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Simulated Role-Play to Improve Attitudes and Empathy Towards Older Adults in Accelerated Nursing Students

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SIMULATED ROLE-PLAY TO IMPROVE ATTITUDES AND EMPATHY TOWARDS OLDER ADULTS IN ACCELERATED NURSING STUDENTS

by

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Dedication

Mom, you have always supported my crazy ideas and goals and shown me unconditional love throughout this educational journey. Thank you for putting up with the long nights and stressful days. Know something?

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I cannot thank Dr. Lee, my dissertation chair, enough for her guidance and support over the last year. There were days when the end never felt in site, however, you encouraged me to continue and persevere. Thank you, Dr. Chilton, for your support and enthusiasm throughout this process. Your excitement and encouragement helped tremendously throughout this journey. Thank you, Dr. Ruggiero, for always having an open door and an ear to listen. Your guidance and encouragement throughout this journey was much appreciated.

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Table of Contents

List of Tables

List of Figures

Abstract

SIMULATED ROLE-PLAY TO IMPROVE ATTITUDES AND EMPATH TOWARDS OLDER ADULTS IN ACCELERATED NURSING STUDENTS

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Nearly 18% of the United States population will be at least 65 years or older by 2025. Studies suggest student nurses have a negative attitude toward working with this population. There is a need to increase the number of graduate nurses who have positive attitudes towards older adults and an interest in working with this population upon graduation. This pre- and post-test intervention study aimed to: 1) examine the effectiveness of two educational modalities, a case study and simulated role-playing scenarios, on improving attitudes and empathy towards older adults; 2) explore factors affecting attitudes and empathy in accelerated baccalaureate of science in nursing (ABSN) students towards older adults. A convenience sample of 45 ABSN students completed pre- and post-test questionnaires. The results showed role-playing simulation scenarios had no impact on improving attitudes and empathy towards older adults, however, within group, the case study intervention was found to improve students' attitudes. No significant predictor was found for attitudes; one significant predictor was found for empathy. Empathy is highly correlated with attitude. Further study is needed to explore educational modalities that improve attitudes and empathy in the ABSN student population.

Chapter One

Introduction to the Articles

This research portfolio begins with a comparison concept analysis of empathy and compassion, two words commonly heard to describe nurses. Chapter Two, *The Empathy-Compassion Matrix: Using a Comparison Concept Analysis to Identify Care Components*, is a comparison concept analysis that seeks to define both terms, compare their meanings, and explore the potential to teach or enhance both of these concepts in nursing education. This is a topic that interests me on a personal and professional level. Over my tenure as a staff nurse, I had the opportunity to mentor and orient new graduate nurses. While working in various units throughout the hospital, I noticed that some graduates were able to connect with their patients and situations better than others were capable of. I noticed similar interactions while working as a simulation educator in the collegiate setting. Some students were able to 'buy-into' the simulation scenarios and become vested in their patient's best interest while others seemed to go through the motions of the assessments and care needed for the situation. These experiences have guided me to investigate empathy and compassion further.

The manuscript was previously submitted and reviewed by *The Journal of Nursing Education* (2014). While not selected for publication, the author utilized the feedback to make edits with the plan to resubmit to another journal in the future. The newly edited manuscript was resubmitted to *Nursing Forum* (2017) where it was received with high praise from the editor who requested revisions be made prior to possible publication. Revisions were made as requested and the manuscript was resubmitted (2018). It is currently awaiting editorial decision for publication.

With a better understanding of empathy and compassion, the next step was to focus on one of the two concepts. The author chose to focus on empathy first and created a research study to see if the concept could be taught as was suggested by the findings of the comparison concept analysis. Chapter Three, *Simulated Role-Play to Improve Attitudes and Empathy Towards Older Adults in Accelerated Nursing Students*, is a report of a study conducted to examine the effectiveness of two educational modalities on improving attitudes and empathy towards older adults in ABSN students. The study also explores factors affecting attitudes and empathy within the same sample population such as sociodemographics, previous interactions with, knowledge, and clinical preferences toward working with older adults. Prior to the study initiation, permission for use of two of the three instruments (KOPQ, JSE-HPS) was received. The third instrument, KOP, is in the public domain therefore can be used without permission. Additionally, permission was granted to use one of the National League for Nursing's unfolding simulation case scenarios. Chapter Four, *Summary and Implications for Future Research*, is a summary of the research to date. It concludes with future recommendations for research in this area.

Chapter Two

The Empathy-Compassion Matrix: Using a Comparison Concept Analysis to Identify Care Components

Abstract

Empathy and compassion are words commonly seen throughout nursing education, however, there is much discussion as to the meanings of these terms and if these concepts can be taught to nursing students. The emergence of a technology-dependent generation whose social skills have largely involved relationships with electronic devices rather than human beings may pose challenges to helping tomorrow's nursing students to develop empathy and/or compassion for patients. Using Walker & Avant's concept analysis method, this paper seeks to define both terms, compare their meanings and relationship to the nursing profession, provide potential teachable moments relative to nursing education, and determine if one can be present without the other.

Keywords: empathy, compassion, concept analysis

The Empathy-Compassion Matrix: Using a Comparison Concept Analysis to Identify Care Components

Empathy and compassion are key words seen throughout nursing education. There has been much debate as to what the meanings of these terms are with regards to how or whether they can be taught to nursing students. This paper seeks to define both terms, compare their meanings and relationship to the nursing profession using a concept analysis framework, and determine if one can be present without the other.

Significance to Nursing

Society and the nursing profession have numerous mental images of the ideal nurse. Nurses are expected to be caring, critical-thinking, advocates for patients. It is expected that nurses will protect their patients from medical errors and provide the safest care possible. Above all else, nurses are expected to be empathetic and compassionate as these are terms commonly seen in nurse practice acts, public policy, and educational debates (Dewar, 2013; van der Cingel, 2014).

One issue faced by nursing educators is whether it is possible to teach empathy and compassion to students to prepare them to become better nurses. Questions arise as to whether each concept is something that can be taught or if they are innate to our human nature. Some psychologists would have us believe that these concepts are engrained in our psyche (Elliott, Bohart, Watson, & Greenberg, 2011) while others believe these concepts can be fostered and improved through practice and patient interaction (Burnell & Agan, 2013; Ozcan, Oflaz, & Bakir, 2012). Identifying the intervenable aspects of empathy and compassion may be a roadmap to increasing these desirable traits in a technology-focused younger generation of nursing student whose

most formative and consistent social relationships have often been with high-tech devices instead of face to face interactions. The following comparison of empathy and compassion will allow nurse educators to identify where efforts to humanize nursing education should focus. Furthermore, this concept analysis will aide in determining whether empathy and compassion can be taught.

Concept Identification: Empathy

The concept of empathy has been discussed for nearly 50 years in the literature, yet there is still confusion as to what the word means and how it is used in the nursing profession. It is often confused with similar concepts such as sympathy, pity, understanding, and identification.

According to the dictionary definition, empathy is the ability to put yourself in the place of others to better understand their feelings and experiences; to emotionally put yourself in someone else's shoes and identify with their current situation. ("Empathy," 2014). It is the action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experiences of another of either the past or present without having the feelings, thoughts, and experiences fully communicated in an objectively explicit manner ("Empathy," 2014). Empathy is the feeling that persons or objects arouse in us as projections of our feelings and thoughts (Spiro, 1992).

The emotion of empathy begins with being aware of another person's feelings. This can be from a general sense of the situation, reading between the lines, or by asking the person directly. Once it has been determined how the person feels, one begins to show empathy by acknowledging the emotion. Other ways of showing empathy are

through simple things such as touching a shoulder or holding a person's hand. Empathy has been defined as the ability to understand the patient's situation or perspective, to communicate that understanding, and to act on this information in a helpful way (Mercer & Reynolds, 2002). In nursing, this activity can be seen as a form of therapeutic communication.

Early in his career, Carl Rogers, the founder of client-centered therapy, described empathy as a skill that could be taught (Rogers, 1971). In later work and research, his position changed. He believed that empathy was not as much of a skill as it was a way of being (Rogers, 1975). He acknowledged that empathy occurred willfully when one let it occur as through careful listening and mirroring of the person's words and feelings. Empathy in nursing can be traced back to Peplau's work of looking at communication as the foundation of the nurse-patient relationship and the connectedness of the two (Ward, Cody, Schaal, & Hojat, 2012). Peplau believed empathy lived within the nurse-patient relationship and may be one of the greatest skills a nurse could have (McCarthy & Russell, 2009). Empathy is essential for the health and well-being of patients and their care providers, and focus should be on the development of empathetic skill scenarios for students (Ward, Cody, Schaal, & Hojat, 2012).

Types of Empathy

Contemporary researchers commonly differentiate between two types of empathy - affective and cognitive empathy (Topcu & Erdur-Baker, 2012). Affective empathy refers to the sensations and feelings we get in response to other's emotions. This can include mimicking what the person is feeling. Cognitive empathy refers to the ability to identify and understand other people's emotions (Topcu & Erdur-Baker, 2012). We

attempt to non-judgmentally comprehend another person's experiences (Dal Santo, Pohl, Sainai, & Battistelli, 2014).

Another classification of empathy exists that that lends itself as a concept that can be taught. Alligood (1992) recognizes empathy as basic and trained. Basic empathy begins developing as a maturing child and continues into adulthood. It can be viewed as an innate empathetic emotion. Trained empathy is something that can be developed through practice and builds on the skills of empathy formed during the basic empathy timeframe (Alligood, 1992). Therefore, based on these descriptions of empathy, one could believe that empathy is something that can be taught and improved upon if the correct situation is presented.

Defining Attributes of Empathy

Defining attributes, as defined by Walker and Avant (2005), are the traits that must be present in order for the concept to be identified. One defining attribute of empathy, *being present*, has consistently been seen in the literature over the last three decades. A person must be in the "here and now" because empathy cannot be postponed or delayed in the situation. It must be felt in real-time and at the moment of need. Other attributes that must be present include *active emotional link to another person, anticipating needs, and understanding verbal* and *nonverbal communication*. The active emotional link sets the stage for anticipating the person's needs and taking action to meet them. Since empathy does not always spring from a situation in which the other person can verbalize needs, the ability to tune in to both spoken and unspoken cues is basic to providing an empathetic response.

Empathy: Antecedents and Consequences

Antecedents are events that must occur prior to the occurrence of the concept (Walker & Avant, 2005). At its core, the ability to empathize with another human being is one of the most desirable traits in interpersonal communication (White, 1997). Nursing students must have self-awareness in order to properly engage in empathetic behavior with those around them. Some antecedents noted throughout the literature include:

1. Conscience
2. Perceiving others in need
3. Expressiveness
4. Emotional intelligence

Consequences are noted to be the events that happen after the concept has been implemented (Walker & Avant, 2005). These occur after the interaction and empathetic response. Some notable consequences from the review of the literature on empathy include:

1. Understanding
2. Awareness of one's own feelings
3. Sensitivity to the subject
4. Feelings of peace and acceptance by recipient of empathy

Concept Identification: Compassion

While empathy is a present-based, spontaneous response to an experience with another person or group of persons, compassion should be considered an innate, attitudinal state. It is a relational concept which usually precedes interaction.

Compassion, as defined in Merriam Webster, is a feeling of wanting to help someone who is sick, hungry, or in trouble ("Compassion," 2014). It revolves around the way in which people relate to each other. It is not about what people choose to do for each other, but what they choose to do together; this suggests a symbiotic relationship between those involved in the situation (Dewar, 2013). Among emotion researchers, compassion is defined as the feeling that arises when you are confronted with another's suffering and feel motivated to relieve that suffering. This definition conceptualizes compassion as an affective state defined by a specific subjective feeling; differs from treatments of compassion as an attitude (Goetz, Keltner, & Simon-Thomas, 2010).

Martha Nussbaum discussed compassion in her book on the intelligence of emotions (Nussbaum, 2001). She based her view on an Aristotelian view of suffering and what suffering evokes. For Nussbaum, compassion originated in the idea of the eudemonistic argument. People know that fate can strike them as it has struck the one who is the object of their compassion. This recognition of a general human vulnerability calls for compassion.

Historically, engaging in compassionate deeds or actions with the sick or those in need was seen as an act of striving to become God-like and considered to be a prerequisite to salvation (Kapelli, 2008). Being compassionate meant that someone understood how and why another person felt the way they do without passing judgment. This compassionate religious ideal has been perpetuated for centuries.

The notion of compassion in nursing can be attributed to the Christian ideals translated by Florence Nightingale into the characterization of the professional nurse (Straughair, 2012a). Compassion has been defined as a basic awareness of the suffering

of oneself and others with a sincere desire to relieve it (Gilbert, 2009). The belief of compassion being associated with feeling touched by the suffering of others permeates the definitions along with a non-judgmental understanding of the object of compassion (Neff, 2003). Descriptions of compassion often relate to someone who takes the time to listen and communicate freely. Compassionate nurses must be focused on the patient and open to talking about potentially sensitive information. Kindness is needed because patients may feel most vulnerable when sharing information. One of the difficulties in considering issues such as compassion is that everyone will have a personal, subjective definition. This makes the need for a better, all-encompassing definition of the word even stronger, not only for the nursing profession, but for all.

While there are thoughts to support empathy being an emotion that can be taught or further enhanced, there is little understanding on how compassion can be taught and promoted in a healthcare setting (Dewar, 2013). The major focus of compassion is how it can be assessed in practice versus how it can be taught or encouraged. This lack of understanding may actually be the best supporting argument to promote empathy-supportive training methods in order to increase a nurse's compassion.

Defining Attributes of Compassion

The defining attributes of compassion are different from the attributes used for empathy. Attributes of compassion show a patient-centered focus versus focusing on personal feelings and needs. The compassionate nurse is aware of the patient's state of being and has a general emotional tie to the patient.

Defining attributes for compassion include external passive *feelings of concern* about a person or group; projected feelings of *sensitivity*, *humanity*, and *kindness*, and *having a*

non-judgmental desire to help. The external nature of compassion makes it more broadly applied to groups or situations. However, a single event or person can prompt this feeling of compassion. The ability to project these feelings of sensitivity to the situation, recognizing the humanity of the other person, and generally feeling a kind regard for the person in need are part of the fabric of compassion. The desire to help supersedes any feelings of judgment of worthiness or bias toward a group.

Compassion: Antecedents and Consequences

Antecedents are events that must occur prior to the occurrence of the concept (Walker & Avant, 2005). These events, or moments of understanding, must occur before someone can feel compassion. Some antecedents noted in the literature include:

1. Suffering or threat of suffering
2. Illness or risk of illness
3. Vulnerability
4. Empathy

Consequences are events that happen after the concept has been implemented (Walker & Avant, 2005). The consequences seen with compassion are different from those seen in empathy in that they show an attempt at an action. These are traits that may see an increase in the nursing student's self-perception if they progress from empathy to compassion. Some notable consequences from the review of the literature on compassion include:

1. Comfort
2. Acceptance

3. Confidence

Applicability to Nursing Education Settings

Both empathy and compassion are described as human feelings. While empathy refers more generally to our ability to take the perspective of and feel the emotions of another person, compassion is when those feelings and thoughts include the desire to help in a broader, more general way. Having empathy does not necessarily mean we will want to help someone in need, though it is often a vital first step toward compassionate actions (Dal Santo, Pohl, Sainai, & Battistelli, 2014).

Feeling empathy for someone presupposes getting emotional information about them and their situation. By collecting information about another person's feelings, familiarity and acceptance increase. Knowing others on an emotional level creates a greater likelihood of seeing similarities in feelings and basic emotional needs (Dal Santo, Pohl, Sainai, & Battistelli, 2014). Realization that one has similar basic emotional needs promotes the ability and desire to identify with them, relate to them and empathize with them.

Compassion can be defined as a combination of empathy and understanding. Greater empathy promotes greater information and understanding. Higher emotional intelligence makes possible a greater capacity for such understanding. Thus, the logical sequence is as follows: Higher emotional sensitivity and awareness leads to higher levels of empathy. This leads to higher levels of understanding, which then leads to higher levels of compassion. The idea of a unified commonality and desire for others to be free of pain and suffering (Stuntzner, 2014) gives compassion a broader conceptual grasp than empathy which is usually aimed at a more selective relationship between two persons.

It is interesting to note that the concept of compassion heavily depends on the ideas of sympathy and suffering which is not seen with the concept of empathy. Definitions of empathy stress the cognitive element that forms the basic component of all helping relationships (Blane & Mercer, 2011). Empathy has actually been proposed as a requirement to be compassionate (Reyes, 2012). These differences suggest there is a variation on the demands of healthcare providers when providing care.

Table 2.1 A Comparative Analysis of the Concepts of Empathy and Compassion

	Empathy	Compassion	Comparative Terms
Basic conceptual definition	Empathy is a present-based, spontaneous response exhibiting understanding, awareness, and sensitivity to another person's feelings.	Compassion is a basic awareness of suffering or need in another person while communicating a desire to relieve it.	Spontaneous response vs. Perpetual state Response to feelings vs. Response to situation
Defining Attributes	Being present Active emotional link to a person by feeling their feelings ("I know how you feel.") Anticipating needs Intuitively understanding verbal and non-verbal communication	External, passive feelings of concern about the situation of another person ("I am sorry it happened to you.") Projecting feelings of sensitivity, humanity, and kindness Having a non-judgmental desire to help	Action-oriented state vs. Self-contained state
Antecedents	Conscience Perceiving others in need Expressiveness	Suffering or threat of suffering Illness or risk of illness Vulnerability *Empathy*	Emotional openness vs. Cognitive awareness of other person's frailty
Consequences	Understanding and awareness of one's own feelings Sensitivity to the subject Feelings of peace and acceptance by subject	Improved sense of self-worth at helping another Acceptance of one's actions as helpful Confidence in improving the situation	Satisfaction with event vs. Satisfaction with self

Model Case of Empathy with Teaching Moment

A model case of empathy is offered with a teachable moment for the nurse educator. Empathy depends on an internal inclination to feel one's pain. Although there are no studies indicating how to instill an "inclination" in a student, it seems reasonable that calling attention to the phenomenon will raise awareness.

Marty is in her third semester of nursing school and is in her medical-surgical rotation. She has sacrificed a lot to come back to school as a single mother with two small children but believes the sacrifice is worth it to provide for her children's future. Her patient is a 25-year old woman with uterine cancer who is receiving chemotherapy. During her assessment, Marty learns that her patient is very worried about who will care for her 4-year old daughter if she dies. Marty holds her patient's hand and listens to her concerns and uses therapeutic communication, such as summarizing and recognizing nonverbal behaviors, to further understand her feelings. After leaving her patient's room, Marty spends time reflecting on her patient's situation and imagines how she would face this diagnosis with her own children. When she shares this with her instructor, she agrees to talk about her feelings in post-clinical discussion today as an example of empathy.

This case exhibits empathy because Marty puts herself in her patient's place imagining what it would be like to be facing a similar situation. She was able to use that sense of integration with the patient to realize that just sitting and listening (being present) was the best therapeutic action at this point. She cannot make false promises. She realizes that she would not want someone trying to provide false bravado or artificial

cheer. She just needs someone to listen and relate; that is what Marty did as she used empathy to feel her patient's pain and fear.

