DEVELOPMENT AND SUSTAINABILITY OF EMPATHY AMONG NURSES IN KENYA

BY

PIUS GITONGA GERVASIOH

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DECLARATION OF ORIGINALITY

PROFILE:

STUDY TITLE : Development and Sustainability of Empathy Among Nurses in Kenya
STUDENT NAME : Pius Gitonga Gervasioh
REG. NO. : H80/97949/2015
THEMATIC AREA : Nursing Education and Administration
SCHOOL : School of Nursing Sciences
COLLEGE : College of Health Sciences
UNIVERSITY : University of Nairobi

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SUPERVISORS’ APPROVAL

This research thesis has been submitted for examination with our approval as supervisors

1. Prof. Anna Kagure Karani: BScN, MA, PhD

Signature.................................................. Date ........................................

2. Dr. Samuel Thuo Kimani: BScN, MSc, PhD

Signature.................................................. Date ........................................

3. Dr. James Mwaura: BScN, MSc, PhD

Signature.................................................. Date ........................................
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MY PRAYER OF SUPPLICATION

I submit to you, our dear God almighty!

Our Lord Jesus, continue to give us a new desire to share witness to your amazing love.

Dispel all our fears and doubts and fill us with a willingness to be vulnerable.

Grant us, oh Lord courage to connect with our patients, students and colleagues.

Connect us with strong cords of empathy so that we see and hear you as we serve others.

In your holy name.

Amen
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LIST OF ABBREVIATIONS AND ACRONYMS

ANOVA : Analysis of Variance

CME : Continuous Medical Education

ECRH : Embu County Referral Hospital

EI : Emotional intelligence

ECRH : Embu County Referral Hospital

ERC-KNH/UON : Ethics and Research Committee of Kenyatta National Hospital and the University of Nairobi

EQ : Empathy Quotient

FGD : Focus Group Discussion

ICN : International Council of Nurses

IQ : Intelligence Quotient

KNH : Kenyatta National Hospital

MTRH : Meru Teaching and Referral Hospital

NACOSTI : National Commission for Science Technology and Innovation

NCK : Nursing Council of Kenya

PDP : Professional Development Plans

SC : Social Competence

SPSS : Statistical Package for Social Sciences

UNESCO : United Nations Education and Science Conference
OPERATIONAL DEFINITIONS

**Emotional intelligence:** nurses’ capacity to understand emotions of other people and respond to those emotions in a caring manner to others.

**Empathy:** a life skill and a professional competence in nursing that is characterised by ability of an individual nurse to be unconditionally humane, caring and sociable to others. The characteristics involve behavioural attributes that are culturally appropriate observable traits of an individual to another in relation to the universally accepted social norms. Indicators of empathy in this thesis are awareness, wellbeing and prediction.

**Empathy training intervention:** a training schedule with empathy specific learning experiences that is intended to provide and ensure capacity building opportunities to the nurses in Kenya. A training module of learning experiences for empathy development and sustainability among nurses is available as an annex (pg. 140).

**Gaps in empathy:** actual or perceived absence of indicators for establishing empathy among nurses.

**Development of empathy:** a systematic process of acquiring knowledge, skill and attitude that translates to integration of empathy in caring behaviours for nurses.

**Sustainability of empathy:** a consistent and reliable motivative set of practices which ensure that empathy skills are demonstrated in every nurse-patient relationship.
ABSTRACT

Background: Empathy is a crucial competence in nursing care that involves cognitive-social-professional responses to human need for affection, understanding, and help. Empathy is highly associated with altruistic nursing character or caring behaviours observed during nurse-patient transactions. The benefits of empathy include expedited and improved health outcomes for patients and professional wellbeing for nurses. Training nurses on empathy has been associated with positive social and clinical outcomes. Regardless of the benefits of empathy, training for nurses has consistently shown inadequate and inconsistent resources and strategies for development and sustainability of empathy in nursing practice. Aim: The study aimed at conducting a needs analysis, develop and implement an intervention intended to promote development and sustainability of empathy among nurses in Kenya. Methodology: A multi-stage mixed method design was adopted in this research: first phase involved three stage needs analysis while the intervention phase involved three stages. The empathy training needs analysis had exploratory – explanatory sequential approach, quasi experimental design and participant observation were applied included 154 nurses whose information provided basis and rationale for the intervention. The intervention population involved a stratified sample of 384 nurses selected from the four hospital that were participating. A training intervention was developed, implemented, and the pre/post scores compared. The pre-post training questionnaire assessed nurses’ knowledge on observable characteristics related to empathy, factors that favoured development of empathy, factors that favoured sustainability of empathy and factors that hindered both development and sustainability of empathy among nurses. The study variables were statistically compared using a paired samples t-test and variable effect size estimation. Findings: Needs analysis showed gaps in knowledge and skill in integrating empathy in nursing practice. The need to intervene using a constructivist approach by locally developed empathy training tool formed the basis of the training intervention. Factor analysis showed that dependent variables had positive influences on empathy development. Knowledge on observable characteristics related to developing and sustaining empathy was reportedly low during baseline analysis but a significant increase was achieved following the intervention. The knowledge scores on the factors that favoured development of empathy improved significantly following training ($M_b$=0.50, $M_e$=0.87), $t$(384), $=-12.80$, $p<0.05$. Similarly, significant improvements in empathy development skill was observed ($M_b$=0.48, $M_e$=0.88), $t$(384), $=-14.13$, $p<0.05$; and sustainability in nursing practice ($M_b$=0.66, $M_e$=0.83), $t$(384), $=-6.23$, $p<0.05$. Significant change in awareness on sustainability of empathy among nurses ($M_b$=0.34, $M_e$=0.66), $t$(384), $=-9.75$, $p<0.05$ was achieved. Hypothesis tests showed significant relationship between the intervention and empathy knowledge/skill achievement (0.4 - 0.8 ± 0.07; $p=0.001$). Conclusion: empathy development and sustainability among nurses in Kenya was to be achieved through training on empathy knowledge and skill. The contextualised need analysis strategy for developing and sustaining empathy established that a training need existed. Baseline study showed that knowledge was ranging from low to average. Substantial gains in knowledge and observable empathy behaviours was achieved; this gain is attributable to empathy training intervention. Recommendations: Empathy training module should be implemented to all nurses in Kenya

Key Words: Emotional intelligence, Empathy - development, Sustainability, Self-determinism
CHAPTER ONE: INTRODUCTION

1.1 Background information

Empathy is the most important competence that determine quality of health care; where empathy is integral part of caring, there are better health outcomes achieved from the therapeutic processes (Song, Colosante and Malti, 2017). The quality of care refers to the extent to which health care services provided to individuals and patient populations improve desired health outcomes (WHO, 2017). Quality of nursing care indicates the degree of satisfaction as expressed by the recipients of nursing care and the overall experience in the achievement of the desired health outcomes. Consistency in high quality of nursing care can be achieved through rigorous establishment and promotion of caring behaviours and interpersonal relationships among nurses in the healthcare delivery. Furthermore, emphasis of quality of interpersonal relationships in healthcare is a key component of ensuring that empathy is gradually integrated into the caring behaviours of nurses.

Training nurses on empathy is a vital process in professional preparation for nursing practice; this process requires development of multiple intelligences, hard work and persistence in achieving the learning outcomes so that patients and nurses can engage in therapeutic processes safely. A safe practice environment for nurses is characterised by skill proficiency, creativity and emotional warmth whereby the goals of nursing practice are set in the best evidence available as well as the best interest of the patient (Fitzpatrick, 2014). The working environments for nurses have both professional and social locus and functioning in the hospital/clinical settings is founded on the development of professional and interpersonal skills through mentorship and training.

Training for skill mix and maturation of intelligences calls for implementations of the prescribed learning experiences that are designed to develop the specified skills and intelligences. Generally,
in nurse training, majority of learning experiences (desired competences) have higher emphasis on knowing (cognitive) and hands-on (psychomotor) proficiencies. The model of learning that is mainly used in training nurses emphasises on three domains; including cognitive domain (knowing/understanding), psychomotor domain (performing/skills) and affective domain (attitude/associated behaviour). The order of these domains predisposes training into prioritization based on the learnability and ease of implementation and evaluation of achievement for qualification. Cognitive domain receives highest attention and affective domain suffers from being allocated least attention and therefore suffer ‘avoidance syndrome’ where nobody wants to invest more time and attention to it.

Training nurses on areas where avoidance had made significant amount of sense has shown great achievement that motivates attempts to promote behavioural empowerment and counteract the past about what was considered impossible being earmarked as possible and realistic (Coatsworth, Forchuk and Griffin, 2017). Until recently, nurses were not bold enough to even attempt to make a nursing diagnosis or rationalize their nursing actions but were required to take orders. Although this discriminatory ideology of nurses not having the capacity to determine their knowledge and skill persists in some incidences, nurses have actually scaled up the ladder of academia, leadership, skill/content mastery and established themselves as champions of healthcare advocacy and altruistic providers of nursing care (Henderson, 2006)

Empathy in nursing has a psychological and social perspectives that is defined as the identification of own experiences with the object’s feelings or participation in the experiences of other people. Psychoanalysis identifies emotional and affective components of empathy: the emphasis is on the importance of the emotional component of empathy: the emotional sensitivity and ability to co-feel (feel together) the other person’s feelings (Coatsworth et al., 2017).
The concept of empathy is also believed to be a competence; a skill and a value that is associated with abilities in caring, showing concern and often treated as a professional value for nurses. The clientele in healthcare expect that the nurses show empathy during nurse-patient interactions. Empathy is therefore, a major driver of patient satisfaction. In the perspective of preparation for nursing profession, all the exit competences are usually trained, retrained and severely practiced before nurses are allowed certification to practice. It is almost an automatic expectation by the schools of nursing and regulatory body that by licensure, a nurse is well equipped with competences and attitudes to show empathy (Adam, Oster, O’Kane, Hayman and Cochrane, 2016).

In nursing practice, empathy is considered one of most significant characteristics of a nurse offering care in a therapeutic setting within the confines of the professional relationship. This consideration also plays vital role in establishing the extent to which control to human behaviour is possible. Empathy empowers the nurse to be trusted by her patients, significant others and by professional colleagues. Using empathy as an essential inter-personal communication skill in nursing has a positive effect on nurses and their practice of nursing care (Zegwaard, Aartsen, Grypdonck and Cuijpers, 2017). Nurses have consistently adapted to emerging trends of health and professional needs. The current health trends demand that nurses apply their altruistic values in scientific assessment of patient’s needs. In addition, nurses are required to apply empathy competence in providing nursing care to patients. The pre-requisite competences that are usually referred to as hands-on skills in providing nursing care to patients are emphasised in training for nurses. Applying the empathy values in nursing practice requires ability and willingness to develop, practice, promote and configure a empathy sustainability strategy (McSherry, Loewenthal and Cayne 2016).
Recent researches in various areas of nursing care have shown that empathy plays a key role in building trust relationship between nurses and their patients. Once this trust relationship is built, patients can allow nurses to enter into their world and thus provide cues and information for the nurses to understand the patients’ perspectives, feelings and thoughts (Coatsworth et al., 2017). The innovative solution for training and sustaining all the competences of clinical empathy in healthcare is investing in empowering both the health care provider and the patient. For the health care provider, capacity and efficiency while for the patient; trust. Additional competences that involve empowering social and interpersonal praxis of individual, families and groups are inevitable in this decade (UNESCO, 2017)

In nursing care, empathy status plays a significant role in the nature of nurse-patient therapeutic relationships; positive relationships are achieved when nurses have the capacity and motivation to show empathy to their patients. We therefore require empowering nurses with empathy; the skills and competences to show empathy to patients, colleagues and strangers. Although training nurses is an intensely regulated and highly laden with expectation on the nurses, additional competences that involve empowering social and interpersonal praxis of individual, families and groups are inevitable in ensuring that nurses achieve their goal with acceptability (UNESCO, 2017).

Developing and sustaining empathy is a social and professional responsibility for nurses. Although the term empathy is familiar across healthcare professions, the criterion for determining presence and absence of empathy is usually not in the feedback mechanisms for staff evaluation. This study therefore needed to be done to analyse the need for developing empathy training intervention and implementation of the intervention to nurses at all levels of nurse training for high quality nursing care and safe practice. The needs analysis was expected to showcase the importance and rationale of implementing empathy training intervention among nurses in Kenya. This research envisions
that more nurses are immediately and consistently empowered through capacity building for better and more health benefits; for nurses, patients and institutions of healthcare.

1.2 Perspectives of empathy

1.2.1 Social-interpersonal perspectives of empathy

Interpersonal relationships are a great concern to the social stability in the world today. A great deal of negative implications suffices from impaired social and interpersonal relationship between and among people. According to United Nations Educational and Scientific and Cultural Organization (UNESCO), the world is undergoing important social transformations driven by the impact of globalization, global environmental change and economic and financial crises, resulting in growing inequalities, extreme poverty, exclusion and the denial of basic human rights. These transformations demonstrate the urge for innovative solutions conducive to universal values of peace, human dignity, gender equality, non-violence engagements and non-discrimination (UNESCO, 2017).

Communication is an important tool in socialisation processes. This tool enables passage of ideas, information and facts across and among persons. Success in verbal or non-verbal communication involves correctness of messages or information as intended by the sender. Similar to communication, empathy is not only a tool of conveying correctness of our understanding about a phenomenon to a real individual. While expressing this understanding, we also need to accompany the response with the correct emotions. This understanding is also related to the mood or affective components enable persons to create mature human relationships without a concern for the keeping and maintaining own self-identity. These skills are the basis for understanding the other person's feelings, her life situation and allow the prediction of his or her future behaviour (Howe, 2016).
Due to the diversity and uniqueness of patients who seek nursing care, applied empathy in nursing practice is essential. Nursing care requires that the care is coupled with showing empathy to patients. The sociability and interpersonal perspectives in empathy are so interdependent that nurse-patient relationships have been viewed as the basis upon which moral foundation of nursing practice is established (Song et al., 2017).

1.2.2 Feminist perspectives of empathy

Throughout the years, nurses have increasingly experienced devaluation and invisibility of what they do as ‘simple work’ within health care settings. This attitude towards nurses is directly the result of the practices of nurses being associated with “women's work”. Actually, nursing has in several occasions been called a ‘woman’s profession’. The social responsibility of women has long been defined around house chores, feeding, cleaning and washing, caring for and nursing the young ones. Therefore, in the so-called female - dominated profession, has field of opportunities that are being exploited by males. Regardless of males increasing in nursing profession, female nurses are reportedly able to show empathy better than male nurses (Cook-Krieg, 2011).

Women have shown a considerably higher level of empathy and caring abilities compared to males. Even with an intermediate training, it is likely that an ability to understand others, to relate to others, and to treat others as one would like to be treated would enable a person to be a better nurse. Furthermore, women have a higher tendency to focus on other person’s experiences in a fairly objective or unselfish manner rather than focusing on one’s own experiences in a selfish manner (Fitzpatrick, 2014). According to Simon Baron-Cohen (2013), there are observable differences between how males and females behave in similar situations. While most females give most of their attention to social stimuli such as human faces and voices, many males pay most
attention to non-social, spatial stimuli—such as the complexion, movement and sizes. Women focus on socializing and communication, spend more time doing social networking and asking questions to patients, wanting to know more about social settings of a person. In the other hand, men care more about systemizing and functionality of the therapeutic opportunity as a tool for achieving systematic goals of health care. In some isolated incidences, women in female nurses have shown little or minimal empathetic concern to female patients and a considerably higher empathy to male patients and children; especially boys.

### 1.2.3 Paternalist perspectives of empathy

It is worth noting that compassionate care and showing empathy could interfere with objectivity in diagnosis and treatment, if excessive and not mediated. The contextualisation of what excessive and not mediated means is somewhat unclear of the extent through which taking over is accepted. When the assuming of another person’s role responsibility is not clearly defined, the extent of decisions made by the client’s advocate may supersede the social and professional boundaries. When these boundaries are superseded, a possible role-responsibility take-over may present. Over indulgence has always been a negative indicator of autonomy.

The professional distance has to be maintained as we show and offer empathy; all to avoid complicating the nature of therapeutic relationships. A complicated relationship arises when the care giver makes decisions in the interest of the patient but without involving the patient. In this arrangement, the sick role and health seeking behaviour of the patient are compromised, and paternalistic relationships are developed. So, as we practice empathy, let us also remember that there exists a risk for paternalism and numerous ethical-legal issues surround paternalistic practices (Beauchamp and Childress, 2011). Paternalistic relationships are unintended outcomes.
of empathy. Paternalism involves making decisions without involving or consulting the person who is to be directly affected by the decision. In healthcare, paternalistic practices have been on the rise. Whenever paternalistic relationship arises, nurses “feel for” patients but not “feel with” them. Although the decision is believed to be somewhat conforming to ethical principles of beneficence and maleficence, paternalism denies the patient an opportunity to participate adequately in the decision about their health (Beauchamp and Childress 2013).

1.3 Indicators of empathy in nursing practice

Patient hospitalisation and clinical encounter with physicians and nurses has rightly attracted attention, particularly of the quality and nature of therapeutic interactions that transpire in the course of health care delivery. The high-quality healthcare and positive interactions in the clinics, outreach medical services, referral systems and in the primary care setting are related to presence of empathy as a professional competence for the care provider. Progressively, attention is being paid to patients' views on the empathy-care and to developing a more patient targeted approach (Mercer and Reynolds, 2018). Empathy in nursing has been recognised as a professional competence that consists of social traits that promote better understanding and connections between and among people. As a professional competence, empathy has specific roles in connecting the patients to nurses in therapeutic relationship. As a social competence, empathy has the role of making social interactions very interesting, raising genuine concerns and honestly positive. The indicators of empathy are discussed in following sub-sections.

