clinical nursing theory undergraduate course in Fall 2003.

First, can dialogic empathy be assessed? The narratives written by the participants in the experimental condition provided data with which to define and examine the proposed model of dialogic empathy. A repeated measures analysis of narrative content revealed that dialogic empathy (i.e., reciprocal awareness of one's own and another's perspectives),

differed by context: More dialogic empathy was evident in narratives about the more vulnerable populations.

Second, can nursing students learn to perceive empathy as a dialogic process by writing narrative reflections? The pre/posttest randomized design revealed between-group differences. The three primary outcomes were the posttest minus pretest scores for the level of dialogism in the Ideal Nurse responses, and two subscale scores for the dialogic-type subscales of the quantitative measures. The secondary outcome was the thematic responses to the posttest What is Empathy? task. Though statistical power was restricted by the small sample size, all assessments suggested that although empathy was perceived as a personal characteristic, it was more likely to be perceived as an intention or process by those in the experimental condition. Future research is required to explore if a dialogic view of empathy, one that values nurses' needs and interests, as well as those of their clients, increases nurse retention in the health care profession.

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## CHAPTER 1

### BACKGROUND LITERATURE AND RATIONALE

#### *Chapter Overview*

To set the foundation of this study to foster nursing students' perception of empathy as a dialogic process using the method of narrative reflection, this chapter describes the importance of empathy in the nursing context and then presents two different models for thinking about empathy in nursing education: the traditional model, that empathy is a personal characteristic of nurses enacted towards clients, and the proposed model of dialogic empathy, that empathy is a reciprocal process shared by the nurse and client within their interactions. I review the definitions of empathy in psychology and in nursing, then argue that the dialogic model of empathy as a reciprocal process is more compatible with the nursing context than the traditional personal characteristic-based model. I proceed to my definition of dialogic empathy and then draw upon Discourse Theory (e.g., Hermans & Hermans-Jansen, 1995), a component of Bakhtin's dialogic theory (1986) that values the interactivity between self and imagined audiences, for methodology to incorporate dialogic empathy into nursing education. Specifically, writing narrative reflections (narrative nursing), rather than reports (the Nursing Process), of nurse-client interactions is proposed as a theory-based method that may raise the awareness of nursing students of the dialogic nature of these interactions. Narrative writing is expected to help because it is an affectively rich social relationship genre for shaping and reflecting on an experience, as well as, ultimately, developing new knowledge and practice (Daiute & Buteau, 2002; Reissman, 1993; Spence 1982). In addition, this proposed model of dialogic empathy is also generative for teaching and promoting ethical practices in health care.

### *Empathy is Essential (and Expected) in the Nursing Context*

The focus on nursing is caring – in theory, in education, and in practice; empathy is an important element of the caring work conducted by professional nurses (e.g., Fahrenwald, Bassett, Tschetter, Carson, White, & Winterboer, 2005; Reynolds & Scott, 1999). Although nurses are expected to provide both empathic and technical care in health care settings, traditionally nursing education has focused primarily on technical skills, including checking for vital signs, performing wound care, and evaluating EKG reports (e.g., Lundberg & Boonprasabhai, 2001). Although nursing programs have been enhancing their curricula to improve critical thinking skills through writing-to-learn (McCarthy & Bowers, 1994) and problem-based learning (Richardson & Trudeau, 2003) strategies, nursing curricula do not tend to address the experience of empathy within students' course-based clinical interactions. It is this experience of empathy that could be central in the process of providing clinical care.

Recent studies of clients in various nations have indicated the importance of empathy (i.e., being listened to in Scotland-Mercer & Reilly, 2004; i.e., empathy, interest, attention and consideration of the patient in Denmark-Kjaer, Mainz, Sorensen, Karlsmark, & Gottrup, 2004; i.e., nurses communicate that they understand client's situation, known as "empathic communication" in Ireland-McCabe, 2004; i.e., provision of caring, individualized attention in Turkey-Uzun, 2001) to their experience of nursing care. Furthermore, in Sweden, a longitudinal study found that a higher degree of affective empathy (i.e., sensitivity to other's feelings) at baseline among nurses was associated with work satisfaction at the eight year follow-up (Sand, 2003). Thus, further understanding about the nature and role of empathy in nursing and nursing education is needed.

*Traditional Model of Empathy: Empathy as a Personal Characteristic*

Traditionally, empathy is conceptualized as a personal characteristic (i.e., as a trait or as a skill). For example, the importance of an empathic attitude in conducting clinical work is attributed to psychologist Carl Rogers (1957, 1975). Empathy requires following the client's line of thinking, despite its lack of true linearity, and appreciating the value, the meaning, of the presenting symptomatology (Smith, 2001, p. 7). These ideas about empathy in mental health care can be applied to the nursing context as well. Nurses too are faced with the challenge of helping their patients find relief, not just from their symptoms (e.g., headaches), but from the harbingers of those symptoms (e.g., stress). Their success at meeting that challenge involves empathy. For example, the degree of provider empathy in a clinical interaction enhances patient outcomes and satisfaction with care (see review by Reynolds & Scott, 2000).

*Empathy as Defined in Psychology.* Empathy traditionally has been operationalized in psychology as a personal characteristic, like a trait or skill (MacKay, Hughes, & Carver, 1990), not as a dialogic process, as I am proposing in this dissertation. According to social psychologist Mark Davis (1994), unlike sympathy (a purely affective construct), empathy is a multidimensional construct that includes both cognitive (e.g., perspective-taking, fantasy) and affective (e.g., empathic concern, personal distress) qualities. These four dispositional qualities of empathy are typically measured by psychologists with the Interpersonal Reactivity Index (IRI; Davis, 1983), a 28-item scale with four subscales of 7 items each. Research studies with undergraduate participants using the IRI suggest that these qualities are differentially correlated with other psychosocial factors including social functioning, self esteem, emotionality, and sensitivity to others (Davis, 1983). By this definition, perspective-

taking, for example, is positively associated with social functioning and self esteem and negatively associated with emotionality. Fantasy, also a cognitive-based dimension of empathy, is similar to empathic concern (i.e., no relationship with social functioning or self esteem and a positive association with emotionality, though lower than empathic concern).

Those who have studied empathy as a trait have found that the more dispositional empathy (i.e., Empathic Concern subscale of the Davis [1983] IRI) indicated in one's scale responses, the more likely one is to enter emotionally evocative situations where there is an opportunity to help (Smith, 1992). Therefore, it is likely that the desire to enter emotionally evocative situations motivated nursing students to pursue their field of study. To beginning nursing students, nursing is caring: caring and nurturing were motives for seeking education to become a nurse (Kersten, Bakewell, & Meyer, 1991; Rognstad, 2002). Qualitative research indicated that caring/compassion is a characteristic associated with being a good nurse among nursing students (Lundberg & Boonprasabhai, 2001), as well as among registered nurses (Smith & Godfrey, 2002). Nursing students have also identified empathy-related characteristics as being a quality versus a skill or ability (Burnard, 1998). Student perception of empathy as a quality versus as a skill may make it particularly challenging to teach a new model of empathy to students within the typical curriculum: Students could be less likely to attend to a new model of empathy as a dialogic process if they think that they are empathic by nature. But the stresses of training and the job, which inevitably result, are likely to challenge the idea that empathy is fixed.

*Empathy as Defined in Nursing Education.* Nursing is a helping profession; empathy is the core of helping (Carkhuff, 1969; Rogers, 1957). Nursing researchers have designed various quantitative measures to assess attitudes about caring, including empathy

(Watson, 2002 is a compilation of such measures). For example, the 31-item Caring Attributes Questionnaire (CAQ; Arthur, Pang, & Wong, 2001) was designed to assess what caring is according to registered nurses internationally. A representative example is "I am being caring when ... I am being empathic;" participants mark their response on a Likert scale between 1 (I strongly disagree) to 5 (I strongly agree).

Consistent with the social psychological description of empathy above, a current nursing textbook (Potter & Perry, 2001) defined empathy as a skill with affective (i.e., feeling, feelings, sensitive) and cognitive (i.e., understand, perceive, imagine) terms as follows:

the *ability to understand* and accept another person's reality, to accurately *perceive feelings*, and to communicate this understanding to the other... To express empathy, the nurse reflects understanding of the importance of what has been communicated by the other person on a *feeling* level. Such empathic understanding requires the nurse to be both *sensitive and imaginative*, especially if the nurse has not had similar experiences... Statements reflecting empathy are highly effective because they tell the person that the nurse heard *feeling* content, as well as *factual* content of the communication. ... (italics added) (p. 459-460)

It is argued that, without empathy, a client's trust of the nurse may be compromised, thus making it difficult for the nurse to properly assess and address the client's physical and psychological needs and problems (Reynolds & Scott, 2000). As noted above, according to the traditional model of empathy, empathy is believed to exist in the nurse alone.

***Empathy-Enhancement?*** Can one learn empathy as a skill? One can become increasingly empathic through training, but empathy is not necessarily being taught as part of

the current nursing curriculum. For example, empathy scores (measured by Davis' 1983 IRI) of undergraduate nursing students did not significantly increase within cohort over time (Becker & Sands, 1988) and were not significantly different between 1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> year cohorts (Lauder, Reynolds, Smith, & Sharkey, 2002).

Conversely, the empathy scores of participants increased through participation in extracurricula empathy training modules, according to a review of ten experimental studies of nursing students or practicing nurses (Wheeler & Barrett, 1994): Eight of the 10 studies reviewed had a pre/posttest design and the others conducted an assessment only at posttest. The two that conducted an assessment at posttest only and one of the other eight had randomized individuals to condition (control versus experimental) to reduce potential bias. Outcomes (predominantly about empathy) were assessed using different measures, and often multiple measures, including the Carkhuff Index of Communication (nurses write how they would respond to 16 different situations), self-reports of empathy by nurses, and assessments of clients' perception of empathy received from nurses. Although the various models of the tested interventions stressed the importance of interpersonal relations and included methods of role-playing, modeling, and discussion, none of them emphasized the dialogic nature of empathy or used dialogic practices like reflective writing, which I describe in detail later in my explication of Discourse Theory. These studies included between 11 and 109 individuals who participated in an intervention that lasted anywhere from one 30-minute session to 32 hours in 16 weeks. Of this group of 10 disparate experimental studies, 3 reported significant differences for empathy between groups (e.g., Kalisch, 1971—a randomized controlled trial of 49 nursing students); thus, the reviewers concluded that it *is* possible to teach empathy as a skill.

Other research suggests that empathy is both a trait (potential to be empathic) and a skill (ability to be empathic) that can be enhanced through training: A quasi-experimental study of a 10-week (2 hours per week) intervention including didactic and role-playing components was conducted among nurses in medical and surgical units in Turkey. Empathy skills, but not empathic tendency (potential to be empathic, i.e., a character trait), increased among those who participated in the intervention (Oz, 2001). Therefore, although one may be an empathic person (trait-based empathy), s/he can still learn additional empathy-specific skills (skill-based empathy).

*Nursing Education: Add Empathy?* If nursing is caring (e.g., Watson, 1979), and if empathy is an aspect of caring (Reynolds & Scott, 1999), and if empathy is teachable (Wheeler & Barrett, 1994), is there a need to incorporate empathy training into nursing education? Yes, nursing education would be enhanced by empathy-based curricula (e.g., Reynolds & Scott, 2000). Boykin and Schoenbofer (1993) noted:

Because many nurses were trained to overlook their caring ways instead of attending to them, nurses may now need something similar to, or indeed 'sensitivity training' itself, to rediscover and reown the possibilities of self as caring person, possibilities specific to nursing as a profession and a discipline. (p. 45-46)

Instead, empathy training should be integrated into the current student curriculum (Oz, 2001). The question is how.

*Summary.* In the traditional model of empathy, there is a focus on the characteristics of the individual (here, the nurse). "Nurses in practice, education, and administration continue to address nursing primarily in terms of 'what nurses do'" (e.g, nursing interventions; Boykin & Schoenbofer, 1993, p. 96). I submit that explanations of empathy in

nursing education as personal characteristics rather than as discourses embedded in their own and their clients' histories and experiences may contribute to a lack of authenticity in a nursing interaction, resulting in dissatisfaction for both nurse and client. Therefore, I suggest a new model of empathy. In this model empathy is defined as a reciprocal, interactive process that includes sensitivity to the psychological states of the nurse and the client; see Figure 1. This proposed model of dialogic empathy is described in the next section. The advantage of this model is that it shows sensitivity to the natural interactivity of the nursing context, while incorporating recent thinking in social development theory; therefore, this model is a worthy area of inquiry.

***Proposed Model of Empathy: Empathy as a Dialogic Experience***

To develop a method of incorporating empathy training into the typical nursing curriculum, a theory of empathy that values interaction and context is required. The model of dialogic empathy that I propose in this dissertation is a new view of empathy that both encompasses and exceeds the boundaries of the personal characteristics of the nurse and client to create a third space (Gutierrez, Rymes, & Larson, 1995) where intersubjectivity occurs (Vygotsky, 1978). In this third space, the two participants are aware that the interaction of their characteristics is influenced by their characteristic-based (e.g., gender, age, race, role) anticipations of one another in context.

I submit that, perhaps, clients are dissatisfied with the perceived lack of empathy from nurses (Reynolds & Scott, 2000) because they consider empathy to be a drug that the nurse is required to dispense (Daiute, 2002; personal communication). Unlike the traditional model of empathy as a personal characteristic described in the previous section, nursing students could begin to encourage clients to perceive empathy as a process that they, at the

very least, may participate in or, at the very most, are empowered to initiate (Bylund & Makoul, 2002). To begin to foster dialogic empathy within nurse-client interactions, the nursing students require awareness-building in the characteristics of dialogic empathy (i.e., interactivity, awareness of one's own psychological states, anticipation of others' psychological states).

This new view of empathy is hinted at in the health care literature (e.g., discussion of the discursive context of nursing, Crowe, 2000), warranted by contemporary theories of social relations and development, and inspired by my belief that incorporating guidelines to encourage students to think about empathy as a dialogic process in the existing curriculum would be not only parsimonious, but also humane, developmental, just, and productive. Herein I share my journey, mapping the terrain of this model of dialogic empathy using related theory (Discourse Theory), multiple methods (quantitative scales and qualitative open-ended prompts, narratives), and data from empathic (towards me!) nursing students at a public technical college in New York City.

*Exploring the Dialogical Nature of Empathy.* If a person spoke in the middle of the forest and nobody was there to hear her, would she have spoken alone? "No" would be the reply of Bahktin, the Soviet literary theorist of the mid-1900s; he would attest that her speech was multi-voiced (i.e., motivated and influenced by others) and, therefore, dialogical (Bahktin, 1986). Dialogic theory is a component of the broader social constructionist theory that was originally proposed by Vygotsky (1978) while studying language learning by children (Vygotsky, 1962). Social constructionist theory submits that knowledge, thought, and identity develop through social interactions. Like social learning theory (Bandura,

1977), this theory was used to explain cognitive development (Kearsley, 1994-2004). It has been applied to educational practice (e.g., Wells, 1999).

Within Bahktin's dialogical framework (Bahktin, 1986; Wertsch, 1991), the awareness of the other is inherent in one's speaking and writing to the degree that one is multi-voiced. The anticipation of audience, including the understanding by that audience, to each utterance by the author influences diction and tone and affects meaning intended and perceived. This process of expecting another's response to one's words is called addressivity, and it occurs within one's social language or speech genre (Bahktin, 1986). For example, the student who is writing a journal entry to give to her professor draws from their shared speech genre (nursing language) to express her ideas and experiences; learning to use this language is part of the student's professional development process.

Expectations of understanding of her client or from her teacher is dialogic (Voloshinov, 1973):

For each word of the utterance that we are in process of understanding, we, as it were, lay down a set of our own answering words. The greater their number and weight, the deeper and more substantial our understanding will be. (p. 102)

Examples of nurse-client interactions that require this delicate balancing of one's own attention, experience, and understanding with the client's attention, experience, and understanding are the assessment of the client's well-being and the teaching of health-related skills (e.g., change a dressing for a surgical wound; Loxton, 2003).

*Empathy and Nursing Intersect at Dialogism.* "Whatever I embrace, becomes" (from a novel written by Alice Walker, 1989, p. 279). Similarly, nursing as caring entails focusing one's attention on the client so that the client can "become," that is, be heard/be

seen/be understood holistically. Nursing is unique from other studies of science (Boykin & Schoenbofer, 1993):

The manner in which certain disciplines are conceptualizing, especially those dealing in normative contexts, calls for a dialectical form of sciencing, comparing, and contrasting. However, coming to know nursing is a dialogical process – direct engagement with the "word of nursing." Nursing science must be contextual. (p. 92)

This dissertation theorizes nursing as caring, nursing as dialogical, nursing as contextual, but what is the "word of nursing?" Nursing is defined as one attending to the needs of another.

Traditional nursing was based on the concept of nurturing, as in the nurturing received from one's mother (Boykin & Schoenbofer, 1993). Over time, as nursing gained acceptance as a profession, the focus switched to medicalization of nursing skills, although many psychological theories, including Abraham Maslow's hierarchy of needs theory (1968), also have influenced nursing practice. In the past 20 years, nursing theorists have attempted to revive the original objective of nursing, to privilege and praise the humanistic elements of nursing (e.g., Boykin & Schoenbofer, 1993; Crowe, 2000; Watson, 1979).

These nursing theorists (Boykin & Schoenbofer, 1993), among others, have developed interactive models of caring. For example, their Nursing as Caring Theory, which focuses on the nurse as a caring person who perceives the client as a caring person also values interactivity: "The encountering of the nurse and the nursed gives rise to a phenomenon we call *caring between*, within which personhood is nurtured." (p. 26); this theory has been deemed too philosophical for operationalization and testing (McCance, McKenna, & Boore, 1999). In addition, Olson and Hanchett (1997) developed a theory of the empathic process from Orlando's abstract model of nursing as a relationship between the

nurse and client (Orlando, 1961, 1972) that includes attention to nurse-expressed empathy, patient-perceived empathy, and patient distress. Research conducted by Olson (1995) supported the hypothesized relationships between these factors (i.e., negative correlation between nurse-expressed empathy and patient distress; positive correlation between nurse-expressed empathy and patient-perceived empathy; negative correlation between patient-perceived empathy and patient distress). Although the client perspective is included in Olson and Hanchett's (1997) model, the focus is still on the skills and behaviors of the nurse. The proposed model of dialogic empathy, in contrast, emphasizes awareness of one's own thoughts and feelings within the socio-relational context, as well as anticipating the perception of the client of the nurse.

The model of dialogic empathy presupposes that attention to another's needs requires an interaction between the self and the other-nurse and client-not simply a focus on either the nurse's characteristics or the client's needs. Extending the traditional model of empathy as a personal characteristic to a model of dialogic empathy seems necessary on multiple levels – personal, interpersonal, and contextual. First, this theory of dialogic empathy is sensitive to the cultural diversity that often exists in nurse-client interactions through an appreciation of the socio-relational (i.e., influenced by the socio-cultural histories of the actors – actual and intuited) nature of all social interactions. Second, this theory could be particularly valuable in nurse-client interactions because nurses and clients are strangers brought together in challenging circumstances that are embedded in societal hierarchies and systems. Third, the dialogical framework contributes an emphasis on the importance of context, such as the medical context.

Lastly, the dialogical approach adds an important element to the traditional view of nursing because it includes Discourse Theory, which recommends methodology (narratives) to evaluate the use of this model for both encouraging and assessing awareness of dialogic empathy in nurse-client interactions. This link between theory and methodology is described in detail in the next section.

*From Theory to Methodology: Discourse as Social Interaction.* Nursing students may not be introspective regarding the history of their own empathetic interactions, which are the discourses that will inform their interactions with clients. What might invoke such introspection about the complex interactions between self and other and context? How could we assess if that introspection was achieved? Fortunately, just as the Likert-based scales assessed empathy as a personal characteristic (e.g., the Interpersonal Reactivity Index, the Caring Attributes Questionnaire), there are narrative methods that may reveal individuals' experience of dialogic empathy. There have been recent efforts to introduce researchers in the health sciences to the practice of narrative methods in the classroom and in the clinic (Diekelmann, 2003; McCance, McKenna, & Boore, 2001; Overcash, 2003). For example, according to Overcash (2003):

Narrative research is not only the stories or accounts contributed by the participants, it is the evaluating and analyzing [of] those accounts. Systematically looking for themes or other details in the data defined by the research in the research methodology is one of the ways narrative research is different from journalism or creative writing. (p. 180).

Narrative discourse is also inherently social. Discourse Theory suggests how narrative methods may expand upon the traditional Nursing Process to promote self reflection about

self, other, and context in nurse-client interactions and, ultimately, help students perceive empathy as a dialogic process. Here I will introduce that process using narrative methods to describe my vision of dialogic empathy.

*Defining Dialogic Empathy.* Is empathy the aspect of caring that enables the nurse to see the client as a whole person with complex biopsychosocial needs, desires, and limitations and situated in contexts across and within specific times and places? I think so. If I care for you, I give you what I think/feel you need. If I empathize with you, I give you what I think/feel that you think/feel you need. In sum, caring may be skewed toward the person who is doing the caring (like the traditional empathy as personal characteristic view), whereas dialogically-based empathy, requires focused anticipation and awareness of other – coming closer to the perspective of the person who is being cared for. For example, the text "An ideal nurse is one who cares for the needs of another" is dialogic because it shows anticipation of other in its expression of sensitivity to the perspective (i.e., needs) of the client. The text "An ideal nurse is one who cares for others" is less dialogic because it includes reference to the client "cares for" but not to the degree of showing consideration for the client's needs. Lastly, "An ideal nurse is one who is caring" is least dialogic because it is only referring to the personal characteristics of the nurse.

*Describing Discourse Theory.* "The term 'discourse' is sometimes used to refer to patterns of meaning which organize the various symbolic systems human beings inhabit, and which are necessary for us to make sense to each other" (Parker, 1999, p. 3). Discourse Theory explores the interaction between narrative (telling one's story) and identity with dialogicality as a unit of analysis; such interactions have been predominantly explored by literary theorists, psychoanalysts, educators who have been interested in the self, and social

developmental psychologists (e.g., Daiute & Buteau, 2002; Hermans & Hermans-Jansen, 1995; Mischler, 1995; Spence, 1982). This theory suggests that understanding of oneself improves through dialogue – through others and/or with oneself. As self-awareness is a harbinger of empathy (Arnold & Boggs, 1989), Discourse Theory may be applied to the effort to increase students' perception of empathy as a dialogic process within nursing education.

The talking cure advocated by Freud in the early 1900s continues to be utilized in contemporary clinical care, though not without some speculation regarding why talking about one's issues helps to resolve them. Discourse Theory is the study of this phenomenon. Its analysis is intrapersonal, but its experience is interpersonal, thus, existing on multiple levels of the dialogical framework. The levels are "self" as communicator (through speech or writing) with "other" as audience.

***Nursing Education: Add Discourse Theory?*** Theories that focus on the dialogic nature of interpersonal interactions, such as Discourse Theory, include strategies that can enhance the experience of self in interpersonal interactions; therefore, this theory may be applied to the development of interventions to increase awareness of empathy as a dialogic process.

Beginning with the multi-voiced domain of the dialogical framework, we have begun to envision the empathy process as one that requires reciprocity between an awareness of oneself and another. This theory suggests innovative techniques (i.e., reflective writing) for guiding students to think about empathy as a dialogic process that could (eventually) increase the frequency of empathic nurse-patient interactions during nursing education.

Self-concept development (as well as change) is possible in therapeutic environments (Hermans & Hermans-Jansen, 1995; McNulty & Swann, 1991) and, therefore, possible through writing interventions as well. According to Discourse theorists: "The construction of a story is a way of organizing one's interaction with the world, and once this organization has been achieved, a person finds his or her identity in the particular story" (Hermans & Hermans-Jansen, 1995, p. 47). Writing is one method of transforming oneself into who the self is willing to be. Is, wanting to be, and becoming intersect between the lines of this hypothesized experience of dialogic empathy development.

*Summary.* There is the interaction between the student and the real or imagined patient; there is also the interaction between the student and her professor: "Understanding each other's views is essential to the unfolding of this culture. Dialogue assists one to know the other's needs and desires, and to image oneself in the other's place" (Boykin & Schoenbofer, 1993, p. 84). Most importantly, Discourse Theory privileges the imaginal dialogue, a dialogue that occurs in one's head with an imaginal figure (Hermans & Hermans-Jansen, 1995); the imaginal figures a nursing student might dialogue with include a patient, a professor, and a nurse colleague. Representations of these dialogues through reflective writing would possibly allow us to observe, analyze, and reflect on the nursing interaction from an intrapersonal perspective. Moreover, according to the dialogical framework in which Discourse Theory lies, such internal dialogues are actually multi-voiced (Hermans & Hermans-Jansen, 1995, p. 102).

### *Discourse and Dialogism in Nursing*

The nursing situation, according to Boykin and Schoenbofer (1993), is a "shared lived experience in which the caring between nurse and nursed enhances personhood" (p. 24). In

sum, with nurturing, there is opportunity for healing and growth – potentially, ideally, for both participants. The scientific process, however, still permeates the system of dialogue in nursing in the form of the "Nursing Process," the written reporting genre used by nurses to describe work with clients.

*The Nursing Process.* The method of problem solving in nursing care is called the Nursing Process. Developed in 1967 by a faculty group at Catholic University (Doheny, Cook, & Stopper, 1997), this written log of the nursing intervention includes: an assessment of needs and symptoms, diagnosis of those symptoms (using the North Atlantic Nursing Diagnosis Association [NANDA] classification system), planning an intervention (including setting goals and prioritizing them), implementation of the plan, then evaluation of whether or not the goals were met (Gardner, 2003). The Nursing Process is reminiscent of the linear structure of the scientific model in which one describes the background literature that supports a particular question, presents methodology to test the question, explains the results produced by that methodology, and then discusses the results in terms of the methodology and the background literature. Conceptualized this way, the Nursing Process ignores the interactive-intersubjective aspects of the nurse-client interaction, making this genre incompatible with an experience of empathy as a dialogic process. It has also been argued that this system distracts from the objective of seeing the client holistically, or as a whole person (Boykin & Schoenbofer, 1993).

*Narrative Nursing.* Although the Nursing Process is the genre of recording nursing care, the nurse-client interaction is inherently a dialogic experience (Watson, 1987) that may best be represented through narrative. Anticipation of audience (including conventions of story-telling), also included in the dialogical framework, motivates the speaker to impose

structure on her/his story. Imposing structure on an otherwise ambiguous event helps the speaker to ascribe meaning to that experience (Michler, 1995); these ascribed meanings or "valuations" are motivated by desire for self enhancement or for affiliation (Hermans & Hermans-Jansen, 1995).

Like the scientific model of the Nursing Process (i.e., assessment, diagnosis, planning, intervention, evaluation), narrative is linear (Spence, 1982)-including a beginning and an end, as well as an attributed cause and effect. Unlike the Nursing Process, the specific areas of content are not preordained within a narrative. Meaning-making may not start with an assessment of symptoms and end with an evaluation of symptoms in a narrative; instead, it may begin with the description of an interaction, including expectations and concerns that do not fit within the model of scientific method. Smith (2001), a psychiatrist, distinguishes these two models as the biological versus the empathic-relational. Theory-based exercises like the narrative reflection assignment used in this study could support the development of dialogic empathy in clinical training.

*Nurse-Client Interactions: Art or Science?* It is likely that nurses, particularly nursing students, experience conflict regarding their humanistic desire to engage in a caring/healing conversation while performing the science of administering physical care. A narrative description of a nurse-client interaction written by a nursing student follows:

At my first day at the long term care facility I had to interact with my client, so I decided to brush my client's hair after I noticed that her caregiver didn't brush her hair after the bath. I asked her if I could brush it but she just looked at me. So I started to brush it. While I was brushing her hair, I gave her a mirror so she could watch me brush it. After I was done brushing, I asked her if she liked the way it looked. She

smiled at me and then started crying. I gave her a tissue, asked her if she was ok, and left. She scared me. I thought maybe that I did something wrong. I felt as if I violated something. But then I thought maybe nobody ever brushed her hair and gave her a mirror to see how it was being done. Then I started to [f]eel as if I made her day. [At] first she was probably confused and w[o]ndering why I was brushing her hair. After I gave her the mirror, she felt special. She thought why her caregivers couldn't show her this kind of attention and caring instead of not even brushing her hair.

The genre of narrative permits the nursing student to reflect upon the multiple meanings of this interaction for herself and her client, as suggested by Discourse Theory. Dialogic empathy is evident in the interactive diction that is used (e.g., first one perspective is described, then another) and in sensitivity to the psychological states of both participants in the interaction.

In contrast, the same narrative description may look like this in the form of a Nursing Process (Ellen McGuinn, personal correspondence, March 13, 2005):

*Assessment:* Two systems of human needs are affected: Musculoskeletal Needs -- Client is unable to perform grooming activities; Psychosocial Needs -- Client's appearance; in particular, hair not combed.

*Diagnosis:* Low self esteem related to lack of ability for self-grooming.

*Planning:* Client will show an increase in self-esteem by having hair groomed every day.

*Intervention:* 1) Ask client if I can comb hair, 2) secure the client's hair brush, 3) allow the client to view grooming through a portable mirror.

*Evaluation:* Student: Asked if she [client] liked the way it looked (subjective: seeking feedback). Client: Smiled at student and then started crying (objective: nonverbal feedback). Future action: Grooming each day using mirror each time at grooming.

This presentation is focused on the problem-solving action by the nurse. Although the need of the client is identified (assessment, diagnosis) and addressed (intervention), the true psychosocial, dynamic nature of this nurse-client interaction (expressed in the nursing narrative that preceded the Nursing Process) is restricted by the confines of the required reporting style.

These examples demonstrate the distinction between functional narratives that are referential (e.g., Nursing Process) versus evaluative (e.g., nursing narrative; Labov & Waletzky, 1967). The stimulus was the same (the nurse-client interaction), but the guidelines for representation of that stimulus influenced the description of that stimulus. The Nursing Process refers to the actions of the nurse in response to the client, but lacks information regarding the attitude or evaluation of the narrator regarding the interaction. In the nursing narrative above, the voice of the student conveys self-evaluation: "I thought maybe that I did something wrong" and client-evaluation "she was probably confused and w[ondering] why." Contrasting functional narratives (referential versus evaluative) is one method used by narrative researchers to identify hidden, self-referential, socio-relational meanings of text (e.g., Daiute & Buteau, 2003; Lightfoot, 2004; Stanley & Billig, 2004).

*Summary.* According to Discourse Theory, the particular epistemological model used by the nurse implicitly in everyday practice is likely to influence her choice and report of interventions: "Actions can always be told, receiving a great deal of their meaning from

the act of telling" (Hermans & Hermans-Jansen, 1995, p. 51). For example, the biological model (the Nursing Process) requires symptom-centered analysis, while the empathic-relational model (the dialogical framework, home of the narrative method) requires attention on the whole person. Therefore, while meeting the goals originally developed to address the client's problem is the objective of the Nursing Process, mutual satisfaction with negotiated meanings of the shared clinical experience may be the objective (or consequence) of the nursing narrative. Moreover, it is unlikely that the traditional Nursing Process format of recording nursing situations in terms of assessment, diagnosis, planning, intervention, and evaluation would provide a tool for self growth or improved other-comprehension. As noted by Boykin and Schoenbofer (1993):

The difference between a nursing story and a typical nursing case report is striking; the first conveys the nursing care given, the second reports the medical-assisting activities performed by the nurse. We have discovered in our work with nurses that while nursing care is usually given, it is frequently neither acknowledged nor communicated. (p. 57)

### *Self in Translation through Social Scripting*

Discourse Theory also suggests that a detailed narrative could lead to self growth and possibly culminate in a dynamic, reciprocal, psychosocial experience of dialogic empathy within nurse-client interactions. Interestingly, Spence (1982) is critical of case studies composed by psychoanalysts, because these case studies are narrative (as interpreted by the psychoanalyst) and not historical (truth of the client's experience). This is the dilemma created by having one person tell the story of another. The fascinating work on expressive

writing suggests that when one tells one's own story, mental and physical health outcomes are improved (e.g., Lepore & Smythe, 2002).

Am I arguing for clients to be the authors of their own medical records? No, I am not advocating for that method of recording nurse-client interactions, although client health may be enhanced by personal writing (e.g., Smythe, Stone, Hurewitz, & Kaell, 1999). Instead, I argue that if writing from one's perspective of a social interaction is beneficial for the self, perhaps writing from the other's perspective in that social interaction (i.e., positioning; Davies & Harré, 1999) would help to increase one's perception of empathy as a dialogic process as a step in the clinical training process. A truly empathic exchange would require a more comprehensive narrative than that inspired by the Nursing Process, as indicated in the contrast between the narrative nursing and the Nursing Process examples in the previous section.

Unfortunately, writing narratives is rarely done in the professional training curriculum, despite the value that such opportunities could have for increasing self awareness about interpersonal relations: "Writing about stressful events can, therefore, be a self-regulative process in which writers represent themselves handling challenging experiences and, over time, crafting effective selves that, whether true or not, are the basis for ongoing self-reflection and motivation" (Daiute & Buteau, 2002, p. 56). Clinical work may or may not be stressful for nursing students, but it is a learning opportunity in which they can perform both technical (medical) and interpersonal (empathy) skills: "-writing about social interactions in a supported educational context could also serve developmental purposes" (Daiute & Buteau, 2002, p. 57). For example, writing about social conflict increased prosocial action in a group of school children (Daiute & Buteau, 2002). According to

Teekman (2000), based on his qualitative research with 10 nurses, "Reflective thinking contributes to better contextual understandings and as such may influence future behavior" (p. 1133). Relatedly, reflective writing about empathy-based clinical care may have an important role in creating a social script that guides future nurse-client interactions. A review of the research on reflective writing in the health care context and its relationship to Discourse Theory follows.

*Reflective Writing by Health Professionals.* According to Discourse Theory, reflective writing, in particular, may increase self awareness about social interactions. Reflective writing has been associated with increased self awareness about caring among master's level nursing students (Shaefer, 2002). In addition, medical students appreciated the opportunity to reflect on their clinical experiences in writing; also noteworthy, "identification with patient" was one of the nine themes identified in their creative narratives (Hatem & Ferrara, 2001). A review of reflective practice research suggested that it is possible for nursing educators to facilitate this practice among their students; the author expressed concern that educator resistance, not student resistance, limits the benefits of incorporating this pedagogical method into the curricula (Ruth-Sahd, 2003). Personally engaging in the process of reflective writing seems like a good method for converting those who are resistant (Jasper, 1999). Moreover, reflective practice has a long history and was originally linked to critical thinking, which is the second (after caring) highest priority in nursing education: "reflective thinking is closely related to critical thinking; it is the turning over of a subject in the mind and giving it serious and consecutive consideration" (Dewey, 1933, p. 3).