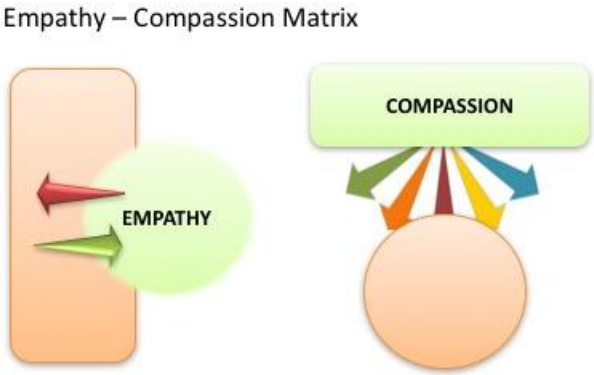
Model Case of Compassion with Teaching Moment

A model case of compassion includes awareness of the situation and a desire or plan to fix it. Compassion may be challenging to teach or model because it a desire to relieve suffering without passing judgment. Judgments are personal feelings which may interfere with a person's ability to feel compassion. Nevertheless, allowing students to see situations which can elicit compassion may strengthen their desire to want to act to improve the situation.

During his community rotation in his last semester of nursing school, Edmond had the opportunity to visit Guatemala as part of a health education exchange program. He spent two weeks working in an orphanage assisting with cleft palate surgeries. He realized his own good fortune with regards to healthcare and felt a deep sense of injustice at how few healthcare benefits the people had that he was volunteering with. He felt the need to help make their lives better and signed up to work with Mercy Ships doing Central American healthcare outreach as soon as he graduated from nursing school.

Although Edmond may not have actually related personally to the plight of the Central American children with cleft palates, he showed concern for the overall well-being of those persons in the area. He desired to do something about more instead of letting it stay as the status quo. His compassion prompted him to volunteer with a group whose role is to bring health care and treatment to those in need. He shared his gratitude to the faculty member who had shown him the great need and how to address it.

Figure 2.1 shows a comparison of the two case models for empathy and compassion and how they differ.



Focus	EMPATHY	COMPASSION
Physical; spatial	Sense of integration, being one with…	Sense of superiority, being external to…
Emotional	Internal belief I share your feelings	I feel sorry for you without any awareness of your feelings
Task	Seeking common ground	Seeking solutions
Reaction	Desire to feel "I feel your pain"	Desire to help "How can I fix this?"
Model case	Young mother facing chemo	Noticing healthcare disparities

Figure 2.1 The Empathy-Compassion Matrix

Recommendations

The purpose of this paper was to compare the concepts of empathy and compassion through the use of case models (Figure 2.1) and a comparison table (Table 2.1). One must inquire as to whether this is a distinction without a real difference. If both concepts are desirable, does it really matter which concept is present in our students? This comparative analysis leads one to consider if empathy is truly the precursor or antecedent of compassion, and if it is more situation-specific.

In the most basic sense, empathy is the ability to feel similar emotions by putting oneself in another person's place or situation. Compassion is an emotional connection in

spite of not being able (or wanting) to put oneself in another person's place. Compassion is more external, more passive. It is about me and how I feel about the situation I am in. A person may want to take action to help, however, they may not actually go through with it. Contrasting, empathy is more active. It focuses on the other person and their current situation because I can see myself in your current situation.

The real question has to be which emotion comes first. Based on psychological teachings, compassion develops from empathy. To ensure that nurses are able to deliver high-quality compassionate care, they need to be supported by effective leadership and corporate strategies that consider human resources, skill mix and workload (Straughair, 2012b). Schantz (2007) maintained that compassion is the most precious asset of the nursing profession; however, the concept is not clearly defined or widely promoted in the context of contemporary nursing practice, and it is further confused as a direct result of using words such as caring, sympathy, empathy and compassion interchangeably.

Nursing educators must decide which concept can be developed in their students with the available resources. The case models offer examples of both concepts with teachable moments for nursing students. Based on this comparison, compassion is more of a general, innate call to action toward someone or something experiencing pain and suffering versus empathy, which is an emotional connection to another person. If one must have empathy before having compassion, it could be argued that nursing educators should focus on activities that foster the emotion of empathy. One way to do this is through the use of simulation scenarios. During debriefing, one might ask the student to talk about how the patient may be feeling at this moment, how to convey an understanding of what the patient is experiencing, strategies to show attentiveness to

needs, awareness of the intuitive nature of the nurse-patient relationship, or optimal communication techniques to show understanding. Allowing students to verbalize the importance of the emotional connection can show a pathway to developing and honing this skill in a proactive and desirable way.

In order to articulate and promote the understanding and acceptance of empathy and compassion as valued attributes of nursing students, nursing must seek to clearly define and differentiate between the two concepts. Simulation and clinical experiences can be used to help students expand on these concepts, but in order for focused scenarios to drill down to the desired concept, a clear definition is essential. Empathy education can be added to lectures as well as student experiences that will allow more exposure to different situations. Students could use methods such as journaling and open discussions to explore their emotional experiences. Finally, using historical figures, such as Nightingale, Mother Theresa, the Dali Lama, can illustrate how compassion can be actualized into actions which produce desirable outcomes and which can be emulated on a smaller scale in patient encounters.

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Chapter Three

Simulated Role-Play to Improve Attitudes and Empathy Towards Older Adults in Accelerated Nursing Students

Abstract

Nearly 18% of the United States population will be at least 65 years or older by 2025. Studies suggest student nurses have a negative attitude toward working with this population. There is a need to increase the number of graduate nurses who have positive attitudes towards older adults and an interest in working with this population upon graduation. This pre- and post-test intervention study aimed to: 1) examine the effectiveness of two educational modalities, a case study and simulated role-playing scenarios, on improving attitudes and empathy towards older adults; 2) explore factors affecting attitudes and empathy in accelerated baccalaureate of science in nursing (ABSN) students towards older adults. A convenience sample of 45 ABSN students completed pre- and post-test questionnaires. The results showed role-playing simulation scenarios had no impact on improving attitudes and empathy towards older adults, however, within group, the case study intervention was found to improve students' attitudes. No significant predictor was found for attitudes; one significant predictor was found for empathy. Empathy is highly correlated with attitude. Further study is needed to explore educational modalities that improve attitudes and empathy in the ABSN student population.

Keywords: accelerated BSN, empathy, attitudes, and older adults

Simulated Role-Play to Improve Attitudes and Empathy Towards Older Adults in Accelerated Nursing Students

Problem and Significance

Nearly 18% of the United States population will be at least 65 or older by the year 2025 (U.S. Census Bureau, 2012) and the prevalence of chronic disease is increasing among this population (Pearson, Bhat-Schelbert, & Probst, 2012). Older adults aged 65 and over grew from 35.0 million in 2000, to 49.2 million in 2016, accounting for 12.4 percent and 15.2 percent of the total population, respectively (U.S. Census Bureau, 2017). An increase in the older adult population will inevitably produce new and challenging demands on our existing healthcare system such need as the need for registered nurses who are interested, competent and empathetic towards the care of older adults (King, Roberts, & Bowers, 2013). Current literature suggests that working with older adults is the least favorable setting for new graduate nurses (Haron et al., 2013; Koh, 2012; Stevens, 2011; Swanlund & Kujath, 2012). This poses a problem considering nurses have been identified as a key health care providers best positioned to meet these increasing demands (Institute of Medicine, 2010).

Improving nurses' attitudes towards older adults should originate in undergraduate nursing education in order to prepare future graduates to comprehend the health care needs of older adults and to establish appropriate skills and positive attitudes for working with this population (Glista & Petersons, 2003; Henry, Ozier, & Johnson, 2011; King et al., 2013; Koren et al., 2008; Lee, 2009). Nursing schools face an uphill battle in changing student attitudes toward care of the older adult due to an already-present negative attitude in working with them (Hanson, 2014; Haron et al., 2013; King

et al., 2013). Perceptions of a slow-paced work environment, lack of understanding about the aging process, and poor experiences with aging family members are some reasons for negative attitudes towards older adults (Abbey, Abbey, Bridges, Elder, Lemcke, Liddle, & Thornton, 2006; Algoso, Peters, Ramjan, & East, 2016; Celik, Kapucu, Tuna, & Akkus, 2010).

Gerontological leaders set forth a goal to increase the number of graduate nurses who have positive attitudes towards older adults and express an interest in working with this population upon graduation (King et al., 2013). This change in attitudes and interest must start during nursing school. Nursing educators should provide creative and impactful methods to improve negative attitudes towards older adults and increase the interest in working with this population after graduation (Henry et al., 2011; King et al., 2013).

A majority of the previously mentioned gerontology studies center around traditional baccalaureate education while few focus on the increasingly popular accelerated second-degree baccalaureate (ABSN). Students in ABSN programs come forth with previous knowledge and experiences that may influence their attitudes and interest in working with older adults. It is prudent to gain an understanding of this population of nursing students. The purpose of this study is to examine factors affecting attitudes and empathy towards older adults such as sociodemographic factors, previous interactions with, knowledge towards, and clinical preferences toward working with older adults in an ABSN program. Additionally, the effectiveness of two educational modalities, a case study and role-playing scenarios, will be used to examine the effect on improving attitudes and empathy towards older adults.

Review of the Literature

The following is an overview of existing literature regarding attitudes and empathy towards older adults in ABSN students. This review explored current trends in gerontology education; knowledge of the ABSN student population including effective teaching strategies for this group; overall attitudes towards older adults in nursing students; empathy towards older adults; and two education methods that can be used to improve those concepts. Gaps in existing literature were identified.

Accelerated Second-Degree Programs

Accelerated second-degree nursing (ABSN) programs are an innovative approach to tackling the nursing shortage in America (Bowie & Camacho, 2013; Cangelosi & Moss, 2010). This type of program targets individuals who hold baccalaureate degrees in a field other than nursing such as business, teaching, public health, public administration, or the physical sciences (Bowie & Camacho, 2013; Raines & Sipes, 2007). In 11 to 24 months, depending on the school, ABSN students can earn a second baccalaureate degree in nursing and be eligible to take the National Council Licensure Examination (NCLEX-RN®) to become a registered nurse (Cangelosi & Moss, 2010; Kaddoura, Vandyke, Smallwood, & Gonzalez, 2015).

It is recognized that ABSN programs are intense and fast-paced; these students are not the typical group of younger, less experienced traditional baccalaureate nursing students (Boellaard, Brandt, & Zorn, 2014). ABSN students typically take upwards of 20 or more credit hours over the course of a semester when compared to the 12-15 credits a traditional BSN student may take. This short time may make it difficult for students to fully engage in learning experiences, such as clinical patient encounters, that foster

empathy and improve attitudes toward varying patient populations. Instead, ABSN students may have to draw from prior experiences to relate to situations they are dealing with in the clinical setting.

ABSN students have demonstrated the ability to quickly assimilate new information and to transfer skills from a previous career into a new field; it is believed that they may benefit from teaching strategies that promote experiential learning (Cangelosi, 2008). Through a hermeneutic phenomenological approach, it was found that the use of an unfolding simulation case throughout the semester helped ABSN students (N=22) effectively improve self-confidence, knowledge of disease processes, and ability to create a safe environment (Cangelosi, 2008). Simulation learning has been shown to be an effective learning method in a fast-paced, intense ABSN program. Boellaard et al. (2014) conducted a mixed methods study looking at how simulation helped ABSN students (N=17) learn about the nursing care of patients. Results were favorable to the simulation activities; however, the small sample size may lack power to prevent type II error making it necessary to conduct further studies using simulation in the ABSN population.

Current Trends in Nursing Education and Gerontology

Health care is constantly changing and nursing education is faced with integrating new developments such as gerontology into the curriculum (Koroknay, 2015). Due to an increasing volume of knowledge, nursing programs reorganize content to ensure essential skills required for nursing graduates is delivered. Many schools have opted to drop or not offer a stand-alone gerontological nursing course and have chosen to integrate gerontological nursing skills throughout other courses (Koroknay, 2015). This poses the

risk of losing the specialized knowledge required for caring for older adults and may give an inaccurate impression that caring for the older adult does not require a unique skill set (Koroknay, 2015).

The American Association of Colleges of Nursing (AACN) 2008 Baccalaureate Essentials points out that while most undergraduate programs include geriatric content, there continues to be a need to completely integrate care of the older adult into didactic and clinical education of baccalaureate prepared nurses. The supplement includes gerontological nursing competency statements including the areas of professional attitudes, values, and expectations about physical and mental aging (AACN, 2010, p. 12).

Nurse educators need to implement strategies to integrate care of the older adults into the curriculum in a way that is effective and engaging for the students. Puentes and Cayer (2001) found that nursing students' (N=33) knowledge and attitudes improved after a 42-hour seminar with community dwelling older adults, but because the program emphasized lecture pedagogy and students' social interaction with older adults was unspecified, the influence of interpersonal processes on student knowledge and attitudes is not known. A literature review by Neville & Dickie (2014) further supported that experience-based pedagogies indicate promise for improving knowledge and attitudes. For example, medical students' social contact with older adults in community-dwelling settings was associated with increased positive attitudes and a desire to work with the geriatric population (Samra, Griffiths, Cox, Conroy, & Knight, 2013). Encounters with community-dwelling older adults were associated with qualitative evidence of improved nursing students' attitudes (Gallagher & Carey, 2012). Implementing engaging strategies to improve attitudes should continue to be incorporated into nursing curricula.

Nursing Students' Attitudes Towards Older Adults

There is no disputing that an aging population will require nursing care in a variety of settings such as the hospital, rehabilitation facilities, and home care. Nurses' attitudes towards older adults may be stereotypical and affect the care given and received. An example of stereotypical treatment is treating older adults as fragile and attending to all their needs, thus endangering their independence (Celik et al., 2010). Nurses who are interested in working with older adults are needed and they should have knowledge, skill, and empathy to care for this population's unique health care needs.

Several studies have suggested that an undergraduate nurse's attitude toward older adults and their perception of working with older adults can influence the quality of care provided and their career choice later in life (Demir, Bicer, Bulucu-Böyüksoy, & Özen, 2016; King et al., 2013; Lookinland & Anson, 1995; Neville, 2014). Attitude in this sense is defined as a settled opinion or way of thinking and an interpretation or impression based on one's understanding of a situation (Neville & Dickie, 2014). It benefits society for all nursing students to graduate with a positive attitude and at least some specialized knowledge towards older adults. Nurses are most often in the frontline of healthcare for this population. The idea that positive attitudes could ensure better health outcomes from older adults was first discussed nearly 20 years ago and continues to be true today (Levy, Ashman, & Dror, 1999).

Studies in the area of nurses' attitudes towards older adults showed controversial findings; several studies showed positive to neutral attitude scores in nursing students (Liu, Norman, & While, 2013) while others reported negative attitudes towards older adults (Bernardini Zambrini et al., 2008; Hanson, 2014; Haron et al., 2013; King et al.,

2013; Lambrinou, Sourtzi, Kalokerinou, & Lemonidou, 2009). The findings from some studies used demographics and education as predictors of attitude towards older adults. The mixed findings of the studies may be a result of recruiting students from various levels of nursing education and the utilization of different measurement instruments to assess the students' attitude towards older adults.

Ageism, the interpretation of inadequacies, limitations and negative changes that occur as one gets older (Butler, 1980) may be tied to negative attitudes towards older adults (King et al., 2013). Ageism could negatively impact empathy if personal distress is experienced. Personal distress has been described as "personal feelings of anxiety and discomfort that result from observing another's negative experience" (Davis, 1980, p. 6). When an individual experiences personal distress in response to negative experiences of older adults, it may be translated into anxiety regarding their own aging thus causing negative attitudes towards older adults (Allan, Johnson, & Emerson, 2014).

Personal experiences with older people, whether they are within families, communities or in the workplace, are linked with both positive and negative attitudes, perspectives and perceptions toward older people (Neville & Dickie, 2014). One study (N=197) showed students' attitudes became less positive after they had clinical experiences with complex older adults (Holroyd, Dahlke, Fehr, Jung, & Hunter et al., 2009). Other studies showed that nursing students preferred to not work with older adults or in a nursing home setting because the environment was found to be depressing (King et al., 2013; Moyle, 2003).

Celik et al. (2010) listed factors such as a lack of understanding about the ageing process and poor experiences with ageing family members having a negative influence on

attitudes towards older adults among the traditional baccalaureate students. While ageist attitudes may persist, learning experiences can improve these attitudes. More exposure to older adults may decrease anxiety (Allan & Johnson, 2009) and a focus on empathy can significantly increase empathy for older adults (Winfield & Chur-Hanson, 2000). As students have more education in gerontology, they feel more prepared, confident, and competent in their abilities to work with this population (Plowfield, Raymond, & Hayes, 2006; Flood & Clark, 2009).

Nursing Students and Empathy Towards Older Adults

Empathy. Nursing in its purest form, is a caring profession (Brown, 2011). Nurses are expected to be caring, critical-thinking advocates who protect patients from medical errors and provide the safest care possible. Above all else, nurses are expected to be empathetic and compassionate as prescribed in nurse practice acts, public policy, and educational debates (Dewar, 2013; Richardson, Percy, & Hughes, 2015; van der Cingel, 2014).

Empathy is a predominantly cognitive attribute that involves understanding rather than feeling. It is the ability to put one's self in the place of others to better understand their experiences and to identify their current situation, (Hojat, 2007). It involves being present to another person in a very personal way so that there is an authentic understanding and experiencing of another's feelings (Sheehan et al., 2013).

Nursing literature suggests there are two types of empathy; that which is innate or basic, and that which is learned or trained (Evans, Wilt, Alligood, & O'Neil, 1998; Williams & Stickley, 2010). Basic, or innate empathy, is the way nurses think about a patient's situation, which is genuine and not always clearly communicated to the patient

(Sheehan et al., 2013). Basic empathy is needed for patients to feel understood and validated and is essential in the establishment of a trusting relationship between the nurse and the patient (Brunero, Lamont, & Coates, 2010; Vanlaere, Coucke, & Gastmans, 2010; Williams & Stickley, 2010; Sealy, 2011; Stanley & Hurst, 2011). Learned, or trained empathy behaviors, such as gentle touch or therapeutic communication, are observable in interactions between patients and caregivers. These behaviors are teachable and reproducible, but may not always be perceived as genuine (Sheehan et al., 2013).

An empathic relationship between caregiver and patient not only defines the quality of the patient's experience as a recipient of care; it also contributes to patient's health outcomes (Ward, Cody, Schaal, & Hojat, 2012). An empathetic nurse can lead to higher patient compliance with regards to treatments as well as increased patient satisfaction (Fields, Mahan, Tillman, Harris, Maxwell, & Hojat, 2011). A systematic review by Lelorain, Brédart, Dolbeault, and Sultan (2012) further supported the beneficial effects of empathy on higher patient satisfaction, better psychosocial adjustment, lesser psychological distress and need for information from patients' perspectives.