1.3.1 Awareness as an indicator of empathy in nursing practice

The awareness indicators of empathy are self and social awareness of qualities and values of empathy. self-awareness involves self-reflection. Nurses are expected to illustrate and implement
utmost keenness and unaltering observation to patients’ health needs in detail. This awareness is as a result of scientific preparation in their training. The awareness of self needs for strategies to meet those needs is also considered a positive indicator as well as promoting self-care as the premise upon which caring for others is founded (Baron-Cohen, 2012).

Secondly, social awareness involves concerns about other people’s needs and how to meet those needs. Social awareness is a very strong indicator of empathy. The indicator illustrates that the nurse cares to know the perspective of the patient and also invest time and resources in meeting that need. Awareness of what our neighbour is going through is a strong quality in social awareness and a quality indicator or caring attitudes in humans. Social awareness may contribute to better inter-personal relationships and social behaviour and thus achieving better and increased engagement of nurses in their nursing care delivery. Furthermore, social awareness increases quality and frequency of positive behaviour, realises better therapeutic relationships and reduce risks for untoward behaviour (Gehlbach, Young & Roan, 2012).

Thirdly, taking action on the basis of the specific awareness that the need presents. This indicator illustrates that the empathiser is able to apply the principles of empathetic concern in taking action to alleviate suffering or basically to meet the health need. The awareness and preparedness in the intervention (taking empathetic perspectives into action) options for solutions in the perspective of the person expressing the needs. Fourthly, overall demeanour a person illustrates as she carries out the activities of care. This indicator involves the positive regard; including communication, gentleness and positive attitudes towards recipients of nursing care. These variables demonstrate empathy as an expression to those who are in need. The empathy expressions involve active listening, showing concern, caring to help and readiness to take action in order to alleviate suffering of those that are dependent on the nurse. Additionally, indicators of positive bodily
gestures and signs of social-professional tolerance are also key in the demeanour for a nurse who has developed empathy to a level of application (Fitzpatrick, 2014).

1.3.2 Wellbeing as an indicator of empathy in nursing practice

The meanings and application of wellbeing and wellness are closely related, and their meaning need not to be over-emphasised. Wellbeing indicators of empathy among nurses are largely related to abilities and qualities of nurses’ performance in their nursing duties. Wellbeing is actually the key driver of all other indicators of empathy in nursing practice. Nurses’ wellbeing is an important factor that influences quality of nursing care, therapeutic relationships and service delivery in hospitals. It also determines whether empathy is identified, offered or not. To improve nurse-patient interactions, nursing staff wellness must be closely monitored and promoted so that to ensure health and satisfaction of nursing staff. Several sub-indicators are associated with wellbeing as an indicator of employees’ characteristic. The sub-indicators are: work engagement, job satisfaction and turnover intention of nursing staff. A result-oriented patient specific wellbeing indicator is better health outcomes for the patients.

Firstly, work engagement is an indicator of wellbeing in nursing practice. Work engagement is defined as a persistent, persuasive and positive affective-motivational state of fulfilment among employees (Schaufeli, Salanova, Gonzalez-Roma & Bakker, 2012). Nursing staff indicate their wellbeing by consistency in the nursing decisions and actions that they make and take. As an indicator of empathy, wellbeing involves the qualities of persuasive and positive motivation towards the nursing duties and responsibilities. Mostly, these indicators are easily observable and can relate very closely to the behaviour of nurses during their interaction with patients or health care delivery colleagues. Evidence has pointed that engaged employees find their work to be more
meaningful and in line with their professional values. In such work engagement situations, the employees have less absenteeism record, lower risk of burnout and or lower tendencies of turnover (Pedersen 2009).

Second indicator of wellbeing is job satisfaction. Nurses’ job satisfaction appears to be central to intrinsic rewards or what many people have referred to as ‘the call’ for service and the connection with others. Job satisfaction is associated with an outright demonstration by an employee that she loves what she is doing. The construct of job satisfaction has a variety of determinants and therefore, it might be limited to the role it plays as indicator of empathy in social-professional exhaustion or intention for turnover. Considering nursing practice as a social-professional endeavour, it is largely associated with higher emotional demands, high workload and increased risk for emotional exhaustion. As an indicator of wellbeing, job satisfaction plays a great role in demonstrating potential to show empathy; when someone doesn’t love what they are doing, then it is very difficult for them to show empathy in that working environment (Mackintosh 2007).

The third wellbeing indicator is turn-over intention of nurses. Nursing turnover continues to present serious challenges in all levels of healthcare. High nurse turnover in healthcare facilities can negatively affect the ability of hospitals to meet patient needs and provide quality care (Chiu, Chung, Wu and Ho, 2010). The increased burdens for the remaining nursing staff, decreased work satisfaction and reduced abilities to show empathy are indicators of strained environment within where empathy can be adequately practiced. The indicators of turn-over intentions include lack of interest or lack of commitment to duties, absenteeism, fewer nurses with shorter length of stay in the same health facility and unrealistic high expectations on the employer (Schaufeli, et al., 2012). Better and faster patient healthcare outcomes are indicators of wellbeing of the providers of nursing care. Emotional contagion and attitude change has an impact on the wellness of the recipient of
nursing care. In this context therefore, when nurses show empathy, patients may also learn how to show empathy. The indicators of empathy point at wellness, wellbeing and conversely, patients who have qualities of empathy report better and expedited recovery (Forrester, Kershaw, Moses and Hughes 2007).

1.3.3 Predictor indicators of empathy in nursing practice

Although empathy is being discussed in this thesis as a life-skill and a professional competence for nurses, it is important to note that it is also conceptualised as a behavioural construct in establishing human relationships. Nurses social-emotional-professional competences seem to play a significant role in predicting patient behaviours. The main character of behaviours is that behaviours have a high tendency for being predicted. The correctness of the prediction depends on whether or not the predictors are correctly defined. Psychosocial analysis of empathy as a predictable behaviour therefore identifies four indicators; Capacity, efficiency, self-efficacy and compliance (Fitzpatrick, 2014).

Behavioural indicators of empathy have a common locus on whether the behaviour is demonstrable or not. General behavioural predictor of empathy in nursing practice is the ability to understand emotional components behind complex situations. This understanding involves the perspective of being respectful and considerate to others’ point of view being able to show concern for another person’s situation. Lack of preparation to handle rapid negative emotional changes could lead to overwhelmed by the stressful situations and early behavioural changes; for example, hopelessness is prevalent before injuries are reported to both physical and mental health for nurses (Edmunds 2010).
1.4 Rationale for empathy training intervention among nurses

Caring for persons involves a certain degree of selfless devotion and motivation. In nursing, caring for the sick involves having the call to care, altruism, professionalism and empathy. It is also argued that empathy is an observable social trait and a professional characteristic that are important in the way people care for one another (UNESCO, 2017). Improving how we care for one another results into improving the quality of lives that we live, improves our social and professional relationships while reducing social discrimination. The social pillar of Kenya’s vision 2030 aims to achieve a just and cohesive society enjoying equitable social development in a clean and secure environment (GoK, 2007). The social pillar is envisioned designed to achieve its purpose of social development through promoting and sustaining empowerment of people of Kenya and ensuring an enabling social environment within which people will function optimally.

The overarching principle of this pillar is that we shall enrich our social and cultural qualities that promote patriotism, national cohesion, tolerance and social responsibility. Empathy promotion strategies in nursing practice will include capacity building, creating awareness and practicing empathy among nurses. In promoting health care through empathy intervention, social awareness and self-determination are important considerations. Being socially aware of our social environments, our clientele health/social needs and ensuring quality nursing care. Self – determining our extent of interaction in therapeutic relationships will also be informed by the learned capacity and experience in empathy (Marcysiak, Dabrowska and Marcysiak 2014).

Professionalism in nursing practice requires persons who do not find it a bother to care for self or for others. Nurses are, according to Virginia (2006) selfless, empathetic, spontaneous and friendly to all persons in an equal measure. It is therefore, a professional responsibility that nurses must
understand the duties and obligations of their profession and be loyal and committed to professional code of conduct for individual, societal and national development (UNESCO, 2013). Further insights indicate that the promise of a profession is signified in a set of values, behaviours, and relationships that underpin the trust of the public (RCP, 2005). It is imperative therefore, to imagine that nurses should appeal to the public in terms of behavioural conduct and role performance. Thinking and thought processes determine human behaviour, type of relationships and the way responses to human needs are packaged. The package is unpacked through role performance, behavioural adjustments and establishment of caring relationships. To perform these activities as prescribed by the professional standards, the nurses as individuals or groups are expected to be able and willing to listen, hear, understand and respond to health needs of their professional clients. To improve empathy, we need to offer more emotional preparation for the nurses and other members of healthcare delivery teams.

1.5 Strategic analysis for empathy training intervention in nursing practice

Nursing practice is an emotionally intense endeavour. To survive the emotional intensity of the daily activities of a nurse, the nurse must be supported and encouraged. The most relevant support is professional support. Additional support strategies include training for capacity building and being allowed and empowered in personal and professional growth. Empathy training intervention for nurses therefore aimed at promoting emotional intelligence and social-professional preparation for nurses in empathy and related expectational challenges experienced in provision of nursing care. Implementing professional development plans on capacity building, retraining for developing and sustaining empathy is important in establishing professional landmarks for (UNESCO, 2013).
Human beings have unique ways of demonstrating empathy and related caring qualities towards others. Empathy is a life skill associated with caring, showing concern and often regarded as a professional value for nurses (McSherry, Loewenthal and Cayne 2016). Nurses are expected to possess a higher level of empathy. Patients expect to receive empathy from nurses during hospitalization. Empathy is therefore, a major driver of patient satisfaction. The science and art of preparing nurses for the world involves hands-on exit competencies. The exit competences are usually trained, retrained and severely emphasised before nurses are certified to practice. Although empathy is not included in the training schedules, it is almost an automatic expectation that, a nurse is well equipped with competences and attitudes to show, offer and promote empathy (Adam, Oster, O’Kane, Hayman and Cochrane, 2016).

1.5.1 Empathy training for nurses

Training empathy involves discovering and promoting emotional intelligence in an individual. It is an awakening of the greatest social and professional behavioural attributes. The awakening of emotional Intelligence is the art of empowering an individual to perceive, assess and manage emotions of his own self and those of other people (Morrison, 2012). Professional development programmes therefore, must inculcate responsible professionalism by developing positive emotions, empathy, effective empathetic communication and rational leadership. The empathy training intervention aims at promoting awareness about empathy, ensuring proficiency and efficacy in empathetic concern for nurses in healthcare settings. This training is needed because empathy is good for establishing and maintaining conducive social environments, ensuring socially acceptable, deserved and high-quality therapeutic relationships. Training and/or retraining empathy helps nurses in demonstrating lower risks of burn-out, higher job satisfaction and they illustrate improved self-esteem (Cohen, 2012).
1.5.2 Strategies used to develop empathy

The ability to identify a phenomenon depends on whether there exist some memory traces of either the whole or of the parts of an event. Building capacity through empathy training intervention in nursing promotes the ability to choose the appropriate responses when faced with a situation requiring empathy. It is worth noting that while we perceive the communicative stimuli we perceive only one percept (the one we are good at) and the problem of choosing the best stimuli from many that are perceived does not exist (Van der Helm, 2014).

The concepts of knowledge management and creation of awareness about empathy are largely associated with emotional intelligence. The core knowledges that are largely relayed to empathy include: the ability to identify own thoughts or feelings and compare those feelings to what someone else is thinking or feeling, and to respond to the thoughts and feelings with an appropriate emotion and action. Theoretical basis of empathy indicates that for successful intervention, the target groups must be prepared with the right information before their skills are developed, promoted od sustained (Baron, 2012).

The choice to learn a skill is associated with self-determination of the learner or the target group. Selfless service to humanity (altruism) is a behavioural quality that makes empathy intervention possible. Self-determination assumes that humans are motivated at different levels and by different motivators. Depending on their needs for motivation, humans acquire knowledge, skills and proficiencies prescribed in the training curriculum. The deeper an individual develops interest to understand a concept, a construct or a theorem, the higher is their potential or possibility to seek additional information and develop awareness of the phenomenon at hand (UNESCO, 2013).
1.5.3 **Strategies used to sustain empathy in nursing practice**

The strategic analysis pointed at an empathy training intervention; with an intention to empower nurses on continued empathy competences in nursing practice. Capacity building in terms of knowledge and skill development was therefore intended and proposed. In empathy training, developing and sustaining empathy forms the basis of intervention planning. In both interventional perspectives, individuals are not overly challenged, but rather helped to experience a behavioural change that recognises and strengthens human connections. Gaining a sense of behavioural change is facilitated by self-drive for autonomy, self-determinism and altruism. That is, once people are volitionally engaged and have a high degree of willingness to change abehaviour, they are then most apt to learn and apply new competencies in their daily activities (Markland, Ryan, Tobin and Rollnick, 2015).

Sustainable empathy is an essential competence in nursing practice because it enables the nurse to perform the roles and duties of nursing care, for the patients, in the most sociably and professionally acceptable manner. Nurses who are consistently empathetic have a higher degree of self-esteem, establish a better healthcare environment and can achieve job satisfaction (Fitzpatrick, 2014). Studies by Fawcett and Garity (2009) noted that all nurses have the potential to take action because they have been transformed by the educational process to bring about the beauty of caring spontaneity to their actions in practice. The expectations for all nurses in Kenya is that they will offer excellent nursing care to their patients. Nurses will efficiently perform the nursing roles and promote equality of human person; either when the person is sick or well.
1.6 Statement of the Problem

Empathy competence is a very important component in nursing practice because most nurse-patient interactions are established as an informative conversation between nurses and patients (Theodosiush, 2008). The conversation is initiated by the nurse using appropriate verbal and non-verbal cues, a friendly tone, a warm smile, and non-judgmental approach to initiate a sense of connection with the patient (Henderson 2006). Empathy thrives where there is a positive regard and respect for persons. This positive regard is achieved by developing skills that empower individuals to consistently prevent their own negative attitudes, emotions and experiences from interfering negatively with the way they relate to others. Professional positioning of empathy points at the claim that some professionals feel that it is not their responsibility to pursue empathy in their practice because its exhausting and overly emotionally demanding. There is therefore a deficiency of empathy skills that is observed across many interpersonal interactions. (McDonald and Messinger, 2013).

Although it is difficult to arrive at a destination whose directions are not explained, that has been the case with empathy in nursing: nurses are expected to show empathy but not trained to do so. In many circumstances the nurses’ capacity building demands are trivialised or constructed around medicine-oriented updates as continuous medical education (CMEs). This trivialisation is an indication that there is an attributive compromise of nurse-specific training interventions; including developing and integrating empathy in nursing practice (KNCHR, 2011). Training nurses prepares them professionally for nursing practice. Training nurses in Kenya has a huge proportion of time and resources allocated and/or used to develop psychomotor skills and least of the time to develop affective skills. The mismatch this means that nurses were not being training on empathy (UNESCO, 2017).
The training guides and syllabus for training nurses didn’t recognise empathy as a trainable skill; or at least identify any learning experiences specific for developing empathy; insofar, there were no learning experiences designated to train empathy across the all levels (certificate, diploma, bachelors and masters) of nurse training curriculums. Absence of institutional and professional blue-print and tools on how to develop and sustain empathy in nursing has resulted into trivialisation of a crucial component in nursing care delivery. Since the expected learning outcomes and exit competences were not consistent with learner needs; we should therefore intervene to close the gap by first developing training tools and propose their infusion in the prescribed training curriculum for nurses.

Regardless of the professional requirement of offering empathy in all nurse-patient interactions, rare attention has been paid to develop and sustain nurses’ empathy wellbeing in Kenya. Empathy has not been prioritised as a goal of nursing in professional development. Institutions and the populations also give very low importance to empathy and psychosocial health. In other words, empathy is either being ignored or trivialised by healthcare institutions and the general public also show little or no empathy to nurses. The result of giving empathy exceedingly low priority is that persons, either sick or well, are treated with less empathy. some critics argue that empathy is a natural quality that evolves with human beings, but we caution that; although every human being has a potential to develop and show empathy, the processes involved pose risks in being considered exhausting and burdensome (Wagoro, Duma, Mayeres and Chitere 2017).

Whenever learning a core behaviour in caring is associated with constraints of emotional overload leading to offering empathy being termed as exhausting and burdensome; institutionalised empathy development will forever be given less attention. The burden of expectation on nurses to show empathy is immense and therefore, an action is needed with much urgency. When empathy
is not adequately developed, the nurses will continue to suffer the blame that they lacked capacity and efficacy to offer empathy. The blame is shifted to nurses without understanding that empathy is a reflective phenomenon; empathy is a give-and-take value. Therefore, the burden of who has the sole responsibility of showing or offering empathy is usually tossed around and shifted across professions, generations and platforms (Coatsworth, Forchuk and Griffin, 2017).