The potential for reflective writing, that is, "a conversation with the self" (Johns, 1999, p. 242), to increase empathy in the health care setting has been suggested but not tested

empirically (Charon, 2001; Hatem & Ferrara, 2001; Wheeler & Barrett, 1994). The one known study of relational writing in health care was with qualified nurses, not nursing students. Four themes were identified in the research diaries of participants in a counseling training workshop: sharper focus on practice, complex situations, emotional labor, and knowing the client (Hollinworth & Hawkins, 2002). Although the research diaries included details about clients' feeling states and reflection positively influenced their thinking about practice, the authors found that the thinking of some nurses was unaffected by these interventions. This led them to conclude that preexisting attitudes and beliefs about how to work with clients may reduce the effectiveness of attempted interventions. In contrast, a reflective writing intervention may be more effective at the student level when individuals are developing their identities as caregivers and eager to incorporate their training into their practice.

I envision the empathy process in nurse-client interactions as one that may be enhanced by self reflection. Discourse Theory suggests innovative, dialogically-based techniques for empathy experiences that could (eventually) improve nurse-client interactions during nursing education. Because writing is one method of representing oneself to the self and others, it is a place to "perform" (and, ultimately, assess) empathy. As noted by Richardson (1994), "Language is not the result of one's individuality; rather, language constructs the individual's subjectivity in ways that are historically and locally specific" (p. 518).

A narrative is described as a mode of discourse that has a beginning, middle, and an end, occurred in the past, is linear and sequential, has a plot, and makes sense to the narrator (Denzin, 1989, p. 37). Narrative is recommended as a method of drawing from the nursing

situation the "tangible seed of awareness of self as caring person" (Boykin & Schoenbofer, 1993, p. 49) not only as a "caring person," but also as an interactively attuned narrator of the medical activities as embedded in the nurse-client (and attendant) relationship. Like the title of Nancy's Diekelmann's "Teacher Talk" article," I hoped that the participants in the experimental condition would experience these intervention assignments as "Thinking-in-Action Journals: From Self-Evaluation to Multiperspectival Thinking" (2003), thus promoting dialogic empathy. Although nursing educators of the past decade have recognized the value of writing to enhance empathy among their students (Bradley-Springer, 1993; Patton, Woods, Agarenzo, Brubaker, Metcalf, & Sherrer, 1997; Pinkstaff, 1985), I know of no empirical research that has investigated this hypothesized phenomenon.

*Summary.* According to Discourse Theory, reflective writing is the best strategy to encourage students to perceive empathy in their nurse-client interactions as dialogic (including appreciation of the characteristics of self, other, and context). This dialogical approach differs from the kind of testability that I reviewed in the section on empathy as a personal characteristic where survey methods are theoretically appropriate. In this study, I am trying to establish theory and research methods to be more consistent with the context of nursing education and, more importantly, more consistent with the dialogical nature of nurse-client interactions.

### *Chapter Summary and Study Rationale*

Although intent to care or be empathic is a quality that brought nursing students to the nursing profession, mentorship may be required to enhance that quality (Lauder et al. 2002). Mentorship may take the form of guided assignments in which students learn by drawing from their own experiential knowledge (Van Manen, 1990).

The objective of this study was to build a clinical practice with dialogic empathy development using narrative reflection exercises to improve communication and potentially enhance care. In doing so, I wanted to establish and test theory-based research methods that account for the dialogical nature of nursing encounters. In consideration of Bahktin's dialogical framework (1986), the nursing encounter is one that is interactive and potentially transactional, but theory, research, and practice and education are not consistently stating that which may, in turn, allow for the reduction of the potential for empathy as a dialogic process, rather than its enhancement.

Methods from each theory (scales from empathy as personal characteristic and narratives from empathy as a dialogic process) were used to compare and contrast the traditional model of empathy with the emerging model of dialogic empathy across study conditions. Although it was expected that the quantitative scales would predominantly measure empathy as a personal characteristic and the narrative texts would predominantly assess empathy as an interactive process, to develop a comprehensive theory of dialogic empathy in nursing education it was also important to consider if and/or how these different methods could provide data to test both models. Lastly, as recommended by Wheeler and Barrett (1994), this study included a control group and an experimental group, a subsequent posttest, randomization, and multiple measures of empathy. A detailed participant flow chart is included as Table 1.

### *Study Hypotheses*

The hypotheses for this study were:

- Experience of empathy as a dialogic process could be both fostered and assessed using narrative methods in the experimental condition. I expected an indication of

increased levels of dialogic empathy over time (i.e., across the three intervention narratives).

- Participants in the experimental condition would have more change on the primary outcome, level of dialogism, in their responses to the "What is your idea of an ideal nurse?" question compared to participants in the control condition.
- Participants in the experimental condition would have significantly more dialogically-oriented responses on the secondary outcome, responses to the What is Empathy? task, than would the participants in the control condition.
- Participants in the experimental condition would have more positive change on the dialogic-type subscales than the participants in the control condition. The research design used to test these hypotheses is described in the next chapter.

## CHAPTER 2

### RESEARCH DESIGN

#### *Chapter Overview*

As discussed in Chapter 1, Discourse Theory suggests that it may be possible to define and assess the development of dialogic empathy through a review of narrative reflections about nurse-client interactions. Dialogic empathy was defined as a reciprocal process that occurs within the clinical interaction when there is enhanced sensitivity to the perspectives of both participants. This model of empathy was distinguished from the traditional model of empathy that empathy is dispensed by health care providers during the clinical interaction due to their empathic traits or abilities.

In Fall 2003, I collected data from 44 participants from a first semester clinical nursing theory course at a public technical college in New York City. One class section (determined by a coin toss) received the standard curriculum. The other class section received the standard curriculum plus a narrative reflection exercise for three different clinical experiences across the semester. Participants from both class sections completed various pretest and posttest measures. These measures were selected to assess empathy from both of the theoretical models described in the introduction: empathy as a personal characteristic model and empathy as a dialogic process model. The goal of this study was to change students' perception of empathy as a personal characteristic to empathy as a dialogic process to improve communication within nurse-client interactions and potentially enhance care. The major hypothesis was that the narrative reflections of the participants in the experimental condition and the measures used to compare the empathy model-related

outcomes between the experimental condition and the control condition would support the proposed model of dialogic empathy.

### *Participants*

With IRB-approval, nursing students in two separate class sections of the first semester clinical course of the Associate Degree Program in Nursing at a public technical college in New York City were invited to participate in this study. The course, like all of the courses within this Nursing Department, uses Watson's Theory of Caring (1987) as its foundation (Richardson, 1997/1998). There were approximately 40 students per section. These students had all completed their prerequisites (e.g., math, English, psychology, anatomy, physiology) to take this first semester clinical course.

Forty-four of the 79 students in the course (a 55.7% response rate) agreed to participate in this study. Twenty-four of the students who signed consent were in the experimental group, 20 were in the control group. The majority of the sample was female (86%). It was ethnically diverse: 16% were Caucasian; 46% black; 14% Latino; 5% Asian; 17% other. The mean age was 30 years ( $SD = 10.64$ ), ranging from 19 to 56 years. Eighteen countries were represented in this sample; 30% were American-born. English was the first language of 71% of the participants. It had been an average of 7.45 ( $SD = 6.84$ ) years since they had graduated or passed the GED. About half of the sample was working in the health field at the time of the survey (48%).

Table 2 shows the demographic variables by condition (experimental versus control). Of note, the mean number of years since they graduated from high school or passed the GED was significantly higher in the control group ( $M = 10.80$ ,  $SD = 8.01$ ) than in the experimental group ( $M = 4.31$ ,  $SD = 3.46$ ,  $t(18.79) = 2.89$ ,  $p < .01$ ). In addition, a significantly higher

percentage of the control group participants (68%) were currently working in health care than the experimental group participants (30%,  $\chi^2 = 6.02, p < .01$ ) at the time of the survey.

### *Measures*

The structure of each measure and the rationale for its inclusion in this study are explicated below. These measures are presented here in the same order that they were presented to the participants.

***The Ideal Nurse Question.*** All participants were asked to write a response to the question "What is your idea of an ideal nurse?" on a page with 10 triple-spaced lines. This same writing task was conducted at pretest and posttest. The purpose for including this question was to assess change in participants' descriptions of what an ideal nurse is with a focus on if and/or how they explained empathy-type components of nursing as dialogical. Descriptions of an ideal nurse, rather than empathy, were requested so that participants would not suspect that the study was about empathy and, thus, increase the likelihood of self report bias between pretest and posttest. (See Appendix A.)

***Interpersonal Reactivity Index (IRI; Davis, 1983).*** This instrument is a multidimensional scale assessing empathy as a character trait, that is, an individual's tendency to react to the experiences of others in consistent ways. It has 28 items, divided into four 7-item subscales: Perspective-Taking, Fantasy, Empathic Concern, and Personal Distress. Published alphas range from .71 to .77 (Davis, 1983). This scale was selected to assess participants' degree of empathy as a personal characteristic as it is traditionally measured. In particular, the Empathic Concern subscale, has been used to measure empathy as a trait (e.g., Smith, 1992).

Participants indicated the extent to which each item described them, using a five-point scale. Sample items of the Perspective-Taking subscale include: "I try to look at everybody's side of a disagreement before I make a decision." and "I sometimes try to understand my friends better by imagining how things look from their perspective." Sample items of the Fantasy subscale include: "I daydream and fantasize, with some regularity, about things that might happen to me." and "After seeing a play or movie, I have felt as though I were one of the characters." Sample items of the Empathic Concern subscale include: "When I see someone being taken advantage of, I feel kind of protective towards them." and "I am often quite touched by things that I see happen." Sample items of the Personal Distress subscale include: "Being in a tense emotional situation scares me." and "I tend to lose control during emergencies."

The items are summed to form separate subscales ranging from low on the subscale (0) to high on the subscale (28). These subscales are intercorrelated: Perspective-Taking was positively correlated with Empathic Concern ( $r=.33$ ) and negatively correlated with Personal Distress ( $r = -.25$ ); in addition, Fantasy and Empathic Concern also were positively correlated ( $r=.33$ ) (Davis, 1983). This scale has been validated for use with health professionals, college undergraduates (e.g., Yarnold, Bryant, Nightingale, & Martin, 1996), and first year nursing students (Becker & Sands, 1988). (See Appendix B).

*Caring Attributes Questionnaire (CAQ; Arthur et al., 2001)*. This 31-item scale ( $\alpha = .77$ ) is a short version of the original scale Caring Attributes, Professional Self and Technological Influences (CAPSTI; Arthur, Pang, Wong, Alexander, Drury, Eastwood et al., 1999). The four subscales of this scale are Caring Communication (11 items,  $\alpha = .89$ ), Caring Advocacy (7 items,  $\alpha = .86$ ), Caring Involvement (8 items,  $\alpha = .74$ ), and Learning to

Care (5 items,  $\alpha = .72$ ). Published alphas for these subscales range from .72 and .89 (Arthur et al., 2001). This scale is also associated with the traditional view of empathy as existing in the individual rather than as a dialogic process; however, unlike the empathy-centric IRI, this scale predominately assesses the attitudes of nursing students about various caring activities or skills. This scale was included to capture a more context-sensitive, but caring-focused, component of the nursing education experience.

Participants indicated the extent to which they agreed or disagreed with each item, using a five-point scale. Sample items of the Caring Communication subscale include: "Talking to the patient." and "Helping the patient clarify thinking." Sample items of the Caring Advocacy subscale include: "Speaking up for the patient, when it is perceived that something harmful will be done to the patient." and "Working collaboratively with colleagues to ensure continuity of care." Sample items of the Caring Involvement subscale include: "Avoiding the patient." and "When I don't give the patient all the information he/she needs." Sample items of the Learning to Care subscale include: "Caring is learned by modeling in the clinical setting." and "Nurses learn about caring by observing other nurses work." The items are averaged to form separate subscales ranging from low on the subscale (1) to high on the subscale (5). This instrument has good internal reliability and validity with international samples of registered nurses (Arthur et al., 1999, 2001). (See Appendix C.)

*Nursing Department Student Survey.* This survey is used every semester by the Nursing Department to collect demographic information for administrative purposes. Specifically, participants were asked to check the boxes that best represent their gender, race, age, education, and current employment. The form was augmented to include "other" among the race categories, a line upon which to write "country of origin," and categories for

previous experience in nursing. Because this hypothesized model of dialogic empathy emphasizes the importance of socio-cultural factors in interpersonal relationships, it was necessary to have these demographic data, particularly from the experimental group, in analysis of the intervention data. (See Appendix D.)

*The What is Empathy? Task.* This writing task was completed by the participants during the posttest phase of the study only. Five purposefully vague questions were written to elicit narratives on the research topic (Reissman, 1993)-specifically, attitudes and experiences with empathy, particularly empathy as an interaction. Participants were asked to: 1) define empathy, 2) explain if they considered themselves to be empathic, 3) write a narrative about an empathic interaction in which someone else (preferably a client) required empathy, 4) write a narrative about an empathic interaction in which they required empathy themselves from someone else (preferably a health care provider), and 5) describe the relationship of empathy to their choice to be a nurse. Preferences for a health care situation were stated in order to restrict the range of experiences participants chose among, thus, ideally, facilitating the coding process. This task was included to elicit more detailed characteristics and contexts related to empathy for comparisons across conditions; for example, I expected that participants in the empathy writing experimental group would have significantly different responses (specifically, more dialogic-type responses) to these questions than the control group. (See Appendix E.)

*The "Most Meaningful Intervention – With Whom?" Task.* This task was included as the last page of the posttest packet of the experimental group participants only. The directions were as follows: "During the course of this semester you have described your 'most meaningful interaction' with clients in various settings. Please use this form to describe

their personal characteristics and how you think they may or may not interact with your own." Then there were several lines requesting gender, race, estimated age of the client that the participants wrote about in each of the three clinical settings (i.e., child care center, senior citizen center, long term care facility). As noted above in the rationale for requesting the participants' demographic characteristics, it was important to request this information about the clients because dialogic theory suggests that history and culture of both actors (nursing student and client) influence one's social interactions. It was expected that the participant's demographic characteristics might interact with the client's demographic characteristics, influencing the student's description of the outcome of interest, i.e., degree of dialogic empathy. (See Appendix F.)

### *Procedure*

A coin toss determined which one of the two class sections of the course received the standard curriculum assignments from their professor. The other class section received the standard curriculum and dialogical-based writing intervention prompts. All students were invited to sign the consent form and complete the pretest measures. Students who signed the consent form and completed the pretest measures were asked to complete the posttest measures. Students had originally been randomly assigned to these different sections (i.e., one new student is put in one section, the next new student is put in the other), but some students requested a specific section to accommodate their schedules.

*Time 1: Recruitment and Data Collection.* I had permission to recruit students during the pre-semester intersession. The students from both cohorts were meeting in a classroom. The Chair of the Nursing Department introduced me to the students as follows: "This is Kimberlee Trudeau. She is a CUNY graduate student who used to work with the

department. Now she is back to invite you to participate in the study she is conducting on nursing education. This is an excellent opportunity for you to help possibly yourselves, as well as future students ... Whether or not you participate will have no effect on your grades. In fact, at no point will the faculty be informed of who participated in the study." Then the professor left the room and I read the oral script (Appendix G) to the students.

I passed out two copies of the consent form (Appendix H), then the Ideal Nurse question, to all students. Students who wanted to participate were asked to sign the consent form and respond to the Ideal Nurse question. The Ideal Nurse question was distributed by itself, without the quantitative scales, because the quantitative scales (i.e., IRI; Davis, 1983; CAQ, Arthur et al., 2001) might have cued the participants into the focus of the study. Then the packet including the Davis' (1983) Interpersonal Reactivity Index (IRI), the Caring Attributes Questionnaire (CAQ) of the Arthur et al.'s (2001) Caring Attributes, Professional Self and Technological Influences (CAPSTI-2) instrument, and an augmented Nursing Department demographics form were distributed. Of these quantitative assessments, the IRI (Davis, 1983) was included first in the survey packet because it is a trait-based assessment; it measures multidimensional empathy from a social psychological perspective. The CAQ (Arthur et al., 2001) is the more skill-based assessment of the two instruments; it has been used with health professionals to measure caring attributes.

Each of the instruments had a blank sheet on the front and on the back to protect the participants' privacy while completing the study materials and while passing it in. In addition, the Ideal Nurse question, the CAQ, and the IRI were printed on double-sided pages. These instruments were described above in the Measures section.

To collate these materials per student for analysis, the participants affixed labels with a random number (one number per student) on each document (i.e., 1 label for the signed consent form, 1 label for the Ideal Nurse question pretest, 1 label for the pretest survey packet). Because of the pretest/posttest design, participation was not anonymous; however, the use of the labeling system enabled me to keep participants' names separate from all of their study materials (this was explained to students in both the recruitment script and consent form).

Students who wanted to participate in this study had an opportunity to fill out the study materials at that time. All participants returned the study materials to me within the forty-minute time frame that was allotted.

At the end of the data collection session, all students listed on the two class roster sheets were automatically entered (i.e., regardless of participation, as explained in the recruitment script, to reduce potential coercion) into a lottery for a \$50 gift certificate from the campus bookstore as thanks for their time and attention. One student per class section was selected as a winner.

***Intervention and Collection of Student Assignments.*** One class section of 39 students received the standard curriculum and the other class section of 40 students received the standard curriculum plus three writing assignments augmented by a narrative reflection exercise, regardless of participation in the study.

Written assignments were evaluated by each student's clinical preceptor (i.e., the instructor who works with a group of students in the clinical setting). There were six preceptors for eight clinical groups of students. There were 10 students per clinical group. The course coordinator was preceptor for one clinical group. All of the students were asked

to hand in a second copy of the four written assignments to the course coordinator. I collected only the written assignments by students who signed the consent form to participate in the study. A new identification number was created to connect students' names with their essays to reduce contact with the participants' pre/posttest identification number. This number was created by counting alphabetically by last name (e.g., Adams = 1 ... Jones = 32 ... Smith = 64, etc.) across the rosters for the two class sections. This kept group assignment (experimental versus control) unclear during the coding process.

The course coordinator was told which class received the intervention materials and which class received the standard curriculum materials because she needed to explain the assignments and be available for questions about them. The other clinical preceptors were told that the course coordinator was piloting new assignments as part of a study.

***Time 2: Data Collection.*** I had permission to enter each class at the end of the semester (at weeks 11 and 13) to collect the posttest data.

The professor reintroduced me to the class: "Kimberlee Trudeau, the CUNY graduate student, who invited you to participate in her study on nursing education at the beginning of the semester, has returned to collect data from those of you who participated in her study. I am going to leave the class during data collection." At that point, I thanked the class for their attention and handed out the posttest materials to the participants (i.e., the Ideal Nurse question, the IRI, the CAQ, and the What is Empathy? task). There was a post-it with the participant's first name on the front blank page of the survey packet; the survey itself had a label with the participant's pretest identification number. All students were invited to enjoy snacks during the 30 minutes allotted for data collection. Study materials (with the post-it

removed) were collected at the end of the class. This process occurred multiple times (described in detail below) due to low recruitment during the first effort.

***Collecting Posttest Materials from Control Group.*** The multiple recruitment sessions for posttest data from the control group class occurred as follows: The first recruitment session took place on the last day to withdraw from the course within a 30 minute period between lab and tutorial in the early afternoon. Of the 17 participants from the three of four clinical groups present, only one participant opted to complete the survey; the others headed to lunch or left for the day. The fourth clinical group had a make-up session the following week. The clinical instructor took a break from the make-up lab for students to participate (5 more participants completed surveys – making a total of 6), and then the students returned to their lab work. Two weeks later, I went into the last 15 minutes of their class to recruit one more time. One student from the first recruitment day handed in her completed survey and another student completed a survey (making a total of 8). Three more were left in my box in the Nursing Department that week. One student who had not participated at the pretest signed consent and completed a posttest survey. (Final total is 12/20.)

***Collecting Posttest Materials from the Experimental Group.*** The multiple recruitment sessions for posttest data from the experimental group class occurred as follows: The first recruitment session took place a few days after the last day to withdraw from the course within a two hour period between lab and tutorial in the early afternoon. Of the 20 original participants still in the class, 17 completed the survey. The second recruitment session took place two weeks later in the last 20 minutes of the last class. One more student, absent during the first recruitment session, completed the survey (making a total of 18).

NOTE: One more student who had not participated at the pretest signed consent and completed a posttest survey. (Final total is 19/24.)

A \$50 college book store gift certificate was given to the participant who won the posttest lottery at the end of the data collection period.

*Debriefing.* Debriefing and preliminary results were provided to the classes via a one-page summary sheet at a subsequent semester. (See Appendix I.)

### ***Integrating Empathic Reflection into the Current Curriculum***

#### ***Standard Curriculum***

In the standard curriculum, students were required to do several written learning activities related to their work in clinical laboratories (i.e., clinical settings). Specifically, individual groups of 10 students spent one day in a child care center, one day in senior citizen center, and three days over three weeks at a long term care facility working with the same resident under the guidance of the preceptor. Based on these clinical laboratories, students composed two reports and two essays during the semester.

***Rationale for the Order of Clinical Experiences.*** The rationale of the course coordinator for conducting the clinical sessions in this order is as follows (Ellen McGuinn, personal communication, February 10, 2005): the students are new to nursing and, thus, the objective is to ease their socialization into their new role by focusing on normal growth and development along the life span using Erikson's theory (1963; as explicated within the student's textbook Potter & Perry, 2001). Therefore, the course is outlined across a wellness continuum beginning with a discussion of the maintenance of health through the transition to illness. A focus on wellness enables them to draw from their personal experiences and those that they know of through their social networks. Such comparisons between their

experiences and the new content they are learning should help them to feel less overwhelmed by the rigorous curriculum of the nursing program.

The first stop along the clinical experience continuum is the child care center. In their first clinical nursing course, healthy children are the main focus, with emphasis on community experience with well toddlers and pre-schoolers. (Ill children are covered in the second clinical nursing course.) Again, this focus on understanding what "well" is (e.g., a child typically is walking by the age of 15 months) helps students to identify circumstances where investigation is needed, as opposed to concentrating on learning a list of illnesses. Another benefit of the child care center context is that it is expected to be less threatening or intimidating to the new students than an adult setting might be.

The second stop is the senior citizen center. This original curriculum was expanded with a thread in gerontology, implemented through a faculty development grant awarded to the nursing department. The students interact with clients who are maintaining their own health and seek social networks through the center. A problem at this stage might be identified through the student's knowledge of health (e.g., the importance of the maintenance of a good body weight to body size ratio in adulthood). If a client is losing 2-4 pounds per month over time, then it suggests the need for further assessment and potential clinical intervention.

The third stop is the long term care facility. Clients in this environment can no longer maintain their health independently, perhaps due to the death of a spouse. The student focuses on the current assessment of the resident in long term care and not on the original admitting diagnosis, which might have been several months or years earlier.

At the end of the semester, the acute care setting of the hospital and its respective clients are introduced. The students' clinical experience has moved toward an illness model on the health-illness continuum. This last context was not part of this research study.

This context-sensitive curriculum design is more sensitive to the dialogic perspective than a typical skill-based model would be expected to be. As noted in the introduction, the dialogic perspective is consistent with current nursing theory (e.g., Boykin & Schoenbofer, 1993), though not necessarily with professional practice (e.g., the use of the Nursing Process to record nursing actions).

*Learning Activities across the Curriculum.* Among the learning activities for the child care center and the senior citizen center were written reports of students' observations and experiences in these clinical settings (see Appendices J and K, respectively). For these assignments students were required to write what is expected of the clinical experience prior to entering the setting ("Expected" column; written as bullet points) and then write what was observed during the clinical experience after entering the setting ("Observed" column; written as narrative) based on Erikson's theory of growth and development.

In addition to these two reports, students completed two essays. The assignment for the senior citizen center essay was: "Project yourself into the future, and visualize how you see yourself as an older adult. Include activities and interests that you will be actively participating in during your 'senior years.'" (See Appendix L.) The assignment for the long term care facility essay was to "Contrast your expectations before your visit to the long term care facility with your views and feelings after having attended the facility." (See Appendix M.)

### ***Experimental Curriculum***

All students in the experimental condition section of the class were required to complete the standard curriculum assignments and respond to an additional dialogical-theory-based exercise (i.e., narrative reflection) on a separate page for the child care center report (Appendix N), the senior citizen center report (Appendix O), and the long term care facility essay (Appendix P). At the discretion of the course coordinator, the senior citizen center essay was the same for both groups.

The dialogical-theory-based exercise added to the other three assignments was designed to encourage the students to take on the perspective of the client, as well as to elaborate their own subjectivity in relation to the interaction with the client. It required them to describe the interaction in two ways: first, from the client's perspective only, and second, from both of their perspectives (student and client). They were directed to include thoughts and feelings in both of these scenarios. The idea was that students would represent both perspectives better if they had focused first on the client's perspective. Lastly, students were asked to reflect back on the interaction critically. This last prompt was added to motivate the student to be self-critical about the experience and, ideally, to use that awareness to inform subsequent clinical practice. Consistent with the rationale of the course curriculum, these narrative reflection exercises provided another opportunity for students to combine personal and clinical experiences through the active use of "I" (Hecker, Amon, & Nickoli, 2001), which is not permitted in the traditional Nursing Process structure.

### ***Timeline of Data Collection and Course Assignments***

The semester-based (15 weeks total) timeline for these intervention components in relation to the pre/posttest data collection occurred as follows:

Week 0 (intersession):	PRETEST -- Consent, Ideal Nurse question, surveys
Week 2:	Child Care Agency clinical lab
Week 3:	Child Care Agency report DUE
Week 5:	Senior Citizen Agency clinical lab
Week 6:	Senior Citizen Agency report DUE
Week 8:	Long Term Care Facility clinical lab I Senior Citizen essay DUE
Week 9:	Long Term Care Facility clinical lab II
Week 10	Long Term Care Facility clinical lab III
Week 11:	Long Term Care Facility essay DUE
Weeks 11-13:	POSTTEST – Ideal Nurse question, What is Empathy? task, surveys

See Table 1 for participation rates for each assessment/essay.

**Management of Data.** The class assignments all had unique identification numbers that were connected to their survey packet identification numbers after the data had been coded. These numbers did not reflect the different conditions (control versus experimental) to ensure that group identity was unclear during coding. Other data handling details are included in "Defining Dialogic Empathy – The Codebook" that was designed for use in this study (see Appendix Q).

### **Chapter Summary**

To assess the development of a model of dialogic empathy in a cohort of beginning nursing students, a two-group pre-post design, including an intervention (i.e., three narrative reflection exercises), was used in this study. Measurements were chosen to capture the two

models of empathy described in this dissertation – empathy as a personal characteristic and empathy as a dialogic process. The dialogic empathy outcomes were assessed using coding strategies that I developed as my understanding of the model of dialogic empathy evolved. These coding strategies are described in the following chapters.

## CHAPTER 3

### APPLYING AND TESTING A MODEL OF DIALOGIC EMPATHY

#### *Chapter Overview*

In Chapter 1, I outlined a theory of dialogic empathy within nursing education using literature from psychology and nursing for support. Then, based on Discourse Theory, I suggested the use of narrative reflections to encourage nursing students to compose nursing narratives that focus on the interactive, reciprocal nature of nurse-client interactions. This, I proposed, would lead to the development of dialogic empathy among these students.

In this chapter, I further explicate my conceptualization of dialogic empathy using the two coding systems at different units of analysis (i.e., essay as coding unit, sentence as coding unit) that I developed to assess dialogic empathy among the participants in the experimental group across the course of three clinical assignments. I tested my hypothesis that there would be increased use of dialogic-type descriptors over time. Results indicated that the use of dialogic-type descriptors varied across context and were associated with similarity of the socio-relational characteristics (e.g., gender, race) of the participants in the interaction. These findings are consistent with Bahktin's dialogical framework.

#### *Developing Dialogic Empathy?: The Intervention*

The theory-based narrative reflection exercise, "Describe the most meaningful interaction," that was added to three standard curriculum assignments in the experimental condition was designed to encourage the students to take on the perspective of the client (Client's Perspective Only) and prompt the students to describe the nurse-client interaction as a dynamic process that includes reciprocal actions and psychological states between the nursing student and client (Both Perspectives).

These data could not be coded without knowledge of time because the context of the assignment was confounded with time (e.g., the child care center essay was first). To prevent expectation of dialogic development within participant, the identification number used on the essays for coding was not consistent for participant across context. Dialogism was coded for each section of the narrative reflection exercise (i.e., the Client's Perspective Only section, the Both Perspectives section) using two methods. Each coding system, based in narrative analysis methodology, evaluates use of dialogism with a different unit of analysis. The unit of analysis in the holistic coding system is the section; level of dialogism is assigned to each section based on an evaluation of the diction used in that section. The unit of analysis in the sentence-by-sentence coding system is the sentence; each sentence is coded for level of dialogism based on the use of dialogic-type indicators (e.g., use of psychological states), and a sum of the level of dialogism for each sentence is the outcome used in subsequent analysis. The rationale for the use of each of these systems is explained below.

### *Holistic Coding of Dialogism*

First, each section of the essays was evaluated holistically for diction to assess for evidence of an appreciation for the interactivity of perspectives that is discussed in the dialogical framework. Separate coding rubrics were used to code the sections for holistic level of dialogism (dialogic, less dialogic, or least dialogic). Each section of the essay received one code. The specific coding is described here with specific examples. The examples listed were reproduced verbatim; that is, grammatical errors within the original text were preserved. Additional examples (described as "more" or "less" clear) of each of these levels were included at the end of the codebook (see Appendix Q).

*Client's Perspective Only.* Client's Perspective Only essays were coded "dialogic" because participants who wrote in the client's voice best demonstrated their ability to take on another's perspective, which is the core of empathy, and in this context shows an anticipation of other that indicates dialogism. An example of a dialogic child care center essay is: "A stranger came into class today. She sat down and showed me how to hold scissors. I was embarrassed because I could not figure out how to cut the paper with my scissors. The strange lady asked me if I wanted some help and I nodded yes. She took my hand and showed me how to put my fingers into the holes of the scissor and how to cut a straight line. I am so glad that she helped me." This participant wrote directly in the voice of the client, indicating the participant's awareness of the client's perspective (i.e., dialogism).

Client's Perspective Only essays were coded "less dialogic" when participants described a client's thoughts and feelings in the student's voice; this provided a more distal and, therefore, less dialogic and less empathic representation of the client's perspective. An example of a less dialogic senior citizen center essay is: "It was clear to me that the client was enjoying the process of 'reliving' her life through pictures and felt proud of how rich her life was and how many people depended on her, at one time or another, and still cared about her in her old age. In addition, she was teaching me about life, as well. The client told me on more than one occasion that I remind her of one of her granddaughters, and perhaps some sort of transference occurred, and she in fact considered me her granddaughter, in need of her guidance and advice." This text indicates the participant's sensitivity to the client's perspective (e.g., use of psychological states such as "enjoying" and "felt" [emotions] and "considered" [cognition]) and, therefore, has some quality of dialogism, but did not speak directly from the client's perspective as in the "dialogic" example reported above.

Client's Perspective Only essays were coded "least dialogic" when participants did not express their recognition of the anticipated thoughts and/or feelings of their audience. An example of a least dialogic long term care facility essay is: "My client, a Russian-Jew did not speak. Based on the information, which I had obtained from his chart, he only speaks Russian. In view of this communication barrier, no meaningful interaction took place between him and me. However, his only responses to questions such as 'may I help you with your meals, do you enjoy your meals,' and 'how is your day' were by nodding of his head." This example consists of reporting behaviors only. There is no effort to connect with this client, to empathize with his perspective; it is void of any dialogic qualities.

***Both Perspectives.*** A preliminary review of the data indicated that participants described an interaction including multiple perspectives, as requested by the assignment/intervention (narrative description, considered more dialogic), or wrote an overview (summary report, considered less dialogic). Again, the examples listed were reproduced verbatim.

Both Perspectives essays were coded "dialogic" when they reflected an appreciation of both context (i.e., narrative description versus reporting/summary diction) and how they and/or their actions were perceived by the client. An example of a dialogic senior citizen center essay is: "The table with the three ladies sitting quietly not talking to each other seems the best to approach but as I introduce myself I feel as if they're really curious. Ms. B seems very interested in hearing why I want to become a nurse and she can't stop talking about her own nursing career. [new paragraph] I feel so good talking to someone about my country again; this student wants to hear about what it was like being a nurse in Yugoslavia. Talking about my home brings back so many happy memories. And I like the way the other women

are listening, they also want to know about me. I feel as if they want to get to know me, maybe I'll have people to talk to here when I come to lunch again." In this example, the student, in the client's voice, anticipates the student (i.e., use of psychological state "wants" as desire). This indication of anticipation warrants the coding of this essay as dialogic because it shows the student's awareness of how s/he was perceived by the client. Such awareness is not only dialogic, but also demonstrates empathy, as described in Chapter 1.

Both Perspectives essays were coded "less dialogic" when participants provided a narrative description of the interaction, but did not make an attribution regarding the client's perception of the student and/or her/his actions. An example of a less dialogic long term care facility essay is: "He told me that he sometimes hates to be at the center and he just wants to go home. Then I asked him where he lived. Her talked really slow hence I was very patient with him. He reminded me of my deceased grandpa in the sense that when we spoke there periods of silence in between just as when grandpa and did." This example is a narrative description of the interaction (first the client says something, then the student says/does something). In addition, the student's psychological states are disclosed ("patient" and "reminded" [cognitions]). This essay is coded as less dialogic because the client's perspective, including how the client perceived the interaction with the student, is not mentioned.

Both Perspectives essays were coded "least dialogic" when/if participants reported what happened without expressing their recognition of the anticipated thoughts and/or feelings of one's audience. An example of a least dialogic child care center essay is: "The little boys behavior was one that I have learn to recognize from my studies to be a fairly universal one for children. That behavior is called the peek-a-boo game. I made an effort to

establish common ground with him by mimicking his behavior of coming in and out of his field of view. We played peek-a-boo back and forth for a few moments but then the teacher called him back to join his group." Unlike the dialogic and less dialogic examples presented above, this essay is a summary report of the interaction, not a narrative description of one action and reaction, as requested in the directions for the assignment. In addition, this essay does not show any indication of appreciation of the client's perspective in the form of psychological states, such as how the client perceived the behavior of the student. Interrater reliability between myself and a second coder for this outcome was acceptable at 86%.