Teaching Empathy in Nursing. It is debatable whether empathy, primarily a cognitive attribute, can be taught or is innate to our human nature (Hojat, Louis, Maio, & Gonella, 2013; Richardson et al., 2015). Psychologists would have us believe empathy is ingrained in our psyche (Elliott, Bohart, Watson, & Greenberg, 2011) while others suggest it can be fostered and improved through practice and patient interactions (Bearman, Palermo, Allen, & Williams, 2015; Brunero et al., 2010; Burnell & Agan,

2013; Ozcan, Oflaz, & Bakir, 2012). Transformative Learning Theory, an adult learning theory, suggests that a person may be able to alter their understanding and viewpoints through experiences, thus making empathy something that can be fostered (Mezirow, 1991).

Empathy education should be added to current healthcare curricula (Hojat et al., 2013). Empathy can be taught through the use of educational activities such as case studies, role-playing (Hojat et al., 2013; Richardson et al., 2015; Williams & Stickley, 2010), acting as the patient in simulation (Pamosky & Diaz, 2009), reflective writing (Larocco, 2010), and reading memoirs (Low & LaScala, 2015). Based on these assertions, it is the responsibility of educators to foster development of empathy among nursing students (Sheehan et al., 2013).

The evidence from the literature demonstrated participating in seminars and lab sessions (Cunico, Sartori, Marognolli, & Meneghini, 2012), a semester long course exploring aspects of suffering to understand empathy (Sheehan et al., 2013) and inter-professional workshops (Williams et al., 2015) improved empathy skills among nursing and health professional students. In addition, strategies such as collective experiences, readings, reflections, and discussions led to improved empathy (Cunico et al., 2012; Sheenhan, Perrin, Potter, Kazanowski, & Bennett, 2013; Williams et al., 2015). A study by Maruca, Diaz, Kuhnly, & Jeffries (2015) used an experiential learning simulation, similar to role-playing, to enhance nursing students' empathy during care of the patient with an ostomy. Students were fitted with an ostomy bag instructed on how to measure a correct opening of the wafer and apply it. Students were to wear the ostomy bag with fecal moulage for 48 hours continuously while performing normal daily activities.

Content analysis was conducted on essays using Krippendorff's technique to quantify the simulation (Maruca, Diaz, Kuhnly, & Jeffries, 2015). Of the total sample, 22.8 percent had three or five empathic comments; 10 percent had four, and 9 percent had six or more comments per paper. Eighty-five percent of participants felt this simulation experience was beneficial for enhancing empathy in clinical practice (Maruca, Diaz, Kuhnly, & Jeffries, 2015).

A program evaluation study (McMillan & Shannon, 2011) examined the relationship between senior baccalaureate nursing students' perceptions of their nursing program effectiveness in teaching them to empathetically communicate with patients and family members and perceived competence in empathetic communication. Findings from the regression analysis showed that academic exposure, curricular emphasis, and program effectiveness in teaching students to empathetically communicate with patients and family explained 22.4% ($F [3, 592] = 42.71$, $p < .001$) of the perceived competence, and academic exposure as the strongest predictor ($r^2 = .187$). This study reinforced a need for greater attention to be focused on clinical instruction, maximization of faculty input and feedback, and reinforcement of theoretical tenets that are taught academically (McMillan & Shannon, 2011). Research has shown that empathy tends to decline over time among undergraduate nursing students, particularly as they spend more time in clinical practice focusing on technical skills (Ward, Cody, Schaal, & Hojat, 2012). It is important to consider the need for empathy education integrated throughout the entire nursing curriculum as a way to reverse this decline.

Characteristics of Adult Learning in ABSN Students

Compared to first-time degree students, ABSN students are in a unique position.

ABSN students have knowledge and work experiences in other fields and are not novices in a rigorous academic program or new profession (Cangelosi & Moss, 2010). Some choose to enter an ABSN program due to the need for a career change while others are fulfilling a dream to become a nurse due to personal experiences; therefore, they tend to enter a program with enthusiasm for mastering new skills for clinical practice and have demonstrated the ability to learn complex material quickly (Raines & Sipes, 2007). It is important to remember that while ABSN students are adult learners with a broad range of educational and experiential backgrounds, their knowledge level of nursing is similar to that of a traditional baccalaureate nursing student (Boellaard et al., 2014). A priority in bridging the knowledge gap is identifying teaching methods that appeal to and appreciate adult learners' experiences (Rico, Beal, & Davies, 2010; Spies, Seale, & Botma, 2015).

Effective Teaching Methods in ABSN Education

Several effective teaching methods have been identified in the literature that support positive learning outcomes for ABSN students. A student-centered focus is most valued by ABSN students as it is a collaborative learning environment (Brandt, Boellaard, & Zorn, 2012; Boellaard et al., 2014; Hegge & Hallman, 2008). Accelerated students are typically focused on the tools and task at hand to solve problems versus a systems approach as taught in traditional BSN programs (Bowie & Camacho, 2013). Other effective strategies noted in the literature include incorporating their previous degrees and experiences (Hegge & Hallman, 2008; Raines & Sipes, 2007); frequent feedback during educational activities and clinical experiences (Spies et al., 2015); the use of visual aids, mixing lecture and use of technology, emphasizing experiential learning, and learning through case studies (Robert, Pomarico, & Nolan, 2011).

Several studies looked at the educational environment that help promote teaching and learning needs within ABSN nursing students (e.g. Driessnack et al., 2011; Payne, 2013; Raines, 2010). Driessnack et al. (2011) determined this population needed a more "learner-centered" environment consisting of encouragement to develop life-long learning skills. Teaching emphasis should be on how to learn, rather than just content delivery (Driessnack et al., 2011). Due to the heavy work load and fast pace of an ABSN program, it is reasonable to believe students take on a surface learning style (Lizzio et al., 2002). That is, students only focus on the facts versus the overall concepts linked to the topic at hand. This surface style of learning lends to the perception of need for greater short term learning, rather than mastery, within an ABSN program (Lizzio et al., 2002). This learning style does not lend itself well to the development of empathy within the context of nursing and patient interaction.

Teaching Methods Used in Proposed Study

Nursing education has traditionally relied on didactic methods of delivering information to students. While considered an efficient method of delivery in a short period of time, it inhibits inductive reasoning (Boctor, 2013). One of the greatest challenges faced by nursing educators is offering teaching methods that increase interest, develop student learning, and appeal to the needs of adult learners (Boctor, 2013). Two methods of learning that may appeal to adult learners are case-based scenarios and role-playing simulations. Both methods are learner-centered, can provide immediate feedback, and provide information and experiences that can be directly applied to patient care.

Case-Based Learning

Case-based learning, an active form of learning, is a relatively new term for an older instructional design method more commonly known as case studies. Case studies can be used in almost every nursing course as a means to bridge the gap between classroom knowledge and clinical application (Aitken & Marshall, 2007). They also offer students opportunities to discuss real-life situations and nursing challenges in a safe environment that stimulates students to think critically since there are no concrete answers (Chen & Lin, 2003; Kaddoura, 2011). A case study requires students to have a degree of prior knowledge in the topic being covered (Aitken & Marshall, 2007; Forsgren, Christensen, & Hedemalm, 2014). A case study not only describes, but facilitates understanding and conveys an educational message through explanation of the chosen aspect of care. A particular strength of the case study is that it describes the clinical decision-making that progressed throughout the care, rather than just the presentation of individual elements (Aitken & Marshall, 2007).

Case studies can take multiple formats but usually consist of a description of specific aspects of a patient's clinical condition and care, as well as critical evaluation of at least one aspect of that condition or care (Aitken & Marshall, 2007). Unfolding case studies, another form, are increasing in popularity in nursing education. It is a case study that evolves over time in a manner that is unpredictable to the learner (Kaylor & Strickland, 2015). The patient remains the same, however, new situations develop and are revealed with each encounter with the patient. Typically, unfolding case studies are aligned with simulation scenarios (Kaylor & Strickland, 2015), however, paper-based unfolding case studies are possible as well.

Compared to “low-technology” (paper-and-pencil) methods, case-based learning helps to improve competency and give students the opportunity to use critical thinking skills, it also gives them a chance to become aware of their own values (Forsgren et al., 2014; Raurell-Torredà et al., 2015). It has not been adequately discussed as to how effective case studies are in forming an empathetic response to a situation or the effect they may have on attitudes towards specific patients, such as older adults.

Role-playing Simulations

Simulation is a pedagogy using one or more typologies to promote, improve, or validate a participant's progression from novice to expert (International Nursing Association for Clinical Simulation and Learning, 2013). Simulation activities can take many forms including gaming activities such as Second Life, online streaming videos, board games, role-playing, the use of high and low fidelity mannequins, and standardized patients to mimic real-time interactions (Broom, Lynch, & Preece, 2009; Corbridge, Robinson, Tiffen, & Corbridge, 2010; Dutile, Wright, & Beauchesne, 2011; Guzic et al., 2012; Honey, Connor, Veltman, Bodily, & Diener, 2012; Hutton et al., 2010; Kopp & Hanson, 2012). Allowing students to role play a scenario hold’s their attention longer and enables a deeper understanding of the situation, which promotes self-reflection and active learning (Cogo et al., 2016; Mezirow, 1991).

Role-play allows students the opportunity to play a character and experience situations from a different point of view. Role-play can advance the student’s experience of patient-related empathy (Hermanns, Waldo, & Lilly, 2013) and further develop empathy, compassion, respect, and positive attitudes (McNaughton, Ravitz, Wadell, & Hodges, 2008). Students respond to role-play as though they are involved in real

situations, which gives them an opportunity to practice new skills and engage in meaningful learning (Nelson & Blenkin, 2007). Chen, Kiersma, Yehle, & Plake (2015) suggest students may have difficulties in understanding and empathizing with older adults, as they have not personally experienced aging-related challenges, such as disability and disease. The use of case studies and role-playing may be one way to increase empathy towards older adults and should further explore.

The desirability of using simulation as an educational strategy, particularly role-playing, arises from the ability to incorporate multiple elements of practice within a learner centered activity, address national health priorities and, trigger participants' reflection on and about practice (Kelly, Berragan, Husebø, & Orr, 2016). Case-based learning, while effective, does not always allow students to actively engage in a scenario. They can analyze the situation using the nursing process, however, there is little to no emotional connection which may make it difficult to understand the overall impact the illness may have on the patient.

Summary of Relevant Research

It is no surprise that our population is aging and will need nursing care to help support their future needs both in and out of the hospital. More nursing students are graduating with little interest in working with older adults, which poses a problem for the future. In addition, current research supports a decline in empathy in nursing students over time as a student progresses through a nursing program. Traditional nursing education has relied on didactic methods of delivering information to students. Educators must take the initiative to promote positive attitudes and empathetic responses towards

older adults during the formative nursing education years by taking advantage of engaging educational modalities such as case studies and simulation.

A majority of nursing education research focuses on traditional four-year baccalaureate (BSN) programs, not accelerated second-degree programs. The fast-paced environment of ABSN education and previous experiences and knowledge from fields outside of nursing may influence future preferences and attitudes towards working with older adults. The existing literature has several limitations. Some of which include focusing on traditional nursing programs and neglecting the non-traditional nursing students; use of small sample sizes, which may not have enough power to prevent type II errors; adoption of wide inclusion criteria which resulted in controversial findings; and lacking a theory based intervention. Literature showed personal characteristics and education determine attitude toward older adults (Bernardini Zambrini et al., 2008; King et al., 2013; Hanson, 2014; Liu, Norman, & While, 2013). However, the current trend in nursing education is to integrate gerontological content throughout other courses instead of offering stand-alone courses (Koroknay, 2015); therefore, a theory-based intervention with a focus of the ABSN students may be one way to help improve attitudes and empathy towards older adults.

Theoretical Framework

The ability to critically reflect on one's own practice is often seen as the starting point for gaining new perspectives in the daily routines of working professionals (Lundgren & Poell, 2016). Mezirow's Transformative Learning Theory (TLT, Mezirow, 1991) served as the framework to guide this study. TLT is a theory that encourages personal reflection and change based on a specific situation. A tenet of the theory

includes the concept that contemporary adult learners must develop the ability to become autonomous thinkers (Mezirow, 1991; 2000). It assumes learners can be equipped to become agents of self-change by identifying self-limiting factors and freeing themselves through reflection and discourse (Dirkx, 1998; Mezirow, 1991). Engaging in transformative learning requires emotional maturity, awareness, empathy, and control (Mezirow, 2000).

Mezirow (1978a) first applied the label 'transformation' in a study of U.S. women returning to postsecondary study or the workplace after an extended time away. Through a qualitative study, Mezirow tried to identify factors that impeded or facilitated the women's progress in the re-entry programs. Through a secondary study (1978b), Mezirow and his colleagues concluded that respondents had undergone a "personal transformation" and identified 10 phases that the women could experience (Table 3.1).

Table 3.1 Mezirow's (1978a, 1978b) Ten Phases of Transformative Learning

Phase 1	A disorienting dilemma
Phase 2	Self-Examination with feelings of guilt or shame
Phase 3	A critical assessment of epistemic, sociocultural, or psychic assessments
Phase 4	Recognition that one's discontent and the process of transformation are shared and that others have negotiated a similar change
Phase 5	Exploration of options for new roles, relationships, and actions
Phase 6	Planning a course of action
Phase 7	Acquisition of knowledge and skills for implementing one's plans
Phase 8	Provisional trying of new roles
Phase 9	Building of competence and self-confidence in new roles and relationships
Phase 10	A reintegration into one's like on the basis of conditions dictated by one's perspective

TLT reasons that every individual has a particular view of the world, and this view is typically based on a set of paradigmatic assumptions that come from an individual's upbringing, life experiences, culture, or education (Christie, Carey,

Robertson, & Grainger, 2015; Mezirow, 1991). Particular points of view can become so ingrained in a person that the only way to change is by experiencing a disorienting dilemma (Christie, Carey, Robertson, & Grainger, 2015). This acts as a catalyst for change in beliefs starting with self-examination followed by a change in beliefs. Figure 3.1 offers a visual representation of the ten phases of Mezirow's TLT. Much like the original study of women returning to education or the workforce, an ABSN student is returning to school to obtain a new career. Without doubt, ABSN students will encounter new experiences both in the classroom and clinical settings.

Over the last three decades, three main phases have emerged from the original ten phases of transformative learning (Mezirow, 1991). These phases are highlighted in a darker gray color (Figure 3.1). The initial stage involves the learner becoming engaged in an unfamiliar experience, a disorienting dilemma (Hodge, 2014; Mezirow, 1991). This disorienting dilemma acts as a catalyst to bring to light assumptions that have been shaping and individual's experiences to date. The next phase is self-examination and critical reflection of assumptions (Hodge, 2014). Mezirow argued that the central element to the perspective transformation is critical self-reflection; through critical reflection, a person's interpretation and interactions with others will change (Mezirow, 1991; 2000). Critical reflection is a period where people realize the limitations of their assumptions and potentially renounce them. This can be a painful time of alienation from familiar ways of being-in-the-world (Hodge, 2014; Mezirow, 2000). Critical reflection leads to the final phase in TLT, a change in perspective and understanding (Hodge, 2014).

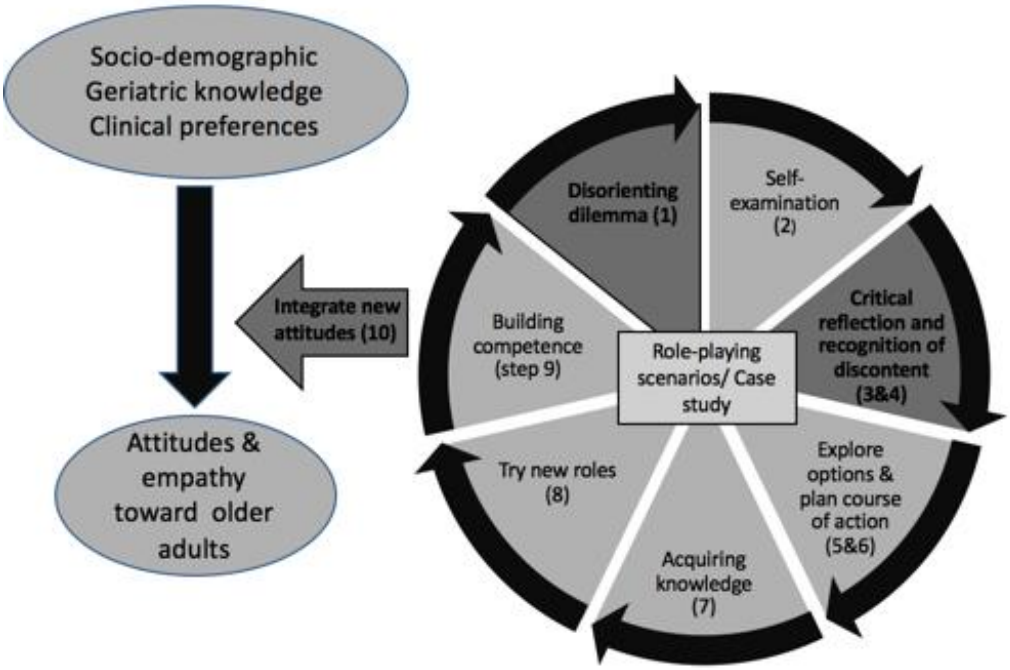

Figure 3.1. Mezirow's Transformative Learning Theory

TLT lent itself to the current study because ABSN students came into the nursing program from another field of expertise. They brought knowledge and prior experiences that were incorporated into their nursing practice and potentially guided their preferences towards working with different patient populations, particularly older adults. Through transformative learning opportunities, students acquired practical knowledge while reflecting on their experiences, evaluating their reason for learning, and restructuring their experiences (Dirkx, 1998). Transformative learning adds value to other types of organized learning by helping us to regularly re-assess the validity of our learning (Christie, Carey, Robertson, & Grainger, 2015).

Conceptual and Operational Definitions

The theoretical concepts, variables, and conceptual and operational definitions of the study can be found in Table 3.2.

Table 3.2 Conceptual and Operational Definitions of Variables

Variable	Conceptual Definition	Operational Definition
Role-playing	A teaching method that allows someone to play someone else's role, to sensitize the other participants (Cogo et al., 2016)	Three TLT theory-based role-playing simulations designed by the PI
Case studies	Narratives within a determined context experienced by the student in practice fields, adding prior knowledge to the theme proposed, stimulating the elaboration of questions to be answered, and researching sources that may contribute to the course learning outcomes (Cogo et al., 2016)	The National League for Nursing ACES unfolding case of Red Yoder utilizing the opening monologue
Previous Exposure	Prior encounters with older adults in the home and community	Sociodemographic survey questions 6-9 (yes/no questions)
Knowledge of Older Adults	Student-reported knowledge level of older adults	The Knowledge About Older Patients – Quiz (KOP-Q): 30 true/false items measuring knowledge of older adults. Scores range from 0 to 30 with higher scores indicating more knowledge
Clinical Preference	The desire to work with older adults	Sociodemographic survey question 10 (1-5 Likert Scale)
Attitudes	A settled opinion or way of thinking and an interpretation or impression based on one's understanding of a situation (Neville & Dickie, 2014)	Kogan's Attitudes Towards Older People Scale (KOP): 34 items, scores range from 34 to 204 with higher scores on the positive scale designates a favorable disposition towards older adults; a higher score on the negative scale designates an unfavorable disposition; items from the negative scale are reversed scored. (Kogan, 1961)
Empathy	The ability to put one's self in the place of others to better understand their experiences and identify their current situation, which further lead to help others in need' (Hojat, 2007)	Jefferson Scale of Physician Empathy – Health Professions Student version (JSE-HPS): 20-item survey, scores range from 20 to 140, higher scores indicate a more empathic orientation (Ward et al., 2009)

Hypothesis/Research Questions

Mezirow's TLT was used as the framework for this study to test the following hypothesis (H) and research questions (R):

H1: Students participating in simulated role-playing scenarios will have significantly better scores in attitude and empathy measured by Kogan's Attitude Towards Older People Scale and the Jefferson Scale of Empathy – Health Professions students when compared to those students participating in the case study.