Anecdotal sources have pointed at strained interpersonal relationship skills among nurses; this has been observed during nursing care interventions. There has been public outcry about strained nurse-patient relationships in Kenya that has been attributed to limited empathy training for interpersonal communication and caring behaviours. Furthermore, allegations have been made regarding nurses who have occasionally portrayed gaps in both knowledge and skills as pertains empathy during nursing interventions. The gaps on attitude of nurses towards patients and significant others were somewhat perceived as giving a cold shoulder in the way they related to their patients (Wagoro, Duma, Mayeres and Chitere 2017).

Shelving off opportunities to develop, promote and integrate empathy in nursing practice has shown that either empathy is not understood or was not treated as a priority. This observation points out that, if empathy intervention is implemented and thus understood, the priority and focus will be in building capacity on empathy; both as a social construct and a professional competence (UNESCO, 2013). This study was therefore needed to establish empathy needs among nurses, develop and implement an empathy training intervention as a matter of urgency in nursing practice in Kenya and describe the effect size of the intervention to empathy and empathy-related caring behaviours.
1.7 Significance of the study

This research analysed empathy training needs and implemented an empathy training intervention among nurses in Kenya. Empathy is a behavioural attribute that is attached to responses that accompany main actions towards persons who require to be understood and helped. This research established that although it is a great challenge to intervene on a population that was facing severe shortages and were culturally diverse, implementing behavioural learning experiences that are universally consistent across diverse social settings can be achieved. In preparation for the training the customization of the learning experiences must conform to the baseline learning characters of the target group. The context and basis of the empathy training manual that was developed reflects the nurses’ empathy and its application in specified situations and healthcare environments in Kenya. This research envisaged that the empathy training manual will provide practical guide for developing and sustaining empathy indicators to nurses in Kenya. Empathy training intervention is also expected to improve the interpersonal relationship skills for nurses, reduces risk for negative experiences, caretaker role overload and prevent emotional exhaustion for nurses.

These achievements are long term and therefore we also need immediate achievements, those that can be applied in daily routines for nurses in their practical nursing experience environment. A positive self-reflection helps in realisation of person’s knowledge and skill gaps and the available options to close the identified gaps. Empathy training intervention manual provides nurses with a focus on intentionally integrating empathy in nursing practice. This study is significant and transferable; however, the results should not be generalised. The paradigm of inquiry, theoretical frameworks and conceptual model of variables present an empirical and realistic platform for making recommendations on empathy as a core competence for positive transformation of the nursing profession.
1.8 Research Questions

This study provided the researcher with an opportunity to answer the following four questions:

1.8.1: What are the empathy training needs among nurses in Kenya?
1.8.2: What are the strategies for developing and sustaining empathy among nurses in Kenya?
1.8.3: What is the implementation process for a empathy training manual for nurses in Kenya?
1.8.4: What are the factors influencing developing and sustaining empathy for nurses in Kenya?

1.9 Research Aim and Objectives

1.9.1 Research aim

To develop and implement a training intervention on development and sustainability of empathy among nurses in Kenya. To achieve this aim, this research was designed to meet four objectives.

1.9.2 Research objectives

1.9.2.1: To explore the empathy training needs among nurses in Kenya
1.9.2.2: To establish strategies for developing and sustaining empathy among nurses in Kenya
1.9.2.3: To develop and implement empathy training manual for nurses in Kenya
1.9.2.4: To describe the factors influencing development and sustainability of empathy among nurses in Kenya
1.10 Research Hypotheses

**Hypothesis 1:** Nurses experience significant difficulties in integrating clinical empathy in care of patients in Kenya.

**Hypothesis 2:** Empathy training intervention has significant influence on developing empathy knowledge and skill performance in nursing practice

**Hypothesis 3:** There is a statistically significant relationship between knowledge attainment and empathy training intervention among nurses in Kenya.

1.11 Justification for the Study

Every patient presents an opportunity for the nurse to show empathy. In this context, the nurse assumes the role of a leader. Being a great nurse leader means having a clear vision and mission of every nursing opportunity. It also means being committed, and knowing how to listen and communicate, but it involves much more. It’s about having a caring heart, professional or clinical empathy and a naturally uplifting spirit. Empathy can be viewed as an outcome of successful patient engagement in their care and in the healing process. Engaging patients in their care promotes their autonomy and improves health outcomes for consistent adaptation achievements; both in social and therapeutic relationships (Cohen, 2012).

Empathy involves experiences that empowers and adds value in people’s lives. It is with empathy that nurses can engage and empower their patients. With empathy and the courage to be vulnerable, nurses can help their patients feel good, valued and respected. Empathy allows nurses to engage and empower patients to take charge of their health and wellbeing (UNESCO, 2017). It also strives to promote client satisfaction while in healthcare environment. Developing and sustaining empathy
is core in nursing practice. Caring and quality of care in nursing is reliant on empathy, altruistic commitment in development and application of care protocols for patients; either as individuals or as groups (Fitzpatrick, 2014). Integration of empathy intervention in a training manual for nurses applies the principle of professional responsibility. It also lives to the expectation that since contemporary nursing practice is becoming more intense and emotionally demanding, nurses need to be prepared for the world of work. Empathy intervention is important because it is intended to empower nurses and protect them from a stressful, emotionally exhausting work environment leading to burnout, disability, stress and high absenteeism (Mayer, Salovey and Caruso, 2000).

Nurses in Kenyatta national hospital, Tenwek mission hospital, Emu county referral hospital and Meru teaching and referral hospital were actively engaged in nurse-patient relationships at different levels. The resources, the infrastructures, patient populations and sizes of catchment areas, the level of nurse engagement in their work, nurses’ wellbeing and turnover tendencies played a role in profiling the study population. These provided the basis and baseline upon which end line was be compared. The nurses who have social skills and competence are easily able to recognize the needs of the patients, listen, hear, understand and interact with individuals; sick or well, on a more sophisticated level to improve the perception of patients regarding the quality of healthcare experience. Nurses whose practice is integrated with empathy competences assist their patients to achieve desirable health, emotional and social outcomes. Such nurses are easy to work with, they are friendly and report less turn-over intentions.

1.12 Benefits of the study

The mission of health sector in Kenya is to provide evidence-based health care that is patient centred. This mission will be achieved by deliberately building a progressive, responsive and
sustainable healthcare system (Kenya Health Sector and Investment Plan 2013-2017). This study recognised that nurses constitute the largest workforce in Kenya’s health sector however, the nursing staff shortage, increase in turn-over intentions and empathy challenges persists. Empathy development and sustainability interventions could greatly alleviate these challenges but for a long-term solution attainment of the highest quality and best quality nursing care will be achieved through empowering nurses on empathy. Empathy integration in nursing caring behaviours will significantly empower nurses to actively participate in the health promotion and health seeking behaviours (wellbeing) for themselves and their patients.

Empowering nurses through implementation of empathy training module will greatly contribute to speedy achievement of national goals of healthcare. Intervening on empathy training in this research provided nurses with knowledge and competences that prepare empathy among nurses in meeting both professional and social expectations of healthcare. The findings of this study provide the context and empirical evidence for developing and sustaining empathy among nurses. The context is based on the needs analysis, rationale and results from intervention. The study envisages an improvement in positive regard for nurses and appreciation of nurses in what they do. The findings would also be very useful in policy formulation for regulation for nursing training and pre-service preparation of nurses in empathy. This research would benefit the main stakeholders of nurse-patients’ relationship. It would promote nurses’ and patients’ autonomy, self-determinism and application of core values of emotional intelligence. The researcher intended to develop a empathy training manual for pre-service and in-service nursing programs. The manual would be pre-tested and pre/post intervention analysis conducted.

While implemented as an intervention for developing and sustaining empathy among nurses, the manual can also be used for nursing students in the curriculum. The intervention is intended to
benefit the nurses by helping them acquire knowledge and skills in integrating empathy in nursing practice. The researcher also intends to recommend replication of the findings of this study in other hospitals in Kenya for continued development and sustainability of empathy among nurses. The change of behaviour in developing, showing, offering and sustaining empathy would play a pivotal role in sustainable health care standards of nursing care and professional pride in nursing practice for nurses in Kenya.

1.13 Assumptions for the Study

This study assumes that empathy is a core competence in caring and helping others. Professionals need empathy to perform their responsibilities with integrity. Preparing and ensuring that empathy among nurses is adequately developed and sustained helps them find balance in their practice. As a core competence therefore, a needs analysis is considered mandatory before the need is contextualised into a gap for intervention following analysis. designing an intervention. The needs analysis will contextualise the intended intervention and provide immediate feedback to the constructs that underpin the core competences of the empathy intervention training manual.

The roles that ensured success of the processes in this study were based on the information from needs analysis on empathy among nurses, decision making on the nature of intervention, rationale for empathy training intervention, justification of the study, and implementation of the interventions that were assumed that they would close the identified knowledge and skill gaps.
1.13.1 Assumptions on needs analysis

During the empathy needs analysis phase, the following assumptions were made about nurses in Kenya:

1.13.1.1: Nurses are not aware about empathy and its importance in nursing practice

1.13.1.2: There exist gaps in empathy knowledge and competences among nurses in Kenya.

1.13.1.3: Nurses do not experience challenges in developing and offering empathy to patients.

1.13.1.4: Nurses can give a rationale for empowering them on empathy in nursing practice.

1.13.2 Assumptions on gap-reduction empathy training intervention

During the empathy training intervention phase the following assumptions were made.

1.13.2.1: Training nurses on empathy can help improve their empathy competence.

1.13.2.2: Empathy training intervention can close the gaps in knowledge skills management.

1.13.2.3: Motivation and professional support are essential in developing empathy.

1.13.2.4: Institutional support or lack of can negatively impair self-empathy.

1.13.3 Assumptions on post-intervention analysis

During post training intervention phase the following assumptions were made.

1.13.3.1: Empathy training intervention can positively influence nurse-patient relationship.

1.13.3.2: Empowering nurses on empathy promotes professional and social identity.

1.13.3.3: Empathy training intervention can be shared across nursing professionals as a feedback.
1.14 Organisation of the Thesis

**Chapter 1:** In this chapter, the background of the study, the indicators of empathy, needs analysis, rationale for intervention, strategies for developing and sustaining empathy, statement of the problem purpose, aim and objectives, significance, benefits of the study are elaborated.

**Chapter 2:** This chapter discusses literature review relevant to empathy and to this study. In addition, this chapter describes theoretical, philosophical and conceptual background as well as their decisive influence on the identification of the focal points of the study and methodological choices.

**Chapter 3:** In this chapter the methodology of the study, including the study design, rationale for choice of the design, data collection, treatment and analysis processes of the study are discussed.

**Chapter 4:** This chapter presents the findings of the study including the needs analysis, pre and post intervention analysis.

**Chapter 5:** In this chapter, discussions, conclusions and the recommendations are presented. The empathy training manual is annexed at the end of this chapter.

**List of references:** This contains the sources of information used to support this study as cited to acknowledge the authors of the sources.

**List of Appendices:** This contains materials that were relevant in the development and implementation of the study.
CHAPTER TWO: REVIEW OF RELATED LITERATURE

2.1 Introduction

This chapter details a review of empirical evidence and theoretical perspectives of empathy in nursing practice. This literature review is presented to showcase the context of empathy in nursing practice. Contextualizing empathy through epistemology, empathy needs analysis and impact of intervention on nursing care is conducted. The chapter also provides a brief review of nursing and psychological theoretical frameworks that informed gap analysis and conceptualization of variables for the study. The literature sources were databases: MEDLINE, CINAHL, PUBMED and web search using empathy-nursing, empathy-development terms and Boolean operators. Key words used in the search included: empathy, empathy in nursing, empathizing, development of empathy, sustaining empathy. Literature search on empathy, its development or sustainability empathy in Africa and Kenya yielded minimal results. The sub-sections herein include; background of empathy, theoretical framework, conceptual model of variables, empathy as an essential competence in nursing practice and finally, a summary concludes this chapter.

2.2 Background of empathy

2.2.1 Origin and trends of empathy

The term empathy was initially expressed in ancient Greek as empatheia to refer to physical affection of passion to an object (something or someone). Later, empatheia was contextualized to en-pathos; to indicate a set of binary human circumstances (passion or suffering) that are normally believed to be present in individuals. En-pathos referred to emotional undertones of self and to others. This reference aimed at sensitizing and creating awareness of the appropriate responses towards human suffering. Passionate and positive responses were encouraged and considered
compulsory to helping humanity from pain, injury, illnesses and unjust judgment (Titchener, 2014). However, in modern Greek *empatheia* means malice or hostility.

The term empathy was later adapted in German and a meaning of *Einfühlung* was given; to refer to feeling into. The power of an individual to understand what another is going through; and emotionally support the person who is burdened, sick, frustrated or aggrieved. The most commonly perspective of empathy as was translated to *meaning into someone*. Related to feeling into is *to be in someone’s shoe*. A relatively recent concept that identifies how feelings are perceived in a binary fashion. Upon translation in English; empathy is the ability to perceive what another feels by paying attention to what she says and being open to their preoccupations and consequently consider one’s own view on the matter of concern (Gallese, 2003). More recent definition indicated that empathy is the vicarious experiencing of another’s emotional state which may be experienced in some form of understanding what an individual perceives in their social-emotional-psychological world (Goleman, 2006).

Empathy development is gradual and progresses in a linear predictable manner. The ability to empathize is an important part of social and emotional development, affecting an individual’s behaviour toward others and the quality of therapeutic relationships (McDonald & Messinger, 2013) integrating empathy in professional practice requires understanding of the basic kinds of empathy. Empathy has three main kinds as recognized by Ekman, (2003). The first is “cognitive empathy,” which involves knowing how the other person feels and what they might be associating their feelings to. Sometimes called perspective-taking, cognitive empathy helps in a negotiation or in motivating people. The cognitive perspectives give individuals a degree of leadership in their practice. Certainly, empathy qualifies as one critical measure of the right leader in a crisis, along with being cool under pressure (Goleman, 2007). When it comes to the right leader for a crisis,
cognitive empathy alone seems insufficient. However, “emotional empathy,” that is when you feel physically along with the other person, as though their emotions were contagious. This emotional contagion, social neuroscience tells us, depends in large part on the mirror neuron system in our brains (Goleman, 2001).

Emotional empathy makes someone well-attuned to another person’s inner emotional world, a plus in any of a wide range of professions, callings, from sales managers to nursing, counsellors, parents or lovers. In contrast, cognitive empathy, which is also sometimes referred to as theory of mind or perspective taking, is the ability to accurately imagine another’s experience and respond in almost similar or supportive manner. Emotional and cognitive empathetic components may not have an effect unless the person decides to take action; this is known as empathetic concern (Salovey & Mayer, 2008). Empathy is defined as an affective response that stems from the apprehension of another person’s emotional state (Eisenberg & Liew, 2009).

The ability to empathize is an important part of social and emotional development. Behavioural adjustments plays an important role to the nature of relationships. Researchers and socialists agree that human beings have a limited capacity to demonstrate empathy or empathy-related behaviour to other people for prolonged periods of time due to emotional exhaustion (Hastings, Zahn-Waxler, & McShane, 2006). Factors affecting an individual’s behaviour toward others determine how they respond to the behaviour. The factors identified as essential are empathy in training environment, emotions and daily life, emotional intelligence, social competence, self-determination and adaptation into new roles. Positive regard attracts positive responses thus higher possibility of improving the quality of social, professional or therapeutic relationships (McDonald & Messinger, 2013). The limited capacity to empathy could be associated to the developmental and sustainability of empathy and empathy-related behaviors.
2.2.2 The context of empathy in nursing profession

Nursing practice aims at promoting autonomous and collaborative care of individuals of all ages, races, families, groups ad communities, sick or well and in all settings (ICN, 2013). Empathy plays an important role in nursing care because it helps the nursing profession retain its uniqueness and ensures nurses apply the professionalism in clinical situations. Prescribed as essential or related to the expected performance of an individual nurse. Such a nurse is believed to be ready; emotionally, socially, and possibly able to offer empathetic concern. Training nurses is a noble responsibility for the noble profession and nursing faculty share the pride of achieving professional responsibility. Preparation for nursing practice must inculcate responsible professionalism by development of empathetic competence through development of positive emotions, good behaviour, effective communication, and rational leadership.

To perform the activities that reduce risks for exhaustion as prescribed by the professional standards, the nurses as individuals or groups are expected to be able and willing to listen, hear, understand and respond to emotional wellbeing of their professional colleagues and clients. To survive the intensity of the daily activities of a nurse, she requires high emotional intelligence and good social preparation for the world of work. Regardless of the preparation and in-service empathy interventions, high emotional load in nursing practice presents a higher risk for burnout, stress and social fatigue for nurses (AACN, 2010).

Development and sustenance of empathy among nurses will reduce the risks and encourage longer stay in the same health facility. Golman (2003) claimed that, 20% of individuals’ success is predicted with cognitive intelligent and 80% of it depends on their emotional intelligence. We can therefore argue that, although cognitive intelligence is key to learning, emotional intelligence is
the key of how learning and achievement is attained. To improve empathy, we need to offer more emotional preparation for the nurses and other members of healthcare delivery teams.

Finally, emotional intelligence makes it possible to develop and practice empathy. Interventions to develop emotional intelligence are designed to promote the ability of an individual to perceive, assess and manage emotions of his own self and of other people (Morrison, 2012). Nursing practice gives nurses their professional recognition as professionals who offer qualified caring the journey into achieving the requisite qualifications is accompanied with opportunities to improve. Patients who have an advantage of encountering nurses who have empathy qualities are ready in showing empathy achieve better health benefits in an expedite rate. At the exit of training, it is a professional expectation that a qualified nurse has achieved the prescribed competence, skills, wisdom and are not be limited in their empathy abilities (Karani and Kang’ethe, 2008).