### *Sentence-by-Sentence Coding of Dialogism*

The holistic unit of analysis described above focused on the diction of the entire section of essay (i.e., Client's Perspective Only, Both Perspectives). The second unit of analysis that I used in coding the separate sections of these essays was the sentence. Level of dialogism based on the use of dialogic-type indicators (e.g., use of psychological states) was evaluated for each sentence of each section of the essays and then summed within section for a total. It was necessary to conduct analyses at this unit of analysis because the holistic coding (essay as unit of analysis) system of dialogism consisted of only three levels. In seeking change within a small sample such as this ( $n = 24$ ), it is wise to increase the level of variability when possible by looking at the data in more detail. Fortunately, narrative data such as these essays can be viewed in increasingly detailed units (from essay level to sentence level) for more in-depth analysis.

The same sentence-by-sentence coding system was used for both the Client's Perspective Only and the Both Perspectives essays, although they were summed separately. For each sentence, seven variables were coded. Collectively, these variables informed the

level of dialogism assigned to each sentence. Each of these variables, including its relationship to the level of dialogism, and the dialogic coding rules are described below:

***Speaker of the Sentence.*** The speaker of each sentence (student or client) was coded. This was an important variable because the intervention assignment required the students to describe the same clinical interaction from different viewpoints (i.e., first from the client's perspective only and then from both perspectives). Coding entailed identifying who was the "I" in each sentence. For example, "I came into the room to attend to the client" suggested that the speaker was the student. "I was sitting in bed when the student nurse came into the room to attend to me" suggested that the speaker was the client. When a participant wrote, "If I were the client, then I would have felt . . .," the speaker was the client, because it indicated that the participant was making an effort to take on the client's perspective.

The speaker code affected which dialogic coding was used for the sentence (i.e., the dialogic coding started at a higher level if the sentence was written from the client's voice, because that form of perspective-taking suggested dialogism). If participants followed the assignment guidelines, there would be more sentences with the speaker as client in the Client's Personality Only essays than in the Both Perspectives essays.

***Number of Behaviors.*** The number of behaviors by the student and by the client were each coded. In the typical nursing report, only the behaviors of the nurse-client interaction are recorded; therefore, it was important to have this assessment to distinguish from the next category regarding psychological states. Examples of behaviors mentioned by the participants in their narrative reflections included smile, talk, put on shoes, etc.

***Number of Psychological States.*** The number of psychological states of the student and the client were also recorded. Examples of psychological states mentioned by the

participants in their intervention essays included thought, scared, feel, and try. Specific psychological states, such as emotions (e.g., enjoyed), cognitions (e.g., decided), intentions (e.g., tried to start a conversation), desires (e.g., wanted), traits (e.g., nice), abilities (e.g., able to tell me), and perceptions (e.g., observed), were also noted. When psychological states were described for either the student or client, the dialogic level was coded as high (a 3 or 4 on a 4-point continuum), because it indicated greater awareness of self and other in the interaction (i.e., dialogism) than required in the written representation of an interaction in the typical Nursing Process report.

*Number of Context Words.* The number of context words (i.e., time, location, condition) were counted, because sensitivity to context is an important part of dialogism.

See the codebook (Appendix Q) for additional examples of phrases that were associated with each of the coded variables described in detail above.

*Dialogic Coding.* The level of dialogism was the last category that was coded because it was influenced by the coding of speaker and the use of psychological states. To conduct this coding, it was necessary to divide the dialogic coding by speaker status, because the choice of speaker was done by the student and, therefore, has discourse value. Speaker is related to level of dialogism (e.g., speaker = client is more dialogic because it shows the student's anticipation of other's perspective). Interrater reliability between myself and a second coder on this outcome was also good (i.e., 87.5%). See the codebook (Appendix Q) for details regarding dialogic coding.

### *Results: Dialogic Empathy across Context*

I designed the intervention assignment to complement the existing standard curriculum as a parsimonious way of encouraging students to think about empathy in a more

dialogical fashion, through writing about a clinical interaction, from the client's perspective and then from both perspectives (i.e., student and client). However, the students completed only three intervention assignments over the course of about eight weeks. Could there be a development effect with this short term minimal intervention?

*Hypothesis:* Experience of empathy as a dialogic process could be both fostered and assessed using narrative methods in the experimental condition. I expected an indication of increased levels of dialogic empathy over time (i.e., across the three narrative reflections).

As the results below show, the level of dialogism was more a factor of context than of time. Dialogism is, in theory, context-sensitive (e.g., the socio-relational factors of participants in an interaction are important), so the finding was important. Although context and time were confounded in this particular study design, it suggests an area for future research.

*Attendance to Intervention Guidelines.* As described in Chapter 2, the participants wrote essays from the client's perspective and then from both perspectives for their experiences in the child care center (CC), the senior citizen center (SC), and the long term care facility (LT). Paired t-tests of the variables for the number of sentences written with the speaker as the client between the Client's Perspective Only (CC  $M = 1.95$ ; SC  $M = 1.57$ ; LT  $M = 3.30$ ) and Both Perspectives (CC  $M = 0.55$ ; SC  $M = 0.86$ ; LT  $M = 0.50$ ) indicated that significantly more sentences were written with the speaker as the client in the Client's Perspective Only (CC  $t(21) = 2.73, p = .01$ ; SC  $t(20) = 1.89, p = .07$ ; LT  $t(19) = 3.88, p = .07$ ). This finding provided some evidence of construct validity and served as a manipulation check (i.e., in general, participants followed the specific guidelines of the intervention assignment).

*Tests Using Holistic Coding of Dialogism as Outcome.* Repeated measures of dialogism coded holistically for the narrative reflections were run to find out if there were significant differences across time. These analyses indicated no significant relationship for dialogism in the Client's Perspective Only essays (Wilks' Lambda  $F(1,18) = 0.97, p = .73$ ), but they indicated a significant relationship for dialogism in the Both Perspectives essays (Wilks' Lambda  $F(2,18) = 3.07, p = .05$ ). Tests of within-subject contrasts indicated that this latter relationship was quadratic ( $F(1)=3.00, p = .05$ , not linear ( $F(1) = 1.23, p = .11$ ). Table 3 includes percentages of each dialogic coding by intervention essay.

*Tests Using Sentence-by-Sentence Coding of Dialogism as Outcome.* Two separate repeated measures analyses were then run to test the hypothesis that participants wrote more dialogic sentences over time in their Client's Perspective Only essays and their Both Perspectives essays. The independent variable was time, recognizing that the child care essays preceded the senior citizen essays, which preceded the long term care facility essays. The dependent variable in these analyses was the level of dialogism by number of sentences for each of the narrative reflections (child care, senior citizen, long term care facility). The first analysis, using the data for the Client's Perspective Only essays, was significant (Wilks' Lambda  $F(2,18) = 4.19, p = .03$ ) and tests of within-subject contrasts indicated that this relationship was quadratic ( $F(1)=8.13, p = .01$ , not linear ( $F(1) = .02, p = .88$ ). The second analysis, using the data for the Both Perspectives essays, suggested a trend towards significance for Both Perspectives (Wilks' Lambda  $F(2,18) = 2.59, p = .10$ ) and tests of within-subject contrasts suggested a quadratic ( $F(1)=5.83, p = .08$ ), not linear ( $F(1) = .65, p = .59$ ), relationship. See Figure 2.

Consistent with the focus on context in the dialogical framework, the descriptive data suggested that, overall, participants' essays had higher levels of dialogism in the child care center narrative reflections and in the long term care narrative reflections than in the senior citizen narrative reflections (see Table 4). Subsequently, I conducted analyses of reports of client's emotion separately for the Client's Perspective Only and Both Perspectives essays at different time points. The analysis for client's emotion from the Client's Perspective Only was significant (Wilks' Lambda  $F(2,18) = 4.17, p = .03$ ) and tests of within-subject contrasts indicated that this relationship was quadratic ( $F(1)=7.89, p = .01$ , not linear ( $F(1) = .08, p = .78$ ), as suggested by the descriptive data; see Figure 3. In addition, the analysis for emotion from Both Perspectives was significant (Wilks' Lambda  $F(2,18) = 4.64, p = .02$ ) and, again, tests of within-subject contrasts indicated that this relationship was quadratic ( $F(1)=9.12, p = .01$ , not linear ( $F(1) = .38, p = .55$ ); see Figure 3.

For contrast, I tested reports of students' emotions using repeated measures and found no significance for this within-subject analysis for either the Client's Perspective Only essays (Wilks' Lambda  $F(2,18) = 0.62, p = .55$ ) or the Both Perspectives essays (Wilks' Lambda  $F(2,18) = 0.13, p = .88$ ); see Figure 4. Therefore, context (child care center, senior citizen center, long term care facility) seems more meaningful than time (3 points across 8 weeks) in appreciating another's perspective in this study, though it appears to have no effect on self-reports of student emotion.

*Does Meaningful Intervention With Whom Matter?* At posttest I collected data on the characteristics of the clients that the participants had described in their intervention essays (Most Meaningful Intervention With Whom? task). I then entered data into the SPSS dataset for whether or not the participant interacted with someone who was of the same or

different gender, race, and the number of differences for each intervention assignment (age was different across all assignments). T-tests of total dialogic score/number of sentences in the essay were also examined post hoc. The dialogical framework suggests that the dialogism scores would be higher amongst those of the same gender and race. That was found in the Client's Perspective Only essays about the child care center, where dialogism scores were significantly higher for those of the same gender ( $M = 11.91, SD = 3.92$ ) than for those who were of a different gender ( $M = 7.98, SD = 1.96; t(9.05) = 2.66, p = .03$ ). In the Client's Perspective Only essays about the senior citizen center, a trend indicated that dialogism was slightly higher for different gender ( $M = 9.34, SD = 3.28$ ) than for the same ( $M = 7.16, SD = 1.63; t(11.22) = 1.83, p = .10$ ).

Similarly, there was also, unexpectedly, more dialogism when a nursing student was different in two respects from her client (CC  $M = 9.41, SD = 2.80$ ; SC  $M = 10.25, SD = 2.53$ ) versus a single basis of difference for the essays about nurse-client interactions in the child care center (CC  $M = 7.52, SD = 1.27; t(15) = -1.88, p = .08$ ) and the senior citizen center (SC  $M = 7.48, SD = 2.24; t(15) = -2.35, p = .03$ ). No significant differences were found in these analyses for the essays about nurse-client interactions in the long term care facility, perhaps because the focus on illness muted the potential othering effects of gender and race in this group of essays.

### ***Chapter Summary***

I hypothesized that student's experience of dialogic empathy could be assessed reliably, with variation, and yield clear results using narrative methods; evaluative statements in the intervention essays provided evidence of dialogic empathy. Secondly, I expected increased levels of dialogic empathy over time (i.e., a linear relationship across the three

contexts) in the narrative reflections composed by the experimental group. Instead I found the following: For the Client's Perspective Only essays, there was a significant difference over time, but it was a quadratic, not a linear relationship; for the Both Perspectives essays, a trend towards significance was also found for a quadratic relationship. Therefore, the data indicated that the levels of dialogism were significantly higher in the essays about the first context (child care) and last context (long term care) than in those about the second context (senior citizen). In addition, these levels of dialogism were influenced differentially by similarity of socio-cultural characteristics (e.g., gender, race) of the student and client in the interaction, depending on the context. So, although the participants did not write about the interactions in increasingly dialogic terms, they did respond differently to the different contexts – as would be suggested by the dialogical framework.

In sum, there is some preliminary support for a model of dialogic empathy. The question of whether the specific experience of writing narrative reflections influenced participants' descriptions of nursing and empathy is addressed in the next chapter.

## CHAPTER 4

### NARRATIVE ASSESSMENTS OF THE EFFICACY OF LEARNING EMPATHY AS A DIALOGIC PROCESS

#### *Chapter Overview*

The assessment of the narrative reflections written by the participants in the experimental condition suggested that dialogic empathy can be operationalized and assessed. Now it is necessary to test if the experience of describing these interactions in more dialogic discourse (i.e., nursing narratives) than is typically used in nursing practice (i.e., the Nursing Process) increased the awareness of interactivity and reciprocity in nurse-client interactions. Therefore, pre/posttest comparisons between the participants in the experimental condition and the participants in the control condition were conducted.

As noted in Chapter 2, the quantitative scales (Interpersonal Reactivity Index [IRI; Davis, 1983] and the Caring Attributes Questionnaire [CAQ; Arthur et al., 2001]) used in this study were designed to measure empathy as a personal characteristic. To evaluate the success of this intervention in developing a sense of dialogic empathy among participants in the experimental group as compared to the control group, assessments specifically designed to measure empathy as a dialogic process were also needed. Therefore, qualitative assessments (Ideal Nurse question and What is Empathy? task) were designed to invoke narrative, potentially dialogic, responses about how these nursing student participants think about empathy in nursing.

In this chapter, I describe the coding systems applied to assess dialogic empathy (including specific examples of these narrative assessments) and then evaluate the efficacy of the intervention using the coded data. The level of dialogism in the responses to the Ideal

Nurse question was the primary qualitative outcome. The thematic analysis results of the What is Empathy? task was the secondary qualitative outcome. Although results indicated that dialogism increased from pretest for posttest for participants in both conditions of the study on the Ideal Nurse question, a thematic analysis of the data from the What is Empathy? task suggested findings in the hypothesized direction (i.e., more participants in the experimental condition described empathy as a process than participants in the control condition).

***"What is Your Idea of an Ideal Nurse?"***

Participants were asked to write a response to the question, "What is your idea of an ideal nurse?" at pretest and posttest as an assessment of dialogic empathy. This task was chosen rather than What is Empathy? task so that the participants would not know of my particular interest in empathy, thus potentially skewing their responses on the related quantitative measures. Open-ended tasks like "What is your idea of an ideal nurse?" have been used in other studies of nursing students to evaluate their attitudes toward nursing (e.g., "What is your definition of nursing?" Cook, Gilmer, & Bess, 2003; "What does nursing mean to you?" Kersten et al., 1991; "A good nurse is one who ..." Smith & Godfrey, 2002).

As with the narrative reflections, two coding systems, based on different units of analysis, were developed to code this text. This text was first coded using the essay as the unit of analysis. Then it was coded using the sentence as the unit of analysis. As described in Chapter 3, use of different units of analysis is most likely to capture varying degrees of evidence of dialogism. All of the examples presented below were transcribed exactly as written by the participants.

### *Holistic Coding of Dialogism*

The first method for dialogic coding of the responses to the Ideal Nurse question was holistic using the participant's complete definition as the unit of analysis. The sentence-by-sentence content coding, though informed by dialogic theory, potentially diluted evidence of dialogism by summing across the more and less dialogical responses. Therefore, each response was evaluated for level of dialogism overall. During the course of coding, three piles of responses were generated. Each pile was shuffled and then read through again; responses were reassigned to different piles, as necessary. This process was repeated two more times, at which time, each pile was read through once without reassigning any of the responses to a different pile.

The pile of "least dialogic" responses included only descriptions of caring traits and/or abilities. For example: "An ideal nurse must have the following qualities: dedication, compassion, empathy, and willingness. These qualities must not only be present towards the patients, but also your coworkers. Knowledge and efficiency is also important." The focus of this essay on qualities (e.g., dedication, compassion, empathy, willingness, knowledge, efficiency) is more consistent with empathy as a personal characteristic model than with empathy as a dialogic process model.

The "less dialogic" pile included responses that mentioned patient needs (e.g., make them comfortable), but did not give the clients a voice in their care. For example: "Someone who puts the patient care first at all times. A good nurse shows understanding and gives respect to their patient. Ideal nurses make the sick feel comfortable and ultimately better." Such responses show "caring for" (action toward the client), but not "empathizing with" (appreciation of the client's perspective) and, therefore, is not dialogic.

The "dialogic" pile included responses that highlighted hearing the client, responding to their needs and/or seeing the other as self. For example: "An ideal nurse is a person who is willing to help others by putting their needs before his or her own needs. Be patient and willing to listen to the patient. Address the problems of the client within a reasonable time frame and communicate the progress of your actions with the client. An ideal nurse never forget that he or she could be a patient themselves." This example is considered "dialogic" because the last line regarding the nurse as patient shows an appreciation of the client's perspective.

### *Sentence-by-Sentence Coding of Dialogism*

The second method of coding used the sentence as the unit of analysis. Each sentence was coded for level of dialogism (least dialogic, less dialogic, dialogic). Specific terms from the pilot study for each of these categories are included in the codebook (Appendix Q). Coding was conducted without knowledge of condition (experimental or control) or time (pre or post) to reduce the likelihood of coder-bias in the expected directions. The following illustrative examples all come from the posttest response of one 20-year old Caucasian, American, female participant.

Sentences that focused on the nursing student's qualities (e.g., great listener) only were coded as "least dialogic" because such sentences do not show an appreciation of interactiveness and the influence of context; for example, "An ideal nurse would be someone who is kind, thoughtful, helpful and someone who doesn't act as though they don't care."

Sentences that focused on the nursing student's personal characteristics (trait, skill, motivation) in actions towards other were coded as "less dialogic" because such sentences

indicate the value of the interaction in ideal nursing practice (e.g., "Who will look out for you and your health."), but did not explicitly mention the client's needs.

Sentences that focused on the client's experience (e.g., with the client) were coded as "dialogic" because these sentences indicate appreciation of the interaction between the nursing student and the client's needs (e.g., "Someone who will help you when you need").

***Results of the Qualitative Primary Outcome: Ideal Nurse = Action or Interaction?***

Among the many benefits of using an experimental design that includes a pretest and posttest of participants in an experimental condition and a control condition is that one is more empowered to conclude that a difference in the scores between groups on the pre and posttest outcomes is related to the intervention and not to the experience of being in the study itself. My question was: Did the intervention increase the likelihood of participants in the experimental group describing an ideal nurse as one who perceives dialogism in nurse-client interactions?

***Hypothesis:*** Participants in the experimental condition were expected to have more change in the level of dialogism, in response to the "What is your idea of an ideal nurse?" question, than the participants in the control condition.

I found that the intervention (i.e., writing three narrative reflections) did not increase the likelihood that participants in the experimental group would describe an ideal nurse as one who perceives dialogism in nurse-client interactions. An analysis of the proportion of "dialogic" sentences in response to the Ideal Nurse question indicated that there was significant change in proportion of dialogic sentences over time for both groups. This finding suggests that during the course of the semester, participants (regardless of study condition) came to see nursing more as an experience than as a skill.

*Tests Using Holistic Coding of Dialogism as Outcome.* First, I looked at the holistic assessments of dialogism for the responses to the Ideal Nurse question at pretest and posttest (see Table 5). Because these assessments are categorical, not quantitative, I ran cross tabulations to see if there were differences in the change scores (i.e., the value when the pretest score is subtracted from the posttest score) of the control group and experimental groups. This analysis was not significant ( $\chi^2 = 4.87, p = 0.18$ ) and underpowered (7 cells [87.5%] had an expected count of less than 5 [75%]).

Perhaps there was not enough room for variability in the responses to the Ideal Nurse question within this three-level holistic coding of dialogism. Therefore, I coded them sentence-by-sentence as well. I recommend coding for both units of analysis in future studies as well, because these different coding systems were designed to capture different elements of dialogism.

*Tests Using Sentence-by-Sentence Coding of Dialogism as Outcome.* To make these categorical values more representative of their quantitative intention (and, thus, conducting the least conservative analysis option with this small dataset), the values were weighted (1 = 1, 2 = 4, 3 = 9). These weighted, sentence-by-sentence, dialogic values were combined to produce a dialogism total for one response; the dialogism total was then divided by the number of sentences for the pretest and the posttest data (for a list of means by study condition, see Table 6). A repeated measures analysis of these outcomes (independent variable = time, dependent variable = dialogism total/number of sentences in the Ideal Nurse responses) also proved to be not significant.

Although that analysis controlled for number of sentences, there was concern that dialogism=3s were diluted in the summing process. For example, a response with three

sentences coded as 2 would have a score of 4 (i.e., 3 sentences [dialogic code = 2 at sentence level \* 2 for weighting] = 12/3 sentences). A response with 2 sentences coded as 3 and 3 sentences coded as 1 would have a score of 4 (i.e., 2 sentences [dialogic code = 3 at sentence level \* 3 for weighting] + 3 sentence [dialogic code = 1 at sentence level \* 1 for weighting]) = 21/5 sentences). Consequently, I conducted an additional repeated measures analysis of these data using the proportion of sentences coded 3 over the total number of sentences as the dependent variable; this analysis was significant for time (Wilks Lambda  $F(1,22) = 4.14, p = .05$ ), but not for group. The results of these repeated measures analyses can be found in Table 7.

Importantly, these various measures of dialogism were significantly intercorrelated with the sentence-by-sentence measure of dialogism. For example, the pretest and posttest holistic assessments were moderately correlated ( $R = .42, p = .04$ ) as well, but the pretest and posttest sentence-by-sentence variables ( $R = .27, p = .21$ ) and the pretest and posttest proportion of sentences coded 3 over the total number of sentences variables ( $R = .22, p = .31$ ) were not significantly correlated (see Table 8).

***Exploratory Analysis of Other Ideal Nurse Characteristics.*** Based on a thematic analysis, the responses also were content-coded (1 point per mention of theme per sentence) for types of Caring Characteristics, such as Cognitive (e.g., listen, patience) or Affective (e.g., caring); Professional Skills and Attitudes included Professional Competence (Self-focused, including common sense, organized; Other-focused, including needs of the patient); and Attitudes toward Nursing (Likes it, including enjoys the profession; Committed to it, including be willing to help people). See the codebook (Appendix Q) for additional

examples of these categories. Exploratory analyses of these variables did not reveal any significant differences between groups across time (see Table 9).

***Results of the Qualitative Secondary Outcome: Thematic Analysis of What is Empathy? Task***

The other narrative assessment used in this study was the five-question What is Empathy? Task measured at posttest only. With study condition known to the coder, the responses to these five questions were analyzed thematically as informed by the dialogical foundation.

***Hypothesis:*** Participants in the experimental condition would have significantly more dialogically-oriented responses to the What is Empathy? task than would the participants in the control condition.

I created separate lists of the responses to the definition of empathy, consider self to be empathic, and qualities of empathy – one of control condition responses, one of experimental condition responses – for qualitative comparison. Then I cut up the lists (condition preserved) and shuffled through the responses in different orders to see if there were particular themes that defined the different conditions for each of these questions. Of these five questions, the responses to the first two questions suggested some difference, albeit small and not significant, between conditions (combined interrater reliability for two coders on the responses to these questions was 83%). The responses to the other questions provided thematic data for consideration in future research on empathy, as described by nursing students. The examples of data that are included below are presented exactly as written by the participants.

In response to the first question, "What is empathy?," I realized that the responses could be separated into groups of a) empathy as an *experience* (typified by the use of "when," such as "Empathy is when...") versus b) empathy as *what a nurse does* (typified by the use of "show" or other actions). Within the control condition, 1/11, or 9%, described empathy as an experience, whereas 6/18, or 33%, of the experimental condition did so. This is not a statistically significant difference ( $\chi^2(1) = 2.19, p = .14$ ).

From the experimental group, an example of empathy-as-experience response is "Empathy is when you can relate to another person's situation but not necessarily feel sorry for them." The only example of an empathy-as-experience response from the control group is: "Empathy is when you relate to what the person is feeling." The remaining responses for the definition of empathy from each group; that is, what a nurse *does*, could be described as: empathy-as-action, empathy-as-cognition, empathy-as-feeling, empathy-as-ability. Coincidentally, responses from both groups were distributed consistently across the different types of empathic actions.<sup>1</sup> Discourse Theory suggests that we should attend to how nursing action is represented: here we see that writing narrative reflections three times across the semester increased posttest representation of the experience of nursing care within some participants in the experimental condition, as predicted. See Table 10 for examples and percentages of these responses to the What is Empathy? task by study condition.

The second question on the What is Empathy? task at posttest was "Do you consider yourself to be empathic? If so, why?" Despite the arguably trait-oriented style of this particular prompt, some participants wrote intention-based (e.g., try, willing, would like to)

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<sup>1</sup> Prior to dividing the data into groups by condition, I coded the essays for each participant for dialogism level of cognitive qualities, dialogism level of affective qualities, and context or skill/trait based as described in Chapter 3. Then I tried to identify which ones were written by participants in the

rather than trait-based (e.g., good listener, caring) responses. Within the control group, 4/11, or 36% explained that they considered themselves to be empathic, in part, due to their empathic intentions whereas 8/17 (1 participant skipped this question), or 47%, of the experimental group did so. This is not a statistically significant difference ( $\chi^2(1) = .31, p = .58$ ). From the experimental group, an example of empathic intentions is "Sometimes I tend to relate myself to other people and try to help out when I can."

The third and fourth questions on the What is Empathy? posttest assessment asked participants to describe interactions in which they had received or given empathy and then to list the qualities of empathy therein. All of the experimental condition participants provided data for this question; however, only 8/11 of the control condition participants provided data for this question. Six qualities were found across the control and experimental condition data (note: some participants listed more than one quality): listening, caring or support, sharing, helping (included commitment to client), and give patient self belief/worth.

The last question on the What is Empathy? task was "Is being empathic an important part of being a nurse? If so, why?" Upon reviewing these data within and across condition, I realized that there were similar themes that could be matched across group. This is unfortunate from an experimental standpoint (i.e., the intervention appears to have not differentially affected the responses between conditions), but interesting from a theoretical standpoint. It was generally agreed that empathy IS an important part of being a nurse. Why it is important is described by the following themes: empathy is treating patients as human beings; empathy fosters trust; empathy is innate; empathy makes clients feel better; if a nurse can't understand another's perspective, how can s/he help?; put oneself in another's position;

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experimental group versus participants in the control group based on the profiles of scores of these three dimensions. Only 50% of the essays were assigned to the correct condition.

and empathic qualities are mandatory (each theme was represented by 1 to 4 participants in each group). This suggests that these nursing student participants, in general, appreciate the value of empathy in nursing work; therefore, they may be receptive to learning about a new model of empathy to apply to their work at the beginning of their nursing education experience.

### *Chapter Summary*

The process of developing a model of dialogic empathy required designing an intervention to invoke dialogic empathy and identifying theoretically appropriate assessments to measure its impact. The Ideal Nurse question at pretest and posttest and the five-question What is Empathy? task at posttest only were the narrative assessments used to evaluate the outcome of interest (i.e., level of dialogic empathy) in the experimental and control conditions.

Specifically, my hypothesis that there would be more change in the primary qualitative outcome (i.e., change scores on the level of dialogism in response to the Ideal Nurse question) in the responses from participants in the experimental condition than from participants in the control condition was not supported. Therefore, the intervention had no apparent effect on participants' descriptions of an ideal nurse. However, the level of dialogism significantly increased from pretest to posttest for participants in both conditions of the study, suggesting a historical effect for the experience of being a first semester clinical nursing student.

I also hypothesized that participants in the experimental condition would have significantly more dialogically-oriented responses (i.e., the secondary qualitative outcome) to the What is Empathy? task (measured at posttest only) than the control condition. Although

this hypothesis was not supported, possibly due to lack of power, the descriptive data indicated a trend in the hypothesized direction. For example, more participants in the experimental condition than the control condition provided intention-based (e.g., I try...) responses to a trait-oriented prompt (i.e., "Do you consider yourself to be empathic?"). In general, participants indicated an appreciation of empathy as an important part of their practice, suggesting that they may be receptive to curriculum activities (e.g., reflective writing) that have the potential to enhance their experience of empathy in nurse-client interactions.

Although these narrative methods did not yield significant findings, it may be because of limitations of the design (i.e., small dataset, missing data at follow-up, no pretest measure of empathy, and conceptual distance between intervention and Ideal Nurse question), rather than their validity. These limitations can be addressed in the designs of future studies.

**CHAPTER 5**  
**SURVEY ASSESSMENTS OF THE EFFICACY OF LEARNING EMPATHY AS A**  
**DIALOGIC PROCESS**

*Chapter Overview*

As noted in the introduction to this dissertation, empathy is typically perceived as a personal characteristic, not as a dialogical experience, as I am proposing for the context of nursing education. To examine how participants in the intervention condition may have been changed by their experience of writing from the other's perspective, and, thus, the robustness of the definition of dialogic empathy I am proposing and examining in this dissertation, I included measures of empathy as a personal characteristic at two time points (i.e., pre and post intervention). The use of both surveys and narrative methods presented an opportunity to make an important comparative analysis of dialogism across methods and models in the development of this theory of dialogic empathy. Therefore, although the surveys could not demonstrate the interactive element of dialogism described during the analysis of the narrative reflections in Chapter 3, expectably, some survey items on these measures of interpersonal attitudes (i.e., empathy, caring) were dialogic; that is, included an appreciation of another's perspective. First, I reviewed all of the scale items to identify those that had face validity as dialogic, and then I designated the subscale as dialogic or nondialogic for subsequent analysis.

I expected that participants in the experimental condition would have more positive change in their endorsement of dialogic-type subscales from pretest to posttest than those in the control condition, thus, indicating a change in their perception of empathy as either a personal characteristic or as a dialogic process. To test this prediction, repeated quantitative

assessments of empathy as a personal characteristic (i.e., the Interpersonal Reactivity Index [IRI], the Caring Attributes Questionnaire [CAQ]) were evaluated for change over time between conditions.

I found that the participants in the experimental condition had significantly more positive change on the dialogic-type survey subscales (i.e., the Perspective-Taking subscale of the IRI and the Caring Communication subscale of the CAQ, the quantitative primary outcomes in this study) than the control condition and had no significant change on the non-dialogic survey subscales. As these dialogic-type items appear to tap into more of the other-focused quality of dialogism, rather than the dynamic nature of nurse-client interactions (i.e., narrative description of the interaction and student awareness of one's psychological states during the interaction), this finding could be the result of the Client's Perspective Only section of the interaction assignment. A study design that includes an intervention assignment without that preparatory step would be required to test that hypothesis effectively.

***Results: Is it Dialogic Empathy Stable across Scale-Based and Narrative Measures?***

***Hypothesis:*** Participants in the experimental condition would have more positive change on the dialogic-type subscales than the participants in the control condition.

The items of the quantitative measures (Interpersonal Reactivity Index [IRI]; Caring Attributes Questionnaire [CAQ]) were evaluated using the same three-level system as the Ideal Nurse responses (i.e., "person-centered" = least dialogic, "caring for" = less dialogic, "empathic with" = dialogic; see Chapter 4 and the codebook in Appendix Q). Through this process I identified one subscale in each scale that was dialogic. These dialogic-type subscales may have existed in these measures of empathy as a personal characteristic because

empathy, by definition, involves another individual (i.e., one is not considered empathic towards oneself). The application of the dialogic lens (in both theory and method) contributes the focus on anticipating/appreciating the perspective of the other as is done in the Perspective-Taking subscale of the IRI and the Caring Communication subscale of the CAQ. Percentages of items of each subscale for each dialogic level are included in Table 11 for the IRI and Table 12 for the CAQ.

*Interpersonal Reactivity Index (IRI; Davis, 1983).*<sup>2</sup> See Table 6 for means for each of these subscales, by condition. In this study, alphas ranged between .62 and .67 at pretest and between .45 and .69 at posttest; these alphas are a bit lower than those reported in other studies (e.g., Davis, 1983), but they are within an acceptable range for subsequent analysis. As expected, the pretest and posttest scores of each subscale were highly correlated (.61 to .78,  $ps < .05$ ; see Table 13).

Within the four subscales of the 28-item IRI, the Perspective-Taking subscale was the dialogic subscale (see Table 11 of qualitative coding of the subscales), because all of the items showed sensitivity to the other's perspective. A repeated measures analysis of this primary outcome (independent variable = time by group, dependent variable = Perspective-Taking subscale of the IRI) indicated a time-by-group interaction was significant (Wilks' Lambda  $F(1,23) = 4.27, p = .05$ ; see Table 14). There was significantly more change in the Perspective-Taking subscale score within the experimental condition ( $M = 1.31, SD = 3.61$ )

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<sup>2</sup> Two rules were used to handle missing data: Rule 1 -- Where more than 25% of the scale items were missing for the participant, then the entire scale was considered missing for the subject. From the pretest data for the IRI and CAQ, five participants of the 44 (11%) were dropped using these criteria. From the posttest data for the IRI and CAQ, 14 participants of the 44 (32%) were dropped using these criteria. Rule 2 -- Where less than 25% of the data was missing for a participant (i.e., less than 6

than in the control condition ( $M = -1.89$ ,  $SD = 3.52$ ). The intervention was not expected to have any effect on the Fantasy, Empathic Concern, or Personal Distress subscales. As expected, separate repeated measures analyses (independent variable = time by group, dependent variable = subscale of the IRI) of these subscales were not significant. Of note, there was a trend for time for the Empathic Concern subscale ( $p = .07$ ); a review of means showed that the means for the control condition remained the same ( $M = 22.5$ ), whereas the mean for the experimental condition was the same as the control condition at pretest ( $M = 22.4$ ), but it then decreased at posttest ( $M = 20.5$ ). Advocates of the traditional model of empathy as a personal characteristic may argue that participants in the experimental condition decreased in their tendency to be empathic during the semester in which they wrote nursing narratives, but I think this finding supports my objective to decrease their focus on perceiving themselves as empathic and increase their perception of empathy as a dialogic process.

*Caring Attributes Questionnaire (CAQ; Arthur et al., 2001)*. See Table 6 for means for each of these subscales, by condition. In the present study, alphas ranged from .57 to .67 at pretest, with the exception of Caring Involvement, which was .28. Dropping 3 items of this 8-item subscale improved the alpha to only .45, so the scale was not used in subsequent analyses. At posttest, the alphas ranged from .63 to .85. Published alphas for these subscales range from .72 and .89 (Arthur et al., 2001); therefore, the subscales retained for analysis have alphas within an acceptable range. The pretests and posttests of each subscale were moderately to highly correlated (.51 to .59,  $ps < .05$ ; see Table 15). Within the three remaining subscales of the 31-item CAQ, the Caring Communication subscale appeared

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missing of the 28 items on the IRI and less than 7 missing of the 31 items on the

to be the dialogic-type subscale (see Table 12 for qualitative codings of the subscales), because the majority of items were about caring for or empathizing with the client. A repeated measures analysis of this primary outcome (independent variable = time by group, dependent variable = Caring Communication subscale of the CAQ) was significant (Wilks' Lambda  $F(1,24) = 6.66, p = .02$ ; see Table 16). There was significantly more change in the Caring Communication subscale score within the experimental condition ( $M = 0.15, SD = 0.24$ ) than in the control condition ( $M = -0.12, SD = 0.28$ ).

The intervention was not expected to have any effect on the Caring Advocacy or Learning to Care subscales. Separate repeated measures analyses (independent variable = time by group, dependent variable = subscale of the CAQ) of these subscales indicated that, as expected, Learning to Care was not affected. Unexpectedly, however, Caring Advocacy was significantly different between conditions from pretest to posttest (Wilks' Lambda  $F(1,24) = 4.94, p = .04$ ; see Table 16). This finding is discussed in detail in the next chapter. The change scores (posttest minus pretest scores) for variables from the IRI and the CAQ that were significant for time-by-group differences were not intercorrelated (see Table 17).