R1: To what extent is a positive attitude toward older adults in accelerated nursing students explained by selected sociodemographics, knowledge of older adults, and clinical preferences?

R2: To what extent is empathy toward older adults in accelerated nursing students explained by selected sociodemographics, knowledge of older adults, and clinical preferences?

R3: What factors during the teaching-learning process (case study and simulated role-playing scenarios) best influence the ABSN students' attitude towards older adults?

Design Statement

A quasi-experimental, pre- and post-test design was used for this study. True randomization could not be completed due to the cohort-based nature of the sample program and previously assigned registration for the course. The Principal Investigator (PI) used four instruments for pre-test data collection including a sociodemographic survey, Kogan's Attitudes Towards Older People Scale (KOP), Jefferson Scale of Empathy-Health Professions Student (JSE-HPS), and the Knowledge About Older Patients – Quiz (KOP-Q), in the form of paper and pencil questionnaires. Post-test data

included the KOP and the JSE-HPS. Two additional open-ended questions were given to assist in answering research question three. Students completed the pre-test surveys the day of the intervention. Prior to lecture the week following the interventions, the post-test surveys were distributed and collected by the PI.

Setting

The study was conducted at a university located in the Northeast using the simulation learning laboratory and classroom space. Both groups received a lecture on physiological changes in the older adult in the classroom by the course instructor. The simulation laboratory was set up with various stations for those participating in the aging changes scenarios.

Sample and Sample Size

Based on a priori testing using G*Power (Faul, Erdfelder, Lang, & Buchner, 2007) to test the hypothesis, a minimum sample size of 90 students was needed (45 in each group) for an effect size of 0.60, alpha of 0.05, power of 0.80 based on a similar study by Bunn & Terpstra (2009). A convenience sample (N=55) was used which included students enrolled in a two-credit Concepts of Gerontological Nursing Practice course. This course was offered during the first semester of an ABSN program. All students enrolled in the gerontology course were eligible.

Ethical Considerations

Institutional Review Board (IRB) approval was obtained from the University of Texas at Tyler (Appendix A) where the PI is a doctoral student as well at New Jersey City University (Appendix B) where the study was conducted. The PI is a full-time

faculty member at NJCU, however, did not teach the students in any graded courses during the time of data collection.

Informed consent (Appendix C) was obtained from all participants prior to beginning the study. The PI discussed the purpose of the study and informed students that participation in the data collection aspect was optional. If a student chose to not participate in the data collection aspect of the activity, they were asked to step outside the classroom until all pre-test surveys were turned in. The classroom activities were not optional since it is a normally scheduled activity for the course they were enrolled in. Students were notified that completion of the surveys would not impact their grades. Student-created unique identifiers were used on all documents pertaining to the study.

Confidentiality was ensured in several ways. All hard-copy survey responses were stored in a locked filing cabinet in the PI's possession. Electronic data was stored on a password-protected computer. Data will be kept for three years. After that time, hard-copies of surveys will be shredded, and computer files deleted and emptied from the trash folder. A record of how many students were recruited, how many agreed to participate, and how many actually participated was kept for data analysis to determine if there are any significant differences between pre- and post-test participants. The PI and committee members had access to any study related data for review.

Instruments

Sociodemographic Data Survey

A sociodemographic survey containing 11 questions (Appendix D) was created by the PI to collect gender, age, marital status, race, highest level of education. Additional questions on the sociodemographic data survey explored students' previous experiences

interacting with older adults and their current preferences in working with this population.

The Knowledge About Older Patients - Quiz

The Knowledge About Older Patients Quiz (KOP-Q) measures general knowledge about older patients: normal aging; signaling problems in old age; interventions; family interventions; combined with a variety of geriatric conditions (Dikken, Hoogerduijn, & Schuurmans, 2015). Permission was granted to use this instrument for the purposes of this study (Appendix E). The KOP-Q consists of 30 true/false questions and takes approximately ten minutes to complete (Appendix F). After every knowledge question, a certainty bar is included to indicate how certain participants are about the answer given. The KOP-Q contains 30 dichotomous items (true/false) measuring knowledge with every correct answer assigned 1 point and incorrect answer 0 points. Scores range from 0 to 30. The KOP-Q demonstrated adequate face validity, good readability, a good Scale-Content Validity Index/average (S-CVI/avg = 1⁄4 .91), good psychometric validity and reliability for the knowledge items (Kuder-Richardson Formula 20 1⁄4 .70) (Dikken, Hoogerduijn, Lagerwey, Shortridge-Baggett, Klaassen, & Schuurmans, 2017). Furthermore, the KOP-Q was considered valid for use in the United States (Dikken, Hoogerduijn, Klaassen, Lagerwey, Shortridge-Baggett, & Schuurmans, 2017). It was previously used with nursing students and registered nurses.

Kogan Attitudes Towards Older People Scale

Kogan's Attitudes Towards Older People Scale (KOP) (Kogan, 1961) is rooted in the belief that older adults belong to a "minority group" which experience stereotypes

such as ageism and discrimination in the workplace and other areas of life (Appendix G). Stereotypes are classified by domains within the scale, including residential status, cognition, appearance, personality and general comfort with older adults. The KOP contains 34 items, 17 pairs of contrasting positive and negative statements concerning older adults which are scored on a Likert scale from 1 = strongly disagree to 6 = strongly agree. The total score range is 34 to 204. A higher score on the positive scale designates a favorable disposition towards older adults. Conversely, a higher score on the negative scale designated an unfavorable disposition; items from the negative scale are reversed scored. The KOP is in the public domain and is the most commonly used scale to assess attitudes towards older adults in a variety of healthcare professions (Liu et al., 2013). Kogan (1961) used odd-even Spearman-Brown prophecy to establish reliability of items created for his scale. Positive items obtained correlation coefficients from .66 t0 -.77 and negative items achieved correlation coefficients of .73 to .83 (Khan, 2011). A Cronbach alpha of .82 was reported for the total scale (Yen, Liao, Chen, Kao, Lee, & Wang, 2009); .73 for the negative scale and .65 for the positive (Lambrinou et al., 2009). Content validity was based on literature review and construct validity was determined by factor analysis of the positive and negative subscales (Kogan, 1961). Reliability coefficients range from .66 to .85 with a trend toward greater reliability for the negative scale as opposed to the positive scale. A more recent study found the content validity index of the KOP to be 0.81 (Matarese et al., 2013).

Jefferson Scale of Empathy – Health Professions Student

The Jefferson Scale of Physician Empathy is one of the few instruments developed to measure healthcare professionals' empathy (Hojat et al., 2001). Originally

developed for use by physicians, the Jefferson Scale of Physician Empathy has been adapted by Ward et al. (2009) for use with nursing students. Permission was granted to use this instrument for the purposes of this study (Appendix H). The author agrees to all conditions set forth by the owners of the JSE-HPS tool such as using the scale exactly as it is and maintaining copyright.

The Jefferson Scale of Empathy-Health Professions Student (Appendix I) is a 20-item survey with Likert responses ranging from 1 = strongly disagree to 7 = strongly agree. Ten items are positively worded while the remaining are negatively worded (Ward et al., 2009). It can be completed in approximately 10 minutes. Scores range from 20 to 140. Higher scores indicate a more empathic orientation. The coefficient alpha score was .77 at pre-test and 0.80 at post-test (Ward et al., 2009). While the alpha score is borderline, this tool was more effective measurement of empathy in healthcare providers as compared with other scales that do not focus on healthcare providers or are for use in the general population (Hojat, Mangione, Nasca, Choen, Gonnella, Erdmann, & Magee, 2001). Factor analysis provided support for the construct validity of the scale though the author did not address how much of the variance in the construct of empathy is explained by the attributes. Additional studies found the content validity to be 0.89 (Hsiao, Tsai, & Kao, 2013).

Open-Ended Questions for Exit Survey

A brief exit survey with two Likert-style questions and two open-ended questions (Appendix J), created by the PI, was completed with the post-test surveys. The survey questions solicited students' preference for working with older adults; the results were compared to their initial opinion to see if changes occurred. The open-ended questions

were used to ask students to describe a previous encounter with an older adult and discuss if it had a positive or negative influence on their attitude. This information may provide details that increase understanding of other confounding variables in the study. The second open-ended question was used to help students identify a point in the activity that may have influenced a change in their attitude.

Study Procedures

Pre-test data collection occurred on the same day as the intervention while post-test data was collected one week after the intervention occurred. A study timeline and flow chart depicting the interventions is located in appendices J and K. Unique identifiers were used to pair pre- and post-test surveys. Participants were asked to create a unique identifying code to aid in matching pre- and post-test survey forms. To create a personalized code, students were asked 'What day of the month is your birthday?' and 'What is the first three letters of your mother's maiden name?' If a participant's birthday is February 25th and mother's maiden name is Johnson, the unique identifier would be '25joh.' Pre- and post-test surveys were color-coded to differentiate the data collection time.

The PI handed out all pre-test surveys and asked students to place responses in a locked-box when completed. The box was located in the same classroom as the students. The PI left the room while the surveys were completed to maintain participant confidentiality and anonymity. The pre-tests included a sociodemographic survey, the KOP, the JSE-HPS, and the KOP-Q.

Since the JSE-HPS cannot be changed as requested by the owners, students were instructed to not fill out the demographic section of the instrument. This data was

collected on the sociodemographic survey. The same instruments were used for post-testing with the exception of the sociodemographic survey a week after the interventions were completed. Instead of the sociodemographic survey, a short open-ended response survey was given in the post-test. All survey material was compiled into pre- and post-test packets for the students to ensure all participants received the surveys.

Intervention

Students in the ABSN program were randomly registered for their courses by the ABSN program coordinator. They were alternated between two different sections of the course for registration. Both sections of the Concepts of Gerontological Nursing Practice course were offered and taught by the same faculty member who was not a part of the study. The PI had no teaching responsibility for the course. The class met weekly and was scheduled for a two-hour lecture. A coin flip determined which of the two sections of the course was designated Group A (case study) and Group B (simulated role-playing scenarios). The interventions were designed to be incorporated into a two-hour class that focused on chronic diseases of older adults. Both groups received the same one-hour lecture at their scheduled meeting time directly followed by the one-hour intervention. Students who are not in the first section of the Gerontology course were in a different course that meets at the same time. After a one-hour lunch break, student switched classes for the afternoon. Participants in the study were asked to not discuss what occurred during their particular class with anyone outside of their section in an effort to prevent contamination between the groups.

Group A. The course section selected for group A participated in a case study. The focus of the case study was the introductory monologue for the Sherman "Red"

Yoder unfolding case study from the NLN. The introductory monologue was used to tie in the concepts of chronic diseases that were covered during the lecture in the first hour. Permission was granted from the NLN for use of the case study (Appendix K). One hour of class time was allotted to complete the case study (Appendix L). The story of Sherman 'Red' Yoder came courtesy of the National League for Nursing's Advancing Care Excellence for Seniors (ACES) program. Yoder is one of four unfolding case scenarios that presents students with realistic encounters and simulated patients in varied healthcare settings (King, Cline, Mengel, McLaughlin, Rizzolo, & Tagliarini, 2011).

The voice-recorded monologue took approximately 10 minutes to complete. After listening to the monologue, students were asked to form groups of two to three and complete the six reflection questions attached to the monologue. Students were given a paper copy of the monologue for reference. Approximately 20 minutes was allocated for the groups to answer the questions related to the monologue. The remaining half hour was spent as a class discussing group responses. Questions were provided by the NLN and a group discussion based on the questions was led by the PI. Group discussion offered a chance for several students to voice their responses and concerns for the patient as well as potentially learn from different the perspectives.

Group B. Students in this section of the course participated in several short role-playing scenarios designed to mimic age-related changes seen in older adults (Appendix M). This section received the same one-hour lecture by the same course instructor as group A. An hour was allotted for completion of the role-playing scenarios. Two gerontology content experts reviewed the role-playing scenarios to make sure they appropriately depict age-related changes of the older adult. Both reviewers agreed the

role-playing scenarios are appropriate for use with students. Similar role-playing scenarios have been found in the literature to be effective as well (Eymard, Crawford, & Keller, 2010).

Three stations were set up around the classroom with duplicated items available so that multiple students can participate in the scenario at the same time. Students were divided into three groups and asked to start at one of the stations. Students rotated every 15 minutes until all activities were completed. These activities were designed to mimic arthritis, hearing loss, and visual disturbances (Appendix M). Fifteen minutes was given for each station with the remaining 15 minutes allotted for open discussion of the role-playing experiences. The PI was available to assist with the role-playing scenarios and conducted a brief group discussion regarding the experiences of the students.

Data Collection

Students completed the pre-test sociodemographic survey, KOP, and JSE-HPS, and the KOP-Q prior to the learning activities taking place. Surveys were taken by paper and pencil in the classroom on the day the education activities were scheduled to take place. One week after the interventions were completed, the post-test instrument packet was given to the students to complete in the classroom setting. The post-test instruments included the KOP, JSE-HPS, and a brief open-ended survey. The PI was not present while students complete pre- and post-test instruments.

Results

Data was double entered and prior to statistical analysis, outliers, missing data, and normal distributions were evaluated. All variables were normally distributed with an exception of the KOP scale; however, after log transformation, it was normally

distributed. The findings reported here include descriptive information about the study participants, reliability of instruments, and data regarding the hypothesis and research questions.

Characteristics of Study Participants. A total of 55 students enrolled in the Concepts of Gerontological Nursing Practice course were recruited to participate in the study. Of those students, 10 students were absent from their respective section and the remaining 45 students (24 in the case study, 21 in the role-playing simulation scenarios) took part in this study. The participants consisted primarily of females (80%), single (64.4%), and with an age range from 22-53 years (M=29.4, Mdn = 27, SD= 6.69). About 38% of the participants identified as White and the rest identified as Hispanic or Latino (31%), Asian (18%), and Black or African American (13%). All participants had a previous baccalaureate degree with 11% reporting also having attained a master's degree prior to beginning their course of study in the ABSN program (Table 3.3).

All but one participant (n = 44) reported spending time with an older adult in the past. A majority of the participants (67%) had previously cared for an older adult prior to entering the ABSN program, and 80% of them worked with older adults at previous job. Approximately 39% of the participants are currently caring for an older adult while attending school (Table 3.3). There was no significant difference in intentions to work with older adults after graduation between the groups.

Table 3.3 Characteristics of Entire Sample

Demographic Data	N (%)
Gender	
Male	9 (20%)
Female	36 (80%)
Marital Status	
Single	29 (64.4%)
Married	15 (33.3%)
Separated	1 (2.2%)
Race	
Asian	8 (17.8%)
Black or African American	6 (13.3%)
Hispanic or Latin	14 (31.1%)
White	17 (37.8%)
Highest Degree Received	
Bachelors	40 (88.9%)
Masters	5 (11.1%)
Have you spent time with an older family member (aged 65+) or friend?	
No	1 (2.2%)
Yes	44 (97.8%)
Have you cared for an older family member (aged 65+) before entering nursing school?	
No	15 (33.3%)
Yes	30 (66.7%)
Have you cared for older people (aged 65+) during nursing school?	
No	6 (13.3%)
Yes	39 (86.7%)
Have you worked with older adults (aged 65+) at your job?	
No	9 (20%)
Yes	36 (80%)

To determine if there were any demographic differences between the case study and role-playing simulation scenario groups, chi-square statistics was used for analysis (Table 3.4). This analysis indicated this was a homogenous group.

Table 3.4 Characteristics Between the Two Groups

Variable	Intervention Group		p value[1]
	Case Study n = 24	Role-Playing Simulation n = 21	
Gender			.881
Male	5	4	
Female	19	17	
Age			.208
Mean Age	30.58	28.05	
Marital Status			.636
Single	15	14	
Married	8	7	
Separated	1	0	
Race			.668
Asian	4	4	
Black or African American	3	3	
Hispanic or Latino	6	8	
White	11	6	
Highest Degree			.751
Bachelors	21	19	
Masters	3	2	
Have you spent time with an older family member (aged 65+) or friend?			.344
No	1	0	
Yes	23	21	
Have you cared for an older family member (aged 65+) before entering nursing school?			.526
No	9	6	
Yes	15	15	
Have you cared for older people (aged 65+) during nursing school?			.292
No	2	4	
Yes	22	17	
Have you worked with older adults (aged 65+) at your job?			.550
No	4	5	
Yes	20	16	

[1] x^2 or t-test statistic

Table 3.4 Characteristics Between the Two Groups (continued)

Preference of Work with an Older Adult			.383
Strongly Disagree	1	1	
Disagree	4	2	
Neutral	7	4	
Agree	8	6	
Strongly Agree	3	8	
Feeling comfortable Interacting with Older Adults			.770
Strongly Disagree	1	1	
Disagree	1	0	
Neutral	2	1	
Agree	11	8	
Strongly Agree	9	11	

[1] x^2 or t-test statistic

Description of Research Instruments. The internal consistency of the instruments used in this study was assessed by using Cronbach's alpha and Kuder-Richardson Formula 20 scores. The Kuder–Richardson Formula 20 (KR-20) is a measure of internal consistency reliability for instruments with dichotomous choices such as the KOPQ. The means (M) and standard deviations (SD) of each questionnaire are detailed in Table 3.5.

The Knowledge About Older Patients Quiz (KOP-Q) (Dikken, Hoogerduijn, & Schuurmans, 2015) was used to measure the student's knowledge of older adults. The KR-20 was .229, which was not acceptable; after removing one item from the test, the KR-20 became .312, which still falls below the normally accepted KR-20 score of .50. However, this is not an issue in this situation because the test was used to discriminate the students who have knowledge of older adults. The total score of the 29-item of KOPQ was used for data analysis. Scores ranged from 17 to 28 (M = 21.24, SD = 2.53).

Kogan's Attitudes Towards Older People Scale (KOP) (Kogan, 1961) was used to measure attitudes towards older adults. The Cronbach's alpha was .774 and .840 for pre- and post-tests, respectively. For the pre-test, the total score range was 122 to 193 (M=

145.96, SD= 13.73). The post- test total score range was 76 to 122 (M = 148.96, SD = 15.35). However, the pre-test KOP was not normally distributed; a log transformation was performed and after, became normally distributed. There was no significant difference between the case study and role-playing simulation group (t (43) = -.933, p = .356) in the pre-test.