2.3 Perceptions of empathy in nursing practice

Perceiving empathy as an observable or non-observable stimulus is an interesting process to figure out how humans use behaviour/actions to connect to other humans. Empathy builds on a likened emotional believe that humans have the capacity to develop empathy within self and demonstrate it to other people. When stimuli are not perceived, they might either not be coded for storage, or their threshold might have not reached the levels that initiate memory processes. What about the receptors of those stimuli? What about the message-transporting channels? Human beings have intricated, shared neural circuits in motor, sensory, and emotional (limbic) areas of the brain to help them understand the experience of others, leading to caring and helping behaviors. In other words, stimuli and perceptions dominate responses. Empathy and related behaviour tends to
increase in both frequency and complexity with age and experience of individuals (Eisenberg, Fabes, & Spinrad, 2006).

Emotions rule our daily lives. Salovey (2007) termed emotions as “organized and short-term responses to stimuli, crossing the boundaries of many psychological subsystems, including the physiological, cognitive, motivational, and experiential systems”. Since emotions affect our behaviour and the decisions that we make could be termed as emotional, such decisions might impact us and influence our near acquaintances in a considerable emotional measure. Empathizing means we leave our comfort zones and delve into another person’s situation/phenomena and socialize with them within their imaginary or actual social-emotional environments.

In perceiving an emotional stimulus, it moves the empathizer, in most cases, to a vulnerable status. This perception could lead to exposure into emotional instability, injury or contagion. Positive targets of empathy therefore, promote positive energy and yield positive professional feedback results for nurses. Evidence suggest that empathy motivates nurses to becoming more likely to persist in helping and caring for patients, regardless of the patients’ emotional or intellectual abilities (Odom-Forren, 2007). The persistence in helping relationships by nurses may be due to tolerance, kindness, understanding and selflessness. Nurses persist to help and care for the patients even when patients are difficult, hospital managements are oppressive and even when the nurse is socially and emotionally fatigued.

Relevant experiences for empathizers suggest that in daily life experiences, perceptions and communicative perspectives involves organized values and empowering experiences that motivate both the giver and the receiver of empathy (Goleman and Whitener, 2012). Behavioural responses have a certain way for imparting positive or negative reinforcement. Positive perception of
empathy provides initiatives for repeating the experience whereas hurting experiences demotivate empathy. Such vulnerability causes difficulties in establishing positive attitude towards empathy.

2.4 Developing empathy in nursing practice

Traits of empathy have been reported as both intrinsically and extrinsically motivated. Although imitation plays a significant role in individual of team aspects of learning, empathy has proved to be both naturally learned and professionally trainable set of skills (AMA, 2013). In nursing for instance, social and professional identity suggests that nurses can explore such opportunities in developing their own empathy traits.

2.4.1 Social role identity

Human beings are social beings. Social identity forms the basis of socialisation and learning. All human processes involve a degree of learning or unlearning. In learning for instance, the learners’ social experience and environment plays an influential role. Developing human character or social identity requires a set of influences which has both social and emotional influence to the subject. Social skills involve emotions in professional nursing practice (ACHE, 2014). Being a skilled nurse leader means being a friendly servant or subject to the leadership of others. A good leader is like a good teacher; these have a chance to lead and learn something new, in a new and improved way, every day as they lead and teach others. According to Gehres (2011), leadership skills help those in leadership and those in service to offer quality leadership and service, because in good leadership, good service quality is free. Gehres (2011) proposed that for leadership to promote development, those in leading positions must be able to know where to start, when to start and why to start a development plan. This helps in mapping the scope of responsibility which further helps the professionals to be aware of all they should.
For Kenya, a good mix of societal and social identities co-exist. In the context of social development and emotional locus in empathy development, nurses recognise that showing clearly defined leadership and empathy skills to patients at all levels would have a largely positive impact on the position of nurses in the society, and effective management of social and professional relationship will propel this country into higher levels of sustainable health care practices. General perspectives of competence development argue that professionalism involves practical and steady nurse as a social identity (AMA, 2003).

2.4.2 Professional role identity

Healthcare constitutes of interdisciplinary interactions. Giving an ardent example in nursing, nurses altruistically offer their care empathetically within the therapeutic environments; nursing homes, hospitals, schools clinics and other clinical encounters. In each clinical encounter, the nurse’s behaviour can be easily accepted if she uses the concept of emotional reasoning more than often. Emotional reasoning is a type of connection between the care provider and care giver that is used to inform clinical empathy. In relation to nurses’ practice and delivery of healthcare, Coulehan et al. (2001) defines empathy-related behaviours as the efforts that a nurse makes to empathetically respond to patients’ needs.

Empathetic responses can be influenced by a number of variables; gender, personality traits, interpersonal style, social culture, status of the working environment and the effectiveness of communication skills that have been applied across the healthcare delivery system (Alligood, 2000). In medicine, nursing and other healthcare professions, a good deal of learning the skill and competences goes into the preparation before certification or licensure to practice. Practicing medicine or related disciplines requires proficiency level or expertise to build social-therapeutic
relationships. Social relationships rely on emotional communication of needs, care and ability to thrive in a peaceful environment. Empathy related behaviours include and are not limited to kindness, gentleness, effective listening and communication, accurate social imagination, peacefulness, compassion and a caring attitude.

2.4.3 Challenges in developing Empathy

Developing empathy is both socially and professional involving. Any skill that has a higher emotional involvement requires higher social, emotional and professional support; this is usually not an easy task to do. Although it is easier said than done, we find difficulty of assuming another person’s situation temporarily. No matter how temporarily it may seem, it leaves some untoward sub-conscious after taste. Several encounters and prolonged performance in the emotionally demanding environments like hospitals predisposes to emotional fatigue. It is possible that developing empathy doesn’t cross over the healthcare provider boundaries (Gray, 2009).

The main challenge in emotional support for persons in patient care is that empathy is professionalized. In some occasions, empathy exhaustion can progress to emotional guarding or emotional numbness. This status of numbness is associated with continual hurt, loss of motivation and frustration acquired from investing into other people’s situations without the adequate skill for maintaining a healthy distance from the situation. However, some situations are so contagious that if we have not fully developed our prowess in empathy we have little option but to delve completely into them. In nursing practice, there care isolated cases of massive trivialization of nursing efforts by public and some patients with accusatory, relatives of patients. It can be a worse experience in circumstances when the patients, hospital staff and the public take nurses for granted. Nurses have emotional needs, too.
2.5 Sustaining Empathy in Nursing Practice

Sustaining empathy is important because it helps nurses survive from a stressful, emotionally exhausting work environment thus reducing the risk for burnout, disability, stress and high absenteeism (Fitzpatrick, 2014). The nurses who have empathy are easily aware about self-empathy and empathy needs of patients. These nurses have the ability and motivation to listen to patients concerns, hear them with the ‘inner ear’ and communicate effectively with patients. Basically, the overall qualities and demeanour achieved through sustaining empathy is the nurses’ ability to relate to people with regard and care.

2.5.1 Nurses knowledge, attitude and integration of empathy in daily nursing practice

Knowledge and knowledge management have been largely associated with professionalism and as major determinants of professionals’ commitment to their professional responsibilities. In this context therefore, inadequate knowledge result into inefficiencies and thus leading to failure to meet various professional expectations. Knowledge on empathy, its indicators and strategies to sustain it among nurses has been incredibly low (Oliveira and Moura, 2013). Expectation for empathy skills is considerably high among practicing nurses; it is never an excuse for lack of empathy knowledge or empathy attitudes or integration of empathy in nursing care. Inadequate knowledge may predispose nurses to error because of missed opportunities to acquire new and progressive information and (Mahmoud and Bayoumy, 2014).

Sustainability of empathy largely depends on the perspectives and practices that determine how empathy and values of caring are managed. Caring involves understanding the needs that require to be met and making sure that those needs ae met. This knowledge Management of empathy in nursing includes self-management, positive attitude towards empathy, and institutional support on
nurses’ wellbeing and their values of empathy. Lack or inadequate knowledge about how to integrate empathy in nursing practice is a functional gap. Functional gaps affect efficiency, effectiveness and quality of performance. Increase in workload and increased turnover tendencies/rates in nursing result into needs for capacity building for sustaining empathy. Sustaining empathy is increasingly being highlighted as an important strategy to improve quality of health care having been linked to improved patient satisfaction, better health outcomes, and cost-effective care (Cosgrove, Fisher, Gabow, Gottlieb, Halvorson, James and Toussaint, 2013).

A study conducted in Nigeria on integration of behavioural competences in nursing practice and the factors considered influential in the application of theoretical models in promoting nurses’ wellbeing the findings reported showed that the combination of all predictor indicator variables provides an holistic approach for intervention. The factors considered were knowledge, institutional support, professional preparation, and attitude towards the intended or expected outcomes of interaction/transaction of care. Attitude had a positive influence on the persistence in the skill perfection or intervention to improve the skill whereas knowledge factor had the most intended influence and a positive predictive value on behavioural adjustment for interventional processes (Adeyemo and Olaogun, 2013)

2.5.2 Relationship management for sustaining empathy growth

Empathy has a commonly associating global view with highly diversified and specialized modulation of human responses to yield a socially acceptable functional relationship. Nursing care delivery and maintenance of social wellness of patients, nurses required to manage the therapeutic relationships effectively. While emotions are organized responses to immediate stimuli, human beings have demonstrated capacity to develop skills to show empathy to others. Every humanistic
interaction has emotional load and social perspectives. Empathy is closely related to special motivational values of altruism and empathetic responses. Humans are well described as self-determining their actions and behaviours. Positive and negative emotionality have an impact on empathy and empathy related behaviour towards self or others. Socialization as a process requires empathy to be a founding feature and value for forming relationships amongst humans.

Limited skills in relationship management during training, empathy is expected to be attained, somehow along the cognitive and technical practices of the nursing role. Sometimes, however, the training may overlook the empathy facet of contemporary nursing practice (Bellack, 1999; Rochester, Kilstoff, & Scott, 2005). Emotions involved in making and sustaining human relationships affect the type and quality of relationships established among people all over the world (Decety, 2007). Emotional - social competence is recognized as a causal attribution of helping relationships and those individuals thought to be emotionally intelligent are compassionate (Goleman, 2006). Nurses recognize that empathy plays a key role in offering nursing care for patients. Nursing roles are multidimensional and involve constant commitment to patient wellbeing (Hastings, Zahn-Waxler, & McShane, 2006).

2.5.3 Capacity building for sustaining empathy in nursing

The indicators for a well developing profession are so distinct and specific to the profession, however, the beauty of professionalism is that all those with these qualities have a positive and a supportive attitude towards self, others and the environment where they live and work. Empathy has a lifelong endeavour; to keep improving. While providing additional training for nurses, it should be recognized that training materials, guides and mentors are not for mere transfer of
knowledge but organized to provide caring experiences and capabilities that help achieve outstanding empathy in nurse role performance (Goleman, 2001).

Research has indicated that self-awareness and affective social competence determines sustainability of nursing empathy (Goleman, 2006). The processes involved in preparing nurses for professional practice are effective listening skills (Frenk & Chen, 2010). Effort to train those who can listen and feel another’s emotions is changing. It is important to know whether the trainees can accurately identify self and another person’s emotions and respond professionally and accurately to health needs that demand such responses. The road map to continual intelligence and competence development is entirely based on professional collaboration between nurses, teachers and the clinical mentors. In nursing, a continuous quality assurance, an evidence-based approach to teaching and practice, continued competency development and sustenance aimed to improved. Self-management is highly considered as a precursor for higher professional competence and performance. Examples of self-management are enlisted in the society leadership and managerial excellence which involves rational expense, taking calculated risks, reducing the frequency of complaining and engaging into intellectual bargaining and listening to others (Morrison, 2012). Those with these competences are better placed to take the responsibility of developing their empathetic competence, improving the quality of their guesses and developing social competence (Crosby, 2009).

### 2.5.4 The role of empathy in reducing nurse turn-over tendencies

High nurse turnover in healthcare facilities results into reduced population of nurses and poses a risk for vulnerability, risk for emotional contagion, mental exhaustion and burn out. Nurses’ shortage is getting worse and will negatively affect the ability of hospitals to meet patient needs
and provide quality healthcare (Chiu, Chung, Wu and Ho, 2010). The increased burdens for the remaining nursing staff, decreased work satisfaction and reduced abilities to show empathy are indicators of strained environment within where empathy can be adequately practiced. In nursing profession, learning for leadership recognizes that nursing roles are multidimensional and an ongoing commitment to develop and maintain professional competence in the nursing practice is essential (Reiss, 2015). Empathy plays a role in maintaining nurses’ organizational interest and promotes commitment to professional engagement. When nurses empathize with the employer and patients, institutional cohesion is established and tendencies for turn-over are largely reduced. Lack of clearly defined roles may present conflict of interests and negative group dynamics. Empathy improves recognition of professional common sense, improved work ethic, organizational skills, knowledge management and cultivate interest in lifelong and continued learning (Bellack, 1999).

Empathy interventions suggests that leadership style drove up nurses’ engagement in nursing duties and responsibilities by directly improving hospital climate. When the hospital management were showing empathy to other employees and exercised flexible in leadership style nurses tended to be motivated and patients’ care was improved. When nurses are empowered with empathy, they demonstrated a variety of emotional intelligence abilities, nurses’ attitudes were positive and patients’ healthcare quality higher. Effective nurse leaders not only created a working climate conducive to achievement but were more attuned to nurses’ perceptions of such aspects of climate and organizational health as clarity of vision and level of teamwork (Goleman, 2006).
2.6 The paradigm of inquiry

2.6.1 Introduction of the paradigmatic approach

A paradigm of inquiry is the guiding principle through which philosophical basis, theoretical assumptions and intellectual structure of a research and development in a field of inquiry is based (Kivunja and Kuyini, 2017). The term paradigm is used to describe a researcher’s ‘worldview’ My worldview on empathy is laced with complexities multifaceted and compound ideologies about developmental and practical aspects of human relationships. Importance of expressing a personal world view is that it helps the researcher describe his reality, experience in the context of the problem at had. Upon critical consideration of his world view, the researcher explored the nature of the topic of study and chose pragmatic paradigm of inquiry; because pragmatism is more focused in describing human behaviors that may require a lot of flexibility in the mythology. Pragmatism is assumed to enrich factual perspective with social values and interests, analyze human behaviour and propose interventions that would benefit people stimulate critical thinking and appraisal of various schools of thought or set of shared beliefs and therefore inform the process of deriving the meaning or interpretation of research data (Mackenzie & Knipe, 2006).

2.6.2 The pragmatic paradigm of inquiry

Pragmatism arose among philosophers who argued that it was not possible to access the ‘truth’ about the real world solely by virtue of a single scientific method as advocated by the Positivist paradigm, nor was it possible to determine social reality as constructed under the Interpretivist paradigm (Kivunja and Kuyini, 2017). For them, a mono-paradigmatic orientation of research was not good enough. Rather, these philosophers (such as Alise & Teddlie, 2010; Biesta, 2010; Tashakkori and Teddlie, 2003a, and 2003b; Patton, 1990) argued that what was needed was a
worldview which would provide methods of research that are seen to be most appropriate for studying the phenomenon at hand. Therefore, pragmatism vouches for approaches to research that could be more practical and pluralistic approaches that could allow a combination of methods that in conjunction could shed light on the actual behaviour of participants, the beliefs that stand behind those behaviours and the consequences that are likely to follow from different behaviours. This paradigm that advocates the use of mixed methods as a pragmatic way to understand human behaviour – hence Pragmatic paradigm. So, pragmatism advocates a relational epistemology (relationships in research are best determined by what the researcher deems appropriate to that particular study), a non-singular reality ontology (that there is no single reality and all individuals have their own and unique interpretations of reality), a mixed methods methodology (a combination of quantitative and qualitative research methods), and a value-laden axiology (conducting research that benefits people) (Martens, 2015).

Pragmatism is a philosophical construct that is usually progresses an outcome-oriented approach which is interested in determining the meaning of phenomena and mainly focusing on the product of the research to inform interventions and improve professional practice (Biesta, 2010). It is characterized by an emphasis on communication and shared meaning-making interactions to create practical solutions to socially attributive problems. Pragmatism is based on the belief that theories can be both contextual and generalizable by analyzing them for transferability to another situation. The pragmatic researcher is similarly able to maintain both subjectivity in their own reflections on research and objectivity in data collection and analysis and events that interact in an observable, determinable, predictable, flexible and socially/professionally regular in manner that promotes social identity and unity (Collins, 2010).
Research located within this paradigm demonstrates the following characteristic advantages:

i) A search for useful points of connection within the research project that facilitate understanding of the situation/phenomenon under study.

ii) Seeking to utilise the best approaches to gaining knowledge using every methodology that helps that knowledge discovery.

iii) Adoption of a worldview that allows for a research design and methodologies that are best suited to the purpose of the study.

iv) Choice of research methods depending on the purpose of the research.

v) The use of what works to allow the researcher to address the questions being investigated without worrying as to whether the questions are wholly quantitative or qualitative in nature.

vi) Utilising lines of action that are best suited to studying the phenomenon being investigated.