### ***Chapter Summary***

As discussed in Chapter 1, I expected that nursing student participants would be a fairly empathic group at pretest because they were drawn to the vocation of nursing (Kersten et al., 1991; Rognstad, 2002) and nursing is a helping profession; empathy is the core of helping (Carkhuff, 1969; Rogers, 1957). Their scores on the Empathic Concern subscale reflected that, and there was no significant change on this subscale across time or between conditions.

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CAQ), mean substitution was employed.

The next question was: Could nursing students learn to perceive empathy as a dialogic process through narrative nursing exercises (i.e., the narrative reflections)? I hypothesized that the participants in the experimental condition would show more change between pretest and posttest on only the primary outcomes, dialogic-type subscales of the quantitative assessments of empathy as a personal characteristic (i.e., the Perspective-Taking subscale of the Interpersonal Reactivity Index; the Caring Communication subscale of the Caring Attributes Questionnaire), than those in the control condition. This hypothesis was supported; these time-by-group interactions were significant.

**CHAPTER 6**  
**REFLECTIONS ON A STUDY DESIGNED TO DEVELOP**  
**DIALOGIC EMPATHY THROUGH REFLECTION**

*Reflection on Study Rationale*

The primary goal of this dissertation was to change students' perception of empathy from empathy as a personal characteristic to empathy as a dialogic process to improve communication within nurse-client interactions and potentially enhance care and job satisfaction among nurses, leading to increased retention of nurses in the profession. This required the development of a theory of dialogic empathy in nursing education through comparing and contrasting the models and methods of the traditional model of empathy (survey method) with the proposed model of empathy (narrative method). The topic of empathy was selected for this study because without empathy there is limited nurse-client trust, which may compromise the assessment and subsequent care of the client (Reynolds & Scott, 2000).

Theory, research, education, and practice discuss and analyze empathy as a personal characteristic of the nurse (e.g., trait or skill). However, I hypothesized that the concept of empathy could be broadened from this characteristic-based model to an experiential one. Bahktin's dialogic theory was selected to study empathy because empathy is expected of nurses and clinical interactions would benefit from an appreciation of the reciprocity between social expectations/anticipations and personal behaviors/attitudes associated with dialogism (Wertsch, 1991). The nursing education setting was selected because of the compatibility of the clinical context with the dialogic framework. Teaching dialogic empathy within the existing curriculum appears more parsimonious and productive than adding multiple weeks

of empathy training to a course (Wikström, 2001) or post-education training programs (Reynolds, Scott, & Austin, 2000).

Consideration of Discourse Theory presented ideas for how structured narrative reflection exercises could provide an opportunity for students to think about their clinical interactions dialogically and to develop that orientation increasingly. The intervention was intended to assess individual nurses' development of humanistic skills in terms of the theory. Therefore, the selected intervention was a self-reflective exercise designed to enhance nursing students' awareness of the perspective of others, including recognition of the empathic reciprocity that may occur in clinical interactions.

### ***Chapter Overview***

In the introduction, I proposed that dialogic empathy is a dynamic process that includes interactivity, awareness of one's own psychological states, and anticipation of another's psychological states. The nursing narratives (i.e., the narrative reflections) enhanced and extended this operationalization of dialogic empathy to include the value of context (e.g., more vulnerable populations invoke more dialogic empathy than less vulnerable populations). Then I compared the new dialogic model of empathy with the traditional personal characteristic model of empathy using surveys and narrative assessments. In general, these multiple methods yielded similar findings. I conclude with a discussion of the limitations of the study and implications for future work.

### ***Reflecting (versus Recording) Nurse's Work***

***Traditional: The Nursing Process.*** In this dissertation, I proposed that empathy can be a dynamic process involving an appreciation of the perspective of the other and contextual elements. In contrast, current nursing practice requires the description of nurse-

client interactions as laboratory reports of sorts; the Nursing Process includes an assessment of needs and symptoms, diagnosis of those symptoms, planning an intervention (i.e., setting goals and prioritizing them), implementation of the plan, then an evaluation of whether or not the goals were met (Gardner, 2003). Learning the scientific reporting style of the Nursing Process is an important part of students' professional development in nursing. However, in addition to conducting assessments and evaluations (what a nurse DOES), there are humanistic elements of nursing (Boykin & Schoenbofer, 1993), such as caring and empathy. Nursing students, even the empathic students in this study, require professional development to acquire clinical expertise.

***Proposed: Nurses' Processing.*** Empathy begins with self awareness (Arnold & Boggs, 1989). Discourse Theory (i.e., understanding of oneself improves through dialogue) contributed the method for an intervention to guide students towards a perception of empathy as a dialogical experience: narrative reflections. This theory suggested that narrative reflection exercises would provide the best forum for students to "[come] to know nursing as a dialogical process – direct engagement with the 'word of nursing'" (Boykin & Schoenbofer, 1993, p. 92) as they built their vocabulary of the social language of nursing ("addressivity," according to the dialogic framework). If this method was effective, these students would not be "trained to overlook their caring ways," and maybe they wouldn't "need ... 'sensitivity training'" (Boykin & Schoenbofer, 1993, p. 45-46) in the future. Nursing educators have suggested, but not tested, this potential link between writing and enhanced empathy among their students (Bradley-Springer, 1993; Patton et al., 1997; Pinkstaff, 1985).

***The Intervention: "Pathography".*** Spiro (1993) provides an analogy for learning empathy:

Just as artists learn to see by drawing, so doctors [and nurses] can learn empathy by putting themselves in their patients' place. That does not mean suffering through the tubes or tests; it means trying to feel the story as the patient feels it. 'Pathography,' the stories of illness from the inside, help nourish empathy. (p. 5).

I proposed that a structured narrative reflection exercise that included sensitivity to the attitudes and attributions, as well as the behaviors, of both actors in the nurse-client interaction would help students to perceive empathy as a dialogical process. Therefore, in 1 to 2 double-spaced typed pages, the participants were required to write one essay from the Client's Perspective Only and one essay from Both Perspectives, the client's and their own. The intention of the Client's Perspective Only essay was to focus the student on the client's perspective before s/he participated in the exercise of thinking about the interaction from Both Perspectives (the dialogic-based intervention). The same variables were coded for each of these variables. Paired t-tests of the number of sentences with the speaker-as-student and the speaker-as-client indicated that there were significantly more sentences written with the speaker as the client in the Client's Perspective Only. Therefore, as expected, responses were significantly different to each of these perspective-based prompts.

My hypothesis was that the narrative reflection essays (written by the experimental group only) would become more dialogic over time. That is, I predicted that the level of dialogism would be higher in the third essays (about the long term care context) than in the second essays (about the senior citizen center context) and in the first essays (about child care center context; i.e., a linear relationship). That would have provided evidence that participants' perception of empathy as a dialogic process increased with experience with the assignment over time. For the Client's Perspective Only essays, there was a significant

difference over time, but it was a quadratic, not a linear relationship; for the Both Perspectives essays, a trend towards significance was also found for a quadratic relationship. Rather than indicating that levels of dialogism increased with experience at composing narrative reflections, participants wrote essays with higher levels of dialogism in the essays for the first context (child care center) and for the third context (long term care facility) than for the second context (senior citizen center). This may have occurred because the essays written about the child care center and long term care facility contexts predominantly included descriptions of interacting with more vulnerable clients who required help (with using scissors [children] and with bathing [long term care facility residents]). In contrast, the senior citizen center clients were capable of handling their own needs. These findings suggest the importance of context effects (a very important part of the dialogic foundation), although not definitively, because the variable is confounded by time.

Was this relationship related to socio-cultural similarity between the students and the clients (e.g., on the dimensions of race and/or gender)? The findings of this study suggest that it wasn't. Gender was significantly associated with higher dialogism for the Client's Perspective Only essays about the child care center context, but there was a trend in the opposite direction for the same version of the essays about the senior citizen center context. Similarly, there was also, unexpectedly, more dialogism when one had two differences versus one difference for the essays written in both the child care and the senior citizen center contexts. Notably, these essays were all about interactions with healthy individuals.

In addition, the relationship found for dialogism by sentence (high in child care and long term care essays, but low in senior citizen essays) was also found for the number of words used to describe the client's emotion, but not for the number of words used to describe

the student's emotion. Therefore, the students' self representations were relatively consistent across context, but their reports of others' emotions were not. As the intervention guidelines were the same in all conditions (only the setting itself was manipulated), this is further evidence of the influence of context on the students' dialogic representations of their interactions.

These narrative descriptions provided preliminary evidence of the dialogical nature of nurse-client interactions, as proposed by the theory. The next question was: Did the experience of writing these essays affect the students' conceptualizations of empathy (e.g., as a personal characteristic versus as a dialogic experience)? To test that question adequately, it was necessary to include a control condition and pre/post assessments of these two disparate models of empathy.

#### *Evaluating Different Models of Empathy with the Same Methods of Inquiry*

Interestingly, the data from the surveys and from the narrative analyses indicated similar trends. These nursing students are empathic (as a personal characteristic), according to their scores on the Empathic Concern subscale of the Interpersonal Reactivity Index, as well as according to their qualitative responses to the What is Empathy? task. In addition, the participants in the experimental condition differentially endorsed (on the IRI and the CAQ) the dialogic-type subscales and described empathy (on the What is Empathy? task) more dialogically than did the participants in the control condition.

*Traditional: Empathy is a Personal Characteristic.* Although I have theorized empathy as a dialogic process in this dissertation, empathy is typically considered a personal characteristic, like a trait (MacKay et al., 1990). Even the nursing textbook definition of empathy includes specific traits: "empathic understanding requires the nurse to be both

sensitive and imaginative" (Potter & Perry, 2001, p. 459-460). In fact, it is to be expected that empathic individuals would be drawn to the vocation of nursing because the more dispositional empathy one has, the more likely one is to seek out opportunities to be helpful (Smith, 1992). This appears to be true within this sample as well as in other nursing student samples (e.g., Beddoe & Murphy, 2004). At pretest, the participants in both groups of this study were similarly high on the traditional measure of dispositional empathy, the Empathic Concern subscale of the IRI (average score of 22 out a possible score of 28; this is similar to the mean score of a sample of female undergraduates, Davis, 1980). At posttest, there was no significant difference for study condition, although, the trend for time [.07] is likely, because the mean for the experimental condition decreased to 20, (suggesting that these participants identified less with a trait-based model of empathy over time), while the mean for the control condition stayed the same.

In this study, there was also a posttest only narrative assessment of self-identification as "empathic." The answers to this question (i.e., "Do you consider yourself to be empathic?") was a resounding "yes;" however, a higher percentage (albeit not significant) of participants within the experimental condition (44%) explained that they considered themselves to be empathic, in part, due to their empathic intentions (suggesting the privileging of context over trait, i.e., dialogism!) versus the control condition (36%). This finding is in the hypothesized direction even though it was not statistically significant. Considering that the prompt itself was biased toward a trait-based response, this difference has theoretical relevance.

In the introduction, I expressed concern that nursing students would be less likely to attend to training in a skill that they think that they already have. That concern was

unfounded in this sample. It appears that these nursing students consider themselves to be empathic, but they still appreciate how they can demonstrate empathy as a skill to their clients in clinical care situations. In fact, when the participants were asked to define empathy at the end of the semester, the majority of participants from both study conditions defined empathy as what a nurse *does*; the students' textbook also defines empathy as an ability (Potter & Perry, 2001, p. 459-460). Defining empathy as what a nurse *does* included the following categories, which I created based on a careful review of the narrative data: empathy as action, empathy as cognition, empathy as feeling, and empathy as ability. The use of these definitions was equally distributed across the experimental condition (3/18 or 17% for each one); these definitions were also equally distributed across the control condition (3/11 or 27%), except for empathy as ability (1/11 or 9%). These students, regardless of study condition, learned that empathy is a skill, a personal characteristic.

In this study participants focused on what a nurse does rather than what qualities she has. This is in contrast to previous work in which beginning students have defined empathy-related characteristics as being a quality rather than a skill (Burnard, 1998). It is possible that this difference is related to the advanced status of the students. By the time these students responded to the What is Empathy? task, they already had completed one semester of clinical nursing experience.

***Proposed: Empathy is a Dialogic Experience.*** "Empathy is when you can relate to another person's situation but not necessarily feel sorry for them" (an example of empathy-as-experience from a participant in the experimental condition). I have argued that nurses and clients would benefit from training on how to experience empathy dialogically, because anticipating and understanding each other would enhance their interactions emotionally (both

feel valued) and instrumentally (appropriate client care). For example, a nurse conducting an assessment could most effectively evoke the information that s/he requires to provide nursing care to the client through the process of dialogic empathy, but was it possible to invoke dialogic empathy through narrative reflections?

I repeat this quotation from Chapter 1: "Nurses in practice, education, and administration continue to address nursing primarily in terms of 'what nurses do'" (Boykin & Schoenbofer, 1993, p. 96). As the discussion in the previous section shows, the majority of the participants define empathy in that way; however, 33% (6/18) of the experimental group, as compared to 9% (1/11) of the control group, used "when," suggesting a context-related, experiential-based conceptualization of empathy, rather than defining empathy as what a nurse *does* (typified by the use of "show" or other actions). In addition to being consistent with the a priori hypothesis about expected differences in level of dialogism in between-group responses, these findings are similar to a qualitative study on student definitions of nursing (i.e., 45% described nursing as a verb, 33% described nursing as a noun, 22% described nursing as a transaction; Cook et al., 2003).

Another narrative assessment method that I used to test this theory was the primary qualitative outcome, the pretest and posttest responses to the Ideal Nurse question. These responses provided contextually relevant data with which to develop the coding systems for dialogism. I operationalized dialogism based on Bahktin's framework (Wertsch, 1991), which suggests that the anticipation of the audience's perspective influences the speaker's presentation of ideas in dialogue. The two coding systems that I developed for dialogism differed in unit of analysis: One coding system used the response as the unit of analysis (i.e., holistic coding of dialogism). The other coding system used the sentence as the unit of

analysis; a dialogical total was created based on the sum of the dialogism value per sentence, which was then divided by the number of sentences in the essay (i.e., sentence-by-sentence coding of dialogism). Both of these coding systems distinguished a lower level of dialogism (e.g., focus on the self) and a higher level of dialogism (e.g., focus on the perspective of other) with an interim phase of the self attending to the other.

I expected more dialogism in the posttest narratives (in response to the "What is your idea of an ideal nurse?" question) written by the experimental condition than in those written by the control condition; this hypothesis was not supported. Statistical analyses of the qualitative coding of the responses to the Ideal Nurse question were not significant for the hypothesized time-by-group differences. Unexpectedly, the factor of time was significantly different, suggesting that the perception of an ideal nurse had become more dialogic for participants in both conditions over the course of the semester.

In addition to the limitations due to the small size of this data set, particularly at the posttest assessment, it may be that the "ideal nurse" concept was too distal to capture differences in personal philosophies about empathy in interpersonal situations. The What is Empathy? task would have provided a more proximal measure of the participants' thoughts about empathy for pretest and posttest comparison, but this was not done because I did not want to the participants to know that this study was testing different models of empathy. This could potentially be avoided if students were asked to define empathy as part of the curriculum, rather than when they were filling out the empathy-specific surveys. Lastly, the coded thematic content (Caring Characteristics, Professional Competence, Attitudes toward Nursing), though not different across time or group, was consistent with previous literature

regarding the values of nursing students (i.e., Personal Development and Altruism; Thorpe & Loo, 2003).

Although quantitative measures (i.e., Interpersonal Reactivity Index [IRI], Caring Attributes Questionnaire [CAQ]) were included to assess empathy as a personal characteristic, not as a dialogic experience, I evaluated these items for dialogic qualities as well, because they measure an interpersonal dimension. The sentence-by-sentence dialogic coding system was used to evaluate each item of the IRI and the CAQ scales. The subscales in which differences were expected between conditions from pretest to posttest were the Perspective-Taking subscale of the IRI and the Caring Communication subscale of the CAQ. As hypothesized, these time-by-group interactions were significant. Notably, scores on Perspective-Taking have been increased in previous studies, but such studies typically include a training intervention (e.g., Lane-Garon, 1998; 10-hour mediation training for elementary students by adult mediators), not independently written essays.

Also, based on this item-by-item dialogism evaluation, I did not expect the intervention to have any effect on Fantasy, Empathic Concern (conceptually similar to traits [i.e., "imaginative," "sensitive"] mentioned in the textbook definition; Potter & Perry, 2001, p. 459-460), or Personal Distress subscales of the IRI or the Caring Advocacy or Learning to Care subscales of the CAQ. Analyses showed that there were no differences between the groups on any of these subscales – except for the Caring Advocacy subscale.

Initially, this finding was surprising. The Caring Advocacy was not correlated with Perspective-Taking (i.e., one has to take on another's perspective to be a good advocate for them), not even when I analyzed the data for the experimental group only. A review of the dialogic coding of the items of this subscale indicated that 2/7 (or 28.6%) of its items were

scored as a 3 (Other's experience is highlighted), 2/7 (or 28.6%) of its items were scored as a 2 (Nurse's trait/skill in actions towards others without mention of the client's experience), 3/7 (or 42.9%) of its items were scored as a 1 (i.e., Trait/skill of a nurse; no other person is explicitly mentioned as receiving an action). In contrast, Personal Distress and Learning to Care were predominantly coded with 1s. Fantasy and Caring Advocacy had both 1s and 3s, but Caring Advocacy also had items coded with 2s.

Therefore, what appeared to distinguish the Caring Advocacy subscale from the other subscales was that it had items that equally represented the three different levels of dialogism. To best explain this time-by-group interaction, the mean score for the experimental condition would be higher than the mean score for the control condition on the Caring Advocacy subscale, because the experimental condition participants completed three narrative reflection exercises. In fact, the experimental condition had a higher mean on this subscale at posttest than at pretest, whereas the control condition had a lower mean at posttest than at pretest, confirming this post hoc hypothesis.

*Summary.* Survey and narrative assessments indicated that the nursing students in this study began the semester as similarly empathic (by character trait standards). By the end of the semester, however, the participants in the intervention group described empathy more as an experiential process than did those in the control group, and their essays showed significantly more change on subscales regarding perspective-taking and advocating for another (including both other- and self-focused items). This is consistent with the dialogical framework.

### *Limitations of this Study*

This feasibility study provided support for a theory of dialogic empathy and the intervention that was designed to invoke it; however, replication and expansion of this work is needed because there were several limitations. To begin, although the sample size was similar to other studies of this kind (e.g., Kersten et al., 1991), it was very small, which negatively impacts the ability to find differences between groups (i.e., increases potential for Type I error). In addition, there may have been self-selection bias, because only about 40 students out of 79 students agreed to participate; students may not have wanted to participate in a "Writing in Nursing" study because they do not like to write or, perhaps, the more empathic students were inclined to participate because they wanted to help me, the principal investigator of the study. Results indicated that, at pretest, the majority of the participants across the experimental and the control groups were relatively high on Empathic Concern, a subscale of the IRI associated with an empathic disposition. However, the participants did not significantly differ at posttest on that measure.

Instead, as hypothesized, participants in the two conditions differed on the only measure of empathy that was associated with dialogism, i.e., perspective-taking. This could have been due to cohort effects versus the intervention (i.e., perhaps there was more discussion about the client in one clinical section of the class than another), though this is unlikely, because there were four clinical groups for each of the two classes. This finding is also limited in that it seems more connected to appreciating the other's perspective (i.e., the Client's Perspective Only section of the interaction assignment that was included to help students focus on the client's perspective), rather than appreciating the dynamic nature of nurse-client interactions (i.e., the Both Perspectives section of narrative reflection exercise

which was designed to evoke dialogic empathy). It would be interesting to try to replicate the effect for the Perspective-Taking subscale using only the Both Perspectives section of the assignment as the intervention.

The participants in the two study conditions were also significantly different on two of the demographic variables that were assessed: Participants in the control group had graduated from high school more recently and more of them were currently working in the health care environment at pretest than the participants in the experimental group. I had no a priori hypotheses about these variables, but here are my post hoc ideas about these findings: Perhaps recent graduation or work in health care may have led control condition participants to be less likely to change their thinking about empathy as assessed by the primary outcomes (i.e., Ideal Nurse responses and dialogic-type subscales of the quantitative measures) than participants in the experimental condition through experience in the course itself. Perhaps significant change was found between the study conditions because less recent high school graduates (experimental condition) are more receptive to changing their thinking about empathy than more recent high school graduates (control condition); this could be because less recent high school graduates are more committed to their reclaimed opportunity for education. Not currently working in health care (experimental condition) may make it easier to incorporate new ways of thinking about empathy than currently working in health care (control condition), because they have had less practical experience with the traditional model in the health care setting.

Participation in the posttest was low. Although the first posttest data collection section was at an especially difficult time for the participants (i.e., their only break for lunch between two class sessions and the last day they could withdraw from the class without

academic penalty), there were subsequent opportunities to participate; however, the response rate remained low, particularly for the control condition (i.e., only 50% posttest participation). Those from the control condition who participated in the posttest did not significantly differ on any of the primary outcomes or on demographic characteristics from those who didn't participate. This indicates that nonresponse at posttest was not related to these measured factors but, unfortunately, it does not provide new information regarding the low response rate. At the time, I hypothesized that had they received the intervention, they might have been more inclined to participate! The 98% response rate by the experimental group does not provide concrete evidence for that hypothesis, but it is suggestive.

In replicating this study, it would be advisable to make the qualitative pretests and posttests part of the curriculum (i.e., What is your idea of an ideal nurse?), so that data are available from all participants who signed consent at the pretest session. In addition, future studies may include a more proximal measure of the topic of interest, empathy, at these different time-points, also as part of the curriculum, to reduce potential response-bias skew on the self-report surveys regarding empathy and caring. Another significant confound in this study was the time-by-context interaction in the intervention condition. In addition, the cultural diversity of this small sample (only 30% were born in America) made it impossible to make comparisons between cultural subgroups. Lastly, it is unknown if this intervention could be used in other nursing education programs. Below I propose a study design that will address these limitations of the current study, while preserving the original objective of changing students' thinking about empathy.

*Recruitment:* In the proposed study, the selection criteria for participation would be self-identification with one cultural group (e.g., West Indian) to a) increase the opportunity to

conduct subgroup analyses (e.g., length of time since immigration, country of origin) and b) limit the number of potential socio-relational patterns for analysis. All West Indian nursing students in the first clinical semester of several Nursing Departments located throughout New York City (to increase sample size and assess generalizability of the effects of the intervention) would be invited to participate in a longitudinal study of "Education in Nursing." A monetary incentive per assessment completed would be offered at recruitment in the hopes of increasing participation among students who are less empathic towards the experimenter (selection bias), and, subsequently, lead to an increase in the sample size.

*Study design:* This multiple site, longitudinal, experimental design would a) increase the potential sample size, b) allow for analysis between cohorts by site as well as within cohort analysis, c) permit within-participant comparison of data from students working with clients with various socio-relational characteristics in the same and different contexts at different time periods, and d) be another opportunity to test the efficacy of the intervention (i.e., through the inclusion of pretest and posttest assessments of experimental and control groups). The intervention (i.e., narrative reflection) would be completed for the child care center experience by all experimental group participants. Then the experimental group would be randomly divided into two conditions that determine the order in which they visit the context and write their nursing narratives to avoid the time-by-context confound that existed in the current study. Experimental condition A writes about the senior citizen center context first, then the long term care facility context. Experimental condition B writes about the long term care facility context first, then the senior citizen center context.

*Assessments:* The same pretest and posttest qualitative (Ideal Nurse question and What is Empathy? task) and quantitative assessments (Interpersonal Reactivity Index, Caring

Attributes Questionnaire) would be used in this proposed study, but the qualitative assessments would be part of the curriculum to decrease the students' association of the narrative assessments with the survey assessments and increase availability of posttest data of those who signed consent at pretest. The intervention assignment (i.e., the narrative reflection exercise) would remain the same.

*Within group hypotheses (experimental groups only):* The primary outcome for this proposed study is level of dialogism for the Client's Perspective Only and Both Perspectives essays. Expected context effects: Dialogic empathy is expected to be higher in the long term care facility context than in the senior citizen center context regardless of order of clinical experiences or semester. Expected client socio-cultural characteristic effects: Dialogic empathy is expected to be higher with clients who have similar socio-cultural characteristics to the nursing student. No time effects are expected: Based on the findings of the current study, I expect context to be more important than time. Expected interactions between client socio-cultural characteristics, context, and time: It may be that some students are uncomfortable with individuals who are of a different (possibly, specific) gender or race. That discomfort could interact with context (e.g., long term care facility versus child care center). The intervention assignment enables them to acknowledge and reflect upon the difficulties they have in these interactions (i.e., socio-cultural characteristics of client by context). That acknowledgement, with reflection over time (and repeated contact), could, possibly, positively influence their aptitude in giving future care to similar clients in those contexts. This longitudinal design would enable one to test that hypothesis.

*Between-group (experimental group and control group) hypotheses:* The primary outcome is level of dialogism for each qualitative assessment (see the codebook, Appendix

Q) and the dialogic-type subscales of the quantitative assessments (i.e., Perspective-Taking subscale, Caring Communication subscale, Caring Advocacy subscale). The hypotheses of the proposed study would be the same as those of the current study; that is, there would be more positive change in dialogism from pretest to posttest in the experimental group than in the control group. It is important to replicate the findings of the current study with a larger, more homogeneous sample from multiple sites to assess both internal and external validity of the narrative reflection intervention.

In closing, this proposed study design will test factors identified as limitations in the current study (e.g., cultural diversity within sample, small sample at pretest and posttest, confound of time and context in the intervention, and lack of known external validity) and continue to advance our understanding of the model of dialogic empathy and provide additional data on the effectiveness of this intervention in increasing students' awareness of dialogic empathy in their nurse-client interactions.

### *Implications of this Study*

The problem of not appreciating empathy as a dialogic experience in the nursing environment is important because we do not just need more nurses (in light of the nursing shortage), we also need trained nurses to continue working as nurses. Job satisfaction is low within this profession (O'Sullivan for the American Nurses Association, 2001). Empathic individuals are drawn to nursing, but they are not being reinforced by the nursing profession. As noted in O'Sullivan's testimony, dissatisfaction is related to the consequences of the nursing shortage (e.g., burnout), but, perhaps, a dialogic view of empathy, one that involves their own needs and interests, could enable them to feel more empowered in their roles and less vulnerable to burnout. These students became more sensitive to others' perspectives, but

not, it seems, at the cost of their own desires. Personal reflection has helped them to see from the other's perspective; perhaps, with guidance, nursing students could elicit reflection from their clients and potentially enhance their experiences of these illness-based interactions.

Furthermore, in conducting this study, I raised the awareness of the importance of the inclusion of empathy in existing nursing courses at the public technical college where I collected these data. For example, after three semesters of using this series of three reflective writing interventions, the course coordinator reported to me (Ellen McGuinn, personal communication, December 17, 2004):

I have continued to use your interactive reflections—in fact, today I copied my own clinical students' papers for some inclusion in *The Pulse* (department newsletter).

They continue to be insightful—some make me cry. So, I think what you started will have long term effects not just for your cohort but for subsequent classes to come. I feel that this early exposure and reflections will influence their later clinical experiences.

I have also suggested a parsimonious, nurse-education-based method of increasing students' awareness of empathy as a dialogical process. These ideas can be disseminated to other courses within the department and, eventually, disseminated to nursing education programs at other universities through publication and presentation for further evaluation and application. In addition, Professor McGuinn has recommended that I introduce this model to the other health science departments at the college (e.g., Dental Hygiene, Radiologic Technology, Vision Care Technology) through faculty workshops and/or guided assignments like the "Most Meaningful Interaction" essay used in this study (see Appendix P).

I developed this model of dialogic empathy to contribute to the theoretical and practical approaches to caring that exist in nursing education. Of the various theories of nursing as caring, this dissertation comes closest to the Boykin and Schoenhofer theory (1993). The premise of their Theory of Nursing as Caring (Boykin & Schoenhofer, 1993) is as follows:

Caring is the intentional and authentic presence of the nurse with another who is recognized as person living caring and growing in caring. Here, the nurse endeavors to come to know the other as caring person and seeks to understand how that person might be supported, sustained and strengthened in their unique process of living caring, and growing in caring. (p. 25)

Their theory has been critiqued for being potentially too philosophical for practical application (McCance et al., 1999). I hope that this study has indicated that a model that requires a collaboration in care is not only possible, but has the potential for increasing sensitivity to interactivity and others' perspectives in clinical care. Moreover, this is a model that has important implications for clinical training experiences in other related fields (e.g., dieticians, personal trainers); the future work of these health care workers may also be improved by theory-based reflections about interacting with clients in dialogically empathic ways.

#### *Additional Suggestions for Future Research*

*Dialogic Empathy in Education?* In this study, I used narratives of nurse-client interactions as the method of encouraging students to think about empathy as a dialogic process. Other methods that may be considered in subsequent work are journal-writing, learning about the humanities, and narrative research courses.

Journals provide the vicarious stage for acting as a caring person. This identification (as "I" in journal), versus reporting (as "me" in narrative) (Hermans & Hermans-Jansen, 1995), is likely to promote one's self-concept development. "Students, as well as faculty, are in a continual search to discover greater meaning of caring as uniquely expressed in nursing. Journaling is an approach that facilitates this search" (Boykin & Schoenbofer, 1993, p. 81).

Nursing educators have cautioned against requiring nursing students to write journals as coursework because students feel threatened by the prospect of being evaluated by their professors on their psycho-social development; they chose nursing to focus on the other, not on the self (Cameron & Mitchell, 1993). Consequently, students may misrepresent their feelings and/or experiences in this genre, thereby disabling its effectiveness as a teaching/learning tool. Although this argument is persuasive, unfortunately for the students, true empathy requires an initial focus on the self and, it is likely, some psycho-social development. Many of these students may have a trait-like potential to be empathic; however, interacting empathetically, as suggested by the dialogical framework, requires practice at appreciating the cognitive and affective experiences of nurse and client in a nursing interaction. Journals provide a setting for this practice, and they are a tool with which students can monitor their own progress, as described below.

Journal writing, if presented with sufficient structure and guidance, offers both a place to practice and to record personal and professional development (Bellas, 2001). The importance of guidance (i.e., "more feedback and direction from the facilitator") was echoed in students' reactions to a journal writing assignment in a second year baccalaureate nursing course (Ibarreta & McLeod, 2004, p. 136). With the use of a new model in which the teacher is proactive, the level of student comfort could change. For example, as a compromise

between student comfort and course objectives, a reflective peer journal (in which one dialogues with one's peer regarding a specific clinical experience observed by the peer), with specific instructions to integrate theory and practice, is recommended (Cameron & Mitchell, 1993). Suggestions for guidelines to use for journal writing in the nursing classroom include: how to get started, what materials to use, how to structure the final product, and how to evaluate it are available (Heinrich, 1992).

Other ways of introducing dialogism to nursing students besides, or in addition to, reflective writing are worth research attention as well. Physicians have been learning the benefits of incorporating the humanities into medical training to enhance empathy. Reading helps to build narrative competence: "Paying close attention to language, diction, metaphor, and reader response in texts permits one to pay similarly close attention to the language, mode of speaking, metaphorical content, and allusiveness of patients' histories" (Charon, 1993, p. 155). Methods to incorporate literature in health care education have been developed for use with medical students (e.g., creative writing exercises, discussions about literature, interviews about illness, etc., Squier, 1998; experiential learning of empathy through attending then discussing a dramatic performance, Deloney & Graham, 2003; drawing the human body, Stewart & Charon, 2002) and nursing students (e.g., in-class, literature-based, book groups with consultation of librarian, Butell, O'Donovan, & Taylor, 2004). Preliminary efforts include teaching empathy using examples from the humanities rather than from personal clinical care experiences. The effectiveness of this curriculum, which incorporated peers (i.e., group discussion), pictures (i.e., Edward Munch's "The Sick Child"), and writing to help a student learn (Wikström, 2001), suggests the validity of other non-client-focused exercises in enhancing the clinical skills of nursing students.

Training in narrative research methods using essays about nurse-client interactions may help students' perceive empathy as a dialogic process. This semester I was hired by the Nursing Department at City Tech to teach a six-hour research methods module to ten self-selected students. I have used this opportunity to introduce these students to narrative methods (see syllabus, Appendix R) using narrative reflections on a most meaningful interaction in the long term care facility context (see assignment, Appendix P). Their verbal feedback has indicated the value of using narratives to think about dialogic empathy, both as a method of inquiry in education, and as a method of caring in practice.

*Dialogic Empathy in Practice?* Personal care and social justice are intertwined in the professional work of the nurse. Through my recent review of all of the major areas of this dissertation (i.e., nursing, empathy, narratives, and the dialogic), I noticed that there is some literature in each area that discusses the value of moral development and ethics: According to Reynolds et al. (2000, p. 242), "The notion of empathy appears to play a fundamental role in perceiving the moral dimension of clinical practice." Nursing students aspire to become "good nurses" (Smith & Godfrey, 2002). Narratives have inherent moralistic orientations (Day & Tappen, 1996) that can be mined from the text (Brown, Debold, Tappan, & Gilligan, 1989). Future work could examine the ethics associated with empathy within the nursing context using the theories and methods of Bahktin's (1986) dialogic framework. Reflection is a method that has been used to encourage moral development among medical students (Branch, 2000). Perhaps one's sense of morality is another implicit audience to which one directs their actions and evaluations (Davies & Harré, 1999) in reflective narratives about nursing interactions.

In addition, measures and activities could be refined to examine some historical and intergroup aspects of empathy as a dialogic process (i.e., diachronic interactions [historical, over time] as well as synchronic [at the same time] are included in the theory). Intergroup interactions that may be of interest are male/female interactions and interactions between nurse and clients of different or similar races. Because nurses and clients are strangers brought together in challenging circumstances embedded in societal hierarchies and systems, appreciation of dialogic empathy could make a significant difference in their interactions. According to an Institute of Medicine report (1996), the effectiveness of patient care may be detrimentally influenced by cultural differences between clients and health care providers. It is hoped that experience of dialogic empathy in clinical interactions may reduce the impact of those differences.

Another method of fostering dialogic empathy in clinical interactions would be to encourage the client to write narrative reflections about the nurse-client interaction. Personal writing about illness has been associated with improved health outcomes (e.g., Smythe et al., 1999). Beginning with that rationale, it may be possible to persuade clients to turn their attention to the reciprocity of their social interactions in the medical context. It is likely that raising the awareness of both the nurse and client about their attitudes, expectations, and behaviors in clinical interactions would increase the satisfaction of both participants.