The Jefferson Scale of Empathy – Health Profession Students (JSE-HPS) (Ward et al, 2009) was used to measure empathy. The pre-test Cronbach's alpha was .701 and the post-test alpha was .613. In order to improve the post-JSE HPS alpha score, item 18 was removed. The total score for the 19-item JSE-HPS scale was used for data analysis. Cronbach alphas were recalculated for both pre- and post-tests. The pre-JSE HPS alpha was .74 while the post-JSE HPS was .65. The total pre-test range of scores was 92-133 (M = 117.84, SD = 9.46) while the post-test range of scores was 97 to 133 (M = 117.24, SD = 8.16). There was no significant difference between the case study and role-playing simulation groups (t (43) = -.171, p = .865) in the pre-test.

Table 3.5 Means and Standard Deviations of the Major Variables and Comparison between Two Groups

Study Variable	Total N = 45	Case Study N = 24	Role-Playing Simulation N = 21	t[a]
KOPQ Score	21.24 (2.53)	21.46 (2.67)	21.00 (2.41)	.601
Pre-Kogan Sum	145.96 (13.73)	144.17 (10.49)	148.00 (16.74)	-.933
Post-Kogan Sum	148.96 (15.35)	149.38 (11.81)	149.37 (18.91)	.194
Pre-Kogan Log	2.16 (.04)	2.16 (.031)	2.17 (.05)	-.842
Post-Kogan Log	2.17 (.04)	2.17 (.03)	2.17 (.05)	.342
Pre-JSE	117.84 (9.46)	117.33 (8.29)	118.10 (10.52)	-.171
Post-JSE	117.24 (8.16)	116.88 (7.28)	117.67 (9.22)	.082

[a] Between groups t-test * $p < .05$

Results for the Hypothesis. *Students participating in simulated role-playing scenarios will have significantly better scores in attitude and empathy measured by Kogan's Attitude Towards Older People Scale and the Jefferson Scale of Empathy – Health Professions students when compared to those students participating in the case study.*

A two-tailed independent t-test was used to assess the differences in attitudes towards older adults and empathy towards older adults between Group A (case study) and Group B (role-playing scenarios) by using the post-test scores. Prior to the t-test, the pre-test scores of the outcome variables were compared between two groups, and there was no statistically significant difference between two groups (see Table 3.5). There was no statistically significant difference between groups for post-test in attitude (t (43) = .342, p = .734) and empathy (t (43) = .082, p = .935) toward older adults; therefore, the hypothesis was rejected.

A paired *t*-test, within group, comparisons was further explored. In the case study group, there was a statistically significant difference (t (23) = .143, p = .049) between the pre- and post-test scores for the KOP, suggesting that the case study intervention had a positive medium effect (Cohen's d= 0.466) on improving attitudes towards older adults. This suggests that the intervention of the case study, but not the role-playing simulation, may have a positive impact on attitudes towards older adults.

Results for Research Question 1. *To what extent is a positive attitude toward older adults in accelerated nursing students explained by the selected sociodemographics, previous exposure, knowledge of older adults, and clinical preferences?*

Research question one was analyzed using hierarchical linear regression. Prior to completing the regression analyses, a Pearson correlation was calculated for all sociodemographic data with regards to the dependent variable, attitudes towards older adults (Table 3.6). Attitudes toward older adults was statistically significant correlated with gender (r = -.395, p = .007), race (r = .294, p= .050), and caring for an older family during nursing school (r = .299, p = .046).

Table 3.6 Correlation of Sociodemographic Data and Dependent Variables

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Gender	1													
2. Age	-.155	1												
3. Marital status	-.063	.681**	1											
4. Race	-.022	-.093	-.098	1										
5. Highest degree	-.177	.363*	.416**	-.203	1									
6. Time	.302*	-.310*	-.177	.126	-.426**	1								
7. Cared for before	.118	-.071	.059	.218	-.350*	.213	1							
8. Cared for during	-.033	-.223	-.091	.242	-.069	.384**	.000	1						
9. Worked with at job	.028	-.365*	-.273	.382**	-.177	.302*	.000	.131	1					
10. Work with	-.227	-.116	-.045	.154	.063	.215	.294	.035	.218	1				
11. Interacting	.045	-.434**	-.103	.264	-.072	.339*	.385**	.214	.499**	.476**	1			
12. KOPQ Score	-.395**	-.140	.132	-.017	-.119	.195	-.100	.299*	.138	.090	.161	1		
13. Pre JSE SUM	-.083	.099	.184	-.084	.227	-.169	.099	.122	-.083	-.100	.222	.174	1	
14. Pre Kogan Log	-.236	-.030	.105	.294*	-.025	-.030	.248	.226	.084	.074	.165	.290	.535**	1

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

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

The selected sociodemographic variables, including gender, race, caring for an older family member prior to nursing school, were entered first to statistically control for their effects. They were not significant and only accounted for 10.1% of the variance in positive attitude (F (3, 41) = 2.65, p = .061).

Knowledge of older adults and the desire to work with older adults after graduation were entered as second step and it explained 9.3% of the variance of positive attitude (F (5,39) = 1.904, p = .116). These results suggest none of the afore mentioned variables are significant predictors of attitudes toward older adults (Table 3.7).

Table 3.7 Summary of Hierarchical Regression Analysis for Variables Predicting Attitudes Towards Older Adults

	Model 1			Model 2		
Variable	*B*	*SE B*	*β*	*B*	*SE B*	*β*
Gender	-.022	.014	-.226	-.015	.016	-.150
Race	.006	.004	.250	.007	.004	.276
Cared for during nursing school	.018	.017	.158	.011	.018	.092
Preference to work with older adults				-.001	.005	-.025
KOPQ Score				.003	.003	.210
Adjusted R^2		.101			.093	
F for change in R^2		2.652			1.904	

*p < .05

Results for Research Question 2. *To what extent is empathy toward older adults in accelerated nursing students explained by demographics, previous exposure, knowledge of older adults, and clinical preferences?*

Research question two was analyzed using hierarchical linear regression. The same correlation analysis (Table 3.6) was used to explore the association among the variables. There were no statistically significant correlations between demographics and empathy towards older adults; however, demographics with a correlation above .20 were

entered first to statistically control for their effects. These demographics include highest education (r = .227, p = .133) and being comfortable with interacting with older adults (r = .22, p = .143). They were not significant and only accounted for 5% of the variance in empathy (F (2,42) = 2.15, p = .129).

Knowledge of older adults and the desire to work with older adults after graduation were entered as second step. Together, the four variables explained 12.3% of the variance of empathy (F (4,40) = 2.54, p = .054) but the model was not significant (Table 3.8). However, comfort with interacting with older adults (β= *.339,* p = .044) was a significant predictor for empathy toward older adults.

Table 3.8 Summary of Hierarchical Regression Analysis for Variables Predicting Empathy Towards Older Adults

	Model 1			Model 2		
Variable	*B*	*SE B*	β	*B*	*SE B*	β
Highest Degree	6.935	4.385	.233	8.478	4.265	.285
Comfortable interacting with older adults	2.045	1.406	.214	3.237	1.555	.339*
Preference to work with older adults				-2.655	1.345	-.319
KOPQ Score				.713	.538	.191
Adjusted R^2		.050			.123	
F for change in R^2		2.150			2.540	

*p < .05.

Results for Research Question 3. What factors during the teaching-learning process (case study and simulated role-playing scenarios) best influence the ABSN students' attitude towards older adults?

Two open-ended questions were used to answer this question. Responses were analyzed by descriptive statistics for the most frequently mentioned factors that best influence students' attitudes towards older adults. Despite the non-significant findings of

the study, the open-ended responses were more favorable towards the role-playing simulation scenarios changing a student's attitudes toward to older adults. Students were asked to reflect back to the activity they participated in the week prior and take note of any changes in their attitudes towards older adults. Students who participated in Group A, the case study, typically reported no change in attitudes or an already favorable attitude towards older adults (n=21). A few students in the group did note a positive change (n=3). Group B, the role-playing simulation scenario participants, however, reported a change in understanding of the difficulties older adults may face with chronic conditions (n=16). Few students in this group reported no change (n=4) while one student (n=1) reported a negative change due to the frustration they felt. Table 3.9 provides a random sampling of responses to the question.

Table 3.9 Sample of Responses to Open-Ended Question 3

Question	Group A	Group B
Last week you participated in an activity after lecture. Using that experience, please answer the following question. During the activity, was there a point in which you began to notice a change in your attitude towards older adults? If so, what was it? Was this a positive or negative change for you?	No, I've always felt the same about them. No, I don't think it changed my attitude towards older adults. My attitude toward older adults has always been pretty positive. I enjoy working with this population although in the healthcare setting this population can sometimes be slightly depressing. Nothing has changed in my opinion since last activity. No specific change noticed.	I experienced a positive change in attitude for older adults. After the activity, I had the chance to experience what older adults deal with on an everyday basis and felt more compassion and understanding for them. Yes, I realized it was much more difficult to age. Performing simple tasks becomes exhausting. It was a positive change I gained more empathy as I realized that physical limitations of elders. It was a positive change. It

Table 3.9 Sample of Responses to Open-Ended Question 3(continued)

Question	Group A	Group B
Last week you participated in an activity after lecture. Using that experience, please answer the following question. During the activity, was there a point in which you began to notice a change in your attitude towards older adults? If so, what was it? Was this a positive or negative change for you?	After taking part in this activity, my attitude towards old people has changed, I believe that more attention must be given to old people who is in need of psychological and affective support. My attitude with older adults has always been positive, however, the experiment/activity allowed me to empathize and understand what they go through. The activity reinforced the issues/risks associated with older adults whole live independently, still active, and with multiple chronic conditions and the importance of nursing care for optimal health outcomes.	will help me be more sensitive to the needs of the elderly. The activity gave me a much better understanding of the factors that limit a person's functionality as they grow older. I have gained much more respect for elderly individuals who live with visual and hearing loss, as well as those who continue to perform ADLs with arthritis. This was a positive change for me. The arthritis exercise helped me see things more through their eyes & how difficult "simple tasks" can be. This was a positive change because it helped me be more understanding. I am always trying to be understandable person and I not judge people. I understand that older peoples experience many difficulties in their lives especially when they deal with chronic diseases. I just had even more positive change in my mind towards older adults and I believe more people should have an opportunity to feel on one's skin how hard it is to cope with diseases.

Table 3.9 Sample of Responses to Open-Ended Question 3(continued)

		It gave me a physical experience that is close to what older adults feel. Before I had just theoretical ideas about it. It's a positive change because it makes me even more empathetic & patient with elderly adults' shortcomings.

The second open-ended question asked students to think of a previous encounter with an older adult and whether or not the experience influenced their attitude positively or negatively. In general, if the student's encounter was positive, such as telling jokes and stories or something the student could relate to, the student's opinion of the older adult was positive. Students reported positive experiences at locations such as the clinical setting (n=13), a home setting (n=6), and a work/volunteer setting (n=8) leading to an overall positive experience with older adults. One student reported a negative encounter with an older adult that negatively influenced their attitude. Table 3.10 provides a random sample of responses to the question.

Table 3.10 Sample of Responses to Open-Ended Question 4

Question	Group A	Group B
Think of a previous encounter with an older adult. Briefly describe this encounter. Did this influence your attitude positively or negatively towards older adults	I went to visit an older neighbor that just moved to a retirement facility/nursing home. She is in her mid-90s but still cognitively "with it." She was watching football and talking to me about school. It was really nice and a positive experience because it showed how she still has the same interests as anybody else, independent of age. The encounter was during clinical at a nursing home. The woman was very upset that her family put her into the home without discussing with her first. I sat and listened to her and realized her concerns were no different than mine. She wanted to maintain autonomy and independence. The experience was positive because of this realization. At the nursing home, most patients were pleasant which took me by surprise. I had expected them to be cranky.	I've had mostly positive experiences with older adults. This influenced my perspective. I love my grandma. But I've also had bad experiences with grumpy patients in my previous jobs I recently cared for a very pleasant elderly woman during clinical. She was old & fragile, but still concerned about her children & grandchildren. Her selflessness amplified my positive attitude towards the elderly. I recently encountered an older patient during my clinical which influenced my attitude positively towards older populations. My hands were cold and the patient held my hands and said he was going to warm them up! My previous experience with an older adult was a pleasant experience as the person was sharing the knowledge with me. The person was telling me stories of old times and giving advice on how to deal with stressors in life. I enjoyed to listen that this patient enjoys small things in life such as staying healthy and interacting with other human beings. The patient was very cooperative with me to practice nursing skills on him.

Discussion

The purpose of this study was to examine the effectiveness of two educational modalities, a case study and simulated role-play, on improving attitudes and empathy towards older adults. The secondary aim was to explore factors affecting attitudes and empathy in ABSN students towards older adults such as sociodemographic data, previous interactions with, knowledge, and clinical preferences toward working with older adults. Findings from the study suggest that role-playing simulation scenarios may not be an effective educational tool for the ABSN population when trying to improve attitudes and empathy towards older adults. Statistically, in this small sample size, the use of role-playing simulation scenarios was not supported; however, the use of case studies showed a significant positive effect in improving attitudes towards older adults. This aligns with previous research by Robert, Pomarico, and Nolan (2011) that suggested case studies are a preferred learning method for ABSN students. The findings of this study are fascinating considering the qualitative feedback from the participants seemed to be more favorable towards the role-playing simulation scenarios than the case study as was found in a previous study by Boellaard et al. (2014).

The sample size for the study was smaller than required by a priori testing and may have led to non-significant findings. Original a priori testing suggested a minimum sample size of 90 students was needed for an effect size of 0.60. This study used 45 students total; 24 in Group A and 21 in Group B. Effect size was calculated for the attitudes variable in the case study group and was found to have a medium effect size (Cohen's d = 0.466). The other effect sizes (Table 3.11) suggest an extremely large

sample size would be needed to see an effect from the simulation role-playing intervention to improve both attitudes and empathy towards older adults.

Table 3.11 Effect sizes for Interventions

	Effect Size
Case Study	
Attitudes	.466
Empathy	.057
Simulation	
Attitudes	.076
Empathy	.043

One issue to consider is whether the JSE-HPS is an appropriate tool to measure empathy among the ABSN student population since the Cronbach alpha was not ideal after items were removed. One item was removed for data analysis purposes, however, further investigation showed that additional items would need to be removed in order to approach an acceptable alpha level of .70. Future studies either need to evaluate the validity or consider increasing the number of testing items in the JSE-HPS for non-traditional nursing students, such as those in an ABSN program, to ensure sound psychometric properties for this specific tool.

The framework used for this study, TLT, may not be the best fit for this population for several reasons. An assumption of the theory is that every individual has a particular view of the world which is based on a set of assumptions that come from an individual's upbringing, life experiences, culture, or education (Christie, Carey, Robertson, & Grainger, 2015; Mezirow, 1991). In order to change these ingrained views, one must experience a disorienting dilemma (Christie, Carey, Robertson, & Grainger, 2015) that acts as a catalyst for a change in beliefs. The study participants were not the traditional college student with an average age of 29 years (Mdn=27, SD=6.689) and

various educational backgrounds. These unique backgrounds indicate the ABSN students have a fixed worldview and may require a different theoretical approach to cause changes in their thoughts and feelings. It is no doubt that ABSN students will encounter new experiences in the classroom and clinical setting, however, these learning experiences may not be disorienting enough to elicit a change in viewpoint.

It should be noted that all participants in the study already had, at minimum, a previous baccalaureate degree before entering the ABSN program. Along with that degree, these students brought previous experiences and education into the ABSN program. Further exploration of their previous majors may be necessary to see if there is any correlation to their previous beliefs and current towards older adults. For example, students in this study had previous degrees in biology, psychology, education, as well as several other fields. They may need alternative learning strategies than those used in the study when compared to traditional nursing students.

Another reason for the TLT-based intervention not having an effect in attitudes and empathy may be related to the amount of exposure to the disorienting dilemma, in this case, the role-playing scenarios. TLT does not specify the length of time one must be exposed for a change in viewpoint to occur. Students participating in the role-playing simulation scenarios were given approximately 15 minutes at each station to complete the simulated task given. Perhaps, this is not enough time to formulate a personal change. Students may see the scenarios as a minor, temporary change in their physical status. They know that once the items are removed (such as tape around the knuckles) normal functional status as they know it will resume. Students participating in the case study may continue to think about the information conveyed after the intervention period has

ended. While no physical changes occurred to the case study participants, they may be able to better relate to the situation described by the case study because of personal experiences. It is possible to think that they may have actually encountered a similar experience on their own, perhaps with their own family member, and use that as a reflection point. Further studies need to explore the dosage (length) of the intervention.

In this study, there was a significant correlation between empathy and attitude (r =.535, p < .001) which indicates the two variables explain 28.6% of the variances for each other. There is limited literature exploring the association between empathy and attitude; however, literature showed a causal relationship that empathy could lead to attitude change (Batson et al., 1997; Geçkil, Kaleci, Cingil, & Hisar, 2017) therefore, an additional 3-step hierarchical multiple regression analysis was run to identify the predictor for attitude toward elderly.

The selected sociodemographic variables, including gender, race, caring for an older family member prior to nursing school, were entered first to statistically control for their effects. Knowledge of older adults and the desire to work with older adults after graduation were entered as second step, and the Pre-JSE (empathy score) was entered as the third step and explained 35.6% of the variance of attitude toward older adult (F (6, 38) = 5.048, p = .001). Race (β = .309, p = .020) and the Pre-JSE score (β =.514, p < .001), were the significant predictors for attitudes. The post-hoc power analysis showed the multiple regression analysis employed a sample size of 45, with an alpha level of .05, and an overall R^2= .356 for six predictors having a power of 80%. This finding indicates to improve the non-traditional nursing student's attitude toward older adults, we may need to explore ways to develop their empathy first. It may be necessary to use a mixed-

intervention approach to increase both attitudes and empathy. Case studies have already shown an improvement in attitudes towards older adults, but alternative interventions to improve empathy must be explored. Alternative interventions that could be used in conjunction with the case study include a revised simulation scenario extending the amount of time participating; guided interactions, such as interviews with older adults; and activities, such as volunteering for a charity cause or participating in a similar interest.

Limitations of the Study

This study is unique in two ways. First, the main focus of this study was on accelerated second degree baccalaureate nursing students. Secondly, the study compared two of the most commonly used education modalities in nursing education, case studies and simulations. Although the study findings contribute to knowledge about ABSN students, the small sample size causes concern. The generalizability of the study findings is limited by the small sample size, the use of convenience rather than random sampling, the inclusion of only ABSN students, and the geographic location limited to urban east coast.

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Chapter Four

Summary and Implications for Future Research

When someone is sick in the hospital, they want to be cared for. They do not want to be looked at simply as body in the bed but as a human being who needs support at a time of need. That support typically comes from a nurse. Nurses are expected to be caring and empathetic. It is no surprise that our population is getting older. We will need nurses who are understanding to the needs of older adults over the age of 65.