Pragmatism provides for the opportunity to conjure either or both observable phenomena and subjective meanings can provide acceptable knowledge dependent upon the research question. Focus on practicality and application of research to integrating different perspectives of same or similar concepts to help interpret the data is a key strength of pragmatism.

2.6.3 Epistemological perspectives of empathy

The concept of epistemology according to the Stanford dictionary of philosophy (2009), also cited by Bracken (2006), "is about description of issues that relate with the creation and dissemination of knowledge in a particular area of inquiry". Inquiry into human social epistemology of concepts (in this case, development and sustainability of empathy) is strongly rooted in scientific methods of investigation akin to the deduction of certainties surrounding psychosocial attributes of healthcare sciences, and logic as applied in nursing. With the control and monitoring of external
conditions (factors with directional influence) surrounding discourse(s), experimental outcome is likely possible to reveal the absolute truth about human behaviour connected with what constitute development that is sustainable, not only in addressing present empathy needs, but also for the good of future of empathy in nursing.

In the view of historical evolution and trends of empathy (ematheia to en-pathos to Einfühlung to empathy to clinical empathy) there is a degree of consistency in passion, compassion and the drive to alleviating suffering. Empiricism suggest that clinicians’ empathic access to the various types of patients’ emotional experiences is a direct process. This process is conceived as analogous to the process of direct observation in the natural eye-to-eye situations and it has presumably maximum accuracy, likening it to the process of vision, however with an ‘inner eye’ (Leuzinger-Bohleber, 2017). Empathy is such an important concept that knowledge has been categorized into cognitive, emotional, behavioral, and moral capacities to understand and positively respond to the suffering of others. Integrating empathy in actual practice is associated with ability in showing compassion; compassion is a tender response to the perception of another’s suffering. In other words, empathy and compassion co-exists in that compassion cannot exist without empathy, as they are part of the same perception and response continuum that moves human beings from being an observer to intervening.

Clinical empathy is the skill-ability to apply empathetic skills in clinical settings during preparation and implementation of care to patients while conforming to professional values and code of conduct of nursing. Indicators for empathy need are generally expressive phenomenon that can be grasped from patient’s physical concomitants such as facial expressions, tone of voice, eye-contact, spontaneous movements by direct observation. However, emotions in general and their
mental experience as feelings cannot be reduced to their associated observable behavioral, especially facial, manifestations which are only their clinical indicators (Damasio, 2009).

My viewpoint in the context and focus of epistemological perspective of empathy is that the nurses’ knowledge on self-empathy and how empathy is applied in care of patients has an influence on whether capacity building is needed or not. Based on this viewpoint, I decided to conduct a need analysis so as to design a user customized intervention. I also assumed that a needs analysis would provide rationale and justification for a capacity building empathy intervention. Owing to the psychosocial nature of empathy and the social sensitivity it commands, I needed a variety of data collection methods and sources (triangulation). The tools included an observation checklist, a self-administered questionnaire and a focus group discussion in collecting data for needs analysis.

2.6.4 Ontological perspectives of empathy

Ontology as defined by Reiss (2017), "is an explicit specification of a conceptualization"; in philosophical concept, this is described as a systematic account of 'existence' and being (Crotty, 1998). The existence of concept such as development and sustainability of empathy, can generate critical discourses amongst scholars based on reality differences between cultures, people/communities and its measurement (through quantitative and [or] qualitative parameters). The quest for pursuing understanding of existence of empathy as a social trait also leads to a formal pursuance of the concept of developing empathy as a professional need.

Contextualizing ontology into a perspective within a pragmatism requires an objective search for existing reality (empathy training needs) within a specified study environment (nurses’ world of work – clinical settings). The reality is consistent with the worldview of empathy competences as
The study setting for establishing this view was clinical settings; where nurses offer care to patients. The intention for reality check was to justify available chances for capacity building through a continuous professional development [CPD] empathy training intervention. Empathy training intervention in clinical settings, requires clarity on the clinical objectives of empathy in nursing practice. Clinical empathy in nursing practice serves two objectives; comprehension and explication. In comprehension, the analyst perceives what the patient is experiencing at a specific moment and observes how the nursing care provider communicates in a verbal or non-verbal manner that the patient’s perspective and experience is understood. In explication, the analyst uses this comprehension, accumulated over time, to explain the meaning of the patient’s experience, connecting it with own past experiences (Reiss, 2017).

In the current empathy needs analysis, a continuum basis of empathy was applied, whereby empathy was viewed as composed of three continuums: the identification of needs continuum, the intervention continuum and post intervention continuum. In the view of these three continuums, it is further proposed that since empathy exists in two dimensions: a non-verbal/facial dimension that is timeless, existing only in the here and now, and a verbal dimension that is necessarily in time and involves communication, such observations should not be ignored. This perspective, if not well understood and conducted, can result into social desirability bias (Basavanthappa, 2014). Experience and motivation promote explication and therefore a careful analysis is intended. Important research on empathy and altruism has demonstrated that enhancing perspective taking, the capacity to see a person’s situation from his or her point of view, coupled with enhanced value being placed on the welfare of those who are unfamiliar can override bias.

Self-empathy is a much-neglected area in need analysis; however, it is necessary to ensure that nurses have relevant and adequate resources to develop and sustain empathy toward others.
However, when emotionally overloaded, overwhelmed, exploited, or burned out, the capacity to show empathy declines as a result of the degree of emotional labor expended. As noted earlier, self-care can be superseded by fatigue, emotional exhaustion and frustration thus leading to medical errors, depression and in some circumstances, losing temper. It is critical that nurses exercise self-care and self-empathy to maintain healthy levels of empathy for their patients (Reiss, 2015).

2.7 Theoretical perspectives for the study

A theoretical perspective is the philosophical standpoint that informs the construction of concepts and variables of a research. They also guide methodology and provide a context upon which the research process is logically executed while maintaining the paradigmatic criteria (Wedge, 2009). On a larger scale, the explication of the theoretical perspective that has been used is what enables peer researchers to replicate a candidate’s research to strengthen confidence in the conclusions that have been drawn (White, 2013). Theoretical perspectives of research contain many factors. These factors can be grouped together in ways that, on one hand, represent the contribution that they make to research, and, on the other hand, to reflect their roles in the structure and dynamics of conceptual model/theory-building. Theoretical basis of improving nursing practice and developing empathy training models is a exercise wherewith a search of adding value and substance has its prime target. Such exercises have achieved great results for nursing; as a scientific, an academic and a professional body of knowledge. The practice of theoretical basis of intervening for professional growth is a scientifically proven model of sustaining a competence organized profession. The whole point of this model is to develop a holistic, ready and creative nurse who has a holistic view of a person who is in the need for nursing care. This involves holistic analysis of needs and evidence-based intervention (Alligood, 2011).
2.8 Theoretical framework of the study

2.8.1 The concept of the theoretical framework

The theoretical framework for this study is a constituent of three theories. Firstly, theory of goal attainment and transactional process by a nurse theorist, (Imogene King, 1990). Secondly, a psycho-motivational theory whose focus is the concept of self-determination by psychologists (Deci and Ryan, 2010). Thirdly, the new science of human relationships whose focus is on social and emotional intelligence. The scope of this study could only allow contribution from the emotional intelligence theory by a psychologist - behaviourist (Goleman, 1995). Integrating goals of nursing and psychological perspectives of motivation and self-determination helps in the construction of empirical basis for variables of this study to contribute the science.

, the theoretical framework is effectively used to conceptualize the nature of the research problem, its basis and the analysis that are appropriate in the process and procedures that are chosen to investigate the problem. When a variety of checkpoints are used to demarcate the scope, the framework determines how ideas are perceived, as in how we make sense of research gaps identified, and the blue print upon which data is interpreted (Grant and Osanloo, 2014).

2.8.2 Theory of goal attainment and transactional process

Integrating the goal attainment theory in development and sustainability of empathy in nursing was decided on after a series of critique and considerations of the constructs of the model. Recognising, understanding and responding to empathy by nurses was conceptualised as a non-biased transactional process of attainment of nursing professional goals of care. Analysing this theory forms the basis of variable conceptualisation.
2.8.2.1 The process of interaction

Imogene King (1990) has interrelated the concepts of interaction, perception, communication, transaction, self, role, stress, growth and development, time, and space into a theory of goal attainment. Her theory deals with a nurse-client dyad, a relationship to which each person brings personal perceptions of self, role, and personal levels of growth and development. The nurse and client communicate, first in interaction and then in transaction, to attain mutually set goals. The relationship takes place in space identified by their behaviours and occurs in forward-moving time until a transaction is achieved whereas a feedback loop is mutually inclusive as shown in figure 2.1.

![Diagram of Imogene King's Theory of Goal Attainment](image)

**Figure 2.1: Process of nurse – patient transaction**
King (1990) describes nursing as a process of action, reaction, and interaction whereby a nurse and a client share information about their perceptions in the nursing situation. This process involves various perspectives; physical, cognitive, psychological and emotional. The nurse and client share specific health related goals, care problems, and situational concerns. This mutuality forms the basis upon which they explore means to achieve a positive health outcome. The health outcome is not limited to wellness or wellbeing. Apart from being a continuum, health is considered as a fluid model of dynamism. King (1990) defines health as a dynamic life experience of a human being, which implies continuous adjustment to stressors in the internal and external environment through optimum use of one’s resources to achieve maximum potential for daily living.

2.8.2.2 Dynamic conceptual systems

King (1990) identified three major concepts of human interactions and calls them the dynamic conceptual interacting systems or open systems framework. These include personal systems, interpersonal systems and social systems. The open systems framework further identifies the constructs of existence and structure, function in reciprocal relations of individuals in interaction, allocation and utility of resources, and decision making in attaining system goals. Theoretical assumptions (King, 1995) on the open systems framework, states that “each human being perceives the world as a total person in making transactions with individuals an things in the environment” and transactions represent a life situation in which perceiver and thing perceived are encountered and in which each person enters the situation as an active participant and each is changed in the process of these experiences. In the context of empathy and interpersonal relationships between nurses and clients, the empathiser and the target enter the therapeutic relationships as active individual systems whose interactions or transaction in care changes because of understanding, social imagination and intervention.
According to King, an individual (self) is a personal system that has composite of thoughts and feelings which constitute a person’s awareness of his individual existence, his conception of who and what he really is. The self includes a system of ideas, attitudes, values, and commitments. The self is a distinctive centre of experience and significance. The ‘self’ constitutes a person’s inner world and therefore is the individual as known to the individual. An individual is entitled to some growth and development; the processes in people’s lives through which they move from a potential for achievement to actualization of self. This growth can be influenced by self-concept, space and time. Personal system is highly characterised by potential for development in different capacities and abilities of leaning new concepts, behaviours and skills (Fitzpatrick, 2014).

Figure 2.2: Dynamism in human interactions (Adapted from King, 1990)
Self-concept is shaped by self-image that is manifested through social imagination within the personal system. Influences of immediate social environment and time spent in the attempts to fit into plays a significant role in goal attainment. King defines body image as the way one perceives both one’s body and others’ reactions to one’s appearance. Positive self-image has a positive influence on the nature and view of another person’s image. Space includes the environments which exists in all directions around an individual, is the same everywhere, and is defined by the physical area known as “territory” and by the behaviours of those that occupy it. Time is a determinant in a variety of phenomena; the duration between one event and another as uniquely experienced by each human being; it is the relation of one event to another event (Alligood 2011).

Development and sustainability of various roles can be challenged by untoward influences within interpersonal systems. These influences are identified as stress; a dynamic state whereby a human being interacts with the environment to maintain balance for growth, development, and performance, which involves an exchange of energy and information between the person and the environment for regulation and control of stressors. Further clarification about delimiting stress is constructed in the empowering of individuals in an interactive system. Power is social force that organizes and maintains society. To empower nurses therefore can be insinuated as giving them the ability to mobilize and use resources to achieve nursing care goals (King, 1990).

2.8.2.3 Empirical implications

The analysis of the theory presents three main areas where clarification can be improved by conceptualising variables that are specific to the gaps identified. The analysis is summarised below

1. The citation of the individual being in a social system was not clearly explained considering that the social system encompasses other concepts and sub concepts in her theory.
2. The model presents *interaction* which is dyadic in nature which implies that its applicability cannot be adapted to unconscious individuals.

3. King (1986) added *learning* as a sub concept but didn’t elaborate what type of learning would be required to achieve the goals of interpersonal systems in nursing. The needs analysis is proposed to identify learning needs as pertains to empathy in nursing practice.

**2.8.3 The Emotional Intelligence (EI) Theory**

A large body of knowledge related to emotional intelligence exists outside nursing. Due to the nature of inquiry for this study, emotional intelligence will improve the quality of variables and facilitate empirical triangulation across epistemological, ontological and methodological concepts. Emotional Intelligence (EI) theory and research within nursing is a more recent phenomenon. A broad understanding of the nature and direction of theory and research related to empathy, EI is crucial to building knowledge within this relatively new field of inquiry.

Goleman (2003) claims that learning has an emotional perspective to it. Further claims indicate that, 20% of individuals’ success is predicted with cognitive intelligent and 80% depends on their emotional intelligence. This research therefore introduces the emotional intelligence theory with a binary standpoint that, although cognitive intelligence is key to learning, emotional intelligence is the core determinant of how learning achievement is attained. Emotional intelligence recognises communication and information processing by their respective degrees of institutionalization. The institutionalization of information refers to the degree to which culture recognizes information as important, records its meaning an acknowledges expertise in the area (Mayer, Salovey and Caruso, 2014).
The Emotional Intelligence Theory [EIT] recognises personality traits that relate to human wellbeing and abilities that are linked to what people feel about themselves and how they feel about others (Goleman 1995). The EIT Personality traits determine whether someone has the capacity to understanding emotions about self and emotions of others. This model focuses on the quality of the performance as an outcome. Emotional intelligence describes emotions and how they interfere with individuals’ abilities to perform. This perspective recommends what humans require emotional intelligence to be successful. Contemporary literature associate emotional intelligence to common sense, work ethic, organizational skills, team spirit, and interest in continued learning (Bellack, 1999). Goleman (2006) identified these qualities as attributes to emotional intelligence, social performance and ability to consistently show empathy. EIT has four main constructs identified as domains.

This social positioning is vulnerable and exposing to risk of judgment, psychological injury and emotional fatigue for a person socially imagining self in another person’s perspectives. According to Goleman (2006), emotional intelligence involves the elements of effectively recognizing and handling own feelings, emotions and relationships, empathy, and finding stable sources of individual and social group motivation. Emotional intelligence provides the benchmarks essential in developing and portray empathy related behaviours. Emotional intelligence of persons showing and receiving empathetic concern. We therefore suggest that the nature of social cues identified from persons can be guide in determining the accuracy of social imagination and emotional connection between nurses and recipients of nursing care. Goleman (1995) recognises two main perspectives upon which emotional intelligence can be conceptualised for further inquiry. Firstly, recognition of the strategic locus of self and social awareness are relates to important competences of empathy. Secondly, capacity for regulation of self vis-a-vis relationship management.
Therefore, the contention of this study supports the notion of refocusing our efforts on development and sustainability of emotional intelligence considering human variance and individual difference in empathy intervention as shown in figure 2.3.

![Emotional Intelligence Model](image)

**Figure 2.3: Emotional Intelligence Model (Goleman, 1995)**

Emotional intelligence theory proposes accurate social imagination as the ability to correctly perceive and respond to another person’s situation of need. The accuracy is subject to: understanding of own feelings, listening to others and to hear them, and expressing the understanding in a productive manner (Goleman, 1995). Emotional Intelligence (EI) has been an area of interest over the last two decades with many authors and scholars argue whether it is
different from Intelligence Quotient (IQ). A person’s situation (situation is commonly called; the other person’s shoes) and to reflect in another person’s perspective.

2.8.3.1 Empirical implications

The analysis of the emotional intelligence theory presents two main areas where situational clarification can be improved by conceptualising variables that are specific to intended empathy interventions in nursing. The analysis is summarised below;

1. The citation of self-awareness as a hallmark of establishing relationships corresponds to intrinsic variables of empowerment of self to perform realistic self-assessment.
2. EI recognises empathy as the ability to understand the emotional makeup of other people; a skill in treating people according to their emotions.

2.8.4 The Self-Determination Theory (SDT)

SDT is an organismic dialectical approach (Deci and Ryan, 2000). It begins with the assumption that people are active organisms, with evolved tendencies toward growing, mastering ambient challenges, and integrating new experiences into a coherent sense of self. These natural developmental tendencies do not, however, operate automatically, but instead require ongoing social nutriments and supports. That is, the social context can either support or thwart the natural tendencies toward active engagement and psychological growth, or it can catalyse lack of integration, defence, and fulfilment of need-substitutes. Thus, it is the dialectic between the active organism and the social context that is the basis for SDT’s predictions about behaviour, experience, and development.
SDT (Deci and Ryan, 2000) is a motivational theory that is concerned with supporting our natural or intrinsic tendencies to behave in effective and healthy ways. Self-determination constructs can be applied as a focus on deciding what to know, do or ignore based on whether the experiences evoke within individuals as they seek to demonstrate social awareness autonomy, competence and efficient performance. SDT supports the intuition and performance of assigned duties and professional obligation. SDT identifies autonomy as a psychophysiological need (Ryan, Patrick and Williams, 2008). The theory identifies three main domains for survival and sustainability; autonomy, competence and relatedness as shown in figure 2.4

2.8.4.1 Autonomy

In autonomy, human beings are perceived as individuals who are able to adequately and rightfully choose what they do or believe. The persons are subject to their own choice of thoughts, actions, reactions or responses to environmental stimulation. Humans live in social environments; a shared plethora of experiences contagiously influence human beings. In this context therefore, we propose the concept of ‘social signalling’. The social signals are a form of human behaviours that indicate a sense or intention for connections. to mean that people send and receive signals for emotional connection and a set of behaviours to display to others. Challenges arise when health-promoting behaviours, such as showing and offering empathy.