*Narrative as Empathy-based Evidence?* In sum, the evaluation of this intervention is a first step in a long line of research that may advance the practice and institution of nursing as described by Boykin and Schoenbofer (1993, p. 93):

Sciencing in nursing from this perspective must go beyond linearity to encompass the dialogic circling involved in the nursing situation. This places the discipline of

nursing among the human sciences, and calls for methods of inquiry that assure the circle of dialogue, and further, fully accommodate that which can be known of nursing. (p. 93)

The conflict between art and science, between humanities and medicine, is represented in the formality of the Nursing Process method. Providing students with opportunities to reflect upon nurse-client interactions in narrative or journalistic ways may positively influence their interpersonal skills, such as empathy, and thus, ultimately, enable art and science to collaborate in care within our health care settings.

In the chapter, "Science, pedagogy, and the transformation of empathy in medicine," Stanley Joel Reiser (1998) presented the results of a study conducted by John D. Stoeckle on medical students' patient interviews in which the clinical interviews of first-year and third-year students were compared:

First-year students listened to the story of illness. Third-year medical students strove to write a story of disease. For them the disease was the thing: classification, or merging the current patient with preceding patients, was their objective.

Understanding each patient's individuality should be the goal of physicians. (p. 129)

This point is echoed elsewhere in writing on narrative medicine: "Far from obviating the need for subjectivity in the clinical encounter, the valid application of empirical evidence requires a solid grounding in the narrative based world" because it "enables us to contextualise and individualise the problem before us" (Greenhalgh, 1998, p. 262-263).

### *Chapter Summary*

As Bahktin (1986) noted: "The work is a link in the chain of speech communion. Like the rejoinder in a dialogue, it is related to other work-utterances: both those to which it

responds and those that respond to it" (p. 76). This work, the dissertation and the discussions inspired by it, joins that chain.

I began this dissertation with the objective of evaluating an intervention I co-designed to teach students to perceive empathy as a dialogic process to improve communication within nurse-client interactions and, potentially, the provision and receipt of care. The evidence provides preliminary support (qualified by the limitations of sample and design) for both the theory and the intervention that it inspired. The implications extend to nursing education itself, as well as to our experience as clients in health care settings. Future work will, hopefully, provide evidence of the relationship between education and practice, but that is not where the inquiry and effort should end.

At this juncture, I find myself empathic towards these nursing students. It appears that I, too, have engaged in the process of reflective learning (i.e., "We learn by doing and realizing what came of what we did," Dewey, 1938). It has been suggested that reflection is a method for taking care of the self (Lauterbach & Becker, 1986), but I want evidence that appreciation of nurse-client interactions as a dialogic process is associated with satisfaction as a health care provider, as well as related to client care and satisfaction. Thus far, I have only the narrative evidence of a physician's hypothesis to go on: "It may also be true that the effective interaction allows the interviewer to feel satisfied, generous and at peace. Feelings of irritation and anxiety, then, may be signs of the doctor's ineffectiveness in narrative domains" (Charon, 1993, p. 151). The issue in nursing is not that there's a nursing shortage, but that there will always be a nursing shortage if nurses do not experience personal satisfaction in their important work to help others. Helping nurses helps clients.

Collaborating in care is our shared social responsibility, a responsibility we must not neglect.

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Our lives depend on it.

TABLE 1

***Participant Flow Chart: Percentages of Participation***

NOTE: All students in the first semester clinical course completed the course materials in their particular cohort (i.e., One section [A] received the standard curriculum; the other section [B] received the intervention materials). Only students who signed the consent form (i.e., participants) completed the pretest and posttest measurements.

Section A (n = 39)

Section B (n = 40)

Control Group (n = 20)

Experimental Group (n = 24)

Date	Study Materials	Study Materials
Wk 0	Pretest (participants only)	Pretest (participants only)
	Ideal Nurse question (85%)	Ideal Nurse question (88%)
	Interpersonal Reactivity Index (90%)	Interpersonal Reactivity Index (88%)
	Caring Attributes Questionnaire (90%)	Caring Attributes Questionnaire (88%)
	Nursing Dept. Student Survey (95%)	Nursing Dept. Student Survey (96%)
	Standard Curriculum (all students)	Intervention (all students)
Wk 3	Child Care Center report (95%)*	Child Care Center report (100%) + narratives (96%)
Wk 6	Senior Citizen Center report (95%)	Senior Citizen Center report (100%) + narratives (95%)*
Wk 8	Senior Citizen essay (95%)	Senior Citizen essay (92%)*
Wk 11	Long Term Care essay (90%)	Long Term Care essay (88%)+narratives (88%)
Wk 11	Posttest (participants only)	Posttest (participants only)
	Ideal Nurse question (50%)	Ideal Nurse question (71%)
	What is Empathy? task (55%)	What is Empathy? task (75%)
	Interpersonal Reactivity Index (60%)	Interpersonal Reactivity Index (79%)
	Caring Attributes Questionnaire (60%)	Caring Attributes Questionnaire (79%)
		Most Meaningful Interaction with Whom? (75%)
	*Withdrawn from Class: 1	*Withdrawn from Class: 2

TABLE 2

*Demographic Data by Study Condition*

		Total Sample		Control (45.5%)		Experimental (54.5%)		Group Differences
Demographic Variables		N=44		N=20		N=24		
Gender (Female)		86%		80%		92%		$\chi^2 (1) = .26$
Race	Black	46%		50%		46%		$\chi^2 (1) = 1.08$
	White	16%		11%		21%		
	Latino	14%		11%		17%		
	Asian	5%		6%		4%		
	Other	16%		22%		13%		
Age		M=	SD=	M=	SD=	M=	SD=	
		29.70	10.64	32.25	10.87	27.52	9.85	
<i>American</i> (see note)		30%		20%		38%		
English as 1 <sup>st</sup> language		71%		68%		73%		$\chi^2 (1) = 0.91$
Years since graduated from h.s. or passed GED		M=	SD=	M=	SD=	M=	SD=	$t(18.79) = 2.89^{**}$
		7.45	6.84	10.80	8.01	4.31	3.46	
Currently working in health care		48%		68%		30%		$\chi^2 (1) = 6.02^{**}$

**\*\* $p \leq .01$**  Note: The other countries of origin listed by participants were Africa, Barbados, China, Costa Rico, Ecuador, Guyana, Haiti, Jamaica, Nigeria, Philippines, Puerto Rico, Russia, St. Lucia, Trinidad, Ukraine, West Indies, and Yemen.

TABLE 3

*Frequencies of Levels of Dialogism Coded Holistically across the Narrative Reflections for the Three Contexts (Child Care Center, Senior Citizen Center, Long Term Care Facility)*

## CHILD CARE CENTER

	Client's Perspective Essay	Both Perspectives Essay
Level of dialogism	# of essays	# of essays
3	10	16
2	10	0
1	1	5
Not coded	1	
Total # of essays	22	

## SENIOR CITIZEN CENTER

	Client's Perspective Essay	Both Perspectives Essay
Level of dialogism	# of essays	# of essays
3	11	7
2	6	3
1	3	10
Not coded	2	
Total # of essays	22	

## LONG TERM CARE FACILITY CENTER

	Client's Perspective Essay	Both Perspectives Essay
Level of dialogism	# of essays	# of essays
3	10	10
2	7	3
1	2	6
Not coded	2	
Total # of essays	21	

TABLE 4

*Descriptive Data for Narrative Reflections about Three Clinical Contexts (Child Care Center [CC]; Senior Citizen Center [SC]; Long Term Care Facility [LT])*

Variable	CC		SC		LT	
	Client Only	Both	Client Only	Both	Client Only	Both
	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>
Total number of sentences	5.27 (3.76)	6.14 (2.88)	4.52 (2.77)	5.95 (2.31)	5.20 (2.44)	5.65 (2.96)
# of sentences in which speaker is student	3.32 (4.43)	5.59 (2.89)	2.95 (3.44)	5.10 (2.59)	1.90 (2.65)	5.15 (3.08)
# of sentences in which speaker is client	1.95 (2.40)	0.55 (1.26)	1.57 (1.66)	0.86 (1.77)	3.30 (3.42)	0.50 (1.15)
# of student Behaviors	1.86 (2.95)	1.73 (1.88)	1.10 (1.51)	1.33 (1.32)	1.05 (1.58)	2.65 (2.60)
# of Student Psych states	.68 (.84)	3.05 (1.73)	0.71 (1.06)	3.19 (1.97)	0.30 (0.92)	3.55 (2.19)
# of Student to Client Psych states	1.73 (1.93)	0.91 (1.19)	1.14 (1.35)	0.52 (0.98)	1.75 (1.74)	0.70 (1.22)
# of client Behaviors	2.55 (3.93)	2.95 (2.55)	2.57 (3.06)	3.19 (2.50)	1.15 (1.53)	2.15 (1.87)
# of client Psych states	5.00 (2.56)	4.45 (2.20)	3.10 (1.61)	3.10 (2.21)	4.95 (3.86)	4.20 (2.53)
Context	2.09 (2.51)	2.55 (2.77)	1.33 (1.56)	2.10 (3.11)	2.25 (2.10)	3.55 (2.61)
Total dial	46.05 (25.31)	47.27 (20.76)	34.29 (17.34)	42.43 (20.04)	49.55 (29.10)	43.95 (25.68)
Other present	0.64 (1.29)	0.73 (0.99)	0.52 (1.08)	0.90 (1.67)	0.10 (0.31)	0.25 (0.55)
Total dial by # of sent	9.41 (3.35)	7.97 (1.74)	8.10 (2.61)	7.18 (1.95)	9.26 (3.12)	7.79 (1.97)

TABLE 4 CONTINUED

*Descriptive Data for Intervention Essays*

Variable	CC		SC		LT	
	Client Only	Both	Client Only	Both	Client Only	Both
	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>
Student emotion	0.05 (0.21)	1.00 (1.31)	0.19 (0.51)	1.14 (1.11)	.10 (.31)	1.25 (1.37)
Student cognition	0.36 (0.58)	1.27 (1.08)	0.24 (0.44)	1.33 (1.71)	0.05 (0.22)	1.25 (1.33)
Student intention	.14 (.35)	.23 (.53)	.00 (.00)	.19 (.51)	0.00 (0.00)	0.50 (0.76)
Student desire	.00 (.00)	.09 (.29)	.00 (.00)	1.33 (1.71)	.00 (.00)	.05 (.22)
Student trait	.05 (.21)	.00 (.00)	.00 (.00)	.19 (.51)	.00 (.00)	.10 (.31)
Student ability	.05 (.21)	.00 (.00)	.10 (.44)	.05 (.22)	.10 (.45)	.10 (.31)
Student perception	.09 (.29)	.32 (.57)	.14 (.36)	.29 (.64)	.00 (.00)	.35 (.49)
Client to Student emotion	.23 (.53)	.14 (.35)	.10 (.30)	.10 (.44)	.00 (.00)	.05 (.22)
Client to Student cognition	.05 (.21)	.05 (.21)	.24 (.63)	.05 (.22)	.15 (.49)	.10 (.45)
Client to Student intention	.27 (.77)	.18 (.50)	.24 (.54)	.14 (.36)	.70 (.98)	.15 (.37)
Client to Student desire	.23 (.53)	.05 (.21)	.05 (.22)	.10 (.30)	.00 (.00)	.00 (.00)
Client to Student trait	.82 (1.05)	.41 (.59)	.48 (.68)	.10 (.30)	.80 (1.11)	.30 (.57)
Client to Student ability	.09 (.29)	.05 (.21)	.00 (.00)	.00 (.00)	.10 (.45)	.00 (.00)
Client to Student perception	.59 (2.15)	.05 (3.21)	.10 (.30)	.00 (.00)	.00 (.00)	.15 (.37)
Client emotion	2.18 (1.68)	1.82 (1.56)	1.24 (1.04)	.71 (.96)	2.60 (3.09)	1.65 (1.69)
Client cognition	1.00 (1.20)	.59 (.80)	1.00 (1.44)	.81 (1.12)	.70 (1.03)	.75 (.91)

TABLE 4 CONTINUED

*Descriptive Data for Intervention Essays*

Variable	CC		SC		LT	
	Client Only	Both	Client Only	Both	Client Only	Both
	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>
Client intention	.50 (.91)	.73 (.70)	.19 (.40)	.24 (.54)	.35 (.81)	.25 (.44)
Client desire	.36 (.58)	.09 (.29)	.19 (.51)	.19 (.40)	.35 (.67)	.10 (.31)
Client trait	.41 (.96)	.68 (.95)	.19 (.51)	1.00 (1.84)	.20 (.41)	.85 (1.35)
Client ability	.18 (.66)	.41 (.59)	.00 (.00)	.05 (.22)	.65 (.99)	.20 (.41)
Client perception	.32 (.48)	.19 (.51)	.24 (.63)	.10 (.30)	.10 (.31)	.35 (.67)

TABLE 5

*Table of Frequencies for the Ideal Nurse Question Dialogic Outcomes Coded*

*Holistically*

Holistic Dialogic Coding	Control		Experimental	
	Pretest (n=17/20)	Posttest (n=10/20)	Pretest (n=21/24)	Posttest (n=17/24)
1 = Trait/skill/motivation of a nurse (no other person is explicitly mentioned as receiving an action)	29.4%	20.0%	61.9%	47.1%
2 = Nurse's trait/skill in actions towards others without mention of the client's experience	47.1%	60.0%	19.0%	23.5%
3 = Other's experience is highlighted	23.5%	20.0%	19%	29.4%

TABLE 6

*Table of Means for Outcome Variables with Standard Deviations in Parentheses*

	Control		Experimental	
	Pretest (n=17/20)	Posttest (n=10/20)	Pretest (n=21/24)	Posttest (n=17/24)
IRI SUBSCALE Fantasy	16.22 (4.62)	17.00 (4.75)	14.33 (5.55)	13.89 (5.54)
IRI SUBSCALE Empathic Concern	22.50 (3.76)	22.55 (3.93)	22.38 (3.71)	20.63 (4.54)
IRI SUBSCALE Perspective-Taking	19.61 (4.06)	18.64 (3.61)	17.24 (4.87)	18.42 (3.73)
IRI SUBSCALE Personal Distress	11.28 (4.60)	12.82 (4.81)	10.52 (4.93)	11.53 (3.75)
CAQ SUBSCALE Caring Communication	4.72 (.32)	4.61 (.45)	4.64 (.25)	4.82 (.16)
CAQ SUBSCALE Caring Advocacy	4.76 (.26)	4.56 (.51)	4.54 (.36)	4.64 (.29)
CAQ SUBSCALE Learning to Care	3.51 (1.05)	3.50 (1.13)	3.81 (1.09)	3.56 (1.16)
IDEAL NURSE Dialogic coding Sentence-by- sentence/number of sentences	3.65 (2.13)	5.31 (2.43)	3.34 (1.91)	4.00 (3.01)
IDEAL NURSE Proportion of sentences in which dialogism=3/ number of sentences	0.20 (0.27)	0.46 (0.32)	0.17 (0.26)	0.34 (0.38)

TABLE 7

*Repeated Measures Analyses of Ideal Nurse Question's Dialogic Outcomes Coded**Sentence-by-Sentence*

Subscale	Source	Df	F	p
Sentence-by-sentence				
	Time	1, 22	1.38	.25
	Time*Group	1, 22	0.21	.65
Portion of dialogism = 3/number of sentences				
	Time	1, 22	4.14	.05*
	Time*Group	1, 22	0.13	.72

NOTE: The *F*'s reported are Wilks' Lambda, \* $p \leq .05$ .

**TABLE 8: Intercorrelations of Ideal Nurse Dialogic Assessments**

		IdealHOL	Follow up Ideal HOL	Post-Pre Ideal HOL	Pre SentbySent Ideal Dial Total/Sent	Post SentbySent Ideal Dial Total/Sent	Post-Pre SentbySent Ideal Total/Sent	Pre SentbySent Ideal 3s/sent (%)	Post SentbySent Ideal 3s/sent (%)
IdealHOL	Pearson Correlation	1	.422(*)	-.568(**)	.544(**)	.393	-.057	.484(**)	.318
	Sig. (2-tailed)	.	.040	.004	.000	.058	.791	.002	.130
	N	38	24	24	38	24	24	38	24
Follow up Ideal HOL	Pearson Correlation	.422(*)	1	.506(*)	.415(*)	.588(**)	.274	.312	.552(**)
	Sig. (2-tailed)	.040	.	.012	.044	.001	.195	.138	.003
	N	24	27	24	24	27	24	24	27
Post-Pre Ideal HOL	Pearson Correlation	-.568(**)	.506(*)	1	-.276	.134	.303	-.289	.159
	Sig. (2-tailed)	.004	.012	.	.192	.533	.150	.171	.459
	N	24	24	24	24	24	24	24	24
Pre SentbySent Ideal Dial Total/Sent	Pearson Correlation	.544(**)	.415(*)	-.276	1	.265	-.378	.897(**)	.244
	Sig. (2-tailed)	.000	.044	.192	.	.210	.069	.000	.250
	N	38	24	24	38	24	24	38	24
Post SentbySent Ideal Dial Total/Sent	Pearson Correlation	.393	.588(**)	.134	.265	1	.792(**)	.222	.974(**)
	Sig. (2-tailed)	.058	.001	.533	.210	.	.000	.297	.000
	N	24	27	24	24	27	24	24	27
Post-Pre SentbySent Ideal Total/Sent	Pearson Correlation	-.057	.274	.303	-.378	.792(**)	1	-.352	.779(**)
	Sig. (2-tailed)	.791	.195	.150	.069	.000	.	.092	.000
	N	24	24	24	24	24	24	24	24
Pre SentbySent Ideal 3s/sent (%)	Pearson Correlation	.484(**)	.312	-.289	.897(**)	.222	-.352	1	.218
	Sig. (2-tailed)	.002	.138	.171	.000	.297	.092	.	.305
	N	38	24	24	38	24	24	38	24
Post SentbySent Ideal 3s/sent (%)	Pearson Correlation	.318	.552(**)	.159	.244	.974(**)	.779(**)	.218	1
	Sig. (2-tailed)	.130	.003	.459	.250	.000	.000	.305	.
	N	24	27	24	24	27	24	24	27

\* Correlation is significant at the 0.05 level (2-tailed).

\*\* Correlation is significant at the 0.01 level (2-tailed).

TABLE 9

*Other Characteristics of an Ideal Nurse Divided by Number of Sentences Reported in Assessments*

Ideal Nurse Characteristics	Total Sample		Control (45.5%)		Experimental (54.5%)	
	N=44		N=20		N=24	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Caring Characteristics: Cognitive	-0.29	1.06	-0.52	1.02	-0.12	1.07
Caring Characteristics: Affective	-0.26	0.81	-0.43	0.99	-0.15	0.67
Empathy	0.02	0.12	0.04	0.16	-0.00	0.05
Professional Competence: Self-focused	0.42	0.72	0.57	0.97	0.31	0.50
Professional Competence: Other-focused	0.49	1.00	0.60	1.51	0.41	0.44
Attitudes toward Nursing: Likes it	-0.25	0.31	0.06	0.31	-0.09	0.31
Attitudes toward Nursing: Committed to it	-0.14	0.32	0.04	0.29	-0.06	0.35

TABLE 10

*Descriptive Data for Responses to Posttest What is Empathy? Task by Study Condition*

	Control (n=11)		Experimental (n=18)	
Empathy- as	Number(%)	Example	Number(%)	Example
Experience	1 (9%)	"Empathy is when you can relate to another person's situation but not necessarily feel sorry for them."	6 (33%)	"Empathy is when you can relate to another person's situation but not necessarily feel sorry for them."
Action	3 (27%)	"Empathy is being compassionate to someone and trying to understand their situation and putting yourself in their situation."	3 (17%)	"Showing understanding about another person's problems and seeking to help them."
Cognition	3 (27%)	"Empathy is putting yourself in someone else [sic] position."	3 (17%)	Empathy is understanding a person's loss or mishaps. You're not feeling sorry for them. But you can relate to them"
Feeling	3 (27%)	"Empathy is the feeling that you can put yourself in another's [sic] position and feel what they are feeling or experiencing"	3 (17%)	"To try to feel (or to feel) what the other person is feeling or going through"
Ability	1 (9%)	"To me empathy is being able to feel what another human being is going through and to not first sympathize which would be more of someone looking down at the misfortunate	3 (17%)	"Being able to feel what another feels"

TABLE 11

*Distribution of Qualitative Dialogic Coding of Items in Interpersonal Reactivity Index**(IRI) Subscales*

IRI Subscales				
Dialogic coding	Fantasy – 7 items	Empathic Concern – 7 items	Perspective- Taking – 7 items	Personal Distress – 7 items
1 = Trait/skill of a nurse (no other person is explicitly mentioned as receiving an action)	3 (42.9%)	2 (28.6%)	0 (0%)	5 (71.4%)
2 = Nurse's trait/skill in actions towards others without mention of the client's experience	1 (14.3%)	5 (71.4%)	0 (0%)	2 (28.6%)
3 = Other's experience is highlighted	3 (42.9%)	0 (0%)	7 (100%)	0 (0%)

TABLE 12

*Distribution of Qualitative Dialogic Coding of Items in Caring Attributes Questionnaire**(CAQ) Subscales*

CAQ Subscales			
Dialogic coding	Caring Communication – 11 items	Caring Advocacy – 7 items	Learning to Care – 5 items
1 = Trait/skill of a nurse (no other person is explicitly mentioned as receiving an action)	1 (9.10%)	3 (42.9%)	4 (80%)
2 = Nurse's trait/skill in actions towards others without mention of the client's experience	5 (45.5%)	2 (28.6%)	0 (0%)
3 = Other's experience is highlighted	5 (45.5%)	2 (28.6%)	1 (20%)

NOTE: As explained in the Measures section, due to low reliability in the pretest scores, the 8-item Caring Involvement subscale was not used in subsequent analyses; therefore, it is not included here.

**TABLE 13**

*Intercorrelations of Interpersonal Reactivity Index (IRI) Subscales at Pretest (n = 39) and Posttest (n =25) for Total Sample*

		Fantasy	Perspective Taking	Empathic Concern	Personal Distress	Follow up Fantasy	Follow up Perspective Taking	Follow up Empathy	Follow up Personal Distress
Fantasy	Pearson Correlation	1	-.018	.110	.349(*)	.713(**)	-.155	.132	.327
	Sig. (2-tailed)	.	.911	.505	.029	.000	.460	.530	.110
	N	39	39	39	39	25	25	25	25
Perspective Taking	Pearson Correlation	-.018	1	.533(**)	-.099	.146	.609(**)	.326	-.073
	Sig. (2-tailed)	.911	.	.000	.548	.486	.001	.112	.729
	N	39	39	39	39	25	25	25	25
Empathic Concern	Pearson Correlation	.110	.533(**)	1	-.115	.165	.506(**)	.607(**)	-.161
	Sig. (2-tailed)	.505	.000	.	.488	.432	.010	.001	.442
	N	39	39	39	39	25	25	25	25
Personal Distress	Pearson Correlation	.349(*)	-.099	-.115	1	.150	-.107	.167	.777(**)
	Sig. (2-tailed)	.029	.548	.488	.	.476	.611	.425	.000
	N	39	39	39	39	25	25	25	25
Follow up Fantasy	Pearson Correlation	.713(**)	.146	.165	.150	1	.034	.137	.295
	Sig. (2-tailed)	.000	.486	.432	.476	.	.857	.469	.113
	N	25	25	25	25	30	30	30	30
Follow up Perspective Taking	Pearson Correlation	-.155	.609(**)	.506(**)	-.107	.034	1	.493(**)	.234
	Sig. (2-tailed)	.460	.001	.010	.611	.857	.	.006	.212
	N	25	25	25	25	30	30	30	30
Follow up Empathy	Pearson Correlation	.132	.326	.607(**)	.167	.137	.493(**)	1	.103
	Sig. (2-tailed)	.530	.112	.001	.425	.469	.006	.	.587
	N	25	25	25	25	30	30	30	30
Follow up Personal Distress	Pearson Correlation	.327	-.073	-.161	.777(**)	.295	.234	.103	1
	Sig. (2-tailed)	.110	.729	.442	.000	.113	.212	.587	.
	N	25	25	25	25	30	30	30	30

\* Correlation is significant at the 0.05 level (2-tailed).

\*\* Correlation is significant at the 0.01 level (2-tailed).

TABLE 14

*Repeated Measures Analyses of Interpersonal Reactivity Index (IRI) Subscales*

Subscale	Source	df	F	p
Perspective-Taking	Time	1, 23	0.14	.71
	Time*Group	1, 23	4.27	.05*
Fantasy	Time	1, 23	1.65	.21
	Time*Group	1, 23	0.85	.37
Empathic Concern	Time	1, 23	3.68	.07
	Time*Group	1, 23	0.51	.49
Personal Distress	Time	1, 23	1.45	.24
	Time*Group	1, 23	0.33	.57

NOTE: The *F*'s reported are Wilks' Lambda, \*  $p \leq .05$ .

**TABLE 15**

*Intercorrelations of Caring Attributes Questionnaire (CAQ) Subscales at Pretest (n = 39) and Posttest (n = 26) for Total Sample*

		Caring Communication	Caring Advocacy	Learning to Care	Follow up Caring Communication	Follow up Caring Advocacy	Follow up Learning to Care
Caring Communication	Pearson Correlation	1	.516(**)	.079	.594(**)	.576(**)	.050
	Sig. (2-tailed)	.	.001	.633	.001	.002	.809
	N	39	39	39	26	26	26
Caring Advocacy	Pearson Correlation	.516(**)	1	.150	.318	.594(**)	.107
	Sig. (2-tailed)	.001	.	.363	.114	.001	.603
	N	39	39	39	26	26	26
Learning to Care	Pearson Correlation	.079	.150	1	.247	.180	.511(**)
	Sig. (2-tailed)	.633	.363	.	.224	.380	.008
	N	39	39	39	26	26	26
Follow up Caring Communication	Pearson Correlation	.594(**)	.318	.247	1	.621(**)	.244
	Sig. (2-tailed)	.001	.114	.224	.	.000	.186
	N	26	26	26	31	31	31
Follow up Caring Advocacy	Pearson Correlation	.576(**)	.594(**)	.180	.621(**)	1	.036
	Sig. (2-tailed)	.002	.001	.380	.000	.	.846
	N	26	26	26	31	31	31
Follow up Learning to Care	Pearson Correlation	.050	.107	.511(**)	.244	.036	1
	Sig. (2-tailed)	.809	.603	.008	.186	.846	.
	N	26	26	26	31	31	31

\*\* Correlation is significant at the 0.01 level (2-tailed).

\* Correlation is significant at the 0.05 level (2-tailed).

TABLE 16

*Repeated Measures Analyses of Caring Attributes Questionnaire (CAQ) Subscales*

Subscale	Source	Df	F	p
Caring Communication	Time	1, 24	0.08	.77
	Time*Group	1, 24	6.66	.02*
Caring Advocacy	Time	1, 24	0.06	.80
	Time*Group	1, 24	4.94	.04*
Learning to Care	Time	1, 24	0.00	.97
	Time*Group	1, 24	1.12	.30

NOTE: The *F*'s reported are Wilks' Lambda, \**p* < .05.

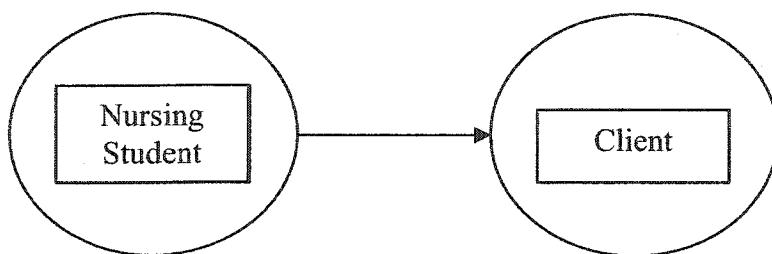
**TABLE 17**

*Intercorrelations of Interpersonal Reactivity Index (IRI) and Caring Attributes Questionnaire (CAQ) Subscales at Follow-Up*

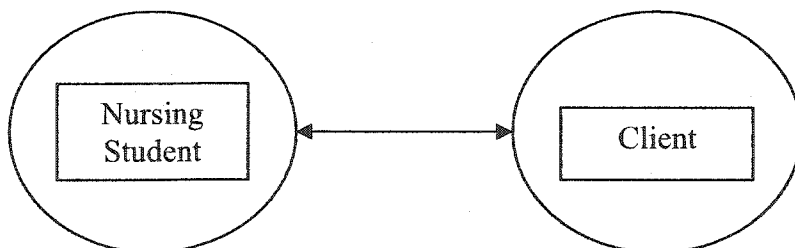
		Post-Pre IRI Perspec Taking	Post-Pre IRI Personal Distress	Post-Pre IRI Fantasy	Post-Pre IRI Empathy	Post-Pre CAQ Communication	Post-Pre CAQ Advocacy	Post-Pre CAQ Learning to Care
Post-Pre IRI Perspec Taking	Pearson Correlation	1	.278	.027	.361	.273	.144	.056
	Sig. (2-tailed)	.	.179	.898	.076	.186	.493	.789
	N	25	25	25	25	25	25	25
Post-Pre IRI Personal Distress	Pearson Correlation	.278	1	.394	-.130	.259	.186	.241
	Sig. (2-tailed)	.179	.	.051	.534	.210	.374	.247
	N	25	25	25	25	25	25	25
Post-Pre IRI Fantasy	Pearson Correlation	.027	.394	1	.150	.372	-.009	-.030
	Sig. (2-tailed)	.898	.051	.	.474	.067	.965	.889
	N	25	25	25	25	25	25	25
Post-Pre IRI Empathy	Pearson Correlation	.361	-.130	.150	1	.003	-.222	-.211
	Sig. (2-tailed)	.076	.534	.474	.	.987	.287	.312
	N	25	25	25	25	25	25	25
Post-Pre CAQ Communication	Pearson Correlation	.273	.259	.372	.003	1	.295	.048
	Sig. (2-tailed)	.186	.210	.067	.987	.	.143	.817
	N	25	25	25	25	26	26	26
Post-Pre CAQ Advocacy	Pearson Correlation	.144	.186	-.009	-.222	.295	1	-.273
	Sig. (2-tailed)	.493	.374	.965	.287	.143	.	.177
	N	25	25	25	25	26	26	26
Post-Pre CAQ Learning to Care	Pearson Correlation	.056	.241	-.030	-.211	.048	-.273	1
	Sig. (2-tailed)	.789	.247	.889	.312	.817	.177	.
	N	25	25	25	25	26	26	26
	Sig. (2-tailed)	.702	.564	.048	.521	.823	.625	.539
	N	25	25	25	25	26	26	26

FIGURE 1

*A graphic representation of the difference between the traditional model of empathy and the proposed model of empathy.*



*Traditional Model of Empathy:* Focus on the personal characteristics of an individual. Empathy is dispensed by the health care provider during the clinical interaction. This occurs due to the health care provider's empathic traits and/or empathic skills.



*Proposed Model of Empathy:* Awareness of the reciprocal interaction. Dialogic empathy is a process that occurs within the clinical interaction when there is enhanced sensitivity to the perspectives of both participants and/or context.