Current research supports a decline in empathy in nursing students over time as a student progresses through a nursing program. Traditionally, nursing education has relied on didactic methods of delivering information to students. Nursing educators must promote positive attitudes and empathetic responses towards older through use of other educational modalities.

A majority of nursing education research focuses on traditional four-year baccalaureate (BSN) programs, not accelerated second-degree programs. Existing literature for this subject has several limitations; some of which include focusing on traditional nursing programs and neglecting the non-traditional nursing students; use of small sample sizes; adoption of wide inclusion criteria which resulted in controversial findings; and lacking a theory based intervention.

The predictors for the empathy and attitude toward the older adults identified in this study should be further explored and be taken into consideration when implementing into the future interventions which focus on activities that could positively influence empathy and further to improve the attitudes toward older adults among the in non-

traditional nursing student populations. Additional studies should look at the amount of exposure to an experience to potentially improve empathy and attitudes.

Adverse attitudes toward the elderly may persist in the nursing profession, however, it is our job as educators to prepare students to work and empathize with all patient populations. As the United States population grows older, so does the number of elderly patients with chronic diseases (Pearson et al., 2012). Producing nursing students with the needed knowledge, skills, empathy, and attitudes to care for older adults must be a priority. Compared to the traditional nursing student, ABSN students have a unique background and may need different modalities to improve their empathy and attitudes toward the older adults. In the current study, the case study showed an effect to improve the attitudes; however, strategies to improve empathy are needed. The simulation scenario will need to be revised and retested. Future studies should include the use of both modalities to assist in improving both attitudes and empathy towards the older adult in this student population.

Appendix A: UT Tyler IRB Approval

THE UNIVERSITY OF TEXAS AT TYLER
3900 University Blvd. • Tyler, TX 75799 • 903.565.5774 • FAX: 903.565.5858

Office of Research and Technology Transfer

Institutional Review Board

November 1, 2017

Dear Ms. Galetz,

Your request to conduct the study: *Simulated Role-Play to Improve Attitudes and Empathy Towards Older Adults in Accelerated Nursing Students*, , IRB #F2017-37 has been approved by The University of Texas at Tyler Institutional Review Board under expedited review. This approval includes the written informed consents that are attached to this letter, and your assurance of participant knowledge of the following prior to study participation: this is a research study; participation is completely voluntary with no obligations to continue participating, and with no adverse consequences for non-participation; and assurance of confidentiality of their data.

In addition, please ensure that any research assistants are knowledgeable about research ethics and confidentiality, and any co-investigators have completed human protection training within the past three years, and have forwarded their certificates to the IRB office (G. Duke).

Please review the UT Tyler IRB Principal Investigator Responsibilities, and acknowledge your understanding of these responsibilities and the following through return of this email to the IRB Chair within one week after receipt of this approval letter:

- This approval is for one year, as of the date of the approval letter
- **The Progress Report form must be completed for projects extending past one year.** Your protocol will automatically expire on the one year anniversary of this letter if a Progress Report is not submitted, per HHS Regulations **prior** to that date (45 CFR 46.108(b) and 109(e): http://www.hhs.gov/ohrp/policy/contrev0107.html
- Prompt reporting to the UT Tyler IRB of any proposed changes to this research activity
- **Prompt reporting to the UT Tyler IRB and academic department administration will be done of any unanticipated problems involving risks to subjects or others**

- Suspension or termination of approval may be done if there is evidence of any serious or continuing noncompliance with Federal Regulations or any aberrations in original proposal.
- Any change in proposal procedures must be promptly reported to the IRB prior to implementing any changes except when necessary to eliminate apparent immediate hazards to the subject.
- Approval with signed consent form

Best of luck in your research, and do not hesitate to contact me if you need any further assistance.

Sincerely,

Gloria Duke, PhD, RN
Chair, UT Tyler IRB

Appendix B: New Jersey City University IRB Approval

NJCU

November 29, 2017

NOTICE OF IRB REVIEW

Elizabeth Galetz
Department of Nursing
New Jersey City University
2039 Kennedy Boulevard
Jersey City, NJ 07305

INITIAL, REVISED OR CONTINUATION

The project identified below, for which you requested review and approval by the NJCU Institutional Review Board for the Protection of Human Participants in Research, has now been reviewed and approved. This approval is based on the assumption that the documents you submitted to the NJCU IRB contain a complete and accurate description of all the methods and processes in which human subjects are involved in your research.

As Chair of the Institutional Review Board (IRB), I have evaluated the involvement of humans as research subjects in the proposed study, entitled: **"Simulated Role-play to Improve Attitudes and Empathy Towards Older Adults in Accelerated Nursing."**

In accordance with Title 45 *Code of Federal Regulations Part 46.101, b, 2,* policy guidelines from the U.S. Department of Health and Human Services, I inform you that this study is determined to be **APPROVED.**

This approval is subject to the following conditions:

1. That you will conduct the research according to the plans and protocol you submitted.
2. That you will immediately inform the IRB of any injuries to any subject that occurs during your research.
3. That you immediately inform the IRB of any problems that arise during your research.
4. That you will immediately inform the IRB of any changes that you make in the protocol of the research.
5. That you will give each person who signs the consent form a copy of that document as part of your research. The consent form must be the same one submitted with your application materials and approved by the IRB.
6. That you will retain all signed consent documents for at least three years after the termination of the research.
7. No further review and approval by the IRB are required if the study is conducted as proposed. Any proposed change in the study must be submitted to IRB Chair for further review before the proposed change can be implemented.

Failure to comply with these conditions will result in the withdrawal of this approval.

Name of the Principal Investigator: Elizabeth Galetz

Title of the Project: "Simulated Role-play to Improve Attitudes and Empathy Towards Older Adults in Accelerated Nursing."

Approved [X] Not Approved [ ]

Signed:

Ashok Vasavada

NJCU IRB Chair

November 29, 2017

Date

Dr. Ashok Vasavada, Chair, NJCU IRB
Executive Director, Office of Research Grants and Sponsored Programs
2039 Kennedy Boulevard, Jersey City, NJ 07305
NJCU: The blueprint for tomorrow. http://www.njcu.edu

Appendix C: Informed Consent

THE UNIVERSITY OF TEXAS AT TYLER
Informed Consent to Participate in Research

Institutional Review Board # F2017-37
Approval Date: October 30, 2017
Expires: October 30, 2018

1. Project Title: Simulated Role-Play to Improve Attitudes and Empathy Towards Older Adults in Accelerated Nursing Students

2. Principal Investigator: Elizabeth Galetz, MSN, PhD(c), RN

3. Participant's Name:

To the Participant:
You are being asked to take part in this study through The University of Texas at Tyler (UT Tyler). This permission form explains:

- Why this research study is being done.
- What you will be doing if you take part in the study.
- Any risks and benefits you can expect if you take part in this study.

After talking with the person who asks you to take part in the study, you should be able to:

- Understand what the study is about.
- Choose to take part in this study because you understand what will happen

4. Description of Project
The purpose of this study is to examine the effectiveness of two educational modalities, a case study and role-playing simulation scenarios, on improving attitudes and empathy towards older adults among the adult learner.

You are invited to participate in the study because you are a currently enrolled as an accelerated nursing student. A total of 55 participants from two ABSN classes will be recruited for this study. You have an equal chance of participating in either educational modality based on your section of the course.

5. Research Procedures
If you agree to be in this study, we will ask you to do the following things:

- Participate in either a case study or role-playing scenario.
- Complete 4 questionnaires, twice. Once before the above educational activity and again one week after the educational activity. You will be asked about your demographic data, attitudes and empathy towards older adults, and willingness to work with older adults. These surveys should take approximately 20 to 30 minutes to complete.

6. Side Effects/Risks

There are no known side effects or risks to participating in this study other than potential breach of confidentiality, but all measures are taken to protect your confidentiality. Your classroom faculty will not be informed by the research as to who does or does not participate.

7. Potential Benefits

There will be no direct benefit as a result of your participation. The findings from this study will help to develop a larger plan to improve education in gerontological nursing.

Understanding of Participants

8. I have been given a chance to ask any questions about this research study. The researcher has answered my questions.

9. If I sign this consent form I know it means that:
   - I am taking part in this study because I want to. I chose to take part in this study after having been told about the study and how it will affect me.
   - I know that I am free to not be in this study. If I choose to not take part in the study, then nothing will happen to me as a result of my choice.
   - I know that I have been told that if I choose to be in the study, then I can stop at any time. I know that if I do stop being a part of the study, then nothing will happen to me.
   - I will be told about any new information that may affect my wanting to continue to be part of this study.
   - The study may be changed or stopped at any time by the researcher or by The University of Texas at Tyler.
   - The researcher will get my written permission for any changes that may affect me.

10. I have been promised that that my name will not be in any reports about this study unless I give my permission.

11. I also understand that any information collected during this study may be shared as long as no identifying information such as my name, address, or other contact information is provided). This information can include health information. Information may be shared with:
   - Organization giving money to be able to conduct this study
   - Other researchers interested in putting together your information with information from other studies
   - Information shared through presentations or publications

12. I understand The UT Tyler Institutional Review Board (the group that makes sure that research is done correctly and that procedures are in place to protect the safety of research participants) may look at the research documents. These documents may have information that identifies me on them. This is a part of their monitoring procedure. I also understand that my personal information will not be shared with anyone.

13. I have been told about any possible risks that can happen with my taking part in this research project.

14. I also understand that I will not be given money for any patents or discoveries that may result from my taking part in this research.

15. If I have any questions concerning my participation in this project, I will contact the principal researcher: Elizabeth Galetz, MSN, RN at 732-266-0052 or email egaletz@patriots.uttyler.edu.

16. If I have any questions concerning my rights as a research subject, I will contact Dr. Gloria Duke, Chair of the IRB, at (903) 566-7023, gduke@uttyler.edu, or the University's Office of Sponsored Research:

    The University of Texas at Tyler
    c/o Office of Sponsored Research
    3900 University Blvd
    Tyler, TX 75799

    I understand that I may contact Dr. Duke with questions about research-related injuries.

17. CONSENT/PERMISSION FOR PARTICIPATION IN THIS RESEARCH STUDY

    I have read and understood what has been explained to me. I give my permission to take part in this study as it is explained to me. I give the study researcher permission to register me in this study. I have received a signed copy of this consent form.

    _____ _____
    Signature of Participant Date

    _____ _____
    Signature of Person Responsible (e.g., legal guardian) Relationship to Participant

_____
Witness to Signature

18. I have discussed this project with the participant, using language that is understandable and appropriate. I believe that I have fully informed this participant of the nature of this study and its possible benefits and risks. I believe the participant understood this explanation.

_____ _____
Researcher/Principal Investigator Date

Appendix D: Pre-test Sociodemographic Data Survey

1. What is your gender?

   Male Female Chose not to identify

2. What is your age? _____

3. What is your current marital status? (Circle one)

   Single Married Separated Divorced Widowed

4. What is your race? Please Circle

   American Indian or Alaska Native | Asian | Black or African American

   Hispanic or Latino | Native Hawaiian or Other Pacific Islander | White

5. What is your highest level of education and major?

Bachelor's Degree Master's Degree Doctoral

   Major: _____

6. Have you spent time with an older family member (aged 65+) or friend?

   Yes No

7. Have you cared for an older family member (aged 65+) before entering nursing school?

   Yes No

8. Have you cared for older people (aged 65+) during nursing school?

   Yes No

9. Have you worked with older adults (aged 65+) at your job?

   Yes No

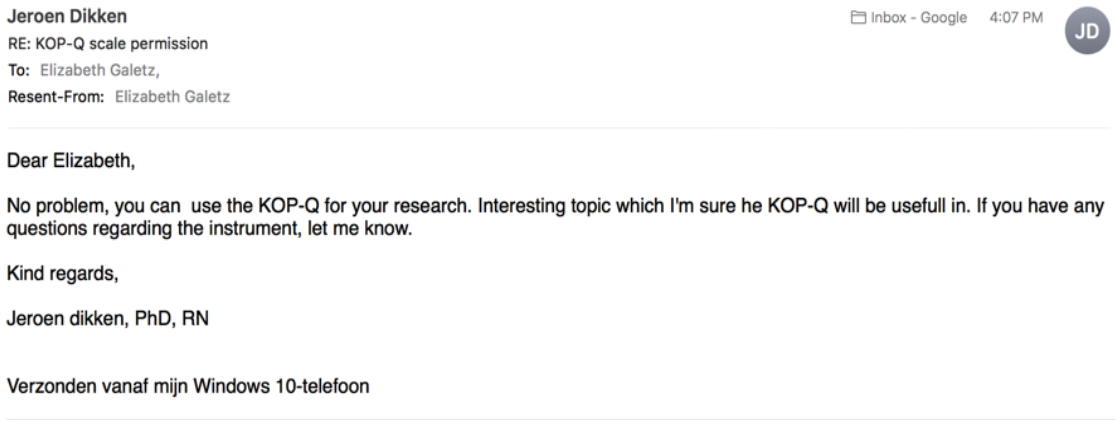
10. I will work with older adults upon graduation.

   1 - Strongly Disagree 2- Disagree 3 - Neutral 4 - Agree 5 - Strongly agree

11. I am comfortable with interacting with older adults.

   1 - Strongly Disagree 2- Disagree 3 - Neutral 4 - Agree 5 - Strongly agree

Appendix E: Permission to use the Knowledge About Older Patients Quiz (KOP-Q)



Jeroen Dikken
RE: KOP-Q scale permission
To: Elizabeth Galetz,
Resent-From: Elizabeth Galetz

Inbox - Google 4:07 PM

JD

Dear Elizabeth,

No problem, you can use the KOP-Q for your research. Interesting topic which I'm sure he KOP-Q will be usefull in. If you have any questions regarding the instrument, let me know.

Kind regards,

Jeroen dikken, PhD, RN

Verzonden vanaf mijn Windows 10-telefoon

Appendix F: Knowledge About Older Patients Quiz (KOP-Q)

Knowledge-about-Older-Patients Quiz (KOP-Q)

For each statement, please answer "True" or "False". Along the certainty bar, please indicate how certain you are about your answer (ranging from 0 – 100% certain).

		True	False
1	**Forgetfulness, concentration issues and indecisiveness are parts of aging rather than indicators of depression.**	☐	☐

How certain are you about this answer?

0% 50% 100%

		True	False
2	**Unexpected urinary incontinence in an older person may indicate that the person is suffering from a urinary tract infection.**	☐	☐

How certain are you about this answer?

0% 50% 100%

		True	False
3	**Patients with a cognitive disorder, such as dementia, are at increased risk for delirium.**	☐	☐

How certain are you about this answer?

0% 50% 100%

		True	False
4	**Malnutrition can have negative effects on thinking and observation skills.**	☐	☐

How certain are you about this answer?

0% 50% 100%

		True	False
5	**In general, older people are more sensitive to medication because their kidney and liver functions are declining.**	☐	☐

How certain are you about this answer?

0% 50% 100%

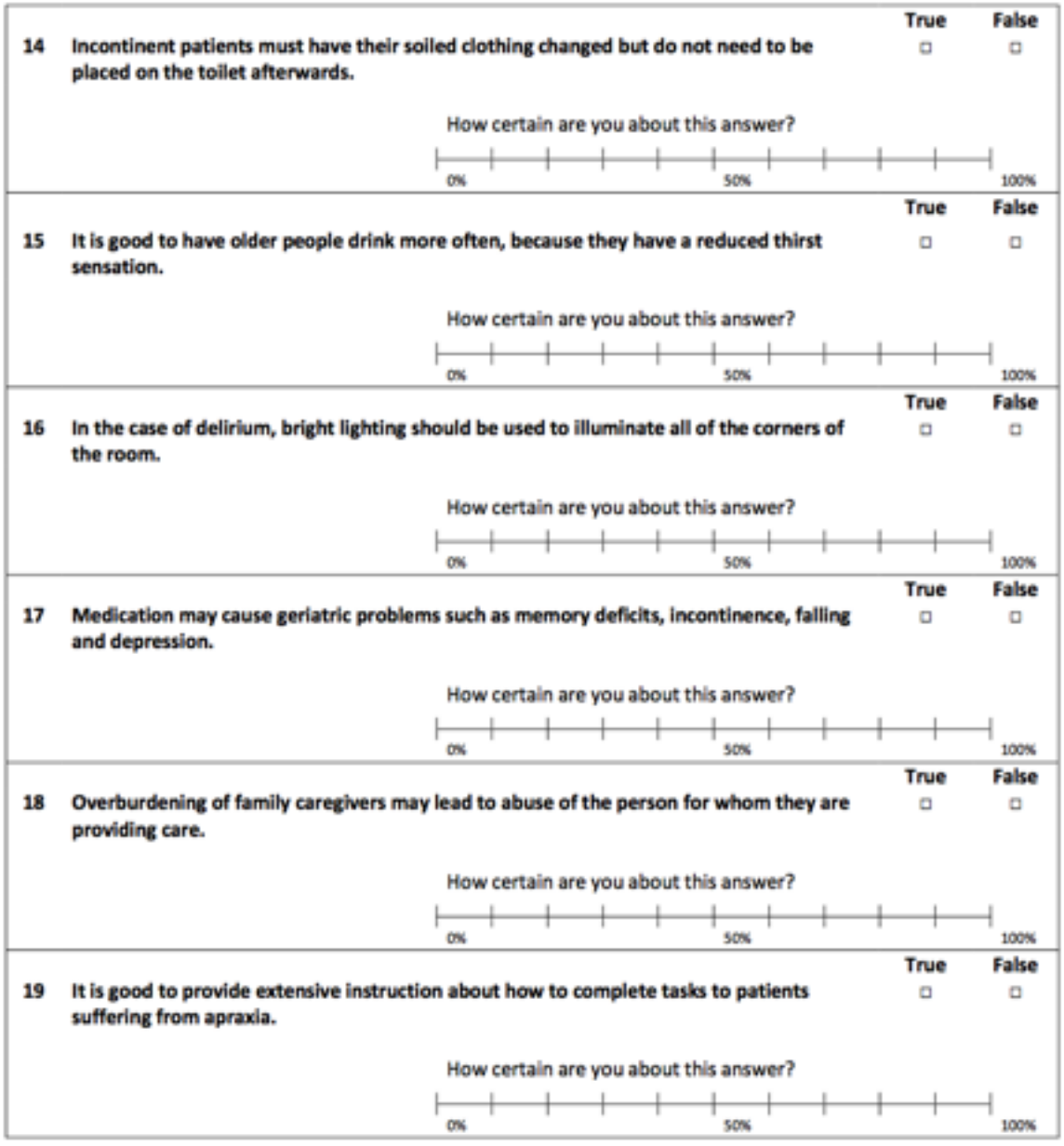
		True	False
6	**Meeting with families during patient assessment is only required for persons suffering from dementia.**	☐	☐

How certain are you about this answer?