2.8.4.2 Competence

The domain of self-determined competence (Deci and Ryan, 2000) combines learning needs to performance of the learned skill; moving from less knowledge to higher knowledge, lower skill to higher skill in both theoretical and practical aspects of performing a skill. Skill development starts with need analysis, skill identification, persuading the trainees to satisfaction of their competence
needs through autonomous relatedness of the need with their professional roles. In such an intense skill-mix for competence development and sustainability, a variety of supportive factors apply.

2.8.4.3 Relatedness

Relatedness concept proposes development and maintenance of close personal relationships such as best friends and romantic partners as well as belonging to groups, is one of the three basic psychological needs. The domain of relatedness requires that the intended competences are developed seamlessly to account for the identified professional or social need. Training skills have been associated with emphasising on competence or task performance abilities. Empathy depends on the level of motivation or demotivation in performing the tasks related to professional responsibility for nurses. To satisfy competence domain therefore, a sustainable motivation has to be established.

Figure 2.4: Self-Determination theory (Adapted from Deci and Ryan, 2000)
2.8.4.4 Formal Theoretical perspectives of SDT

Formally, SDT comprises six mini-theories, each of which was developed to explain a set of motivationally based phenomena that emerged from laboratory and field research. Each, therefore, addresses one facet of motivation or personality functioning (Deci and Ryan, 2000).

1. **Cognitive Evaluation Theory (CET)** concerns intrinsic motivation, motivation that is based on the satisfactions of behaving “for its own sake.” Prototypes of intrinsic motivation are children’s exploration and play, but intrinsic motivation is a lifelong creative wellspring. CET specifically addresses the effects of social contexts on intrinsic motivation, or how factors such as rewards, interpersonal controls, and ego-involvements impact intrinsic motivation and interest. CET highlights the critical roles played by competence and autonomy supports in fostering intrinsic motivation, which is critical in education, arts, sport, and many other domains.

2. The second mini-theory, **Organismic Integration Theory (OIT)**, addresses the topic of extrinsic motivation in its various forms, with their properties, determinants, and consequences. Broadly speaking, extrinsic motivation is behaviour that is instrumental—that aims toward outcomes extrinsic to the behaviour itself. Yet, there are distinct forms of instrumentality, which include external regulation, introjection, identification, and integration. These subtypes of extrinsic motivation are seen as falling along a continuum of internalization. The more internalized the extrinsic motivation, the more autonomous the person will be when enacting the behaviours. OIT is further concerned with social contexts that enhance or forestall internalization—that is, with what conduces toward people either resisting, partially adopting, or deeply internalizing values, goals, or belief systems. OIT particularly highlights support for autonomy and relatedness as critical to internalization.
3. Causality Orientations Theory (COT), the third mini-theory, describes individual differences in people’s tendencies to orient toward environments and regulate behaviour in various ways. COT describes and assesses three types of causality orientations: the autonomy orientation in which persons act out of interest in and valuing of what is occurring; the control orientation in which the focus is on rewards, gains, and approval; and the impersonal or amotivated orientation characterized by anxiety concerning competence.

4. Fourth, Basic Psychological Needs Theory (BPNT) elaborates the concept of evolved psychological needs and their relations to psychological health and well-being. BPNT argues that psychological well-being and optimal functioning is predicated on autonomy, competence, and relatedness. Therefore, contexts that support versus thwart these needs should invariantly impact wellness. The theory argues that all three needs are essential and that if any is thwarted there will be distinct functional costs. Because basic needs are universal aspects of functioning, BPNT looks at cross-developmental and cross-cultural settings for validation and refinements.

5. The fifth mini-theory, Goal Contents Theory (GCT), grows out of the distinctions between intrinsic and extrinsic goals and their impact on motivation and wellness. Goals are seen as differentially affording basic need satisfactions and are thus differentially associated with well-being. Intrinsic goals such as community, close relationships, and personal growth are associated with higher wellness and greater well-being.

6. Relationships Motivation Theory (RMT), the sixth mini-theory, is concerned with these and other relationships, and posits that some amount of such interactions is not only desirable for most people but is in fact essential for their adjustment and well-being because the relationships
provide satisfaction of the need for relatedness. However, research shows that not only is the relatedness need satisfied in high-quality relationships, but the autonomy need and to a lesser degree the competence need are also satisfied. Indeed, the highest quality personal relationships are ones in which each partner supports the autonomy, competence, and relatedness needs of the other.

2.8.4.5 Empirical implications

The analysis of SDT presents three main areas for variable construction. The theory identifies conditions supporting the individual’s experience of autonomy, competence, and relatedness are argued to foster the most volitional and high-quality forms of motivation and engagement for activities, including enhanced performance, persistence, and creativity.

1. Cognitive *evaluation* in metaparadigmatic approach of establishing need for knowledge management and intervention

2. Organismic *integration* of motivation in volition and professional performance

3. Relationship *motivation* in an emotionally intense environments while stabilising causality

2.9 Research gaps identified

Improving healthcare outcomes for the patients is the primary focus of nursing care. Although the primary role responsibility of nurses in their professional undertakings is well defined, there are still prevalence of isolated cases of quality and efficiency compromises. The goal of nursing is that patients are empowered to prevent themselves from falling ill, and when ill access treatment to recover from ill-health and be free from disability. So, patient wellness and wellbeing are the core businesses of care. The care provider is completely forgotten or is assumed to be a supernatural being who has no carative needs to be met. In this view, the analysis of available evidence requires
healthcare providers show and offer empathy but there are no strategies to empower them in how to go about empathy development. The wellness of the nurses is not even mention anywhere in the preparation of the nurses for their world of work.

According to Parker and Smith (as cited in Wagoro et al., 2017), the models that were once developed with impetus to help define the unique scope and domain of nursing fell out of favour with the nurses who neglected and rejected them. Nursing models are criticized for representing specific values and beliefs about nursing from a narrow perspective of individual authors thereby failing to capture what the holistic perspectives of nursing. The Kings’ goal attainment theory could provide a strong basis for developing empathy and other altruistic competences in nursing. However, rarely is the model used as a theoretical framework in capacity building for nursing staff professional development programs. King (1990) recognised learning as a sub-concept in self-system; but did not elaborate what kind of learning is required in the transactional processes in goal attainment.

In the model for emotional intelligence, constructs of self and social awareness and regulation evoked in-depth search for self-concept of own emotional wellness among nurses. Social awareness and development of high levels of self-esteem in practice is also a challenge in nursing; especially in Kenya. Therefore, improvement of self-concept and identification of other feasible recommendations for application of both nursing and psychological theories to practice is critical now. Self-development programs in terms of developing target specific empathy training materials, resources and positive attitudes for improving on core competences of empathy has been lacking. Development of training materials in nursing is a professional responsibility for nurse scholars. Analysis of training files and manuals that are published to date, very little is being done on empathy skill development among nurses. Being a nurse scholar means being a friendly servant
and offer scholarly leadership to fellow nurses. A good scholar is like a good teacher; these have
a chance to teach and learn in an improved way as the strive, search for and share knowledge with
others. Nursing professional has been lately facing backlash from clientele for not ‘knowing
enough’ and this notion or allegation is not a good feedback for any professional who put so much
in the line to care for sick persons.

Nursing profession is unique and should therefore develop and sustain unique qualities of empathy
in its justifiably rightful autonomy, ensure high standards of empathy competence and promote
relatedness of nursing and psychological care of clients. There have been several allegations that
nursing is a woman dominated profession who make bed and manage bedpans. Such trivialisation
of what nurses are and what they do has been of detriment to professional pride among nurses. So,
nurse evaluation from a prejudiced spectrum would yield serious internal validity and bias. Self-
reflection and peer reporting among nurses are therefore preferred for this intervention. Increased
nurse turn-over tendencies have significantly influenced nurse-patient ratios thus the available
population of nurses require capacity building to empower them manage work-related stress and
improve on role relationships.

2.10 Conceptual Model

The study variables were categorised into independent, dependent, and intervening. The
conceptual model of variables was developed to show the relationships and effects between the
independent, dependent and intervening variables. The sequence of the relationship was such that
independent variables directly influenced the dependent variables. Then, the intervening variables
influence both the independent and dependent variables. Independent variables were not
manipulated in this study however, the dependent variables were directly measured and analysed.
2.10.1 The Independent variables

Independent variables are the objects of research interest that the researcher has control over, and if needed, can manipulate them. In some cases, it might not be possible to manipulate the independent variables (Nieswiadomy & Bailey, 2018). The independent variables included intensity of nursing care demands, nurse’s workload, knowledge and skill in empathy adaptation strategies, social awareness, and working environment for nurses.

2.10.2 The dependent variables

The dependent variables are the elements, features or factors that are measured in an experiment (Basavantappa, 2010) or elements whose variance is estimated as an outcome of either a research intervention of other manipulations of independent variables in a research. This research measured three indicators of empathy as dependent variable in categories of; nurses’ levels of knowledge in empathy, professional wellness as a result of emotional demands of patients on nurses and observable characteristics of empathy skills among nurses in nursing practice in the participating hospitals.

Level of empathy knowledge is assumed to influence empathy competence development, transferability and sustainability. The knowledge of factors and their influence on development and sustainability of empathy was compared in two phases before and after training intervention. Other measurements included awareness of missed opportunities an indicator of empathy among nursing colleagues in a peer reporting approach. The factors whose effect size was estimated included: social awareness, relatedness, opportunity to show empathy, intrinsic motivation, multiple intelligences, mentoring nurses on empathy, personal values, extrinsic motivation, an nurses’ professional wellness.
2.10.3 The intervening variables

The intervening variables mediate between independent and dependent variables to achieve a significant or otherwise effect or influence (Nieswiadomy & Bailey, 2018). Intervening variables are extremely important in behavioural studies due to the contribution that it is possible to consider and measure unseen behaviours. This study conceptualized intervening variables as individual’s personality, emotional intelligence, self-determination and professional experience on empathy. The intervention size and overall effect of dependent variables was not measured but empirical support and assumptions were made in the paradigm of enquiry and theoretical framework analysis.

The conceptual model of variables is shown in figure 2.6
Independent Variables
- Nursing care demand
- Nursing care workload
- Empathy knowledge and skill
- Adaptation strategies
- Working environment
- Institutional support

Intervening Variables
- Personality
- Emotional intelligence
- Professional experience
- Self determination

Dependent Variables
Knowledge of Empathy
- Factors with influence
- Missed opportunities
- Indicators
Wellness of nurses
- Role complexity
- Turn-over intentions
Empathy skill mix
- Attitude towards empathy
- Social management

Figure 2.6: Conceptual model for the study  (Gitonga, Karani, Kimani and Mwaura, 2017)
2.11 Operationalization of the study variables

Table 2.1: Operationalization of variables

<table>
<thead>
<tr>
<th>Independent variables</th>
<th>Study Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Variable</strong></td>
<td><strong>Operationalization</strong></td>
</tr>
</tbody>
</table>
| Adaptation to empathy demands by nurses | • Requirements for providing nursing care  
• Emotional constrains  
• Quality of nursing decisions  
• Feeling exhausted  
• Feeling overwhelmed at work  
• Feeling like quitting nursing | |
| Dependent variables | | |
| **Variable** | **Operationalization** | **TNA** |
| Indicators of empathy | • Knowledge of factors influencing empathy  
• Social awareness  
• Professional wellbeing  
• Predictability of positive empathy | |
| Characteristics of empathy among nurses | • Conduct themselves professionally  
• Provides simple and clear communication to patients  
• Shows kindness to others more easily  
• Recognises gender needs equality  
• Has a ready and warm smile  
• Honest to peers and strangers | **ETI**<sup>*</sup>2 |
| Constructivist | • Implementation of empathy training model  
(knowledge, skills and attitudes) | **Training** |
| Training of nurses on development and sustainability of empathy skills in nursing practice | • Theoretical implications of the theoretical framework  
(introductions of the manual)  
• Factors and their effect size on empathy  
• Developing empathy in nursing  
• Sustaining empathy in nursing practice | **ETI** |

<sup>*</sup>1 = The Needs Analysis  
<sup>*</sup>2 = Empathy Training Intervention
2.12 Summary

In this chapter, I have described the literature review in the context of empathy development and sustainability in nursing profession and practice. I have also highlighted that nurses have not been adequately empowered to offer empathy and yet they are highly expected to do so. I have also integrated three main theories in establishing the basis for this research through descriptions and implications of the theoretical framework for conceptualization, research tool development and implementation. I have positioned empathy as an attainable goal in nursing; achievable through skill mix and interventional strategies of extensive relatedness of nursing goals to capacity building needs.

The believe from these descriptions is that nurses will prioritise development and sustainability of empathy competence. Massive lack of recommendations about how nurses should be treated positively, facilitated and empowered on empathy knowledge and skill was observed across all the theories and literature sources reviewed. Understanding of development and sustainability is founded on recognising that empathy is a life skill and a socially dependent competence.

I have also used various literature excerpts to identify theoretical standpoint on development and sustainability of empathy in terms of indications of interventional strategies in wellness of nurses as they pursue personal, professional and social responsibilities. In this view therefore, models of nursing are rich in constructs which can be extracted and tested for feasibility in nursing practice. Integrating psychological models in nursing discipline is important in establishing the sub concepts that might have not been clarified by the theorist about training, learning and behaviour development.
CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the approaches, methods and materials through which answers to the research questions were achieved. The scope of this description includes the choice and justification for the design, study area, study population, sample size determination, sampling method, instrumentation, methods of data collection, data management, analysis and presentation. The purpose of this research was to develop and implement a training manual for development and sustainability of empathy among nurses in Kenya. Pragmatism was chosen as the unitary paradigm that justified the choice of mixed methods and consistently determine the design of this research. This chapter is organised in six main parts: description of the concept of triangulation of methods, implementation of mixed methods and multistage description of the research methodology.

3.2 The concept of triangulation of methods

This research has embedded mixed methods strategy and therefore a clarification of how the methods, paradigms, approaches are applied is important. When engagement of multiple methods and multiple researchers is required to justify the concept of triangulation. Chinisa (2011) describes those research issues that support the use of mixed methods as those that require triangulation of perspectives to understand a complex problem. Flick (2014) acknowledge that when a pragmatic paradigm precedes the framing of the research issue the basis for the choice of mixed methods would be established; more so, the impetus for triangulation.

3.2.1 Exploratory approach

Explanatory research is conducted to help us find the problem that has not been described empirically in a specified population and environment (Gobo 2012). The Explanatory research is
not used to give us some conclusive evidence but helps us in understanding the problem more efficiently. When conducting the research, the researcher should be able to adapt to the new data and the new insights that are discovers about the subjects. Exploratory research has three main purposes (Nieswiadomy & Bailey, 2018). First, to fulfil the researcher’s curiosity and need for greater understanding of the situation as expressed by the study subjects. Second, to test the “livability” of elements that are decided on to be studied and be subjected into deeper review. Third, to build up the techniques and resources that might be utilized as a part of any after research ventures.

3.2.2 Exploratory sequential approach

The explanatory sequential approach involves conducting a quantitative survey, then it is followed by a qualitative data collection and analysis. The information in the quantitative (numerical) phase is complimented by qualitative (narrative) information acquired though focus group discussions (Basavanthappa, 2011). The findings of this approach utilise the information from exploratory phase to inform the preparation of materials that will be used in an empathy training intervention. The elements or factors identified from the analysis are further categorised as direct, indirect and total effect that such elements have on empathy. The list of emerging elements/factors/variables was used to develop an empathy training manual.

3.2.3 Quasi-experimental approach

A quasi experiment research is conducted on subjects that have not been randomly selected or when they are not randomly assigned to conditions/orders of conditions (Campbell and Stanley, 2011). A non-equivalent pre-post design was used to implement empathy training intervention among nurses. A researcher developed assessment tool was used to establish the
knowledge scores on development and sustaining empathy. A paired sample was used to compare the difference between pre-and-post intervention scores. The pre-training quiz was completed in 10 minutes before a week-long training intervention. Similarly, the same pre-test was administered four months after the training for similar timeline.

3.2.4 The constructivist approach to training intervention

Acquiring nursing knowledge through constructivist method involves intelligent action and productive thinking, promotes goal-oriented, behavioral changes that are reflected in experience or practice. In this case, learning is defined as an intentional action, that is, an action directed toward a goal (Vila, Diogo and Vieira, 2011). Building nursing knowledge is a professional responsibility for nurses. in current research, knowledge development is based on constructivist approach which gives priority to methods that are an extension of the universal paradigms of developing human resources for health. Constructivist approach seeks personal and collective balance; searches the knowledge necessary for complementary, simultaneous, and continuous interaction; and takes actions to repattern that knowledge for vital human processes.