FIGURE 2

*Bar graph of dialogism/sentences across the Client's Perspective Only and Both Perspectives essays about the three clinical contexts (child care center, senior citizen center, long term care facility)*

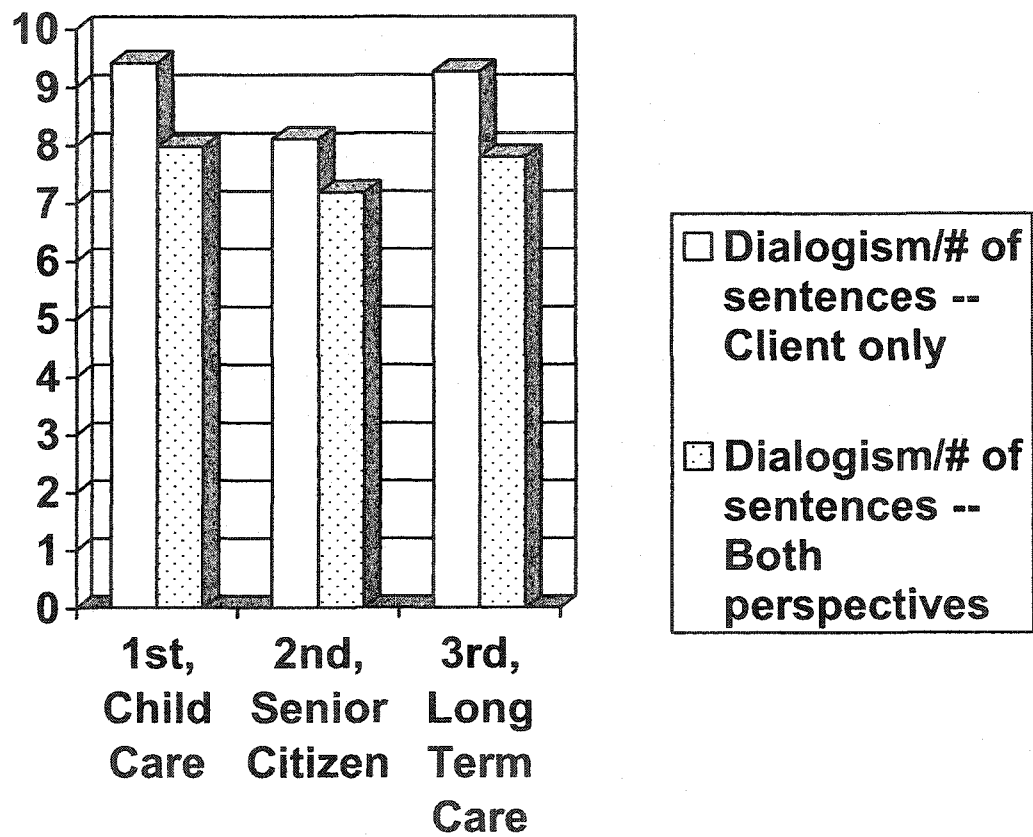


FIGURE 3

*Bar graph of number of mentions of client's emotion across the Client's Perspective*

*Only and Both Perspectives essays about the three clinical contexts (child care center, senior citizen center, long term care facility)*

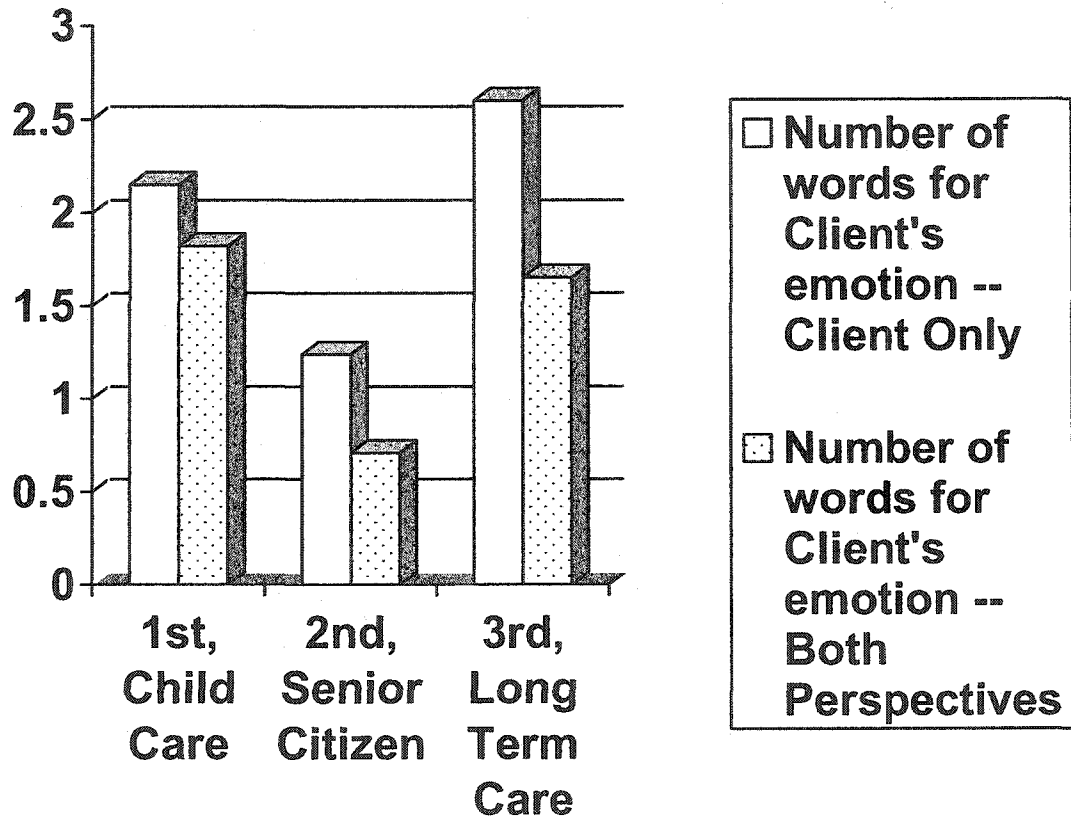
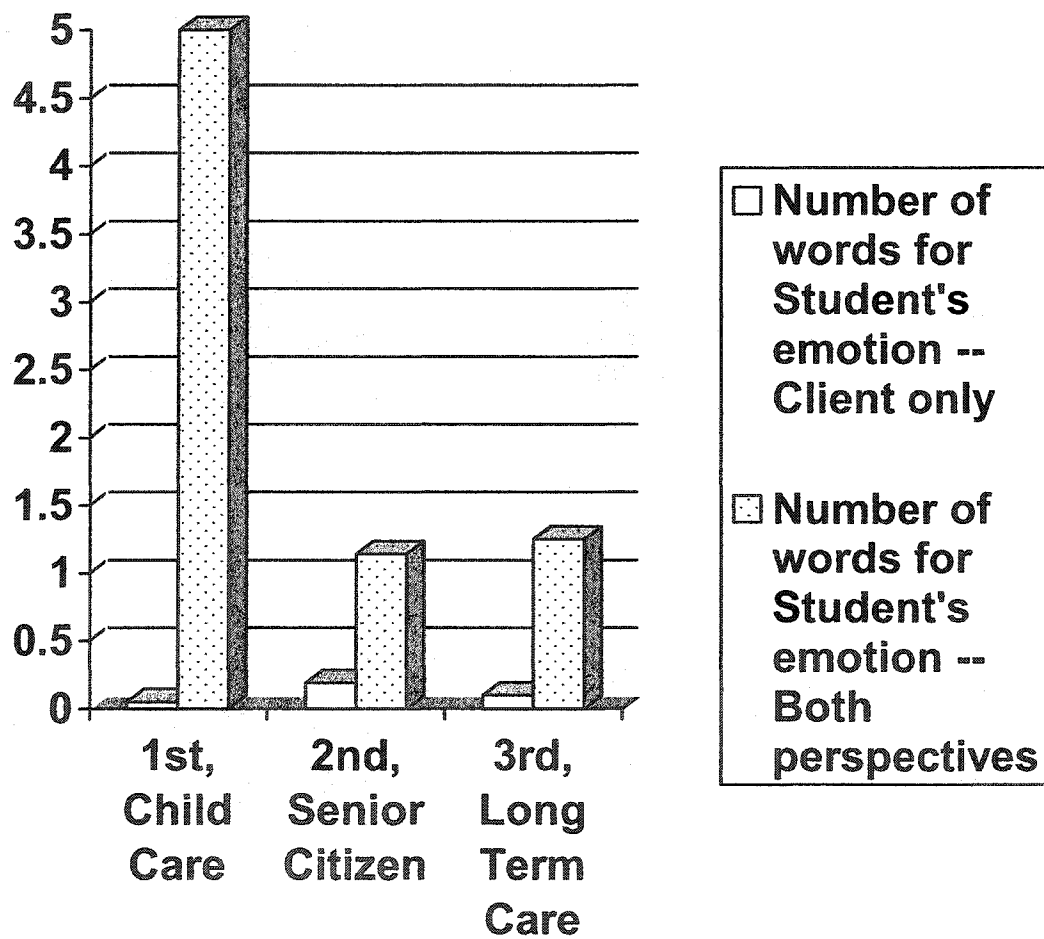


FIGURE 4

*Bar graph of number of mentions of student's emotion across the Client's Perspective Only and Both Perspectives essays about the three clinical contexts (child care center, senior citizen center, long term care facility)*





**APPENDIX B**

**DAVIS' INTERPERSONAL REACTIVITY INDEX, 1983 (FOLLOWING PAGES)**

PLEASE PUT RANDOM NUMBER LABEL HERE:

*Please indicate the degree to which the items describe you by circling the appropriate point on a five-point scale running from 0 (does not describe me well) to 4 (describes me very well).*

Item	0 = does <u>not</u> describe -- -- 4 = describes me <u>very</u> well				
1. I daydream and fantasize, with some regularity, about things that might happen to me.	0	1	2	3	4
2. I often have tender, concerned feelings for people less fortunate than me.	0	1	2	3	4
3. I sometimes find it difficult to see things from the "other person's" point of view.	0	1	2	3	4
4. Sometimes I don't feel very sorry for other people when they are having problems.	0	1	2	3	4
5. I really get involved with the feelings of the characters in a novel.	0	1	2	3	4
6. In emergency situations, I feel apprehensive and ill-at-ease.	0	1	2	3	4
7. I am usually objective when I watch a movie or play, and I don't often get completely caught up in it.	0	1	2	3	4
8. I try to look at everybody's side of a disagreement before I make a decision.	0	1	2	3	4
9. When I see someone being taken advantage of, I feel kind of protective towards them.	0	1	2	3	4
10. I sometimes feel helpless when I am in the middle of a very emotional situation.	0	1	2	3	4
11. I sometimes try to understand my friends better by imagining how things look from their perspective.	0	1	2	3	4
12. Becoming extremely involved in a good book or movie is somewhat rare for me.	0	1	2	3	4
13. When I see someone get hurt, I tend to remain calm.	0	1	2	3	4
14. Other people's misfortunes do not usually disturb me a great deal.	0	1	2	3	4

Item	0 = does <u>not</u> describe -- -- 4 = describes me <u>very</u> well				
15. If I'm sure I'm right about something, I don't waste much time listening to other people's arguments.	0	1	2	3	4
16. After seeing a play or movie, I have felt as though I were one of the characters.	0	1	2	3	4
17. Being in a tense emotional situation scares me.	0	1	2	3	4
18. When I see someone being treated unfairly, I sometimes don't feel very much pity for them.	0	1	2	3	4
19. I am usually pretty effective in dealing with emergencies.	0	1	2	3	4
20. I am often quite touched by things that I see happen.	0	1	2	3	4
21. I believe that there are two sides to every question and try to look at them both.	0	1	2	3	4
22. I would describe myself as a pretty soft-hearted person.	0	1	2	3	4
23. When I watch a good movie, I can very easily put myself in the place of a leading character.	0	1	2	3	4
24. I tend to lose control during emergencies.	0	1	2	3	4
25. When I'm upset at someone, I usually try to "put myself in their shoes" for a while.	0	1	2	3	4
26. When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me.	0	1	2	3	4
27. When I see someone who badly needs help in an emergency, I go to pieces.	0	1	2	3	4
28. Before criticizing somebody, I try to imagine how I would feel if I were in their place.	0	1	2	3	4

**APPENDIX C****D. ARTHUR, S. PANG AND T. WONG (2002)**

Caring Attributes Scale of the  
Caring Attributes, Professional Self and Technological Influences  
(CAPSTI-2) instrument (following pages)

The following items relate to *what caring means to you as a nurse*. Rank your degree of agreement (circle the number). Try to write what you believe, not what others say, or what others might expect you to say.

Item	1 = disagree	2 = tend to disagree	3 = uncertain	4 = tend to agree	5 = agree
1. Caring is a planned nurse activity designed to meet patient's needs.	1	2	3	4	5
2. Caring makes no difference to the patient's health condition.	1	2	3	4	5

Rank your degree of agreement (circle the number) with the following items. *When I am working with my patient, I am being caring when I am:*

Item	1 = disagree	2 = tend to disagree	3 = uncertain	4 = tend to agree	5 = agree
3. Treating everyone as an individual.	1	2	3	4	5
4. Being empathic.	1	2	3	4	5
5. Avoiding the patient.	1	2	3	4	5
6. Touching the patient when comfort is needed.	1	2	3	4	5
7. Talking to the patient.	1	2	3	4	5
8. Helping to make experiences more pleasant.	1	2	3	4	5
9. Demonstrating professional skills.	1	2	3	4	5
10. Putting the needs of the hospital before the patient.	1	2	3	4	5
11. Communicating with the patient.	1	2	3	4	5
12. Helping the patient clarifying thinking.	1	2	3	4	5
13. Expecting the patient to do what I tell him/her.	1	2	3	4	5
14. Treating patient's information confidentially.	1	2	3	4	5
15. Giving the patient explanations concerning his/her care.	1	2	3	4	5

Item	1 = disagree	2 = tend to disagree	3 = uncertain	4 = tend to agree	5 = agree
16. When I don't give the patient all the information he/she needs.	1	2	3	4	5
17. Educating the patient about some aspects of self-care.	1	2	3	4	5
18. Keeping the relatives informed about the patient as negotiated with the patient.	1	2	3	4	5
19. Preventing any anticipated problems/dangers from occurring.	1	2	3	4	5

Rank your degree of agreement (circle a number) with the following items. *When I am working with my patient, I am being caring when I am:*

Item	1 = disagree	2 = tend to disagree	3 = uncertain	4 = tend to agree	5 = agree
20. Knowing what to do in an emergency.	1	2	3	4	5
21. Speaking up for the patient, when it is perceived that something harmful will be done to the patient.	1	2	3	4	5
23. Documenting care given to patient.	1	2	3	4	5
24. Working collaboratively with colleagues to ensure continuity of care.	1	2	3	4	5
25. Not involving the patient in the planning of their care.	1	2	3	4	5

Rank your degree of agreement (circle a number) with the following items. *How well does each item describe a caring nurse:*

Item	1 = disagree	2 = tend to disagree	3 = uncertain	4 = tend to agree	5 = agree
26. Caring nurses do not feel concern for the well-being of others.	1	2	3	4	5
27. A committed nurse is one who is to balance personal desires and professional obligation to provide care to patients.	1	2	3	4	5

Rank your degree of agreement (circle a number) with how each item describes, *how caring is learned and taught*:

Item	1 = disagree	2 = tend to disagree	3 = uncertain	4 = tend to agree	5 = agree
28. Caring is learned through instruction in counselling techniques.	1	2	3	4	5
29. Caring is learned by modelling in the clinical setting.	1	2	3	4	5
30. Nurses learn about caring in the nursing school.	1	2	3	4	5
31. Nurses learn about caring by observing other nurses work.	1	2	3	4	5

## APPENDIX D

## STUDENT SURVEY – REVISED

**Directions:** Follow directions per each item (i.e., circle corresponding letter and/or write in response on line given). Do not put your name or student ID # on this survey.

1	What is your GENDER? (circle letter)	A. Male B. Female
2	What is your RACE? (circle letter or write in)	A. Black (Non-Hispanic) B. White (Non-Hispanic) C. Hispanic (Mexican, Puerto Rican, Cuban) D. Asian (Pacific Islanders) E. Native American/Indian/Alaskan Native OTHER RACE (write in): _____
3	What is your COUNTRY of ORIGIN (write in)	COUNTRY (write in): _____
4	Is ENGLISH your 1 <sup>st</sup> language? (circle letter)	Yes No
5	What is your AGE? (write in)	(write in number) _____ years
6	Did you complete a GED? (circle letter and write in)	A. Yes, Year of graduation (write in): _____ B. No
7	Did you complete HIGH SCHOOL? (circle letter and write in)	A. Yes, Year of graduation (write in): _____ B. No
8	Did you complete a COLLEGE degree? (circle letter and write in)	A. Yes, Year of graduation (write in): _____ and Type of degree (write in): _____ B. No
9	Are you CURRENTLY working in the HEALTH FIELD? (circle letter)	A. Yes B. No
10	Have you EVER been employed as an LPN? (circle letter and write in)	<i>LPN = Licensed Practical Nurse</i> A. Yes, (write in) for ____ yrs. and ____ mths. B. No
11	Have you EVER been employed as a CNA? (circle letter and write in)	<i>CNA = Certified Nurse's Assistant</i> A. Yes, (write in) for ____ yrs. and ____ mths. B. No
12	Have you EVER been employed as a PCT? (circle letter and write in)	<i>PCT = Patient Care Technician</i> A. Yes, (write in) for ____ yrs. and ____ mths. B. No
13	Have you EVER been employed as an NA (circle letter and write in)	<i>NA = Nurse's Aide/Assistant</i> A. Yes, (write in) for ____ yrs. and ____ mths. B. No
14	Have you EVER been employed as an HHA (circle letter and write in)	<i>HHA = Home Health Aide/Attendant</i> A. Yes, (write in) for ____ yrs. and ____ mths. B. No
15	Have you EVER been employed in another health care job? (write in)	OTHER HEALTH CARE JOB (write in): _____ for ____ yrs. and ____ mths.

**APPENDIX E – WHAT IS EMPATHY? TASK**

*What is Empathy?*: People think about empathy in many different ways. As a way to think about its meaning to you in your life, write narrative answers to the following questions.

1) What is empathy? \_\_\_\_\_

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2) Do you consider yourself to be empathic? \_\_\_\_ If so, why or how do you consider yourself empathic?

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3) Write about a time when you responded empathetically to someone in need (e.g., a patient, if possible, or someone you didn't know well). In that interaction, what did each of you do, think, feel?

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What are the important qualities of this empathetic interaction?

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**What is Empathy? response continued:**

4) Write about a time when you needed empathy from a health provider, if possible, or from someone you didn't know well. In that specific interaction, what did each of you do, think, feel?

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What are the important qualities of this empathetic interaction?

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5) Do you think being empathic is an important part of being a nurse? \_\_\_\_\_ If so, why?

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**PLEASE ATTACH AN ADDITIONAL SHEET, IF NECESSARY (include question #).**

## APPENDIX F

### MOST MEANINGFUL INTERACTIONS – WITH WHOM?

During the course of this semester you have described your "most meaningful interaction" with clients in various settings. Please use this form to describe their personal characteristics and how you think they may or may not interact with your own.

#### CHILD CARE REPORT

- Gender: \_\_\_\_\_
- Race: \_\_\_\_\_
- Estimated age: \_\_\_\_\_
- Other characteristics: \_\_\_\_\_

#### SENIOR CITIZEN REPORT

- Gender: \_\_\_\_\_
- Race: \_\_\_\_\_
- Estimated age: \_\_\_\_\_
- Other characteristics: \_\_\_\_\_

#### LONG TERM CARE FACILITY ESSAY

- Gender: \_\_\_\_\_
- Race: \_\_\_\_\_
- Estimated age: \_\_\_\_\_
- Other characteristics: \_\_\_\_\_

How might having personal characteristics *similar* to those your client influence your empathic interaction with her/him?

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How might having personal characteristics *different* from those of your client influence your empathic interaction with her/him?

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## APPENDIX G – RECRUITMENT SCRIPT

Hello. My name is Kimberlee Trudeau. I am a doctoral student at CUNY Graduate Center in the Social-Personality Psychology Program. Today I am here to invite you all to participate in an important study testing writing in nursing education. To thank you for your attention today I am going to give a \$50 gift certificate to the college bookstore to one student in each class. I will hold another lottery for a \$50 gift certificate to the college bookstore at the end of the semester for those who participated in the study.

Here are the details about my study: I am asking you to fill out a few surveys and write answers to some questions now and at the end of the semester. These tasks should take less than 30 minutes and you have time to do them now. Secondly, I am asking for your permission to get a copy of your written assignments for NU103. As you think about whether you'd like to participate, I want to emphasize two points: 1) Participating in this study will not affect your grade in this course. 2) Your professor will not know who chose to participate and who did not.

Here are two copies of the consent form [pass them out]: one for you to sign and return to me today and one for you to take with you. On this consent form it says who I am, the risks and benefits of participating in this study, and who to contact if you have questions about this study. There are no known risks of participation, particularly because your responses will be confidential. That means that I will not share your individual responses with anyone except those officially connected to my project. When I receive your materials, I will remove your name from them and label them with a random number associated with your consent form. The benefit of participating in this study is that you may enjoy the opportunity to reflect upon your experiences and attitudes about nursing as well as "contribute to the ongoing development of the profession's body of knowledge" on writing in nursing education (American Nurses Association's Code for Nurses, 1985). NOTE: You can choose to participate or not to participate in this study. It is your decision. You can also withdraw your data at any time. --Please take 2 minutes to read through the consent form. [PAUSE for 2 minutes.] Are there any questions about this form?

Now I am going to pass out the Ideal Nurse question page. Please put one of these labels on the Ideal Nurse question page and another label on a copy of the consent form to return to me. NOTE: The numbers on these labels are completely random; they are in no way connected to class rank. They are only for me to keep track of materials from each individual. When you have completed the brief writing task please come get the survey packet and put a label on that too. The remaining labels are for the posttest data.

Any last questions about this study right now? --OK. Please take the next 30 minutes to fill out these materials. If you have any questions, please come up to the front of the room to ask me. [30 minutes pass with 5 minute warning] If you require additional time to complete the materials, I will give you an envelope in which to put them when you're done. You can give the envelope to a person at the front desk in the department; I have a mailbox there.

OK, please hand in your consent form and your surveys. Now I am going to conduct the lottery for the two \$50 gift certificates to the college bookstore as a thank you for your attention today. All students names' from each class roster are in these separate bags. I will choose a winner from each class. The winner from section A is: [insert name]. The winner from section B is: [insert name]. Congratulations! -- At the end of the semester, I will return to ask you to fill out a few more surveys. Please feel free to contact me if you have any questions before then. If you have any unused materials, please leave them at the front of the room. Thanks!

## APPENDIX H

### CONSENT FORM

My name is Kimberlee Trudeau and I am a doctoral candidate in the Social-Personality Psychology Ph.D. Program at the Graduate Center of the City University of New York (CUNY), and Principal Investigator of this project, entitled "Writing in Nursing Education." The purpose of this study is investigate how students describe their experiences and attitudes about nursing. Participating in this study entails filling out a few surveys and writing answers to some questions now and at the end of the semester. It also entails giving me permission to get a copy of your written reports for NU103 this semester from Prof. McGuinn. NOTE: You must be at least 18 years old to participate in this study. All 80 students of NU103 are being invited to participate in this study.

Writing answers to some questions and filling out the surveys should take less than 30 minutes. All information gathered will be kept strictly confidential, and will be stored in a locked file cabinet at CUNY Graduate Center, to which only I will have access. I will keep your signed consent form separate from your other materials. At any time you can stop participating in the study and withdraw your submitted materials without penalty. You may also choose not to answer specific questions without penalty. Participating in this study will not affect your grade in this course. Your professor will not know who chose to participate and who did not.

There is no known risk involved in this study. The benefit of your participation is that you may enjoy the opportunity to reflect upon your experiences and attitudes about nursing, as well as "contribute to the ongoing development of the profession's body of knowledge" (American Nurses Association's Code for Nurses, 1985) about writing in nursing education, thus helping future nursing students.

To thank you for your attention today I am going to give a \$50 gift certificate to the college bookstore to one student in each of the two NU103 classes. I will hold another lottery for a \$50 gift certificate to the college bookstore at the end of the semester for those who participated in the study.

I may publish results of this study, but names of people, or any identifying characteristics, will not be used in any of the publications. I will share preliminary findings from this study with the class either in person and/or in a summary page next semester. Those of you who would like a copy of the final results of the study, please write your address on the back of the consent form you return to me.

If you have any questions about this research, you can contact me at (212) 817-8742 or [kjtrudeau@prodigy.net](mailto:kjtrudeau@prodigy.net) or my faculty advisor, Dr. Colette Daiute (212) 817-8711 or [cdaiute@gc.cuny.edu](mailto:cdaiute@gc.cuny.edu). If you have questions about your rights as a participant in this study, you can contact Hilry Fisher, Sponsored Research, The Graduate Center/City University of New York, (212) 817-7523, [hfisher@gc.cuny.edu](mailto:hfisher@gc.cuny.edu). Thank you for your participation in this study.

**Consent Statement:** I have read and understood the information above. The researcher has answered all of the questions I had to my satisfaction. She gave me a copy of this form. I consent to participate in the "Writing in Nursing Education" study.

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 Participant's signature

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 Date

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 Investigator's signature

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 Date

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 Participant's printed name

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 Investigator's printed name

## APPENDIX I – DEBRIEFING FORM

Spring 2005

Dear Participants of The "Writing and Nursing" Study,

This past year I have spent reviewing the data that you and/or your classmates provided for my dissertation study "Collaborating in Care: Developing a Dialogic Theory of Empathy in Nursing Education." Below is the debriefing, that is, where I get to tell you what I was doing and why:

Perhaps you know that empathy is typically considered a personality trait that people are born with (Davis, 1994; MacKay et al., 1990). Fortunately (for us social scientists!), empathy is also a skill that can be taught (Wheeler & Barrett, 1994); however, explanations of empathy in nursing education simply as traits or skills deny the opportunity to empower both nurse and client to *experience empathy dialogically* within the nurse-client interaction. As more empathic nurse-client interactions may benefit both nurses and clients, including empathy training within nursing education seemed like a good idea.

The format of this study was (a) a dialogical theory-based writing intervention (i.e., the three Meaningful Interaction papers) and (b) pre/posttest surveys and open-ended essay questions (e.g., "What is your idea of an ideal nurse?" in a randomized design (i.e., one section—determined by a coin toss—did the Meaningful Interaction papers, one did not). In Fall 2003, 44 of you signed consents for me to use your data (surveys and essays) for this study.

My major hypothesis was that, at the end of the semester, there would be more evidence of dialogism in the surveys and essays in the group that wrote the Meaningful Interaction papers than the group that didn't. I ran some statistical tests on the data and found that the Meaningful Interaction group showed more change on the dialogic items of the surveys but not on the ideal nurse essays. When I asked you to define empathy at the end of the semester, the responses from both groups included: empathy-as-action, empathy-as-cognition, empathy-as-feeling, and empathy-as-ability. Preliminary review of the Meaningful Interaction papers themselves suggest that participants described more client emotions (implying sensitivity to the other's perspective or empathy) for the child care and long term care assignments than for the senior citizen assignments. Therefore, it appears that participants' appreciation of the other's perspective (i.e., reports of client's emotions) was influenced more by which group they were interacting with than their experience with the assignment over time. This finding is consistent with dialogism theory.

In closing, because nurses and clients are strangers brought together in challenging circumstances, appreciation of dialogic empathy (i.e., empathy as a mutual experience rather than the responsibility of the nurse alone) could potentially empower both nurse and client and, ultimately, make a significant difference in their interactions. If you have questions or would like further information, email me at [kt Trudeau@gc.cuny.edu](mailto:kt Trudeau@gc.cuny.edu).

AND THANK YOU SO MUCH TO THOSE OF WHO HELPED MAKE THIS STUDY POSSIBLE!!

Kimberlee J. Trudeau, Doctoral Candidate, CUNY Graduate Center

## APPENDIX J – CONTROL CONDITION

NEW YORK CITY COLLEGE OF TECHNOLOGY  
DEPARTMENT OF NURSING

NU103L

Prof. McGuinn

**Learning Activity:** Growth and development in the Well Child:

Toddler and Pre-Schooler

**Clinical Lab:** Child Care Center**Objectives:**

After completion of assigned reading and viewing required audio-visual material, the student will:

1. In the first paragraph(s) of your paper, describe in writing the developmental tasks appropriate for the **toddler and preschooler** according to Erikson's theory of growth and development.
2. Participate in activities at the center.
3. Observe psychological characteristics of growth and development of the child at this age.
4. Describe in writing expected and observed psychosocial characteristics of growth and development appropriate to the child of age groups selected using the following guide (use two column format) with the expected column written in short bullet format and the observed column written in complete sentences.

**Characteristics:****Expected****Observed**

- a. Emotional development
  - b. Super ego development
  - c. Characteristic of play
  - d. Self Image (Identification-Awareness of sexuality)
  - e. Cognitive development
  - f. Communication/Extent of vocabulary
  - g. Gross and fine motor skills
5. Identify in writing the nutritional needs in general of children at these age groups and compare the nutritional values of the luncheon meal served to the children at the center. Illustrate the expected and observed nutritional requirements using the food pyramid.
  6. Identify in writing safety needs in general of children at these age groups and evaluate safety precautions instituted at the child care center.

7. Identify the following:
  - a. Philosophy and objectives of the center
  - b. Services offered
  - c. Funding of the agency
  - d. Staffing
8. Cite at *least* two references used. (Use the correct A.P.A. bibliography format. See Writing Resources Booklet for guidelines and examples.)

Note: Items # 1,4 (expected), 5 (expected), 6 (expected) and 8 are to be completed **prior** to the experience.

Items # 4 (observed), 5 (observed), 6 (observed) and 7 are to be completed **after** the experience.

**Specifics:** Paper **not** to exceed **12 pages**, not including separate cover sheet with name, section, location and date of experience.

Font: **12 pt**

**For this assignment, every student must utilize the writing tutors in the College Learning Center and submit documentation of utilization directly to Prof. McGuinn.**

Bring in two copies of your report: one copy for your preceptor and one copy for Prof. McGuinn.

**PLEASE PROOFREAD YOUR WORK CAREFULLY BEFORE HANDING IT IN.**

*REV EMFA/03*

## APPENDIX K – CONTROL CONDITION

NEW YORK CITY COLLEGE OF TECHNOLOGY

DEPARTMENT OF NURSING

NU103L

Prof. McGuinn

**Learning Activity:** Growth and Development in the Well Older Adult

**Clinical Lab:** Senior Citizen Center

**Objectives:**

After completion of assigned reading and viewing audio-visual material, the student will:

1. In the first paragraph(s) of your paper, describe in writing the development tasks appropriate for the older adult according to Erikson.
2. Interact with the older adults at the Senior Citizen Center.
3. Participate in activities at the center.
4. Observe psychosocial characteristics of growth and development of an older adult.
5. Describe in writing expected and observed psychosocial development characteristics of normal growth and development of the older adult (use 2 column format) with the expected column written in short bullet format and the observed column written in complete sentences.

<u>Characteristics</u>	<u>Expected</u>	<u>Observed</u>
<ol style="list-style-type: none"> <li>a. Self-Image (include effects of aging, illness, reminiscing, etc.)</li> <li>b. Social development (including isolation categories: behavioral, presentational, geographical, and attitudinal)</li> <li>c. Cognitive development</li> <li>d. Sexuality</li> <li>e. Communication skills</li> <li>f. Gross and fine motor skills</li> </ol>		
<ol style="list-style-type: none"> <li>6. Identify in writing nutritional needs in general of the older adult and compare the nutritional value of the luncheon meal served to the seniors at the center. Illustrate the expected and observed nutritional requirements using the food pyramid.</li> </ol>		
<ol style="list-style-type: none"> <li>7. Identify in writing the safety needs in general of the older adult and evaluate the specific safety precautions instituted at the senior center.</li> </ol>		

8. Identify the following:
- Philosophy and objectives of the center
  - Services offered
  - Funding of the agency
  - Staffing
9. Cite at *least* two references used. (Use the correct A.P.A. bibliography format. See Writing Resources Booklet for guidelines and examples.)

**Note:** Items # 1, 5 (expected), 6 (expected), 7 (expected) and 9 are to be completed **prior** to the experience.

Items # 5 (observed), 6 (observed), 7 (observed) and 8 are to be completed **after** the experience.

**Specifics:** Paper *not* to exceed **12 pages**, not including separate cover sheet with name, section, location and date of experience.

Font: **12 pt**

**For this assignment, every student must utilize the writing tutors in the College Learning Center and submit documentation of utilization directly to Prof. McGuinn.**

Bring in two copies of your report: one copy for your preceptor and one copy for Prof. McGuinn.

**PLEASE PROOFREAD YOUR WORK CAREFULLY BEFORE HANDING IT IN.**

REV EM FA/03

**APPENDIX L – BOTH CONDITIONS**  
**NEW YORK CITY COLLEGE OF TECHNOLOGY**  
**DEPARTMENT OF NURSING**

NU 103L

Prof. McGuinn

**Learning Activity:** Growth and Development in the Well Older Adult

**Clinical Lab:** Senior Citizen Community Center

**Objective:** After completion of the assigned senior citizen community center clinical lab, the student will have the opportunity to utilize his/her critical thinking skills by analyzing the experience and describing in writing the following topic:

Project yourself into the future, and visualize how you see yourself as an older adult. Include activities and interests that you will be actively participating in during your "senior years".

The narrative style paper is limited to one page, *double-spaced*, 12pt font. Please include your name, NU 103L section, and date on a separate cover sheet.

The paper is due on the morning of the first clinical lab day in the Long Term Care Facility (LTCF). Bring in two copies of your essay: one copy for your preceptor and one copy for Prof. McGuinn.

For input and assistance with this paper, every student must utilize the writing tutors at their location in the College Learning Center. Please turn in the paper documenting your utilization of the writing tutors to Prof. McGuinn.

**PLEASE PROOFREAD YOUR WORK CAREFULLY BEFORE HANDING IT IN.**

REV EM FA/03

## APPENDIX M – CONTROL CONDITION

## NEW YORK CITY COLLEGE OF TECHNOLOGY

## DEPARTMENT OF NURSING

NU 103L

Prof. McGuinn

**Learning Activity:** Health Maintenance of the Client as a Resident

**Clinical Lab:** Long Term Care Facility

**Objective:** After completion of the assigned long term care facility clinical lab, the student will have the opportunity to utilize his/her critical thinking skills by analyzing the experience and describing in writing the following topic:

**Contrast your expectations before your visit to the long term care facility with your views and feelings after having attended the center.**

The narrative style paper is limited to one page, *double-spaced*, 12pt font. Please include your name, NU 103L section, and date on a separate cover sheet.

The paper is due one week after the completion of all 3 LTCF experiences. Bring in two copies of your essay: one copy for your preceptor and one copy for Prof. McGuinn.

**PLEASE PROOFREAD YOUR WORK CAREFULLY BEFORE HANDING IT IN.**

EM FA/03

**APPENDIX N – EXPERIMENTAL CONDITION**

**ON A SEPARATE PAGE, ATTACHED TO BOTH COPIES OF YOUR REPORT, PLEASE DO THE FOLLOWING:**

1. Select the **most meaningful interaction** that you had with a client (child) at the center.
2. **Describe the interaction from the client's point of view.** *What would you have been thinking and feeling during the nursing student-client interaction if you were in the client's position.* (NOTE: To protect the client's confidentiality, do not use any names or other identifying characteristics like birth date.)
3. Now **rewrite / redescribe the interaction including the perspectives of both participants.** Write what was happening at the time; include what each of the participants (student and client) were thinking and feeling.
4. Lastly, **reflect back on this interaction.** Is there anything that would have helped you understand the client's point of view? Or is there something that may have helped you in the process of interacting with this client?

**Format:** Put the text for each of the above points (1, 2, 3, 4) under headings as follows:

1. List the date of the lab for the selected interaction
2. "Describe the Interaction from the Client's Point of View
3. "Rewrite / Redescribe the Interaction from Both Perspectives (Student and Client)."
4. "Reflect Back on this Interaction."

**The narrative style paper is limited to 1 typed page per clinical lab, *double-spaced*, 12 pt font.**

**PLEASE PROOFREAD YOUR WORK CAREFULLY BEFORE HANDING IT IN.**

*EMFA/03*

**APPENDIX O – EXPERIMENTAL CONDITION**

**ON A SEPARATE PAGE, ATTACHED TO BOTH COPIES OF YOUR REPORT, PLEASE DO THE FOLLOWING:**

1. Select the **most meaningful interaction** that you had with a client (older adult) at the center.
2. **Describe the interaction from the client's point of view.** *What would you have been thinking and feeling during the nursing student-client interaction if you were in the client's position.* (NOTE: To protect the client's confidentiality, do not use any names or other identifying characteristics like birth date.)
3. Now **rewrite / redescribe the interaction including the perspectives of both participants.** Write what was happening at the time; include what each of the participants (student and client) were thinking and feeling.
4. Lastly, **reflect back on this interaction.** Is there anything that would have helped you understand the client's point of view? Or is there something that may have helped you in the process of interacting with this client?

Format: Put the text for each of the above points (1, 2, 3, 4) under headings as follows:

1. List the date of the lab for the selected interaction
3. "Describe the Interaction from the Client's Point of View
3. "Rewrite / Redescribe the Interaction from Both Perspectives (Student and Client)."
4. "Reflect Back on this Interaction."

**The narrative style paper is limited to 1 typed page per clinical lab, *double-spaced*, 12 pt font.**

**PLEASE PROOFREAD YOUR WORK CAREFULLY BEFORE HANDING IT IN.**

*REV EM FA/03*

**APPENDIX P – EXPERIMENTAL CONDITION**

**ON A SEPARATE PAGE, ATTACHED TO BOTH COPIES OF YOUR ESSAY, PLEASE DO THE FOLLOWING:**

1. Select the **most meaningful interaction** that you had with a client (resident) at the center.
2. **Describe the interaction from the client's point of view.** *What would you have been thinking and feeling during the nursing student-client interaction if you were in the client's position.* (NOTE: To protect the client's confidentiality, do not use any names or other identifying characteristics like birth date.)
3. Now **rewrite / redescribe the interaction including the perspectives of both participants.** Write what was happening at the time; include what each of the participants (student and client) were thinking and feeling.
4. Lastly, **reflect back on this interaction.** Is there anything that would have helped you understand the client's point of view? Or is there something that may have helped you in the process of interacting with this client?