0% 50% 100%

Appendix F: (Continued)

		True	False
7	**For older people, bed rest is important to enhance recovery.**	☐	☐
	How certain are you about this answer? 0% 50% 100%		
8	**Patients rarely remember that they were anxious and/or restless during delirium.**	☐	☐
	How certain are you about this answer? 0% 50% 100%		
9	**Older people need less fluid because they exercise less.**	☐	☐
	How certain are you about this answer? 0% 50% 100%		
10	**Asking patients whether they have fallen in the past 6 months is a good way of assessing increased risk of falling.**	☐	☐
	How certain are you about this answer? 0% 50% 100%		
11	**Pressure that cuts off the blood supply to tissue for two hours may result in pressure ulcers.**	☐	☐
	How certain are you about this answer? 0% 50% 100%		
12	**Depression is recognized in older people less frequently than it is in younger people.**	☐	☐
	How certain are you about this answer? 0% 50% 100%		
13	**Lowering the frequency of a medication is an effective intervention to achieve (medication) adherence by patients.**	☐	☐
	How certain are you about this answer? 0% 50% 100%		



		True	False
14	**Incontinent patients must have their soiled clothing changed but do not need to be placed on the toilet afterwards.**	☐	☐

How certain are you about this answer?

0% 50% 100%

		True	False
15	**It is good to have older people drink more often, because they have a reduced thirst sensation.**	☐	☐

How certain are you about this answer?

0% 50% 100%

		True	False
16	**In the case of delirium, bright lighting should be used to illuminate all of the corners of the room.**	☐	☐

How certain are you about this answer?

0% 50% 100%

		True	False
17	**Medication may cause geriatric problems such as memory deficits, incontinence, falling and depression.**	☐	☐

How certain are you about this answer?

0% 50% 100%

		True	False
18	**Overburdening of family caregivers may lead to abuse of the person for whom they are providing care.**	☐	☐

How certain are you about this answer?

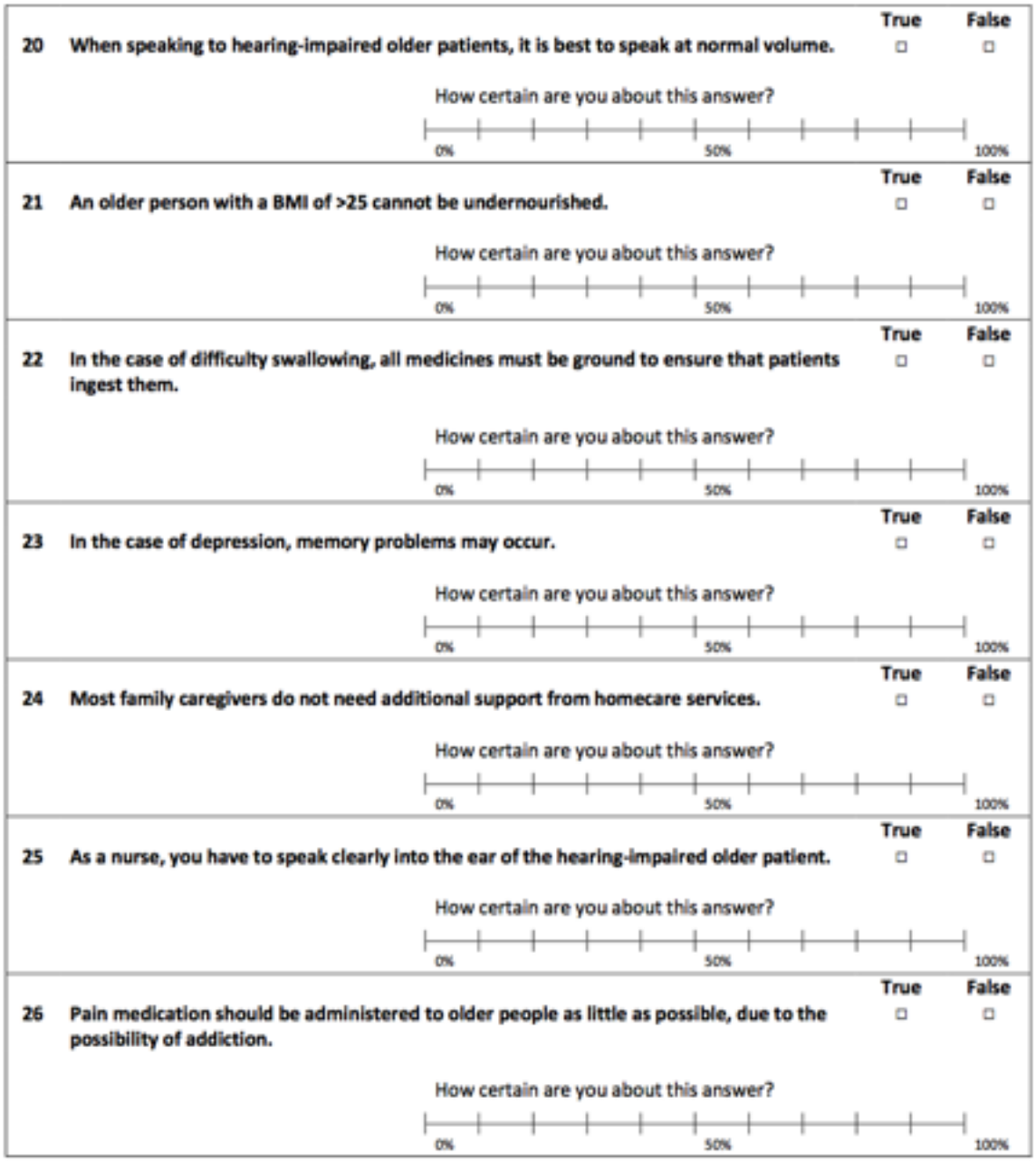
0% 50% 100%

		True	False
19	**It is good to provide extensive instruction about how to complete tasks to patients suffering from apraxia.**	☐	☐

How certain are you about this answer?

0% 50% 100%

Appendix F: (Continued)



		True	False
20	**When speaking to hearing-impaired older patients, it is best to speak at normal volume.**	☐	☐
	How certain are you about this answer? 0% 50% 100%		
21	**An older person with a BMI of >25 cannot be undernourished.**	☐	☐
	How certain are you about this answer? 0% 50% 100%		
22	**In the case of difficulty swallowing, all medicines must be ground to ensure that patients ingest them.**	☐	☐
	How certain are you about this answer? 0% 50% 100%		
23	**In the case of depression, memory problems may occur.**	☐	☐
	How certain are you about this answer? 0% 50% 100%		
24	**Most family caregivers do not need additional support from homecare services.**	☐	☐
	How certain are you about this answer? 0% 50% 100%		
25	**As a nurse, you have to speak clearly into the ear of the hearing-impaired older patient.**	☐	☐
	How certain are you about this answer? 0% 50% 100%		
26	**Pain medication should be administered to older people as little as possible, due to the possibility of addiction.**	☐	☐
	How certain are you about this answer? 0% 50% 100%		

Appendix F: (Continued)

		True	False
27	**We identify pressure ulcers only if blister formation or abrasions have occurred.**	☐	☐
	How certain are you about this answer? 0% 50% 100%		
28	**In the case of delirium, activities should be spread out evenly over the day.**	☐	☐
	How certain are you about this answer? 0% 50% 100%		
29	**The risk of falling is higher for people in the hospital setting compared with those who are living at home.**	☐	☐
	How certain are you about this answer? 0% 50% 100%		
30	**Stress incontinence may occur in patients who are not capable of opening their own trousers.**	☐	☐
	How certain are you about this answer? 0% 50% 100%		

Answer Key KOP-Q (30 item)

Every correct answer on the knowledge questionnaire receives 1 point, and every incorrect answer receives 0 points (total score: minimum = 0, maximum = 30). The average of the certainty scores can be calculated by summing all of the percentages provided per question divided by 30.

1	FALSE	11	TRUE	21	FALSE
2	TRUE	12	TRUE	22	FALSE
3	TRUE	13	TRUE	23	TRUE
4	TRUE	14	FALSE	24	FALSE
5	TRUE	15	TRUE	25	FALSE
6	FALSE	16	FALSE	26	FALSE
7	FALSE	17	TRUE	27	FALSE
8	FALSE	18	TRUE	28	TRUE
9	FALSE	19	FALSE	29	TRUE
10	TRUE	20	TRUE	30	FALSE

Appendix G: Kogan's Attitude Towards Older People Scale

Directions: Circle the LETTER on the scale following each statement, according to the following key, that is closest to your opinion of old people.

Key:

Strongly Disagree	Slightly Disagree	Disagree	Agree	Slightly Agree	Strongly Agree
A	B	C	D	E	F

1. It would probably be better if most old people lived in residential units with people their own age.

   A.....B.....C.....D.....E.....F

2. It would probably be better if most old people lived in residential units with younger people.

   A.....B.....C.....D.....E.....F

3. There is something different about most old people; it's hard to find out what makes them tick.

   A.....B.....C.....D.....E.....F

4. Most old people are really no different from anybody else; they're as easy to understand as younger people.

   A.....B.....C.....D.....E.....F

5. Most old people get set in their ways and are unable to change.

   A.....B.....C.....D.....E.....F

6. Most old people are capable of new adjustments when the situation demands it.

   A.....B.....C.....D.....E.....F

7. Most old people would prefer to quit work as soon as pensions or their children can support them.

   A.....B.....C.....D.....E.....F

8. Most old people would prefer to continue working just as long as they possibly can rather than be dependent on anybody.

   A.....B.....C.....D.....E.....F

9. Most old people tend to let their homes become shabby and unattractive.

   A.....B.....C.....D.....E.....F

Key:

Strongly Disagree	Slightly Disagree	Disagree	Agree	Slightly Agree	Strongly Agree
A	B	C	D	E	F

10. Most old people can generally be counted on to maintain a clean, attractive home.

A.....B.....C.....D.....E.....F

11. It is foolish to claim that wisdom comes with age.
A.....B.....C.....D.....E.....F

12. People grown wiser with the coming of old age.
A.....B.....C.....D.....E.....F

13. Old people have too much power in business and politics.
A.....B.....C.....D.....E.....F

14. Old people should have power in business and politics.
A.....B.....C.....D.....E.....F

15. Most old people make one feel ill at ease.
A.....B.....C.....D.....E.....F

16. Most old people are very relaxing to be with.
A.....B.....C.....D.....E.....F

17. Most old people bore others by their insistence on talking “about the good old days”.
A.....B.....C.....D.....E.....F

18. One of the most interesting and entertaining qualities of most old people is their accounts of their past experiences.
A.....B.....C.....D.....E.....F

19. Most old people spend too much time prying into the affairs of others and giving unsought advice.
A.....B.....C.....D.....E.....F

20. Most old people tend to keep to themselves and give advice only when asked.
A.....B.....C.....D.....E.....F

Appendix G: Scale (Continued)

Key:

Strongly Disagree	Slightly Disagree	Disagree	Agree	Slightly Agree	Strongly Agree
A	B	C	D	E	F

21. If old people expect to be liked, their first step is to try to get rid of their irritating faults.
A.....B.....C.....D.....E.....F

22. When you think about it, old people have the same faults as anybody else.
A.....B.....C.....D.....E.....F

23. In order to maintain a nice residential neighborhood, it would be best if too many old people did not live in it.
A.....B.....C.....D.....E.....F

24. You can count on finding a nice residential neighborhood when there is a sizeable number of old people living in it.
A.....B.....C.....D.....E.....F

25. There are a few exceptions, but in general most old people are pretty much alike.
A.....B.....C.....D.....E.....F

26. It is evident that most old people are very different from one another.
A.....B.....C.....D.....E.....F

27. Most old people should be more concerned with their personal appearance; they're too untidy.
A.....B.....C.....D.....E.....F

28. Most old people seem quite clean and neat in their personal appearance.
A.....B.....C.....D.....E.....F

29. Most old people are irritable, grouchy, and unpleasant.
A.....B.....C.....D.....E.....F

30. Most old people are cheerful, agreeable, and good humored.
A.....B.....C.....D.....E.....F

31. Most old people are constantly complaining about the behavior of the younger generation.
A.....B.....C.....D.....E.....F

Key:

Strongly Disagree	Slightly Disagree	Disagree	Agree	Slightly Agree	Strongly Agree
A	B	C	D	E	F

32. One seldom hears old people complaining about the behavior of the younger generation.

A.....B.....C.....D.....E.....F

33. Most old people make excessive demands for love and reassurance than anyone else.

A.....B.....C.....D.....E.....F

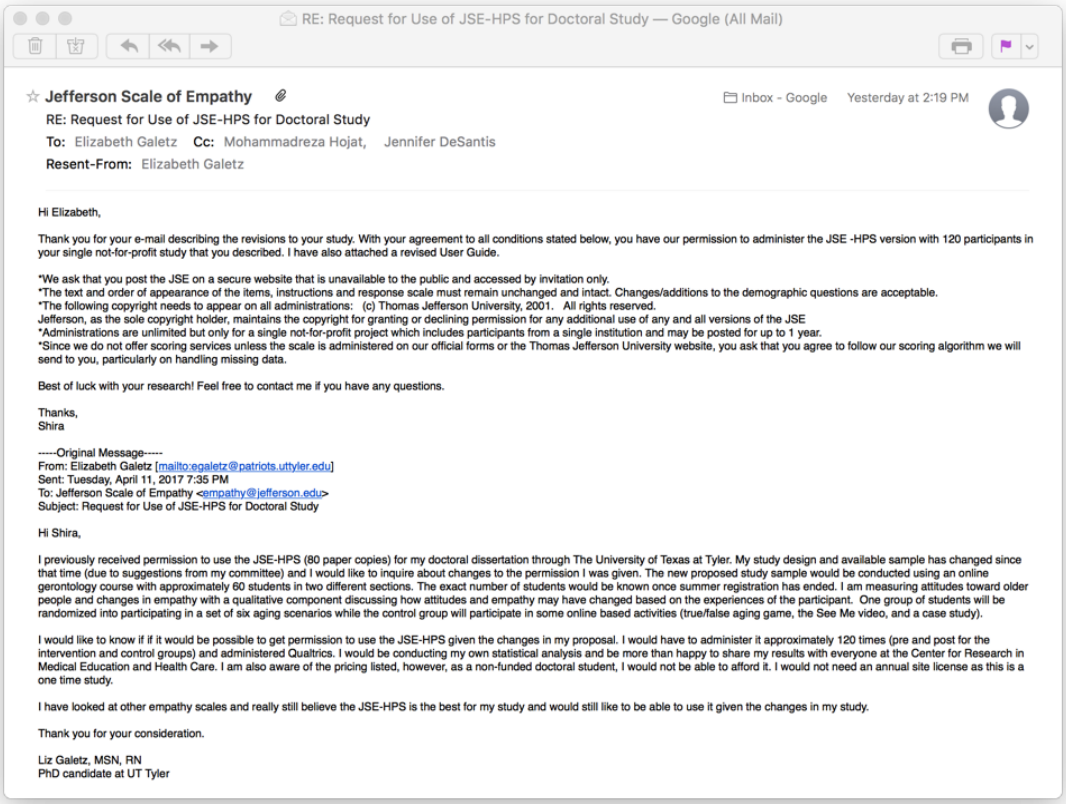
34. Most old people need no more love and reassurance than anyone else.

A.....B.....C.....D.....E.....F

Kogan Scoring:

Positive Statements		Negative Statements	
Strongly Disagree	1	Strongly Disagree	1
Slightly Disagree	2	Slightly Disagree	2
Disagree	3	Disagree	3
Agree	4	Agree	4
Slightly agree	5	Slightly agree	5
Strongly agree	6	Strongly agree	6

Appendix H: Permission to Use JSE-HPS



RE: Request for Use of JSE-HPS for Doctoral Study — Google (All Mail)

☆ **Jefferson Scale of Empathy**

Inbox - Google Yesterday at 2:19 PM

RE: Request for Use of JSE-HPS for Doctoral Study

To: Elizabeth Galetz **Cc:** Mohammadreza Hojat, Jennifer DeSantis

Resent-From: Elizabeth Galetz

Hi Elizabeth,

Thank you for your e-mail describing the revisions to your study. With your agreement to all conditions stated below, you have our permission to administer the JSE -HPS version with 120 participants in your single not-for-profit study that you described. I have also attached a revised User Guide.

*We ask that you post the JSE on a secure website that is unavailable to the public and accessed by invitation only.
*The text and order of appearance of the items, instructions and response scale must remain unchanged and intact. Changes/additions to the demographic questions are acceptable.
*The following copyright needs to appear on all administrations: (c) Thomas Jefferson University, 2001. All rights reserved.
Jefferson, as the sole copyright holder, maintains the copyright for granting or declining permission for any additional use of any and all versions of the JSE
*Administrations are unlimited but only for a single not-for-profit project which includes participants from a single institution and may be posted for up to 1 year.
*Since we do not offer scoring services unless the scale is administered on our official forms or the Thomas Jefferson University website, you ask that you agree to follow our scoring algorithm we will send to you, particularly on handling missing data.

Best of luck with your research! Feel free to contact me if you have any questions.

Thanks,
Shira

-----Original Message-----
From: Elizabeth Galetz [mailto:egaletz@patriots.uttyler.edu]
Sent: Tuesday, April 11, 2017 7:35 PM
To: Jefferson Scale of Empathy <empathy@jefferson.edu>
Subject: Request for Use of JSE-HPS for Doctoral Study

Hi Shira,

I previously received permission to use the JSE-HPS (80 paper copies) for my doctoral dissertation through The University of Texas at Tyler. My study design and available sample has changed since that time (due to suggestions from my committee) and I would like to inquire about changes to the permission I was given. The new proposed study sample would be conducted using an online gerontology course with approximately 60 students in two different sections. The exact number of students would be known once summer registration has ended. I am measuring attitudes toward older people and changes in empathy with a qualitative component discussing how attitudes and empathy may have changed based on the experiences of the participant. One group of students will be randomized into participating in a set of six aging scenarios while the control group will participate in some online based activities (true/false aging game, the See Me video, and a case study).

I would like to know if if it would be possible to get permission to use the JSE-HPS given the changes in my proposal. I would have to administer it approximately 120 times (pre and post for the intervention and control groups) and administered Qualtrics. I would be conducting my own statistical analysis and be more than happy to share my results with everyone at the Center for Research in Medical Education and Health Care. I am also aware of the pricing listed, however, as a non-funded doctoral student, I would not be able to afford it. I would not need an annual site license as this is a one time study.

I have looked at other empathy scales and really still believe the JSE-HPS is the best for my study and would still like to be able to use it given the changes in my study.

Thank you for your consideration.

Liz Galetz, MSN, RN
PhD candidate at UT Tyler

Appendix I: Jefferson Scale of Empathy – Health Professions Student Version

Jefferson
HEALTH IS ALL WE DO

Jefferson Scale of Empathy

Health Professions Student version (HPS- version)

Use a ball-point pen. Mark one response for each item below.
For *ID Code*, write numerals completely inside the boxes, one numeral to a box.

Name (optional) _____ **ID Code**.....