A nursing learning environment will be constructivist only if it promotes meaningful learning through genuine experiences, leads to the integration of new ideas with the prior knowledge of learners, and promotes the personal reflection and collective analysis of learner experiences. In this approach, the teaching and learning process in nursing demonstrates that intellectual development aims at personal maturation; beginning with the learner’s psychic substrates like emotional intelligence and self-determination, in a progressive, complex redevelopment trajectory of goal attainment and transactional processes. Constructing new knowledge from learners’
experiences makes empirical knowledge fit in the practice of the target group and related learner populations with a high level of transferability across a profession (Flick, 2014)

3.3 Implementation of the mixed methods

Mixed methods provide an insight into the research topic from different perspectives and that the combination of methodologies can provide particularly rich and robust data (Sale, Lohfeld, and Brazil, 2002). According to Sale et al., (2002) there are two significant benefits from using mixed methods. First, it provides cross validation by triangulations. Second, it gains complementary results by using the strengths of one method to improve on the other. According to Teddlie and Tashakkori (2003), the use of a mixed methods approach is particularly valuable in complex educational and sociological research where the researcher needs to address multiple questions by implementing an intervention (Newman, Ridenour, Newman, & DeMarco, 2003).

Methodological understanding helps in justification of decision to implement the mixed methods in a varied approach that includes needs analysis, pre and post intervention knowledge analysis, pre-intervention and post intervention observation of empathy in nursing practice. In the current study, the four approaches discussed earlier (exploratory, explanatory, quasi-experimental, and constructivist) are implied in the implementation of the mixed methods research strategy. Triangulation of methods was applied as recommended for the pragmatic paradigmatic approach in selecting, determining and implementing strategies to answer the research questions (Kivunja and Kuyini, 2017). In nursing research, implementation of a nursing theory and theories from related health paradigms like human psychology enriches the overall quality of results of triangulation of methods and provides a stronger basis for making scientific inferences from data generated from such research processes (Basavanthappa, 2014).
3.3.1 The Empathy Training Needs Analysis

Empathy training needs analysis is a process of defining the knowledge or skill gaps that are lacking but required for individuals, a group, team, or departments. The focus on training needs analysis that could be accomplished while nurses attended to their roles was practical. The expectation of the needs analysis was to establish the participants’ knowledge and skills that are needed to perform that empathy tasks more competently. Training is recommended when there is a gap between the desired performance, and the current performance, and the reason for that gap is lack of skill or knowledge (Cook and Cripps, 2005).

The needs analysis process involved three stages whereby each stage was dependent of the preceding one. The first stage was using a researcher developed self-administered questionnaire among nurses in Kenyatta National hospital and Meru teaching and referral hospital. The second stage of needs analysis involved focus group discussions (FGD) that were conducted in Kenyatta National hospital and Embu county referral hospital using a FGD guide. The third stage of needs analysis was conducted using observation checklist in all the four participating hospitals (KNH, MTRH, ECRH and TMH).

3.3.2 Developing an empathy training manual

The empathy training manual is largely associated with specific constructs that were derived from the empathy training needs analysis. The training module was designed using Delphi technique and social constructivist approach that focused on the needs identified from the needs analysis results. Such brief consultancy and analysis to form a basis principle for interventions would be considered as an over ambitious endeavour but when professionals identify their training needs, they can decide whether to do something about it urgently or postpone the endeavours until when
they feel that the time is ripe. For this research, identification of to form the learning experiences for nurses in their working environment make significant sense to intervene immediately. The main experiences are designed around factors that influence (influences that would be either/and/or negative or positive for) development and sustaining empathy among nurses in Kenya).

3.3.3 Pre and Post – intervention knowledge analysis

Knowledge and skill interventions are expected to achieve positive changes in the knowledge levels and improve performance through behavioural modification of the individuals in the target groups. The purpose of a pre-intervention is basically to provide a baseline against which the impact of the intervention can be estimated (Basavanthappa 2014). For this phase of this research, the knowledge levels were analysed and presented as the baseline score before implementation of the module for capacity building in empathy knowledge. This phase involved a self-administered questionnaire for knowledge assessment, self-reflection and peer reporting.

3.3.4 Empathy training intervention

The intervention for empathy training was achieved by implementing the empathy training manual for nurses across the study area. The empathy training manual was developed using constructs that were consistent with factors that influenced development and sustainability of empathy among nurses in Kenya. Dependent variables that were also consistent with indicators of empathy were used to help in identification of specific knowledge attributes that were part of the required outcomes from the training. The conceptual model independent variables were also considered but little modification of the training vis a vis practicing environment for nurses was intended; however, it was not achieved. Factor analysis was considered as part of determining attainment in the intervention. This intervention assumed and actually confirmed that knowledge informs
practice. Implementation of the training intervention was configured in a way that knowing what would improve empathy in development would also play an important role in empathy skill development

3.3.5 Post-intervention observation

Following implementation of the empathy training module to nurses, empathy performance and skill was objectively observed from a selected group of nurses using a structured checklist. The observation checklist was similar in both cases for this study: empathy training needs analysis phase and post-intervention phase. An observation check list was used to collect data for comparison with observations made in the empathy training needs analysis phase (the observed group was the same as that observed earlier).

3.3.6 Implementation summary

The current research was implemented using the structure that was defined by the pragmatic paradigm of inquiry. The structure involved an interactive empathy training needs analysis among nurses was conducted using exploratory and explanatory sequential approaches. The exploratory approach involved quantitative methods of data collection and analysis: while explanatory involved qualitative approaches that complimented the numerical data. Constructivist approach was applied in designing empathy training module using results and recommendations from the needs analysis. Pre-intervention needs analysis established exploratory-explanatory approaches while implementation of the intervention was achieved through quasi-experimental approach as shown in figure 3.1.
The needs analysis
- Exploratory approach
- Explanatory sequential
- Participation observation approach
- Focus group discussion identified indicators of empathy in nursing
- Observation identified skill performance gaps in clinical-empathy

Constructivist approach
(development of empathy training manual)

Pre-intervention evaluation
- Exploratory approach
  - Knowledge assessment
  - Self-reflection
  - Peer reporting

Empathy training intervention
Quasi-experimental approach

Post-intervention evaluation
- Knowledge assessment
- Participant observation approach

Figure 3. 1: implementation of the mixed method in current research
3.4 Multistage research materials and methods

3.4.1 Description of the study area

The study area included Kenyatta national hospital, Embu county referral hospital, Meru teaching and referral hospital, and Tenwek mission hospital. These hospitals were selected purposively because of the diverse nursing practice environments that they present. Attainment of empathy as a core achievement of socially constructed values in healthcare were considered to illustrate autonomy and similarity contexts of nursing care. Healthcare provider social and cultural diversity were to remain constant and but dependent on the professionalism for nurses. the study area was assumed that it would provide this research with a variety of healthcare settings (Mission, county referral and National hospital) for contextual analysis to determine whether the environment where nurses worked might have contributed a significant deal to empathy or caring behaviours of nurses. In so far, the study area was considered adequately diverse for determining the best strategies for developing and sustaining empathy among nurses in Kenya. A brief description of the participant hospitals that were included as the study area is provided below.

3.4.1.1 Kenyatta National Hospital [KNH]

The KNH is the oldest hospital in Kenya. It is a public, tertiary, and national referral hospital for the Ministry of Health. It is also the teaching hospital of the University of Nairobi College of Health Sciences. KNH was founded as the Native Civil hospital, in 1901 with a bed capacity of 40 (Merab, 2016). In 1952 it was renamed the King George VI Hospital, after King George VI of England. KNH became a State Corporation in 1987. KNH is a national teaching and referral hospital with a wealth of both infrastructure and human resources for health. The total bed capacity is 1800. The total nurses’ population in KNH during the time of sampling was 800 at the time of
sampling and data collection. The study was conducted among nurses working in two service divisions: medicine services and surgery services. The medicine services divisions included were at level 3, level 7 and level 8. The surgical services divisions included at level 4, level 5 and level 6. The respondent nurses were practicing care provision in divisions that consisted of male and female medicine division, male and female surgery division and paediatric nursing division.

3.4.1.2 Tenwek Mission Hospital

Tenwek Mission Hospital (TMH) was established in 1935 as a mission hub with least possible infrastructure and human resources. Missionaries offered free healthcare services to the local communities that lived around the areas where they had established small health facilities. TMH is located 240 Kilometres (150 miles) from Nairobi in the Bomet county of Kenya’s Rift Valley. The Tenwek mission hospital is located approximately 7 km North Eastern of Bomet town towards Silibwet. The total nurses’ population was 200. The catchment population is estimated at approximately 1.8 million (KDHS, 2010). The departments that participated in this research at Tenwek mission hospital were medical, surgical, and paediatrics departments.

3.4.1.3 Embu County Referral Hospital

Embu County Referral Hospital (ECRH) was established in 1932 as a community level health facility to promote primary health care and offer curative services to Manyatta and its environs as its main catchment area. The hospital was initially referred to as Embu level five hospital. However, following implementation of the county governments through the new constitution, all the level five hospitals were upgraded to county referral hospitals (GoK, 2010). Embu is approximately 122 kilometres northeast of Nairobi in Embu county with a bed capacity of 620. The total nurses’ population was 320 at the time of sampling and data collection.
3.4.1.4 Meru teaching and referral hospital

Meru teaching and referral hospital was established in 1924 as a community health unit. MTRH offers preventive, promotive and curative health services in a catchment area that is estimated to be around 1.5 million. Located in Meru County, Meru teaching and referral hospital is approximately 226 kilometres from the capital city of Kenya (Nairobi) and it has a bed capacity of 361. Total population of nurses in MTRH was 320. Data was collected from nurses in medical, surgical, paediatrics and maternity departments using a self-administered questionnaire. The process of data collection was carried out by two research assistants for a week.

3.4.2 Description of the Study population

The research was conducted among nurses who at the time of the study were working in the four participating hospitals; Kenyatta National Hospital, Tenwek mission hospital, Embu county referral hospital and Meru county teaching and referral hospital. The study population first stage of the study involved determining the hospitals to be included in the study area. At this stage, purposive samples were selected. Hospital specific selection criterion were based on the following category; national referral, county referral and a mission hospital. Within the selected hospitals, the departments were purposively selected. The departments (service units) that had higher population of nurses were considered. These departments formed the target population strata and thus included as proportions of the sample. The inception of such a biased study area to provide the study population was informed by the fact that training is centrally controlled by the nursing council of Kenya.
3.5 Phase One: The Empathy Training Needs Analysis

3.5.1 Study design

This phase employed an exploratory approach. This is the most useful (and appropriate) research design for those projects that are addressing a subject about which there are high levels of uncertainty and ignorance about the subject, and when the problem is not very well understood due to very little existing research on the subject matter. Such research is usually characterized by a high degree of flexibility and somewhat modifies the formal research structure into flexible process of inquiry (Basavanthappa 2014). The main aim of exploratory research is to identify the boundaries of the environment in which the problems, opportunities or situations of interest are likely to reside, and to identify the salient factors or variables that might be found there and be of relevance to the research.

3.5.2 Study population

The empathy needs analysis study population was categorised in three groups; quantitative, qualitative and observation. These groups were drawn from the accessible population to make the representative sample. The groups were however similar in terms of their professional identity; nurses. Nurses in Kenya are healthcare professional who have been trained and have met licensing/registration criteria as prescribed by the regulatory body for nurses; Nursing council of Kenya. Talking matters of nurse training, the entry to training ensures that persons pursuing nursing have attained at least C (plain) in the Kenya certificate of secondary education (NCK, 2017). The professional preparation for nurses takes a minimum of three calendar years. Its rational to mention that there is no nurse who is younger than 20 years; therefore, they can give informed
consent. It is assumed that a nurse has reached maturity, wisdom and professional readiness for functioning in the world of work (Karani and Kangethe, 2008).

3.5.3 Sample size determination

The needs analysis process involved three stages whereby each stage was mutually dependent of the other stages. The sample was calculated using accessible population of 250 nurses. According to Basavanthappa (2010) regarding accessible population and the actual study sample; the most available population (expressed numerically) forms the basis of sample size determination. Determining representative sample sizes from smaller target populations requires application of proportionate formula (Yamane, 1967) for calculation where margin of error for this research is 0.05. The sample was thus calculated from the accessible population by application the formula.

\[
n = \frac{N}{1 + Ne^2}
\]

Where:

\[
\begin{align*}
n &= \text{Representative sample} \\
e &= \text{Margin of error} \quad (0.05) \\
N &= \text{Accessible population} \quad (250)
\end{align*}
\]

Therefore, by substitution;

\[
n = \left( \frac{250}{1 + [250 \times (0.05)]^2} \right) = \left( \frac{250}{1 + 0.625} \right) = 154
\]

The empathy training needs analysis sample was 154 nurses.

3.5.4 Sampling procedure

The sampling procedure for empathy training needs analysis comprised of three stages involving 154 nurses. During the first stage of sampling, a convenient sample of 110 nurses was recruited...
for the first stage of the study. During the second stage of the empathy training needs analysis, a purposive sample of 32 nurses participated in the focus group discussions. During the third stage, a purposive sample of 12 nurses participate in observation for establishing any gaps in integrating of empathy skill in care for patients in a clinical setting.

3.5.5 Inclusion and exclusion criteria

3.5.5.1 Inclusion Criteria

The inclusion criterial for participants for needs analysis phase of this research was all nurses in the participating hospitals who were;

a) Willing to participate
b) Working in the hospitals that are participants
c) Willing to give an informed consent
d) Licensed by Nursing Council of Kenya

3.5.5.2 Exclusion Criteria

The needs analysis phase excluded nurses who regardless of being potential participants did not meet the pre-determined inclusion criteria set for selection of respondents. The following were excluded.

a) Student nurses without any prior qualification in nursing (direct entry student nurses)
b) Those who were on internship nursing programme
c) nurses who were not interested to participate in the study or not willing to voluntary sign the informed consent
3.5.6 Preparation and pre-testing of the study tools

3.5.6.1 Preparation of the tools

This study involved three data collection tools; self-administered questionnaire, an observation checklist and a focus group discussion guide. The tools were used in different times and in specific data collection stages; alternatively, in quantitative and qualitative phases of needs analysis. In the quantitative phase, a self-administered semi structured questionnaire (appendix iii) and an observation checklist (appendix vii) were used to collect data. The choice of these tools (self-administered questionnaire and observation checklist) was informed by the fact that information collected by use of such tools is easier to code, tabulate and analyse (Basavantappa, 2010). The questionnaire was constructed in English and was not translated into any other language.

The researcher developed self-administered questionnaire established the need for intervention and also determine how relevant the nurses viewed the proposed intervention. The observation checklist was developed to guide needs analysis in establishing presence or absence of empathy indicators. Burke and Depka (2011) describe an observation checklist as tool used to monitor specific skills, behaviours, or dispositions of individual persons in the environment that they optimally function. A checklist only indicates if an individual can accomplish the observation objectives, nothing in the checklist included the quality of performance.

In the qualitative phase, data was collected using a focus group discussion guide; the questions were used to explore the meanings of quantitative findings that couldn’t be explained in detail during the stage. The variables that required deeper explanations for internal consistency of the results included the range of opinions/views on development and sustainability of empathy among nurses and also to collect a wide variety of terms in the Kenya nurses’ context. Krueger (1998)
observed that in bridging research and policy, FGD can be useful in providing an insight into different opinions among different parties involved in the change process, thus enabling the process to be managed more smoothly. It is also a good method to employ prior to designing interventional strategies and development of user specific learning tools.

3.5.6.2 Pre-testing of the study tools

The needs analysis phase of the study tools was pre-tested at Consolata Hospital Nkubu (Meru County) in medical and surgical departments. The Consolata hospital has similar structure to the study area, constituent nursing staff and arguably similar institutional culture to the areas of the main study. A convenient sample of 17 nurses were involved in the pre-test. Data was analysed, and reliability estimated. Reliability coefficient of the questionnaire was 0.74 and a random error of 0.46. These values indicated that the instrument’s reliability was satisfactory. A baseline reliability coefficient of 0.70 is considered satisfactory for small samples (Snow and Wiley, 2012).

3.5.6.3 Recruitment and training of research assistants

Nine purposively selected nurses were trained to help in the processes of administering the research tools. They comprised of three research assistants in KNH two Embu county referral, two in Meru teaching and referral and two in Tenwek mission hospital. Same research assistants were re-trained to implement the empathy training intervention in the selected hospitals.

3.5.6.4 Selection and training of data transcribers

Two qualitative data transcribers with background training in health sciences and experience in conducting focus group discussions and transcription of resultant data were selected to assist with data transcription. They also took part in establishing relationships among and between qualitative study variables for the triangulation process. They were trained on empathy as the main subject of
research for one day with a further engagement during pre-testing of research instruments and data analysis. Training was conducted in the school of nursing sciences. The training for transcribers included the purpose and basic principles of developing a training manual for empathy and the researcher’s expectations from the transcribed data.

3.5.6.5 Data collection procedures

The first stage collected quantitative data using a self-administered questionnaire. was using a researcher developed self-administered questionnaire among nurses in all the four participating hospitals (KNH, MTRH, ECRH and TMH). The second stage of empathy training needs analysis involved collection of qualitative data using focus group discussions (FGD) that were conducted in Kenyatta National hospital and Embu county referral hospital using a FGD guide. The third stage of needs analysis was conducted using observation checklist in all the four participating hospitals (KNH, MTRH, ECRH and TMH).