Format: Put the text for each of the above points (1, 2, 3, 4) under headings as follows:

1. List the date of the lab for the selected interaction
2. "Describe the Interaction from the Client's Point of View
3. "Rewrite / Redescribe the Interaction from Both Perspectives (Student and Client)."
4. "Reflect Back on this Interaction."

**The narrative style paper is limited to 1 typed page per clinical lab, *double-spaced*, 12 pt font.**

**The paper is due one week after the completion of all 3 LTCF experiences.**

**PLEASE PROOFREAD YOUR WORK CAREFULLY BEFORE HANDING IT IN.**

**APPENDIX Q**

**DEFINING DIALOGIC EMPATHY...**

**THE CODEBOOK**

Kimberlee J. Trudeau  
CUNY Graduate Center  
New York, NY

Spring 2003 - Spring 2005

## BACKGROUND

This codebook is designed from developing and applying the proposed model of dialogic empathy to data from first semester clinical nursing students from a public technical college in New York City.

## RATIONALE & ASSESSMENTS

The *narrative reflections* written by participants in the experimental condition were expected to highlight how participants think about their clients in interpersonal interactions. A definition of dialogic empathy was developed from the review of these data.

*Qualitative assessments* ("What is your idea of an ideal nurse?" prompt and What is Empathy? task) were designed to invoke narrative responses about how these nursing student participants think about nursing and empathy.

## WORKING DEFINITIONS

*Traditional Empathy:* Focus on the personal characteristics of an individual. Empathy is dispensed by the health care provider during the clinical interaction. This occurs due to the health care provider's empathic traits and/or empathic skills.

*Proposed Dialogic Empathy:* Focus on the interaction. Empathy is a process that occurs within the clinical interaction when there is enhanced sensitivity/awareness to the perspectives of both participants.

**DIRECTIONS FOR CODING RESPONSES TO  
NARRATIVE REFLECTIONS  
(Experimental Group Only)**

**DATA HANDLING DETAILS**

I transcribed these essays when I first received them. To avoid coding bias based on time (i.e., higher outcomes for essays completed later in the semester [Long Term Care] than earlier in the semester [Child Care]), in transcription identification numbers were replaced with asterisks before the files were printed.

NOTE: Only the paragraphs for Client's Perspective Only section and Both Perspectives section were coded from these essays (Child Care, Senior Citizen, Long Term Care). If an essay did not fit the Client Perspective then Both Perspectives structure (e.g., if it was one long description about an intervention without any clear place to delineate what the student did for one part of the assignment and the other), then the essay was not coded and coded as missing for the variables. Not all students labeled the sections 1 then 2 so a careful review of the text is the only way to determine if the directions were followed for this assignment.

**NARRATIVE REFLECTIONS:  
HOLISTIC CODING OF DIALOGISM**

These essays were first coded holistically. Each essay receives one code (1, 2, or 3). Begin with the coding criteria for number 3. If "yes" the coding criteria applies to that essay, write the ID number in the Dialogism = 3 column on the coding sheet. If not, review the coding criteria for number 2. Again, if "yes" the coding criteria applies to that essay, write the ID number in the Dialogism = 2 column on the coding sheet. If not, review the coding criteria for number 1 to verify that it is appropriate; if so, write the ID number in the Dialogism = 1 column on the coding sheet. If the coding criteria for number 1 does not appear to be appropriate for this essay, then re-review the coding criteria for numbers 2 and 3 for potential application.

**CLIENT'S PERSPECTIVE ONLY**

3 = DIALOGIC: Description by/from client's inner voice (i.e., client = I) at least once in the essay

*Child Care Center essay: "A stranger came into class today. She sat down and showed me how to hold scissors. I. I was embarrassed because I could not figure out how to cut the paper with my scissors. The strange lady asked me if I wanted some help and I nodded yes. She took my hand and showed me how to put my fingers into the holes of the scissor and how to cut a straight line. I am so glad that she helped me."*

Rationale: Participants who wrote in the client's voice best demonstrated their ability to take on another's perspective, which is the core of empathy, and in this context shows an anticipation of other that indicates dialogism.

- 2 = LESS DIALOGIC: Description of client's thoughts, feelings intuited by the student

*Senior Citizen Center essay: "It was clear to me that the client was enjoying the process of "reliving" her life through pictures and felt proud of how rich her life was and how many people depended on her, at one time or another, and still cared about her in her old age. In addition, she was teaching me about life, as well. The client told me on more than one occasion that I remind her of one of her granddaughters, and perhaps some sort of transference occurred, and she in fact considered me her granddaughter, in need of her guidance and advice."*

Rationale: Participants who described client's thoughts and feelings in the student's voice provided a more distal and therefore, less dialogic and less empathic, representation of the client's perspective.

- 1 = LEAST DIALOGIC: Description of facts/actions (including speech) ONLY

*Long Term Care Facility essay: "My client, a Russian-Jew did not speak. Based on the information, which I had obtained from his chart, he only speaks Russian. In view of this communication barrier, no meaningful interaction took place between him and me. However, his only responses to questions such as "may I help you with your meals, do you enjoy your meals," and "how is your day" were by nodding of his head."*

Rationale: Participants who reported what happened without expressing one's recognition of the anticipated thoughts and/or feelings of one's audience indicated a lack of dialogic empathy.

### BOTH PERSPECTIVES

- 3 = DIALOGIC: Play by play interaction (i.e., "first, then this" can be inserted into the text at least 2 times) described in which student demonstrates an appreciation of how s/he and/or his/her actions are perceived by the client (i.e., attribution to/by client) at least once in the essay

*Senior Citizen Center essay: "The table with the three ladies sitting quietly not talking to each other seems the best to approach but as I introduce myself I feel as if they're really curious. Ms. B seems very interested in hearing why I want to become a nurse and she can't stop talking about her own nursing career. [new paragraph] I feel so good talking to someone about my country again; this student wants to hear about what it was like being a nurse in Yugoslavia. Talking about my home brings back so many happy memories. And I like the way the other women are listening, they also want to know about me. I feel as if they want to get to know me, maybe I'll have people to talk to here when I come to lunch again."*

Rationale: Participants who wrote an essay in which they demonstrated an appreciation of the context (i.e., play by play description versus reporting/summary diction) and an appreciation of how s/he and/or her/his actions were perceived by the client best demonstrated their ability to anticipate another's perspective of her/himself, i.e., dialogic empathy.

- 2 = LESS DIALOGIC: Play by play interaction (i.e., "first, then this" can be inserted into the text at least 2 times) described in which multiple perspectives are represented (includes description of dialogue between student and client)

*Long Term Care Facility essay: "He told me that he sometimes hates to be at the center and he just wants to go home. Then I asked him where he lived. Her talked really slow hence I was very patient with him. He reminded me of my deceased grandpa in the sense that when we spoke there periods of silence in between just as when grandpa and did."*

Rationale: Participants described the interaction play by play but did not attribute the client's perception of the student and/or her/his actions which is an important element of dialogism.

- 1 = LEAST DIALOGIC: Reporting by student (overview of multiple weeks or description of what client said ONLY; no specific actions are described). The report/overview *may* include client traits, student representing client's anticipation of her/him, or multiple perspectives.

*Child Care Center essay: "The little boys behavior was one that I have learn to recognize from my studies to be a fairly universal one for children. That behavior is called the peek-a-boo game. I made an effort to establish common ground with him by mimicking his behavior of coming in and out of his field of view. We played peek-a-boo back and forth for a few moments but then the teacher called him back to join his group."*

Rationale: Reporting what happened without expressing one's recognition of the anticipated thoughts and/or feelings of one's audience indicated a lack of dialogic empathy.

NARRATIVE REFLECTIONS:  
SENTENCE-BY-SENTENCE CODING

USING THE CODING FORM

Each essay contains two sections: 1) Client's Perspective, 2) Both Perspectives. The same coding system is used for both sections though they are tallied separately. Use one coding form for each essay. Add extra lines if you need them. On the first read-through, note the number of sentences, behaviors, psychological states, etc. On the second read-through, indicate level of dialogism.

**SENTENCE NUMBER:** Each sentence (group of words that ends in a period) is coded individually, e.g., S1 = Sentence 1, S2 = Sentence 2, etc. If there are more than 10 sentences, please write each subsequent sentence number and code it as you did the others. **NOTE** regarding quotations: If the student or client is speaking within quotation marks then the separate, consecutive lines of speech count as one sentence. For example, "The client said, "Don't bother me. I'm tired today" is one sentence, not two. Sometimes the student will put an entire paragraph or two of client's thoughts with quotation marks around them; those are counted as separate sentences because they are not speech.

On the data itself, circle words/phrases that represent behaviors and psychological states (if applicable) and write above each circled word/phrase the abbreviation for the particular category.

On the separate coding form, for each sentence:

- 1) Note the number of characteristics for each category, and
- 2) Indicate the degree of dialogism.

Example of a sentence from a response to an intervention essay: "The client was very compliant and seemed grateful for any help or attention that was given to her." On the data form, compliant and grateful are circled. As "compliant" is a trait or characteristic of the client [T] and the client's emotion is perceived as "grateful" [E], the dialogism code = 3. No context is mentioned that that is coded as 0.

The coding form would read as follows:

Major cat	SPEAKER		STUDENT		CLIENT		CX DIALOG	
	S	C	Behav	Psyc	Behav	Psyc		
Subcat								
ID #	??	1 0	0	0	0	T,E	0	3
Total		1 0	0	0	0	2	0	3

The narrative reflections are coded for the following characteristics. See Table 1 at the end of this codebook for examples.

1. The speaker (1 in the "S" column for Student, 1 in the "C" column for Client)
2. Number of behaviors of the Student
3. Number of psychological states of the Student

4. Number of behaviors of the Client
5. Number of psychological states of the Client
6. Number of context (i.e., time, location, condition) words
7. The degree of dialogism.

These categories are described in detail below.

#### SPEAKER COLUMN

Because students are asked to describe the same clinical interaction from different viewpoints (i.e., first from the client's perspective then from both perspectives), it is important to note in whose voice the student describes the interaction. For example, who is the "I" in each sentence? "I came into the room to attend to the client" suggests that the Speaker is the student. "I was sitting in bed when the student nurse came into the room to attend to me" suggests that the Speaker is the client. When participants say, "If I were the client then I would have felt ..." the Speaker is the client because it shows that the student is making an effort to take on the client's perspective. If the Client's voice is only represented as a quote then the Speaker is Student.

NOTE: If it's NOT the client (i.e., no use of "I" from client's voice OR "if I were the client"), then default to the student as Speaker. For example, the student is the Speaker when the sentence is written in the 3<sup>rd</sup> person as in the following: "At first the patient was defensive..."

The following categories are designed to assess whether the student is predominately reporting (i.e., listing behaviors) or emotionally relating (i.e., noting psychological states) the clinical interaction. **The number of separate BEHAVIORS and PSYCHOLOGICAL STATES for each sentence are noted for student and client separately on the coding form.** For example, "introduced and explained" is TWO behaviors; this point is described in more detail for the Psychological States column. The total number for each column is reported at the end of each column for Client's Perspective and Both Perspectives separately on the coding form. Only the behaviors and psychological states of the client and student are coded here.

STUDENT: There are separate columns for Student's Behaviors (Actions, Speech) and Student's Psychological States (Emotion, Cognition, Intention, Desire, Trait, Ability, Perception).

CLIENT: There are separate columns for Client's Behavior (Actions, Speech) and Client's Psychological States (Emotion, Cognition, Intention, Desire, Trait, Ability, Perception).

BEHAVIOR COLUMN: Reports of what they are doing or *not* doing  
The next question is: what is the student/client doing? Example: "After I helped her pick out her stockings, I put on her shoes" = 2 Actions for the Student (helped, put) and 1 for the

Client (pick out) because the client was involved in the action. It is also important to include reports of what is NOT being done (e.g., not talking) because it was part of the interaction as perceived by the student. See Table 1 for examples of words for this category. Example: "We interacted" is 1 A for both Client and Student.

If the content can only be known because the Client reported it to the Student then those statements are coded as Client's speech.

- A = Actions
- S = Speech (content is NOT coded)

All behavior, including speech, is indirect (distal) and therefore NOT related to a psychological state unless implied in the use of words. For example, there is speech that includes emotions or cognitions or intent or is described as having emotion (e.g., complaining or opened up) which is coded as S in the Behavior column and E in the Psychological States column, described in detail below. Example of Action with Psychological states are "no overt signs of displeasure" and "appeared to be in pain" because the student is observing the actions of the client and intuiting her/his psychological state from the action (Behavior = A, Psych state = E). Another example: "showed her I was interested" is coded Behavior = Action and Psych state = Cognition for the Student.

**The content of the Speech is NOT coded unless the dialogic process is present.** That is, if the Speaker is the Student describing the psychological state of the Client. Therefore "I explained to her that the vaseline helps lessen the pain" is coded as S for Student's Behavior and E for Client's Psychological State because they are spoken words that show the student's sensitivity of the client's psychological state (i.e., pain); moreover, this shows a relationship between the student's action and the client's emotion. What the client actually says is the student's report only so no dialogic process is possible.

**PSYCHOLOGICAL STATE COLUMN:** Reports of thinking/thoughts, feeling/emotions, desire, intention, traits/characteristics, abilities, intentions

In the course of becoming more empathic, one must observe another's actions and interpret the thoughts, feelings, traits, abilities, and perceptions of the actor. Therefore, psychological states are coded on the following dimensions. DOESN'T talk is a trait and should be noted under Psychological State as T. "Unable to convey thoughts" is coded as AB for Ability, not Cognition.

Other examples: "Warm, friendly, and reserved woman who [went to the store every day]..." = 4 traits/characteristics. "So that he would feel comfortable" is coded as Client's Psychological State = Emotion because it shows sensitivity to the client's psychological state. Client as Speaker: "She reminded me of my children who I miss" is Client = Cognition AND

Emotion because shows student's sensitivity to both. Student as Speaker: "We had an interaction I thought was meaningful" = Student's Psych state = Cognition. Student as Speaker: "It also bothered me he complained" = Student's Psych state = Emotion, Client's Behavior = Speech, Client's Psych State = Emotion. Student as Speaker: "Want to reassure" or "Try to encourage him" = Student's Psych State = Intention and Client's Psych State = Emotion. NOTE: Traits are not diagnoses; they are characteristics perceived by the Student. "Usually they're all stuffing food down my throat" shows Student's sensitivity to client's thoughts so Client's Psych State = Cognition.

**The content of the Thoughts/Feelings/Desires/Abilities is NOT coded unless the dialogic process is present.** That is, if the Speaker is the Student describing the psychological state of the Client. For example, "I thought I might worsen the pain" is coded Student's Behavior = Cognition and Client's Psychological State = Emotion because the student is anticipating the client's emotional reaction to her/his action. In addition, if the Speaker is the Client describing the psychological state of the Student or the Client is suggests dialogism because the Student is intuiting the Client's thoughts. For example, the client as speaker notes "when the student brushed my hair, I felt the carefulness" then it is coded as Student's Behavior = Action and Client's Psychological State = Emotion and Client->Student = Intention. Student as speaker: "I wanted to reassure" = Student's Desire and Client's Emotion.

#### CODING ACTION AND PSYCH STATES

Examples: "She expressed her deep thoughts" – Speech [expressed] and Cognition [thoughts] for Client "I wanted to know" from Client's perspective = Psych of Desire [wanted] and Cognition [know]. "She tried to imitate my action" from Student's perspective = Psych of Intention for Client only [she tried] because do NOT code details of other unless dialogic. "I am very happy I choose to talk to Mrs. X because I provided and ear for her talk to and to share her feelings" Student's Behavior = Action [provided ear], Stud's Psych State = Emotion [happy], Cognition [choose], and Client's Psych = Intention [for her to talk to], Intention [to share her feelings].

#### PLURAL VERSUS SINGULAR FOR BEHAVIORS AND PSYCH STATES

NOTE regarding *number of* psychological states: My objective is to capture the student's awareness of her/his own thoughts/feelings and those of the client. I expect higher numbers of psychological traits to indicate more awareness. Examples follow:

1. e.g., smart, funny, intelligent = "T, T, T" because it shows student's sensitivity to client's three different characteristics.
2. "Wish I was able to do this and wish I could do that" = "Ab[ility], Ab" because it shows student's sensitivity to client's concerns about TWO different abilities. [[As described above, the content of thoughts is not coded

UNLESS (as in this case) it includes the dialogic process, i.e., the student is projecting how the client thinks and therefore the content of those thoughts shows increased awareness by the student of the client's potential experience of the interaction. For example, from student's perspective "I wished I could communicate" = Desire only. However, if client expressed "I wished student had the ability" then it's the Client's Desire and the C->S' Abilities.]]

3. someone "wonders this or that" = "C" because it's ONE comparative wondering/cognition.

4. someone "wonders this AND that" = "C, C" because it's TWO separate wonderings/cognitions, shows more awareness of self/other than just wondering ONE thing.

5. "ready to greet client with a smile and offer him a bath" = "I, I" because student is showing awareness of TWO separate intentions.

6. "friendly person willing to let me assist him" is "T, I" because includes trait and intention.

In addition, if the student's report of the client's thoughts includes a description of the perceived psychological state of the student then it (C = cognition, E = emotion, T = trait, D = desire, I = Intention, Ab = Ability) is noted in the CLIENT Psych State column.

#### CONTEXT (CX) COLUMN

As explained above, an important component in developing an appreciation of empathy as a dialogical phenomenon is appreciating the importance of setting on individuals in the report of one's observations and attributions. Therefore, elements of context are coded; i.e., any term that refers to when or where or under what conditions something happened. Context is typically represented in an indirect clause. There are three types of context: time, location, and conditions. Specific examples are included in Table 1.

*Check: A good test of whether text should be coded as a "context" is to ask the question "Does this statement include an indirect clause [i.e., part of the statement could be dropped and still be a complete sentence] with information about where or when something occurred?" For example, "A stranger came into class today." Today is WHEN (T=time). CLASS is WHERE (L=location).*

#### DIALOGISM (D) COLUMN

It's necessary to divide coding by speaker status because a) choice of speaker was done by the student and therefore has discourse value and b) choice of speaker is related to level of dialogism (e.g., speaker = client is more dialogic because shows student's anticipation of

other's perspective). The Ideal Nurse responses did not include this opportunity to speak in the client's voice. Therefore speaker as student is similar to the coding for dialogism for the Ideal Nurse responses but speaker as client begins at one level higher AND includes the most dialogic level of all = anticipation of client's perspective of the student. These levels are differentiated by weighted coding similar to that used for the Ideal Nurse responses.

### Speaker = STUDENT

1 = student NOT anticipating other (no interaction; overall statements/summary of interaction only; observation is NOT interaction; nothing about particular client; actions that occurred in the past [including speech], i.e., before the interaction described took place, are coded as a 1 because they are general context comments.); NO COMMUNICATION BETWEEN STUDENT/CLIENT

*For example, "Mrs. X is 95year old client who is at present diagnose with glaucoma (with blindness in the left eye), difficulty hearing in both ears and arthritis among other things." The Speaker is the student. There is no Behavior or Psychological State reported in this sentence of an interaction essay about a long term care facility client, just a diagnosis.*

2 = 4 = student anticipating other a little (interaction, e.g., "said" or "coming toward me" because they show implied other, student's perception reported; *one person thinking of other person, one person receiving the action of another person*); REPORTING ACTION/SPEECH or lack thereof

*For example: "He hugged me and sat on my lap." The Speaker is the student. The Behavior of this child at the child care center is reported as "hugged" and "sat" (coded as actions).*

3 = 9 = student anticipating other a lot (other/client-focused); also includes student's reflection on own thoughts/feelings; client's perception intuited; DESCRIBING EMOTIONS/THOUGHTS

*For example: "In the beginning of the interaction he must have been thinking who are these girls and what are they doing here." The Speaker is the student. The Psychological State of the senior citizen described here is "thinking" (coded as cognition).*

This includes, for example, when the student as Speaker notes that the client is "complaining." So it is coded Client's Behavior = Speech and Client's Psychological State = Emotion because the student is intuiting HOW the client feels while s/he is talking and receive a "3" for dialogism. In sum, any sentence with a thought/emotion reported or intuited receives a 3 for dialogism.

### Speaker = CLIENT

2 = 4 = student as client anticipating other a little (interaction, e.g., "said" because it shows implied other, student's perception reported, *one person thinking of other person*,

*one person receiving the action of another person*); REPORTING ACTION/SPEECH.

*For example, "I told her 'no, get the real nurse. Not today.'"* The Speaker is the long term care facility client. The Behavior reported is the quoted speech (coded as speech).

3 = 9 = student as client anticipating other [client] a lot (other/client-focused) ; also includes student's reflection on own thoughts/feelings; client's perception intuited; DESCRIBING EMOTIONS/THOUGHTS/PERCEPTIONS

*For example, "I wanted to read something so I decided to go to the bookshelf that I had seen sitting from my seat."* The Speaker is a man at the senior citizen center. The Psychological States mentioned are "wanted" (coded as desire) and "decided" (coded as cognition).

4 = 16 = student as client anticipating other [student] a lot (self/nurse-focused); student's perception intuited by client; SHOWS HOW STUDENT BELIEVED HER/HIMSELF TO BE PERCEIVED BY THE CLIENT

*For example, "In school today there were three strange-looking people in my classroom."* The Speaker is the child. The Psychological State in the Client → Student column is the attribution of "strange-looking" to the nursing students.

NOTE: Interactions between others are included as 2s (even when the student is not participating; e.g., teacher says to child) because we are interested in HOW the essay was written (indicates appreciation of dialogism, i.e., anticipation of interactivity) versus the specific content.

**DIRECTIONS FOR CODING RESPONSES TO  
"WHAT IS YOUR IDEA OF AN IDEAL NURSE?" QUESTION**

**DATA HANDLING DETAILS**

I transcribed the responses to the pre and post Ideal Nurse question into separate electronic files. To avoid coding bias based on condition (i.e., higher outcome in experimental condition than in the control condition), identification numbers were replaced by asterisks by a person other than the author, then the files were printed. To avoid coding bias based on time (i.e., higher outcome at posttest than at pretest), each file was printed, the separate pages were manually shuffled, then three-digit numbers from a random numbers table were put on the back of each essay. The essays were then reordered by these random numbers for coding. This procedure was conducted twice – once for the categorical coding (i.e., level of dialogism per sentence using the levels of dialogism table) and again for the holistic coding.

**IDEAL NURSE QUESTION: HOLISTIC CODING OF DIALOGISM**

First, these essays are coded holistically. To code each essay was for holistic level of dialogism, please assign each essay to a pile representing one of the following three categories. Then use the Ideal Nurse holistic coding form to list the ID numbers for the essays you put into each category.

- 1 = LEAST DIALOGIC (i.e., 1): essays that included only descriptions of caring traits and/or abilities

*For example: "An ideal nurse must have the following qualities: dedication, compassion, empathy and willingness. These qualities must not only be present towards the patients but also your coworkers. Knowledge and efficiency is also important."*

- 2 = LESS DIALOGIC (i.e., 2): essays that mentioned patient needs (e.g., make them comfortable) but did not give the clients a voice in their care.

*For example: "Someone who puts the patient care first at all times. A good nurse shows understanding and gives respect to their patient. Ideal nurses make the sick feel comfortable and ultimately better."*

- 3 = DIALOGIC (i.e., 3): essays that highlighted hearing the client, responding to their needs, and/or seeing the other as self.

*For example: "An ideal nurse is a person who is willing to help others by putting their needs before his or her own needs. Be patient and willing to listen to the patient. Address the problems of the client within a reasonable time frame and communicate the progress of your actions with the client. An ideal nurse never forget that he or she could be a patient themselves."*

## IDEAL NURSE QUESTION: SENTENCE-BY-SENTENCE CODING

### USING THE CODING FORM

Then code each sentence separately (S# 1-4 on coding forms; add extra lines if you need them). On the first read-through, note the number of characteristics (Caring Characteristics, Empathy, Professional Skills and Attitudes). On the second read-through, indicate level of dialogism.

On the data, 1) circle words/phrases that represent characteristics of an ideal nurse (if applicable) and write above each circled word/phrase the abbreviation for the particular category and 2) underline word/phrases that suggest dialogism.

On the separate coding form, for each sentence:

- 1) Note the number of characteristics for each category, and
- 2) Indicate the degree of dialogism.

Example of response to "What is your idea of an ideal nurse?": "The ideal nurse is caring." On the data form, caring is circled. As "caring" is a trait or characteristic of the nurse, the dialogism code = 1.

The coding form would read as follows:

		CC		PS&C		AT		CN	D
		C	A	S	O	L	C		
ID #	?	0	1	0	0	0	0	0	1
Total		0	1	0	0	0	0	0	1

### CODE FOR CHARACTERISTICS ONLY

If participants' list personal narratives (e.g., "I want to become a nurse because ...") or specific examples of caring that do not include a description of specific characteristics, or self-specific statements without characteristics (e.g., "An ideal nurse is me.", please write N/A for "not applicable" for those particular sentences.

NOTE: If one writes a summary statement (e.g., "There are the main things about being an ideal nurse.") then the specific elements expressed in the prior sentences are repeated and dialogism is determined based on the sentence itself.

### NURSING IS CARING

#### *Caring Characteristics (CC)*

I am interested in the degree to which students describe qualities of being an ideal nurse and empathy as cognitive or affective, as defined by the Webster's Dictionary (1988). See Table 2 at the end of this codebook for examples of these categories.

Cognitive (C) are those related to perception and words of the nursing student (e.g., understanding, very good listener, attentive, patient, unbiased in judgment).

Affective (A) are those related to feelings or emotions of the nursing student (e.g., caring, compassionate, NOT acting angrily towards them).

*Empathy*

If the participant uses the word "empathy" (e.g., empathic, separate sympathy from empathy, description of patient as self or self as patient), please write "E" it in the "DIAL" column next to the dialogical assessment.

These categories will be tallied for each participant response and reported on the coding form.

**PROFESSIONAL SKILLS AND ATTITUDES (coding used for "What is your idea of an ideal nurse" ONLY)**

There are many characteristics associated with nursing included in the pilot responses to the "What is your idea of an ideal nurse?" question. These are organized into the following categories.

- 1) Characteristics, including behaviors and traits, of professional competence (subcategories: Self-focused; Other-focused) and,
- 2) Attitudes about nursing (subcategories: Likes it; Committed to it).

Like the Cognitive and Affective Caring Characteristics, these will be tallied for each response and reported on the coding form. See **Table 3 at the end of this codebook** for examples of these categories.

*Professional Competence (PC)*

This category includes characteristics that indicate traits and behaviors associated with being an ideal nurse. These characteristics are divided into two subcategories: a) Self-focused (S) and b) Other-focused (O).

Self-focused (S) characteristics are those that do not presume interaction with another (e.g., efficient, organized, confident, works very hard, able to balance personal and professional lives, has skills, knowledgeable).

Other-focused (O) characteristics are those that do presume interaction with another (e.g., respectful, honest, friendly, responsible, patient advocate, puts clients first, looks out for client, teach client, collaborate with colleagues, not mistreat, helps patient/provides care for [versus "loving care" which is coded CC/A]).

*Attitudes about Nursing (AT)*

This category includes phrases that indicate that an ideal nurse a) Likes nursing (L) or b) is Committed to nursing (C).

Likes nursing (L) characteristics are those that indicate fondness for nursing (e.g., gets personal satisfaction from helping others, passion for nursing, likes/loves/has pride in job).

Committed to nursing (C) characteristics are those that indicate dedication to nursing (e.g., committed, dedicated, willing to work hard/sacrifice time, thinks no job of nurse is disgusting or dirty, not only in it for the money).

#### CONDITION (CN)

An important component in developing an appreciation of empathy as a dialogical phenomenon is appreciating the importance of conditional factors on individuals in the report of one's observations and attributions. Therefore, elements of context are coded; i.e., any term that refers to when or where or under what conditions something happened. Context is typically represented in an indirect clause including when, even, who, if. **See Table 4 at the end of this codebook** for examples of this category.

#### DIALOGISM (D)

Level of dialogism (1 through 3, see levels below) will be coded for each sentence after the individual sentences have been coded for the characteristics above. Dialogism is represented by words or phrases that highlight the other person's experience. **See Table 5 at the end of this codebook** for examples of these levels.

A focus on the nursing student's qualities (e.g., great listener) only will be coded as LEAST DIALOGIC (i.e., 1). A focus on the nursing student doing something for the client without mention of the client's experience (represented by a verb or noun) will be coded as LESS DIALOGIC (i.e., 2). A focus on the client's experience (represented by a verb or noun) will be coded as DIALOGIC (i.e., 3).

1 = LEAST DIALOGIC: Trait/skill of a nurse (no other person is explicitly mentioned as receiving an action)

*For example: "An ideal nurse would be someone who is kind, thoughtful, helpful and someone who doesn't act as though they don't care."*

2 = LESS DIALOGIC: Nurse's trait/skill in actions towards others without mention of the client's experience

*For example: "Who will look out for you and your health."*

3 = DIALOGIC: Other's experience is highlighted

*For example: "Someone who will help you when you need."*

N/A = Sentence was not coded for characteristics because NOT characteristic of a nurse or empathy

## DIRECTIONS FOR CODING RESPONSES TO THE WHAT IS EMPATHY? TASK (POSTTEST ONLY)

### DATA HANDLING DETAILS

I transcribed the responses to these five questions into an electronic file. To preserve blinding of group, identification numbers were replaced with asterisks by another individual before the files were printed. Once printed, the essays were shuffled several times then numbered 1 through 31 (2 essays with all missing data had been included in the file). These were coded on three dimensions: 1) dialogic coding of cognitive qualities, 2) dialogic coding of affective qualities, and 3) context or skill/trait-based description.

Questions 1 and 2 of this task (What is empathy? Do you consider yourself to be empathic?) were evaluated on three dimensions: 1) dialogic coding of cognitive qualities, 2) dialogic coding of affective qualities, and 3) context or skill/trait-based description.

### DIALOGIC CODING OF COGNITIVE AND AFFECTIVE QUALITIES OF EMPATHY

The dialogic coding of cognitive and affective qualities is guided by the dialogic coding system used for the sentence-by-sentence analyses of the Ideal Nurse question.

- Cognitive empathy = 3 is defined here as relating to and/or understanding the experience of another. Self-centered cognition (e.g., know, find reason) or cognitive action toward the client (e.g. have patience, listen) = 2. Any mention of cognitive when coded as a SKILL = 1.
- Affective empathy = 3 is defined here as feeling what the person feels or not feeling sympathy (because this is an important distinction made in the course). Self-centered affective or affective action toward the client (e.g., caring, help people) = 2. Any mention of affective when coded as a SKILL = 1.

NOTE: If neither cognitive and/or affective empathy by these definitions was present, then "0" was the value given for those variables.

### CODING CONTEXT (0) VERSUS SKILL/TRAIT-BASED (1) DESCRIPTIONS OF EMPATHY

The context or skill/trait description was coded as 0 (context) or 1 (skill or trait). Phrases that implied context were "usually" or "try" or "sometimes" or "when..." Phrases that implied skill were "able to." Phrases that implied trait were "I am good a listener" or "I always."

Then I tried to identify which data came from participants in the control versus experimental condition. Because I only coded 50% of them correctly, I then separated the data by group and looking for patterns. Those patterns are described next.

QUES 1 "What is empathy?" ONLY -- TYPE OF EMPATHY: Experience [Ex], Action [A], Cognition [C], Emotion/Feeling [E], Ability [Ab]

In response to the first question, "What is empathy?" I realized that the responses could be separated into groups of a) empathy as an EXPERIENCE (typified by the use of "when" such as "Empathy is when...") versus b) empathy as described as what a nurse DOES (typified by the use of "show" or other actions).

- empathy-as-action (includes words like "showing" or "being," describes action)
- empathy-as-cognition (includes words like "understanding" and "putting oneself in someone else's position")
- empathy-as-feeling (includes words like "feel" or "feeling")
- empathy-as-ability (includes words like "able")

QUES 2 "Do you consider yourself to be empathic?" -- EMPATHIC INTENTIONS

In a review of the responses to the second question, I noticed that more experimental group participants than control group participants. It suggested sensitivity to context effects on empathic interactions, which is an important component of dialogism.

0 = No empathic intentions mentioned

1 = Empathic intentions mentioned (e.g., try, willing, would like to)

QUES 3 & 4: QUALITIES OF EMPATHY

I conducted a thematic analysis of the qualities of empathy. Six qualities were found across the control and experimental group data:

- listening
- caring or support
- sharing
- helping (included commitment to client)
- give patient self belief/worth

QUES 5: "Is empathy an important part of being a nurse? If so, why?"

I conducted a thematic analysis of the responses to this question. Seven themes were found across the control and experimental group data:

- empathy is treating patients as human beings
- empathy fosters trust
- empathy is innate
- empathy makes clients feel better
- if a nurse can't understand other's perspective how can s/he help
- put oneself in other's position
- empathic qualities are mandatory

**TABLE 1: CODING KEY FOR NARRATIVE ANALYSIS****SPEAKER = Student (1, 0)**

1 = YES

0 = no

**SPEAKER = Client (1, 0)**

1 = YES

0 = no

**BEHAVIOR (A, S, 0)**

A = action (e.g., sociable, drawing, interacted, crying, reading, waiting, smiling/with a smile, i left)

S = speech (what one says AND speech words such as reminisces); didn't speak

0 = none

**PSYCHOLOGICAL STATE (E, C, I, D, T, Ab, P, 0)**

E = emotions (e.g., sad, happy, fascinated, amazed, surprised, like, it's nice...)