Date ____/____/_____

Age:

☐ < 19 ☐ 19 - 21 ☐ 22- 24 ☐ 25 - 27 ☐ 28 - 30 ☐ 31 - 33 ☐ 34 - 36
☐ 37 - 39 ☐ 40 - 42 ☐ 43 - 45 ☐ 46 - 48 ☐ 49 - 51 ☐ >51

Gender:

☐ Male ☐ Female

What is your degree program?

☐ Bioscience/Medical technology ☐ Counseling/Psychology ☐ Dentistry
☐ Diagnostic Imaging ☐ Nursing ☐ Nurse Practitioner
☐ Occupational Therapy ☐ Ophthalmology/Optometry ☐ Pharmacy
☐ Physical Therapy ☐ Physician Assistant ☐ Public Health
☐ Other _____

Year in this program:

☐ 1st year ☐ 2nd year ☐ 3rd year ☐ 4th year ☐ > 4th year

Please leave *Optional* fields blank unless otherwise instructed.

Optional field #1 ....

Optional field #2 ....

PLEASE CONTINUE ⇨⇨⇨

S E L F - S C O R E

206 Page 1

 140716 (ver. 1.2.1)

Jefferson Scale of Empathy

Health Professions Student version (HPS-version)

Instructions: Using a ball-point pen, please indicate the extent of your agreement or disagreement with *each* of the following statements by marking the appropriate circle to the right of each statement.

Please use the following 7-point scale (*a higher number on the scale indicates more agreement):*
Mark one and only one response for each statement.

1-------2-------3-------4-------5-------6-------7
Strongly Disagree ***Strongly Agree***

	1	2	3	4	5	6	7
1. Health care providers' understanding of their patients' feelings and the feelings of their patients' families does not influence treatment outcomes.	○	○	○	○	○	○	○
2. Patients feel better when their health care providers understand their feelings.	○	○	○	○	○	○	○
3. It is difficult for a health care provider to view things from patients' perspectives.	○	○	○	○	○	○	○
4. Understanding body language is as important as verbal communication in health care provider - patient relationships.	○	○	○	○	○	○	○
5. A health care provider's sense of humor contributes to a better clinical outcome.	○	○	○	○	○	○	○
6. Because people are different, it is difficult to see things from patients' perspectives.	○	○	○	○	○	○	○
7. Attention to patients' emotions is not important in patient interview.	○	○	○	○	○	○	○
8. Attentiveness to patients' personal experiences does not influence treatment outcomes.	○	○	○	○	○	○	○
9. Health care providers should try to stand in their patients' shoes when providing care to them.	○	○	○	○	○	○	○
10. Patients value a health care provider's understanding of their feelings which is therapeutic in its own right.	○	○	○	○	○	○	○
11. Patients' illnesses can be cured only by targeted treatment; therefore, health care providers' emotional ties with their patients do not have a significant influence in treatment outcomes.	○	○	○	○	○	○	○
12. Asking patients about what is happening in their personal lives is not helpful in understanding their physical complaints.	○	○	○	○	○	○	○
13. Health care providers should try to understand what is going on in their patients' minds by paying attention to their non-verbal cues and body language.	○	○	○	○	○	○	○
14. I believe that emotion has no place in the treatment of medical illness.	○	○	○	○	○	○	○
15. Empathy is a therapeutic skill without which a health care provider's success is limited.	○	○	○	○	○	○	○
16. Health care providers' understanding of the emotional status of their patients, as well as that of their families is one important component of the health care provider - patient relationship.	○	○	○	○	○	○	○
17. Health care providers should try to think like their patients in order to render better care.	○	○	○	○	○	○	○
18. Health care providers should not allow themselves to be influenced by strong personal bonds between their patients and their family members.	○	○	○	○	○	○	○
19. I do not enjoy reading non-medical literature or the arts.	○	○	○	○	○	○	○
20. I believe that empathy is an important factor in patients' treatment.	○	○	○	○	○	○	○

THANK YOU!

206 Page 2

Jefferson Scale of Empathy

Scoring Algorithm

A respondent must answer at least 16 (80%) of the 20 items; otherwise, the form should be regarded as incomplete and excluded from the data analysis.

If a respondent fails to answer 4 or fewer items, the missing values should be replaced with the mean score calculated from the items the respondent completed.

To score the scale: Items 1, 3, 6, 7, 8, 11, 12, 14, 18, and 19 are reverse scored items (i.e., Strongly Agree=1 Strongly Disagree=7), while the other items are directly scored on their Likert weights (i.e., Strongly Disagree=1 Strongly Agree=7).

The total score is the sum of all item scores.

The higher the score, the more empathic the behavioral orientation.

PLEASE NOTE: This scoring algorithm is provided for the sole use of scoring JSE forms purchased for a single project. Copying or sharing the algorithm with any other person or entity is prohibited.

Appendix J: Exit Survey and Open-Ended Questions

1. I will work with older adults upon graduation.

1 - Strongly Disagree 2- Disagree 3 - Neutral 4 - Agree 5 - Strongly agree

2. I am comfortable with interacting with older adults.

1 - Strongly Disagree 2- Disagree 3 - Neutral 4 - Agree 5 - Strongly agree

3. Last week you participated in an activity after lecture. Using that experience, please answer the following question. During the activity, was there a point in which you began to notice a change in your attitude towards older adults? If so, what was it? Was this a positive or negative change for you?

4. Think of a previous encounter with an older adult. Briefly describe this encounter. Did this influence your attitude positively or negatively towards older adults?

Appendix K: Permission to Use Sherman "Red" Yoder Scenario

Elaine Tagliareni

November 30, 2015 at 3:52 PM

ET

To: Liz Galetz Cc: Susan Forneris, Mary Anne Rizzolo
Resent-From: Elizabeth Galetz
RE: Request for Permission

HI Elizabeth
It is wonderful that you will use Red Yoder in your dissertation study. If you are using the ACES cases that are free on our website, you do not need official permission from the NLN to use the cases, since they are open access and meant to be adapted and used in a wide variety of clinical and classroom settings. Of course we do require that you acknowledge the NLN, as copyright holder, in your dissertation references.

It would be wonderful to see your results; we are always looking for research studies that have used the ACES cases as a vehicle for fostering teaching excellence. Thank you for offering to share your results with us; perhaps you will consider submitting the study results to our journal, *Nursing Education Perspectives*, in the research briefs section.

If I can be of further assistance, please let me know. Bravo for being with Pat at Union County College; we are so impressed with the work in the practical nursing program. I am sure it was a great foundation for future work in nursing education.

Best of luck with your dissertation. Hang in there…..

Warm regards,
Elaine

Elaine Tagliareni, EdD, RN, CNE, FAAN | Chief Program Officer | National League for Nursing | www.nln.org | etagliareni@nln.org /202-909-2481 | Fax: 202-944-8523 | The Watergate | 2600 Virginia Avenue NW, Washington DC 20037

Appendix L: Red Yoder Introductory Monologue and Reflection Questions

Red Yoder Introductory Monologue

I understand you want to hear my story; well I'm not much for talking, but I can give you the highlights. There's a lot that's happened over my 80 years. From the top. My name is Sherman Yoder, but I answer to "Red". No one around here even remembers my real name. I was born in this house in the downstairs bedroom. Mom had already delivered 6 kids and there was no way I was waiting for Dad to finish feeding the hogs and get Mom to town before I come out. Mom used to love to tell that story. Dad bought this farmhouse and the first hundred acres right before he went off to WWI. The folks saw good times and bad in this ol' place and so have I. All my brothers and sisters left the land as soon as they could. I was the only one of the lot to care about this place and want to carry on what Dad started. I really haven't gone far from this spot in my entire life. The one time I got it in my head to try something different; I wound up in Korea with an Army uniform on. I was glad to get back to this place after that stint and here I've been ever since. Married the neighbor girl Bessie when I got back. Her dad wasn't so sure that it would work out since she was 8 years younger than me and she intended to go off to the state college. We sure did prove him wrong; we celebrated our 50th anniversary the week before Bessie died. The ladies at the church had the hall all

decorated up and we brought Bessie home from the hospital for the afternoon. She was bound and determined to live for that day; no way did she want her friends to go to that much work for her to not show up. I couldn't believe it when the ladies had to prepare for the reception after we buried Bessie in that same hall one week later. We had such a good life together.

Appendix L: (Continued)

That was 10 years ago. I don't do much of the farm work anymore. Our son Jon takes care of the crops and the few animals we have. I still go out to the hen house every morning to collect the eggs. I'm a little stiff in the morning, but I get loosened up enough to walk out to gather some fresh eggs to go with my bacon for breakfast. I get in to town at least once a week; on Monday morning, me and my buddies meet at the VFW for our coffee and donut break. I get caught up on all the town gossip and we laugh and bellyache about what's going on in the world. Three weeks ago, I celebrated my 80th birthday. My daughter in law, Judy, organized a big "to do" at the church after the Sunday service with cake and ice cream and all the fixings' for my party. I had a big piece of cake but skipped the ice cream. Doc Baker was there and I knew he would scold me about too much sugar. Six months ago, he told me I had diabetes and I started taking a pill for it, but a few weeks ago he put me on insulin. I figure I should be able to eat what I want; come on, I'm not going to live forever, and it was my favorite cake, German chocolate. I ate it in the kitchen so the Doc wouldn't see me; wouldn't you know, his office nurse Helen came in the kitchen with a load of dishes just as I was putting the last bite in my mouth. She just winked at me and smiled.

After the party, I went out to the mall with Jon and the grandkids. I'm not one for

shopping much, but I needed a new ink cartridge for my printer and the computer store is the one place I like to look around in. Too bad we parked clear on the other end of the mall so the kids could go by their favorite stores for Grandpa to buy them a little something. Jon got real mad at me when I asked if I could sit and rest for a while, so I

Appendix L: (Continued)

just kept walking. I guess my new shoes were a little tight; I didn't feel anything but when I got home there was some blood on my sock, and then I saw a sore on my big toe. It must not be too bad since it's not hurting except when I try to put my shoes on.

I showed the sore to Jon and Judy the other day and Judy said she would call the doctor to see what she should put on it. Jon gets so irritated when I need extra help; I hope I can just continue to soak my foot in hot water to clean it out. Judy was a nursing assistant out at the old folk's home for many years; I'm hoping she will be able to help me with this. I like the idea of the home nurses coming out here as long as my VA benefits pay for it. That way they can see that I'm doing just fine living here on my own.

I was searching on the internet for the best way to treat this sore; there are so many sites that talk about foot sores if you're a diabetic. Some of those pictures of toe sores are pretty scary; I can't sleep at night thinking about what could happen if this doesn't heal. Of course, I haven't slept through the night for years. Even the couple of beers I have at night when I'm on the computer don't seem to be helping anymore. Bessie always gave the kids Benadryl to help them sleep so I've been taking a couple when I go to bed; they seem to help me sleep a little better.

As a matter of fact, I need to wrap this up now. I promised Jack, my grandson in

college that I'd Skype him in a few minutes. He just started the agronomy program at the university. I love to hear about what he's learning and give him encouragement to come back to the farm.

Appendix L: (Continued)

Reflection Questions for Red Yoder Case Study

Focused discussion and questions adapted from: Benner, P., Sutphen, M., Leonard, V., Day, L., & Shulman, L. (2010). Paradigm case: Lisa Day, classroom and clinical instructor. In *Educating nurses: A call for radical transformation* (p. 133). San Francisco: Jossey-Bass.

- What are "Red's" strengths?
- What are your concerns for this patient?
- What is the cause of your concern?
- What information do you need?
- What are you going to do about it?
- What is "Red" experiencing?

Appendix M: Role-Playing Activities

1. Arthritis

Supplies needed: 2 ace bandages, clear tape, laundry basket with small load of sheets, grocery bags with food items such as canned and boxed goods, small water bottles,

Student instructions: Begin by wrapping each of your knees with 1ACE bandage and wrap a small amount of tape around the joints of your index finger and thumb. After completing, please pick up two of the grocery bags and proceed to the stairs. Walk up to the fifth floor while carrying the grocery bags. Walk one lap around the fifth floor and return to the Nursing lab on the fourth floor.

2. Loss of Hearing
Supplies needed: Personal cell phone, cotton balls

Student instructions: Select a partner to work with for this scenario. One of you should place a cotton ball in each ear. Using your cell phone, call your partner and try to have a conversation. Do not change the volume setting on your phone. After a minute or so of conversation, switch roles. The other person should place cotton balls in their ears and continue the conversation.

3. Vision changes
Supplies needed: Vision changing glasses, Snellen eye chart, magazines

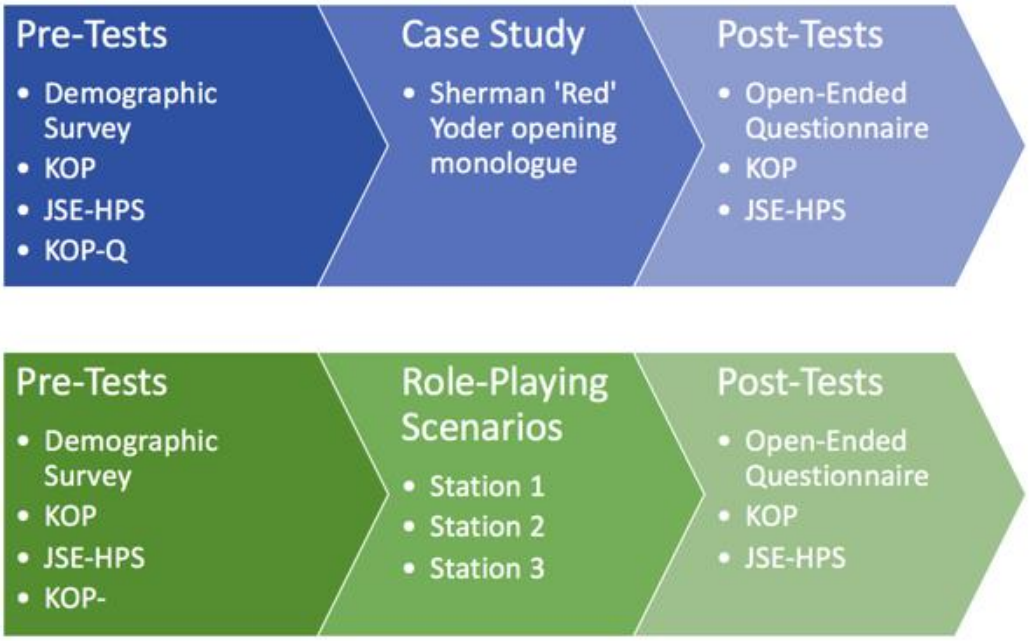
Student instructions: Choose any two of the six glasses that are provided. For each pair of glasses, attempt to read the Snellen eye chart from 20 feet away. After that, attempt to read one of the magazines provided. Students may elect to try walking around the room wearing the vision changing glasses as well.

Appendix N: Study Timeline

Activities	10/17	11/17	12/17	1/18	3/18	5/18
Final Proposal to Committee	X					
Obtain IRB Approval		X				
Patient and Faculty orientation to intervention		X				
Recruit Participants		X				
Pre-test Participants			X (12/1)			

Role-play/Case study			X			
Post-test Participants			X (12/8)			
Data Entry			X			
Data Analysis			X	X		
Interpretation of Findings			X	X		
Prepare dissertation portfolio			X	X	X	
Defend dissertation						X
Graduate						X

Appendix O: Flow Chart of Implementing Study



Biographical Sketch

NAME: Galetz, Elizabeth A (MSN, RN)

POSITION TITLE: Doctoral Student, Assistant Professor

EDUCATION:

INSTITUTION AND LOCATION	DEGREE	COMPLETION DATE	FIELD OF STUDY
The College of New Jersey	BSN	05/2008	Nursing
Drexel University	MSN	06/2012	Nursing Education
The University of Texas at Tyler	PhD	08/2018	Nursing

A. Personal Statement

The purpose of this study was to examine factors affecting attitudes and empathy towards older adults such as sociodemographic factors, previous interactions with, knowledge towards, and clinical preferences toward working with older adults in an ABSN program. In addition, the effectiveness of two educational modalities, a case study and role-playing scenarios, will be used to examine the effect on improving attitudes and empathy towards older adults.

B. Positions and Honors

Employment

In September 2018 – present: Assistant Professor of Nursing, William Paterson University, Wayne, NJ

August 2015 – June 2018: Assistant Professor, Skill Lab Coordinator, New Jersey City University, Jersey City, NJ

August 2012 – August 2015: Skill and Simulation Lab Coordinator: Union County College, Plainfield, NJ

Clinical Practice

September 2017 – present: *Nursing Supervisor*, Arbor Glen Community, Bridgewater, NJ
March 2010 – May 2014: *Staff Nurse, Telemetry/Intermediate Care Unit*, University Medical Center at Princeton, Princeton, NJ
November 2011 – May 2012: *Staff Nurse (per diem, Telemetry)*, Saint Peter's University Hospital, New Brunswick, NJ
June 2009 – February 2010: *Staff Nurse, Surgical Telemetry Step-Down Unit* Saint Barnabas Medical Center, Livingston, NJ
July 2008 – February 2009: *Staff Nurse, Intermediate Medical-Surgical Unit*, Roper Hospital, Charleston, SC

Service Learning and Volunteer Experiences

February 2018 – IFRE Volunteers, Medical Volunteer, Surin, Thailand
January 2016 – African Community Exchange, Medical Volunteer, Kilimanjaro, Tanzania
May 2015 – Tzu Chi College of Technology, Traditional Chinese Medicine course, Hualien, Taiwan

C. Academic and Professional Awards

2014-2015 – The University of Texas at Tyler
Ella Kate & Wallane Ralston Endowed Scholarship
Herbert & Melvina Buie Presdiential Scholarship for Doctoral Students
Smith County Medical Society Scholarship
2014 – Sigma Sigma Sigma Sorority
Foundation Scholarship recipient 2014-2015 academic year

D. Membership in Professional Societies

Sigma Theta Tau International Honor Society of Nursing, *Nu Eta and Kappa Eta*
American Nurses Association (ANA)
New Jersey State Nurses Association (NJSNA)
National League for Nursing (NLN)

New Jersey League for Nursing (NJLN)
International Nursing Association for Clinical Simulation and Learning (INACSL)

E. Contribution to Science

March 2018 – New Jersey League for Nursing Conference, Atlantic City, NJ
"The Use of ePortfolios in Nursing Students"
Breakout Session

May 2017 – New Jersey City University, Jersey City, NJ
"Leading Effective Classroom Discussion: Hatful of Quotes"
CxC Workshops

April 2016 – New Jersey City University, Jersey City, NJ
"*It Begins with a Single Step"*
Research Day 2015

March 2015 – New Jersey League for Nursing Conference, Atlantic City, NJ
"Creation of an Individualized Decision Tree"
Poster Presentation

September 2014 – National League for Nursing 2014 Summit, Phoenix, AZ
"Creation of an Individualized Decision Tree"
ACES Pre-Conference workshop

March 2014 – Union County College, Cranford, NJ
"Engaging Students with a LMS: An Insider's Perspective"
2014 Faculty Showcase: Engaging Students with Technology