C = cognitions (see, know, realize, think, looked as if..., looked forward to, wonder, curious, assume, reminded me, positive attitude, pride, patient, self esteem)

I = intentions (e.g., try, plan, willing, will, maybe, might, won't, I had to go, ready/opportunity to..., took initiative)

D = desires (e.g., want, hope, need, wish, reluctant)

T = trait/characteristic (NOT diagnoses, must be intuited; e.g., inquisitiveness, independence, compliant, fragile, helper, grumpy, nice, doesn't speak, had a lot of friends), includes role like caregiver, stranger NOTE: Client perceiving Student as young = trait

Ab = ability (e.g., can, able..., it was hard), can't speak

P = perception (see, looked at, listen, notice, heard)

0 = none

**CONTEXT (T, L, CN, 0)**

T = time (e.g., before and after, at first, yet, now, first, first time, until)

L = location or "in [a place]" (e.g., "in the yard")

CN = conditions include "when," "while," "although," "as" (e.g., "when classmates take toy")

0 = not applicable

**TABLE 2: CARING CHARACTERISTICS (CC)****SUBCATEGORIES**

<b>COGNITIVE-RELATED (THINKING BY NURSE)</b>	<b>AFFECTIVE-RELATED (FEELING BY NURSE)</b>
<ul style="list-style-type: none"> <li>• Understands, understanding</li> <li>• Listen, very good listener</li> <li>• Looks out for well-being of client</li> <li>• Unbiased in judgment, without prejudice and discrimination, not pass judgments, objectivity</li> <li>• Patient</li> <li>• Attentive</li> <li>• Put self in other's shoes</li> </ul>	<ul style="list-style-type: none"> <li>• Caring, acknowledging care, expressing care, expressing concern and feelings, reach out to others, caring, compassionate</li> <li>• (not) Feeling sorry for someone or their situation</li> <li>• Loves, loving, treat clients with love</li> <li>• Warm, kind, kind heart</li> </ul>

TABLE 3: PROFESSIONAL COMPETENCE (PC)

## SUBCATEGORIES

Self-Centered (S) – is/does alone	Other-Centered (O) – is/does for others
<ul style="list-style-type: none"> <li>• Confident</li> <li>• Competent</li> <li>• Efficient</li> <li>• Able to balance personal and professional</li> <li>• Organized</li> <li>• Clean, neat</li> <li>• On time</li> <li>• Ready at all times</li> <li>• Open to new ideas</li> <li>• Knowledgeable, know what one is doing, clinical knowledge, intelligent</li> <li>• Accurate in calculations</li> <li>• Precise and clear in documentation</li> <li>• Mastery with skills; works very hard; does [job] well</li> </ul>	<ul style="list-style-type: none"> <li>• Advocate for patient</li> <li>• Respectful, treats clients how like to be treated, treats clients with dignity</li> <li>• Courteous, honest, loyal, friendly, pleasant, wonderful personality</li> <li>• Alert, articulate</li> <li>• Responsible; dependable; going out of your way</li> <li>• Does job in a professional and caring manner; ensure client gets best care, physically cares for patient; Deliver care in appropriate way, properly care; provides the care; Help promote good health, puts client first, Not mistreat physically</li> <li>• Makes feel comfortable, finding time to care/listen, give support/comfort, take time to hold hand, sit with them, talk to them, wanting to do something good for others, help the other, giving, give money, offer suggestions</li> <li>• Educate</li> <li>• Cares for as verb ("caring" = CC/A)</li> <li>• Collaborates with colleagues</li> <li>• Care for client holistically, look at spiritual and social well-being, not only deal with physical ... holistic approach, attends to physical and mental</li> </ul>

## ATTITUDES ABOUT NURSING (AT)

## SUBCATEGORIES

Likes Nursing (L)	Committed to Nursing (C)
<ul style="list-style-type: none"> <li>• Gets personal satisfaction from helping others, likes to help people, love of people</li> <li>• Passion for nursing, likes/loves [job]</li> <li>• Pride in job</li> </ul>	<ul style="list-style-type: none"> <li>• Thinks no job of nurse is disgusting or dirty</li> <li>• Dedicated, true heart in nursing, not only in it for the money, committed to the job</li> <li>• Willing to help/works hard/sacrifice time</li> </ul>

**TABLE 4: CONDITION (CN)**

- When/while providing care
- Whenever the need arises
- When she is confident
- Even though/when time is limited
- No matter if...
- If she is needed/ leads to better care...
- Who ... e.g., most need help

TABLE 5: LEVEL OF DIALOGISM (D)

1 = LEAST DIALOGIC Trait/skill/motivation of a nurse (no other person is present)	2 = MORE DIALOGIC Nurse's trait/skill in actions towards others (other as [in]direct object); give/do for client	3 = MOST DIALOGIC Other's experience is highlighted (other as subject)
<ul style="list-style-type: none"> <li>• to care for</li> <li>• a love of people</li> <li>• who cares</li> <li>• organized</li> <li>• responsible</li> <li>• great listener</li> <li>• understanding</li> <li>• knows what they're doing, knows what to do, does job</li> <li>• puts care first (focus on care, not client)</li> </ul>	<ul style="list-style-type: none"> <li>• put patient first</li> <li>• cares for client</li> <li>• looks out for patient</li> <li>• deals with patient</li> <li>• listen to person's problems</li> <li>• help people</li> <li>• participate in care of patient</li> <li>• attending to clients</li> <li>• attend to other</li> <li>• advocate for patient</li> <li>• show respect for clients</li> <li>• handles self with clients</li> <li>• empathic towards patient</li> </ul>	<ul style="list-style-type: none"> <li>• patient requires</li> <li>• patient needs</li> <li>• treat patient like I'd like to be treated</li> <li>• make patient feel comfortable</li> <li>• ensure comfortability</li> <li>• can confide in nurse</li> <li>• puts need first</li> <li>• whenever need arises</li> </ul>

## HOLISTIC DIALOGIC CODING OF INTERACTION ESSAYS

Table 3 of the dissertation includes the frequencies of these levels of coding for the "Client's Perspective" and "Both Perspectives" for the three nursing narrative exercises. Of note, five student essays (1 out of 22 Child Care Center essays, 2 out of 22 Senior Citizen Center essays, 2 out of 21 Long Term Care Facility essays) could not be coded because the students did not follow the directions for the exercise.

### CLIENT'S PERSPECTIVE ONLY

Students in the intervention condition were directed to first select and describe one meaningful interaction for each clinical setting (child care center, senior citizen center, long term care facility). Then they were required to write an essay in response to the following prompt:

**"Describe the interaction from the client's point of view. What would you have been thinking and feeling during the nursing student-client interaction if you were in the client's position? (NOTE: To protect the client's confidentiality, do not use any names or other identifying characteristics like birth date.)"**

The three levels of dialogic empathy coded in the essays from the "Client's Perspective" are described in detail below.

**3 = Dialogic: Description by/from client's inner voice (i.e., client = I) at least once in the essay**

These essay characteristics were deemed "dialogic" because participants who wrote in the client's voice best demonstrated their ability to take on another's perspective, which is the core of empathy, and in this context shows an anticipation of other that indicates dialogism. Clear and less clear examples of a "Dialogic"-coded "Client's Perspective" essay for each of the intervention essays are provided below.

#### *Child Care Center Intervention Essay*

Ten of these essays received a coding of 3 "Dialogic."

**CLEAR:** A stranger came into class today. She sat down and showed me how to hold scissors. I. I was embarrassed because I could not figure out how to cut the paper with my scissors. The strange lady asked me if I wanted some help and I nodded yes. She took my hand and showed me how to put my fingers into the holes of the scissor and how to cut a straight line. I am so glad that she helped me.

**LESS CLEAR:** If I was in the child's position, I would have been very shy and uncomfortable, knowing that there was someone taking notes, watching me and asking me questions. I would have been thinking, "who is this person?" and "why are they here?". Children tend to act unlike themselves when they are with people they are

unfamiliar with. They may act a certain way because they may feel they should behave differently to please others or that it may be the correct thing to do.

The first example is "clear" because it is written directly in the client's voice. The second example is "less clear" because it begins and ends in the student's voice but at least one "I" is from a child's perspective and therefore this essay receives a "3" for dialogic. Some may argue that it is the student's voice as a child but anticipating another's perspective is influenced by our experience (including our own personal experience and exposure to the experience of those in our social networks) therefore it is sufficient to warrant an assessment as "dialogic."

*Senior Citizen Center Intervention Essay*

Eleven of these essays received a coding of 3 "Dialogic."

CLEAR: Today I went to lunch at the center; it was a little different today because we were visited by nursing students. A nice young lady came over to my table and introduced herself to me and the other two women sitting there. She explained the nature of her visit and I was pleased to hear her interest in becoming a nurse. I told her about some of my experiences during my own twenty years in nursing. She made me remember when I was training to become a nurse and it was nice to give her some advice.

LESS CLEAR: He's walking in the lunchroom, probably looking for his favorite seat while a stranger approached him. First, she introduced herself with a beautiful smile which caught his attention. He's probably thinking "Here's another one who wants to interview me." Since she seemed nice and he was in a good mood he accepted. In the midst of the conversation I realized I'm the one doing most of the talking while she listed attentively nodding and smiling appropriately.

The first example is "clear" because it is written directly in the client's voice. The second example is "less clear" because it begins in the third person. It is coded as a "3" because the speaker switches to "I" representing the client directly (i.e., "I realized I'm the one ... talking") meeting the level 3 criteria of "Description by/from client's inner voice (i.e., client = I) at least once in the essay." Only one use of the "I" as the client is required because it indicates the student's creative/cognizant ability to represent the client's inner voice.

*Long Term Care Facility Intervention Essay*

Ten of these essays received a coding of 3 "Dialogic."

CLEAR: Oh brother, here they come again to bother me. Leave me alone. (After having heard the student out)... She's not so bad after all! She is not rushing me to eat, that's a first! Usually they're all stuffing the food down my throat, as if I don't have problems swallowing already. But she is not rough, loud, or impatient. I can get used to this.

LESS CLEAR: If I were in the client's position, I would have wished that the student had to ability to understand me and be able to read my mind since I can't verbalize my thoughts. I would have wished there was someway or somehow I could communicate what I really think, like, or dislike to the people that take care of me. I would be a bit skeptic about having a student-nurse take care of me because he/she does not know anything about me. He/she does not know how I like to be fed, how I'm usually bathed or any preferences.

The first example is "clear" because it is written directly in the client's voice. Like the less clear Child Care Center example above, the second example here is "less clear" because it begins in the student's voice; because it includes at least one "I" is from a client's perspective, this essay also receives a "3" for dialogic.

**2 = Less dialogic: Description of client's thoughts, feelings intuited by the student**

These essay characteristics were deemed "less dialogic" because participants who described client's thoughts and feelings in the student's voice provided a more distal and therefore, less dialogic and less empathic, representation of the client's perspective. Clear and less clear examples of a "Less dialogic"-coded "Client's Perspective" essay for each of the intervention essays are provided below.

*Child Care Center Intervention Essay*

Ten of these essays received a coding of 2 "Less dialogic."

CLEAR: At the time of my interaction, the client must have been feeling upset because he was told to sit out. After a few minutes of sitting together we started to talk and I think his feelings changed because he started to smile and answer me. So the beginning of the interaction started with unhappiness and anger, but towards the end the client was relieved and didn't look upset.

LESS CLEAR: From the first hello, he was immediately drawn to me and we connected quickly. We played with toy animals, dominoes, cooking, cleaning, and grooming (this particular activity I will always remember because he combed my hair). He hugged me, and sat on my lap. He showed off his coloring and writing skills, and his demeanor was nice and quiet.

The first example is "clear" because the thoughts and feelings of the client are described by the student. The second example is "less clear" because it doesn't include obvious emotion words like "upset" and "happy" to describe the client; instead "he was immediately drawn to me" is the indicator of the student's appreciation of the client's experience.

*Senior Citizen Center Intervention Essay*

Six of these essays received a coding of 2 "Less dialogic."

**CLEAR:** It was clear to me that the client was enjoying the process of "reliving" her life through pictures and felt proud of how rich her life was and how many people depended on her, at one time or another, and still cared about her in her old age. In addition, she was teaching me about life, as well. The client told me on more than one occasion that I remind her of one of her granddaughters, and perhaps some sort of transference occurred, and she in fact considered me her granddaughter, in need of her guidance and advice.

**LESS CLEAR** (i.e., coded as a 2 versus a 3): From the clients point of view the interaction was an opportunity for her to express her feelings and talk to someone. This was helpful for her and therapeutic by giving her a chance to discuss her issues.

**LESS CLEAR** (i.e., coded as a 2 versus a 1): She related and reminisced about her past as a nurse and having joined the Peace Corps. She liked sharing her experiences by retelling and recounting certain memories of her active younger years. As much as she loved her life then, she loves her life now.

The first example is "clear" because the thoughts and feelings of the client are described by the student. The second example is "less clear" because it claims the "clients point of view" but does not use diction (i.e., "I" to represent the client's own voice) to achieve coding as a "3 = Dialogic." The third example would have received a coding of "1 = Least dialogic" if the student described only what the client said and had not augmented with the student's perception of the client's emotional state during the student-client interaction (i.e., "liked sharing her experiences").

#### *Long Term Care Facility Intervention Essay*

Seven of these essays received a coding of 2 "Less dialogic."

**CLEAR:** In my opinion my client was very happy to see me. He was from the same are of where my family came from which made him feel like I was his family. He didn't understand why I was there but after I explained to him why it made him feel better knowing that I wasn't there to evaluate if he was staying longer. My patient spoke to me in our language. Which made him also feel like he was at home.

**LESS CLEAR:** From the client's point of view it was a moment for him to talk to someone and express his feelings. This was during lunch and he was in his room because he didn't want to eat. He said he didn't feel up to it at the moment and he wasn't feeling very well.

The first example is "clear" because the thoughts and feelings of the client are described by the student. The second example is "less clear" because, like the Child Care less clear example, it doesn't include obvious emotion words like "upset" and "happy" to describe the client; instead the phrase "it was a moment for him to talk to someone and express his

feelings" shows the student's appreciation of the client's experience. Similarly, in another essay coded as "2" the student demonstrates her/his appreciation of the client's implicit experience with the sentence "She told me a lot of things that seemed as if she was keeping inside for awhile."

**1 = Least dialogic: Description of facts/actions (including speech) ONLY**

These essay characteristics were deemed "least dialogic" because reporting what happened without expressing one's recognition of the anticipated thoughts and/or feelings of one's audience indicated a lack of dialogic empathy. If available, a clear example and a less clear example of a "Least dialogic"-coded "Client's Perspective" essay for each of the intervention essays is provided below.

*Child Care Center Intervention Essay*

Interestingly, only one Child Care essay was coded as "Least dialogic."

"I am going to make a post-card with these papers. When I finish, I will take it to Ms A to check. I am going to use the scissor on my face; I can use it to cut my shirt too. Ah, ah, ah, I wasn't going to use it on my face anyway, I was playing". When asked if he needed help with his post-card, he declined. "I don't need help doing it. I do it everyday. Your school is by Brooklyn Bridge. My mother goes to to your school. So you will give injections to children when they are sick. I don't like injections, but I like vitamins because they are sweet.["]

This essay received this coding because it includes direct quotations of the child and no description of the student's perception of the child's thoughts or feelings. Although some other students used quotations to represent the client's voice (and were subsequently coded "3" for Dialogic), this essay is distinct because it appears to include a report of what the child said rather than an attribution to the child.

For contrast, here is an example of the client's inner voice represented in quotation marks and coded "3."

"I don't undersand why there are so many people here, they seem so huge, why aren't there any visitors my size? I hope they don't stay all day, I am being nice now, but if they stay too long my patience is going to wear thin. Yeh, and this lady why is she so nosy, wanting to know my age and everything and what's it to her if I want to play with those two snobs, I don't care for them anyway. Oh good, they're leaving, good riddance."

Unlike the essay coded "1," this example appears to be the client's inner voice NOT text possibly spoken aloud by the child.

*Senior Citizen Center Intervention Essay*

Three of these essays received a coding of "1 = Least dialogic."

CLEAR: Mrs. X a quiet woman reminisces and talks about her husband of 40 years, who she said was a very nice and warm person that she had loved to do things with. She spends her time at the Park slope senior citizen center doing craft. She volunteers to show me how to make crochet stitches.

LESS CLEAR: He lives in a rent controlled apartment not too far from the center and pays \$275.00 per month. He has colon cancer and wears a colostomy bag, after having had surgery at Long Island College Hospital. He visits his psychiatrist for episodes of depression and is on medication which he believes to be Paxil, but is not 100% sure. He knows everyone at the center, is aware of everything that occurs there, but remains very much to himself, which is what drew me to him and made my interaction with him so meaningful. He pointed out to me that he was unable to coordinate his clothes following the surgery, and was insulted by another client for wearing the same shirt for over a week. He admitted to not liking some of the clients at the center, because he felt they talked too much about everyone else.

Of the two clear examples, one is reproduced above. It is clear because it is a report of the interaction, not a description of the client's thoughts and feelings as required for this essay. The second example above is less clear because "he knows everyone... is aware of everything" suggests an understanding of the client's perspective but is presented as though that was communicated to the student versus intuited by the student (i.e., it is not contextual such as the client wondering about the student or emotionally/cognitively responding to the specific interaction as we see in examples for dialogic empathy coded 2 or 3).

#### *Long Term Care Facility Intervention Essay*

Two essays received a "1 = Least dialogic" coding. Both are clear and are reproduced below.

CLEAR: My client, a Russian-Jew did not speak. Based on the information, which I had obtained from his chart, he only speaks Russian. In view of this communication barrier, no meaningful interaction took place between him and me. However, his only responses to questions such as "may I help you with your meals, do you enjoy your meals," and "how is your day" were by nodding of his head.

CLEAR: Mrs. X is 95year old client who is at present diagnose with glaucoma (with blindness in the left eye), difficulty hearing in both ears and arthritis among other things. She reminisces about the life she once had and the things she was able to do with her family before her illness.

These essays are clearly coded as "1" because both of them describe the client in report-style diction; they not descriptions of the client's thoughts and feelings as required for this essay.

## BOTH PERSPECTIVES

After writing the essay from the "Client's Perspective," students in the intervention condition were asked to describe the same meaningful interaction for each clinical setting (child care center, senior citizen center, long term care facility) for "Both Perspectives." The specific prompt follows:

**"Now rewrite/redescribe the interaction including the perspectives of both participants. Write what was happening at the time; include what each of the participants (student and client) were thinking and feeling."**

The three levels of dialogic empathy coded in the essays from the "Both Perspectives" are described in detail below.

**3 = Dialogic: Play by play interaction (i.e., "first, then this" can be inserted into the text at least 2 times) described in which student demonstrates an appreciation of how s/he and/or his/her actions are perceived by the client (i.e., attribution to/by client) at least once in the essay**

These essay characteristics were deemed "dialogic" because participants who wrote an essay in which they demonstrated an appreciation of the context (i.e., play by play description versus reporting/summary diction) and an appreciation of how s/he and/or her/his actions were perceived by the client best demonstrated their ability to anticipate another's perspective of her/himself, i.e., dialogic empathy. If available, at least one clear example and one less clear example of a "Dialogic"-coded "Client's Perspective" essay for each of the intervention essays is provided below.

### *Child Care Center Intervention Essay*

Sixteen of these essays received a "3 = Dialogic" coding.

**CLEAR:** [Excerpt only] When I sat at the table with this child, he was trying to cut pictures old magazine. I introduced myself and we had a very interesting conversation. I was initially scared for him because of the way he handled the scissors. He knew I was afraid, and he made a big joke of me. By telling me he was going to cut himself and his shirt, he made to understand that the scissors they used at the daycare weren't real.

**LESS CLEAR:** A 4year old was told to sit out because he had pushed someone during playtime. The consequence was for him to sit out while everyone else played. He came and sat down next to me. When he was coming towards me, he looked like he was going to cry. His feelings were hurt. He was thinking that it wasn't fair that everyone else got o play and he had to sit out. We started to talk and it looked like he felt much better. I also felt better because I didn't want to see him cry. He must of thought that he should talk to me because he was next to me and he couldn't play anyway.

**LESS CLEAR:** This boy was thrilling and proud to have met a grown-up friend. He took the initiative to take this new friend away from his peers and involved her in most of his favorite activities. I was very pleased to have interacted with him, and his loving ways touched me.

The first example is "clear" because it is written in play by play diction (e.g., sat at the table, introduced self, scared, he knew that) and because it shows the student's appreciation of how s/he was perceived by the client (e.g., "he knew I was afraid"); other examples from other essays include "he understood me" and "she enjoyed entertaining me." The second example is "less clear" because the client doesn't explicitly make an attribution to the student in the text; instead, this essay receives a "3 = dialogic" coding because the student recognizes how her/his actions affected the client emotionally (i.e., "We started to talk and it looked like he felt much better"). The third example is less clear because of the play by play dimension of the "3 = dialogic" coding criteria (student's anticipation of client's view of the student is clear in "This boy was thrilling and proud to have met a grown-up friend"). Because, the text can be read as "First" the boy was happy to meet the student [make a friend] "then" the boy took the student [his friend] to meet his peers, this essay is coded as a "3."

#### *Senior Citizen Center Intervention Essay*

Seven of these essays received a "3 = Dialogic" coding.

**CLEAR:** The table with the three ladies sitting quietly not talking to each other seems the best to approach but as I introduce myself I feel as if they're really curious. Ms. B seems very interested in hearing why I want to become a nurse and she can't stop talking about her own nursing career.

I feel so good talking to someone about my country again; this student wants to hear about what it was like being a nurse in Yugoslavia. Talking about my home brings back so many happy memories. And I like the way the other women are listening, they also want to know about me. I feel as if they want to get to know me, maybe I'll have people to talk to here when I come to lunch again.

**LESS CLEAR:** When I came in to the center an elderly couple were participating in some activities some were dancing and some were painting. The couple that I had my interaction with were painting. They were painting gorgeous pictures. We enjoyed our conversations about their paintings. We also spoke about my life which interested them very much. They shared some information about their families, and showed me some pictures. This was one interaction that I will never forget. They made me feel very comfortable, and I felt very appreciated being there.

**LESS CLEAR:** At that time I realized she was interested on knowing why I was there and who I was, I knew to introduce myself. I felt confident about the situation and I felt it wasn't inappropriate to tell her my plans when I become a registered nurse. I was thinking

that maybe she was looking at me and thinking about when she was my age and if she made choices in her life that had a good or bad effect on her future.

The first example is "clear" because it is written in play by play diction (e.g., sees table, approaches) and because it shows the student's appreciation of how s/he was perceived by the client (e.g., "student wants to hear..."). The second example is "less clear" because the client doesn't explicitly make an attribution to the student in the text; instead, this essay receives a "3 = dialogic" coding because the student recognizes how her/his actions affected the client emotionally (i.e., "We also spoke about my life which interested them very much"). The third example is less clear because of the play by play dimension of the "3 = dialogic" coding criteria (student's anticipation of client's view of the student is clear in "she was interested in knowing why I was here..."). Because, the text can be read as "First" the student introduced herself "then" the student told her client about her plans for the future, this essay is coded as a "3."

#### *Long Term Care Facility Intervention Essay*

Ten of these essays received a "3 = Dialogic" coding.

**CLEAR:** As I approached my first patient I was really nervous and excited, I introduced myself and got no response. The nursing attendant was passing by and told me that the patient does not talk so I didn't have to talk to her. However, I knew this patient was suffering from dementia and realized I had to approach her differently. I touched her hand softly and softly and spoke closer to her ear because I remembered her chart had documentation of a hearing device. I continued to talk to her for an about half hour and suddenly she said, 'I have nobody'. It made me feel helpless not knowing how to respond but at the same time happy she spoke to me. I soothed her hand and told her to continue talking but that was all she ever said to me.

When the young lady spoke to me I felt really special because she was so interested in me and looked at me with caring eyes. I tried to follow her voice to let her know I could hear her and I was listening.

**LESS CLEAR: Student Perspective:** I was kind of anxious about meeting my resident because I did not know what to expect whether or not the client would be partially or totally dependent on me. When I met my patient I was very pleased with her. She was very cheerful and pleasant to be around. She told me many stories about her life and she introduced me to her friends and her brother. **Client Perspective:** My student nurse is a good listener. I feel very comfortable confiding in her. She listens to me talk and she always acts concern when I have a problem.

The first example is "clear" because it is included a play by play description and how the student intuited s/he was perceived by the client. The second example here is "less clear"

because the client's perspective of the student is not play by play but that is sufficient because the student's perspective is and only one "first, then" is required to receive a coding of "3."

**2 = Less dialogic: Play by play interaction (i.e., "first, then this" can be inserted into the text at least 2 times) described in which multiple perspectives are represented (includes description of dialogue between student and client)**

These essay characteristics were deemed "less dialogic" because participants described the interaction play by play but did not attribute the client's perception of the student and/or her/his actions which is an important element of dialogism. If available, at least one clear example and one less clear example of a "Less dialogic"-coded "Client's Perspective" essay for each of the intervention essays is provided below.

*Child Care Center Intervention Essay*

None of these essays were coded as 2 "Less dialogic:" It appears that students who were inclined to describe play by play interactions always provided some indication of how the client perceived the student.

*Senior Citizen Center Intervention Essay*

Three of these essays received a "2 = Less dialogic" coding.

**CLEAR:** Mr. X talked a lot about his daughters. He saw them regularly and felt that since they're not married then they shouldn't have any kids. He asked me whether I was married. I responded by saying "I'm too young and immature for this." He talked about his time in the Marines- he was a marine policemen. He also held a job doing alterations in tailoring which he still at home. He stated that this was one of the best centers in the United States. He had a wife who he goes to another center with.

**LESS CLEAR:** Mrs. X appears to be a reserve woman. She told me she is a new member at the center, and that she started to visit since her husband died. She said since the death of her husband things have not been the same for her. She lives alone, has one son who comes by to visit her on a daily basis. She said she loves her son but still misses her husband and the fun things they did together. She also said that she visits the center so that she can spend time away from home and be with other people to help her through her loneliness until her son comes. While she showed me how to make crochet stitches I observed that Mrs. X had a look of depression on her face. I became sympathetic towards her and spent time talking to her about her many hobbies. I am very happy that I choose to talk to Mrs. X because I provided an ear for her talk to and to share her feelings.

The first example is "clear" because there is a play by play description of a dialogue between the client and the student; it is a 2 instead of a 3 because there is no indication that the student appreciates how the client is responding to her/him. The second example is "less clear" because the client's emotion is indicated "I observed that Mrs. X had a look of depression on

her face" but that just represents the student's perspective of the interaction, not how the student and/or her/his actions were perceived by the client; therefore, it does not achieve coding as a "3 = Dialogic."

*Long Term Care Facility Intervention Essay*

Three of these essays received a "2 = Less dialogic" coding.

CLEAR: He told me that he sometimes hates to be at the center and he just wants to go home. Then I asked him where he lived. Her talked really slow hence I was very patient with him. He reminded me of my deceased grandpa in the sense that when we spoke there periods of silence in between just as when grandpa and did.

LESS CLEAR: Student: This is my first time having to bathe a patient. I feel uncomfortable but I won't show that to the patient. I will use great care to ensure this client receives the right care, the best way I know how. "Are you feeling okay" I say while I wash his eyes with a warm cloth. Client: "Yes I'm fine, thank you, you know I thank God for people like you who take care of me."

The first example is "clear" because it a play by play description that does not include evidence of the student's appreciation of the client's perception of the student. The second example is "less clear" because although it is a play by play description it does include the phrase "I won't show that to the patient" which COULD imply an appreciation of the client's perspective but isn't sufficient to warrant a "3" in this coding system. Or if the student had written that the client appreciated the attention from the student rather than reporting the client's words verbatim, that would have also warranted a "3."

**1 = Least dialogic: Reporting by student (overview of multiple weeks or description of what client said ONLY; no specific actions are described). The report/overview may include client traits, student representing client's anticipation of her/him, or multiple perspectives.**

These essay characteristics were deemed "least dialogic" because reporting what happened without expressing one's recognition of the anticipated thoughts and/or feelings of one's audience indicated a lack of dialogic empathy. If available, a clear example and a less clear example of a "Least dialogic"-coded "Both Perspectives" essay for each of the intervention essays are provided below.

*Child Care Center Intervention Essay*

Five of these essays received a "1 = Least dialogic" coding.

CLEAR: The little boys behavior was one that I have learn to recognize from my studies to be a fairly universal one for children. That behavior is called the peek-a-boo game. I made an effort to establish common ground with him by mimicking his behavior of

coming in and out of his field of view. We played peek-a-boo back and forth for a few moments but then the teacher called him back to join his group.

LESS CLEAR: At the time, I imagine that the child had no problem answering my questions. I didn't sense that the child was feeling uncomfortable. If the child was uncomfortable, then I believe he would not have answered my questions. The child, as well as the other children, must have been wondering who I was, since they had never seen me before. I, on the other hand, was quite shy in asking him anything at all because I didn't know how the child would have reacted. Yet, it went well and I got responses to my questions. The boy continued in his regular play after I was done.

The first example is clearly a summary of the interaction, not a play by play description. The second example is less clear because at first it seems as if it is a play by play description but when one tries applying "first, then," one realizes that this essay is an overview.

#### *Senior Citizen Center Intervention Essay*

Ten of these essays received a "1 = Least dialogic" coding.

CLEAR: My most meaningful interaction with an older adult was with an 80 year old woman who was playing pool. She told me that she loved the senior center and that it was one of the only reasons she woke up in the morning. She told me the people there were her family. She was very energetic and enthusiastic about life. She also said she rides her bike every single day. She was proud of that. Although she wore glasses and a hearing aid she still seemed so vibrant and young. She laughed a lot and had a lot of friends at the center.

LESS CLEAR: At the time, I knew that the adults would not have a problem interacting with my peers and I. Due to the fact that adults get lonely as they grow older, they would not have minded sharing a few things about themselves. I felt that they had a sense of comfortability with me. I didn't even have to speak at times in asking them questions. They volunteered their information with me. It was a very fluent conversation.

The first example is clear because it is a report of the interaction including what the client said, not a description of the client's thoughts and feelings as required for this essay. The second example above is less clear because "I felt that they had a sense of comfortability with me" suggests an understanding of the client's perspective but it is in a summary of the interaction, not a play by play description.

#### *Long Term Care Facility Intervention Essay*

Six of these essays received a "1 = Least dialogic" coding.

CLEAR: Throughout the period that I was with him, people were interacting among themselves. I was also privileged to interact with a few staff on the unit and my fellow students. There is no doubt in my mind that my client might have been wondering what we were talking about or perhaps having the desire to participate in meaningful

interactions with me and others. But since he could not speak English language, he kept to himself and adopted a quiet posture with despair look on his face.

LESS CLEAR: I liked my client because he was funny and he enjoyed telling stories and jokes about his past. He was very cooperative during the interview and when I took his vital signs. But, I sensed his feelings of loneliness and did not like to hear him say, "I'm still alive" each week after I asked how he was. It also bothered me that he complained about the place driving him and everyone else crazy.

The first example is clearly coded as "1" because it describes the interaction overall (e.g., "throughout the period"). The second example is less clearly coded as a "1" because one could say "first, he was cooperative.. then I sensed his feelings of loneliness" but the reference to a comment the client made "each week" shows that this is a summary report rather than a play by play interaction.

## APPENDIX R

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### RESEARCH METHODS MODULE – SPRING 2005

Independent work (reading, data coding, writing) and group activities during class sessions (working in pairs, informal presenting to other students) will be necessary for full participation in this module. In addition, a short paper based on the above activities will be due in April.

At the completion of all of the module requirements, you will receive a certificate to add to your professional portfolio. Additional benefits for your participation include the opportunity to attend a local nursing conference and a nursing book for use in this module.

Please prepare the required materials **BEFORE** the date under which they are listed as we will be discussing them in class that day.

<i>Date</i>	<i>Time</i>	<i>Objective of Session</i>
<b>Thurs, March 3<sup>rd</sup></b>	<b>10:15-11:45 am</b>	<b>Introduction to research methods</b>
		<p>Leddy, S. K. (1998). <i>Research processes and utilization</i>. In S. K. Leddy (Ed.) <i>Conceptual bases of professional nursing</i> (4<sup>th</sup> ed.). Philadelphia, PA: Lippincott-Raven Publishers.</p> <p>Cook, T. H., Gilmer, M. J. &amp; Bess, C. J. (2003). Beginning students' definitions of nursing: An inductive framework of professional identity. <i>Journal of Nursing Education</i>, 42(7), 311-317.</p>
<hr/>		
<b>Thurs, March 10<sup>th</sup></b>	<b>10:15-11:45 am</b>	<b>Training in method of qualitative analysis</b>
		<p>Overcash, J. A. (2003). Narrative research: A review of methodology and relevance to clinical practice. <i>Critical Reviews in Oncology/Hematology</i>, 48, 179-184.</p> <p>Schaefer, K. M. (2002). Reflections on caring narratives: Enhancing patterns of knowing. <i>Nursing Education Perspectives</i>, 23(6), 286-293.</p>
<hr/>		
<b>Thurs, March 17<sup>th</sup></b>	<b>10:15-11:45 am</b>	<b>Discussion of prelim results (work in pairs)</b>

\*\*\*HYPOTHESES AND METHODS DUE\*\*\*

Goldie, P. (2004). Narrative, emotion, and understanding. In B Hurwitz, T. Greenhalgh, & V. Skultans (Eds.). *Narrative research in health and illness* (pp. 156-167). Malden, MA: Blackwell Publishing Ltd.

Hermans, H. J. M. (1997). Dialogue shakes narrative: From temporal storyline to spatial juxtaposition. *Journal of Narrative and Life History*, 7(1-4), 387-394.

**Thurs, March 31<sup>st</sup> 10:15-11:45 am Discussion of discussions (work in pairs)**

**\*\*\*REVISED HYPOTHESES AND METHODS PLUS RESULTS DUE TO ALL MODULE PARTICIPANTS BY FRIDAY, MARCH 25<sup>th</sup>. (Distribute via email.)\*\*\***

Read other students' reports and make points re: crossover for discussion in class

Smith, K. V., & Godfrey, N. S. (2002). Being a good nurse and doing the right thing: A qualitative study. *Nursing Ethics*, 9(3), 301-312.

**FINAL PAPER DUE BY APRIL 30, 2005.**

**Please email me your paper at [kjtrudeau@prodigy.net](mailto:kjtrudeau@prodigy.net).**

**This work will be shared with the CSTEP grant providers.**

### **GROUP WORK AND INFORMAL PRESENTATIONS**

During this module, we will be working in pairs frequently.

Although coding for concepts within pairs will be independent, discussion of hypotheses and methods will be explored together in the second session.

In the third session, pairs will compare and discuss the findings from their coding (i.e., conduct an inter-rater reliability check).

At the fourth session, pairs will **INFORMALLY** present their hypotheses, methods, and results to the other students. For the presentations, please leave one page of bullet points in my box by 9:30 am, Thurs, March 31<sup>st</sup> and we will display them on the overhead projector while the pairs present their findings.

### **WRITING ASSIGNMENTS**

Within the second session, we will begin discussing hypotheses and methods to apply to our data. Each pair will hand in one of each of the following papers.

- Due Thurs, 3/17: 1-2 double-spaced pages of your hypotheses and methods
- Due Mon, 3/28 (via email to all): 3-5 double-spaced pages type-written pages including the revised hypotheses and methods, as well as a new results section
- Due by Fri, 4/29: 5-7 double-spaced pages including hypotheses (as intro), method, results, and discussion sections.

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