3.5.7 Data management

3.5.7.1 Data generated from questionnaires

This study generated quantitative data from nurse participants using two sets of questionnaires; needs analysis questionnaire and pre/post intervention questionnaire. Both questionnaires were self-administered. The Quantitative data was organized, cleaned and entered into a computer for descriptive and other statistical analysis. The descriptive and inferential statistics were applied. All statistical tests for this research were conducted at 95% confidence interval. Data generated from questionnaire was entered in a computer; statistical package social sciences (SPSS v23) whereby the variables and their descriptive and inferential statistics analysis were statistically performed. Outputs were generated and presented in figures and comparative tables.
3.5.7.2 Data generated from observation checklist

Quantitative data was collected from participant observation that was conducted at two different times of the study; first during empathy training needs analysis and secondly, during post-intervention evaluation of effect size. As expected, the observation of empathy skill and behaviour was marked as observed or not observed. Descriptive statistics were applied for observational data. A comparative analysis was performed to estimate the impact of empathy training on observable qualities of empathy on nurse participants.

3.5.7.3 Data generated from focus group discussion

Qualitative data was collected using focus group discussion through being tape-recorded and taking of discussion notes. The qualitative data was transcribed and compared with additional notes for validation. Scanning primary data for words and phrases used by respondents (and the emotions accompanying use of such words and phrases) was ensured. Emerging themes were categorised, repetitions were deleted, and a resultant table made. Thematic analysis was used for indicators of empathy using NVIVO version 12 for windows. Tests for significance were conducted at 0.05 alpha level. The findings from needs analysis were used in the preparation of the empathy training intervention.
3.6 Phase two: Pre-intervention knowledge/skill analysis

3.6.1 Study design

The second phase of this research involved an explanatory study design. Exploratory design is sometime referred to as analytical study whereby the main aim of explanatory research is to identify any causal links between the factors or variables that pertain to the research problem (Basavanthappa, 2014). The research problem stated that nurses had been observed to have challenges in empathy skills and the training curriculum for nurses had deficits in learning experiences for empathy. So, the research wanted to establish the baseline for knowledge before a capacity building intervention was implemented deficient. Explanatory research is very structured in nature and therefore, the structure for the questionnaire was guided by variables that were highlighted in the empathy training needs analysis using and additional factors that were described in factors that influenced empathy.

3.6.2 Study population

The pre-intervention knowledge/skill analysis study population was unitary group drawn from target population for quantitative data collection and analysis. The group had similar qualities to the groups in phase one; similar in terms of their professional preparation for healthcare delivery. Nurses are healthcare professionals who attract a considerably higher social and professional expectation from clientele and colleagues. Needs analysis had indicated that an empathy training intervention would benefit nurses a big deal. The nurse population is greatly diverse in terms of social and cultural orientation. In this study, it was assumed that the diversities would not affect the variables of assessment; knowledge, awareness and wellness of nurses in integrating empathy in nursing practice.
3.6.3 Sample size determination

During this phase, a stratified random sampling (SRS) strategy was used in determining the representative sample. In SRS strategy, the target population plays a major role in determining the sample. The target population was known but was less than 10,000. In such conditions, the Fischer’s formula is used to determine the sample size. However, each participating hospital formed a stratum within which simple random sampling provided each member in the stratum with an equal chance to be included in the study. This method increases the possibility of achieving an adequately representative sample from the population (Basavanthappa, 2010). Cochran equation (1963) was applied to calculate the representative sample for the second phase of this interventional research.

\[ n_0 = \left( \frac{Z^2(pq)}{e^2} \right) \]

Where;
- \( n_0 \) = Sample size
- \( Z \) = Abscissa of the normal curve (1.96) at 95% confidence
- \( p \) = Proportion of presence of an attribute in a population (0.5)
- \( q \) = 1-p
- \( e \) = Desired alpha level for the tests (0.05)

Therefore, by substitution:

\[ n_0 = \left( \frac{1.96^2(0.5*0.5)}{(0.05)^2} \right) = 385 \text{ Nurses} \]

Since the sample was under proportional allocation in stratified simple random strategy, the sample for each stratum \( (n_h) \) is calculated using Cochran (1977) formula as follows.

\[ n_h = \left( \frac{N_h}{N} \right) n; h = 1, \ldots, 4 \]
Where;

\[ n_h = \text{Stratum size} \]
\[ N_h = \text{Accessible nurse population per hospital} \]
\[ N = \text{Total number of nurses in all the four hospitals} \]
\[ n^* = \text{Study sample} \]

The study sample after stratification \((n^*)\) is recalculated using Cochran (1977) formula to establish that the sample remains similar after stratification

\[ (n_0 = n^* = n_h(1-4)) = 385 \]

Calculating the strata sizes applied the following Cochran equation (Cochran, 1977)

\[
n_{h(1-4)} = \sum_{h=1}^{4} (n_{h1} + \ldots + n_{h4})
\]

Therefore, by substitution;

\[
n^* = \left(\frac{800}{1640}\right) 385 + \left(\frac{320}{1640}\right) 385 + \left(\frac{320}{1640}\right) 385 + \left(\frac{200}{1640}\right) 385
\]

\[ n^* = 188 + 75 + 75 + 47 \]

\[ = 385 \text{ nurses} \]

Three hundred and eighty-five (385) nurses were enrolled to participate in the pre-intervention, empathy training intervention and post intervention phases of the study. The sample for the study was distributed across the four hospitals as follows; 188 nurses in KNH, 75 nurses in Embu County Referral Hospital, 75 nurses in Meru Teaching and Referral Hospital and 47 nurses in Tenwek Mission hospital.
3.6.4 Inclusion and exclusion criteria

3.6.4.1 Inclusion Criteria

The inclusion criteria for participants for needs analysis phase was the nurses who were:

a) Willing to participate
b) Working in the departments that have been selected
c) Willing to sign an informed consent
d) Licensed by Nursing Council of Kenya

3.6.4.2 Exclusion Criteria

The study excluded nurses who regardless of being potential participants were not interested to participate in the study or were not willing to voluntary sign the informed consent.

Table 3.1: Sampling frame

<table>
<thead>
<tr>
<th>Study area</th>
<th>Sample size</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>TNA</td>
</tr>
<tr>
<td></td>
<td>SAQ</td>
</tr>
<tr>
<td>KNH</td>
<td>50</td>
</tr>
<tr>
<td>ECRH</td>
<td>21</td>
</tr>
<tr>
<td>MTRH</td>
<td>21</td>
</tr>
<tr>
<td>TMH</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>110</td>
</tr>
</tbody>
</table>

Key

TNA = The Needs Analysis;
ETI = Empathy Training Intervention
SAQ = Self-Administered Questionnaire;
FGD = focus group discussion;
OC = observation checklist;
PrIsQ = Pre-Intervention Questionnaire;
P0IsQ = post- intervention questionnaire
3.6.5 Preparation and pre-testing of the study tools

3.6.5.1 Preparation of the tools

This study involved three data collection tools; self-administered questionnaire, an observation checklist and a focus group discussion guide. The tools were used in different times and in specific data collection stages; alternatively, in quantitative and qualitative phases of needs analysis. In the quantitative phase, a self-administered semi-structured questionnaire (appendix iii) and an observation checklist (appendix vii) were used to collect data. The choice of the self-administered questionnaire was informed by the fact that information collected by use of a self-administered questionnaire is easier to code, tabulate and analyse (Basavantappa, 2010). The questionnaire was written in English and was not translated into any other language.

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Two qualitative data transcribers with background training in health sciences and experience in conducting focus group discussions and transcription of resultant data were selected to assist with data transcription. They also took part in establishing relationships among and between qualitative study variables for the triangulation process. They were trained on empathy as the main subject of research for one day with a further engagement during pre-testing of research instruments and data analysis. Training was conducted in the school of nursing sciences. The training for transcribers
included the purpose and basic principles of developing a training manual for empathy and the researcher’s expectations from the transcribed data.

### 3.7 Empathy training intervention

The theoretical approaches and paradigm of inquiry applied for this research indicate that such diverse interactions must occur in nursing and that empathy among nurses should be promoted through experiential learning process. This phase was guide by the principle of collective generation of knowledge and implementing what works for the specific group of learners. The learning process applied values the production of knowledge by collective and cooperative work that cannot be individually garnered. The nursing profession commitment to lifelong education and capacity building could benefit in strategies where learning, and teaching are incorporated into work and the daily life of organizations (Gobo, 2012).

#### 3.7.1 Designing effective empathy training interventions

Effective empathy training for nurses in Kenya was achieved through integrating nursing and psychology theoretical frameworks, analysing empirical implications of theoretical basis and implications to develop new knowledge and skills, promote clear and better communication of important ideas, concepts and principles of empathy to on-job-learners. The empathy training intervention in this research was designed using tenets of constructivist approach. This approach assumes that learning is constructed over learner experience and acquired knowledge and skills to achieve a new level of expertise. Constructivist approach focuses on the learner as the sole determinant of their own course in learning.

The focus of constructivist approach in this research was intended to apply themes of effective communication in closing the gaps identified from needs analysis. Engaging learners in the
development and sustainability of a core competence is an important role for the trainer. Research has shown that if a trainer is actively communicating with their participants by structuring and delivering content in a logical sequence, expected learning will occur (Daines and Graham, 2006).

3.7.2 Data collection procedure

The data collection activity involved a multistage strategy where needs analysis, pre and post intervention were used as points for data collection. Needs analysis involved data about knowledge and skill for empathy. Self-administered questionnaires focus group discussion and an observation checklist were used data collection involved quantitative and qualitative methods. Quantitative data collection involved the research assistants providing information about the study and ensuring that informed consent was obtained. A self-administered question was issued to each respondent. Filling in the questionnaire was estimated to be 10 minutes. Upon completion of the questionnaire, the respondents returned them to the researcher and the research assistants for counting and organization. The questionnaires were thereafter serialised from 1-384 after collection and verification of completeness before channelling them to a secure storage ready for descriptive and inferential analysis.

Qualitative study data was collected through a focus group discussion. Four homogenous groups comprising of eight purposively selected nurses discussed factors that influenced development and sustainability of empathy in nursing. The discussions took place in a closed and secluded locations at the Kenyatta national hospital and Embu County Referral hospital. A verbal consent to be audio taped was obtained from the participants. The moderator facilitated the discussion and asked questions, while the assistant moderator took notes and tape recorded the discussion. The
participants narrated their experiences, views and opinions about development and sustainability of empathy in nursing practice.

The moderator guided the discussion, asked question and sought clarifications by probing for more information while the assistant moderator took detailed observation notes; noting body language and facial expressions. The second phase involved pre-intervention questionnaire that was followed by empathy training intervention. An observation checklist One month after the training, a post-intervention questionnaire was administered to nurse participants. Data collection process was completed within six months; where, needs analysis was conducted in two months, pre-intervention was one hour, intervention was one week, and post-intervention was conducted after four months from the training intervention.

3.8 Data management

3.8.1 Data generated from questionnaires

This study generated quantitative data from nurse participants using two sets of questionnaires; needs analysis questionnaire and pre/post intervention questionnaire. Both questionnaires were self-administered. The Quantitative data was organized, cleaned and entered into a computer for descriptive and other statistical analysis. The descriptive and inferential statistics were applied. All statistical tests for this research were conducted at 95% confidence interval. Data generated from questionnaire was entered in a computer; statistical package social sciences (SPSS v23) as variables and their descriptive and inferential statistics analysis performed. Outputs were generated and presented in figures and comparative tables for needs analysis, pre/post intervention (baseline and end-line scores). The mean scores (M_b for baseline score and M_e for post-training scores) were compared statistically. The paired samples t-test provided inferential statistics for test of
significance of the scores. The significance of change in knowledge attainment was determined through paired t-test where a p-value of less than 0.05 was considered statistically significance.

### 3.8.2 Data generated from observation checklist

Participant observation was conducted at two different times of the study; first during needs analysis and secondly, during post-intervention evaluation. As expected, the observation of empathy skill and behaviour was marked as observed or not observed. Descriptive statistics were applied for observational data. A comparative analysis was performed to estimate the impact of empathy training on observable qualities of empathy on nurse participants.

### 3.8.3 Data generated from focus group discussion

Focus group discussion data was collected through tape-recorded and taking noted. The qualitative data was transcribed and compared with additional notes for validation. Scanning primary data for words and phrases used by respondents (and the emotions accompanying use of such words and phrases) was ensured. Emerging themes were categorised, repetitions were deleted, and a resultant table made. Thematic analysis was used for indicators of empathy using NVIVO version 12 for windows. Tests for significance were conducted at 0.05 alpha level. The findings from needs analysis were used in the preparation of the empathy training intervention.

### 3.8.4 Hypothesis testing.

This study tested three hypothesis that were in line with the core activities that gave statistical scope and reference for the variables, constructs and predictions in this research. Test statistic was set at 5% where the level of significance was inversely proportional to the distance from zero value. The process of the first hypothetical confirmation was based on the empathy related difficulties that nurses experienced in delivery of nursing care to patients. The second involved
effect of the empathy training intervention on knowledge and skill development whereas the third focused on relationship between goal attainment and the empathy training intervention among nurses in Kenya. A paired sample t-test was used in the determination of the strength (significance) of the relationship.

3.9 Limitations and delimitations

3.9.1 Limitations to the Study

This study acknowledges that self and peer reporting could yield social desirability bias. Initially, participants felt that the researcher intended to expose them for not having adequate empathy skills. The processes of participant observation are also prone to Hawthorne’s effect. Measuring empathy is difficult; therefore, the possibility of non-response bias was high. Needs analysis was conducted on the same population using a variety of tools and this could lead to participant exposure bias. Factors influencing empathy were determined from selecting a correct response from a list provided in the questionnaire and this could present a higher risk for acquiescence bias. There were challenges in establishing baseline awareness level of empathy among nurses from literature. The excessively demanding nursing schedules made data collection very challenging. Patients’ view on nurses’ empathy was not explored in this research.

3.9.2 Delimitations of the Study

Delimitations to this study were achieved through variables operationalizations, multi-stage triangulation performed to delimit the social desirability bias. Triangulation of data collections methods, analysis strategies, measuring knowledge was used to ensure validity of study results despite using relatively smaller sample. Baseline awareness level was determined using the sample responses. Data collection procedures were organised according to the availability of the nurses in
respect to their busy schedules. Clarifications of indicators of empathy among nurses was achieved through explanatory approaches. Such clarification is important is establishing relationship among and between variables. A repeated test of variables was made to assess the effect of the training intervention on observable characteristics of nursing when offering empathy in nursing practice. Previous research about caring behaviours of nurses in Kenyatta National Hospital medical wards provided foundation for exploring empathy in nursing as a caring behaviour.

3.10 Ethical Considerations

The researcher sought the approval to carry out this research and the study processes were approved by Ethical and Research Committee of Kenyatta National Hospital and University of Nairobi [ERC-KNH/UON] The reference number is P (311/05/2015). Further, this research was also authorization and permit by the National Commission for Science, Technology and Innovation (NACOSTI) refers to permit number NACOSTI/P/17/66076/19443. Respective ethical approval from the ethical committees of the participant hospitals were granted (Appendices viii, ix, xvii, xviii and xix).

Respondents gave a signed consent before participating in this research. Respondent anonymity and confidentiality was ensured by making sure that there was no identification of identity in the data collection tools. It is therefore not possible to identify any response with any participant. All the processes that took place throughout this study followed the guidelines of professional and scientific research as stipulated in the declaration of Helsinki (Maltby et al., 2010) about research involving human subjects.
CHAPTER FOUR: RESEARCH FINDINGS

4.1 Introduction

This chapter reports on the findings of the study with regards to various aspects as indicated by the research objectives, research questions and alternative hypotheses. The findings are presented in tables, charts, graphs and narratives. The first section presents the needs analysis; distribution of demographic characteristics of the study participants (nurses), their qualifications, self-concept, challenges in integrating empathy in nursing practice, attitude towards empathy, emotional burden, indicators of empathy rationale for developing and sustaining empathy in nursing practice, qualities of empathy in nursing and levels of empathy competence in nursing. The second section report on the study findings presents the results related to empathy training intervention; pre and post empathy training intervention knowledge and skill attainment. The study achieved a 100% response rate and therefore, a 0% non-response bias.

4.2 Phase one: The needs analysis

4.2.1 Data collected via Self-administered questionnaire

4.2.1.1 Demographic characteristics of the participants

The demographic characteristics were analysed (Table 4.1). The analysis indicated that 15% \((n=16)\) were aged between 21-25 years, 17.4% \((n=19)\) were aged between 26-30 years, 21% \((n=23)\) were 31-35 years old, 24.1% \((n=26)\) aged between 36-40 years, 10.6% \((n=11)\) were between 41-45 years, 7.5% \((n=8)\) were 46-50 years old and 4.4% \((n=5)\) were above 50 years old. The mean age of the respondents was 33.41 \((\pm 1.64)\) years. The gender distribution showed that females nurses were more than males nurses \((78.8%; n=87, 21.2%; n=23)\). Results about marital status indicated that 20.2% \((n=22)\) were single, 10.1% \((n=11)\) were engaged, 68.7% \((n=76)\) were
married and 1% (n=1) of the respondents were separated from partner or spouse. To establish a relationship between empathy behaviours and emotional load, the perceptions were that empathy was perceived to have minimal association by (8.8%; n=10), below average (4.7%; n=5), average (40.9%; n=45) and above average (45.6%; n=50) emotional load.

Table 4.1: Demographic Characteristics

<table>
<thead>
<tr>
<th>Demographic Variables</th>
<th>Freq</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
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<td><strong>Age (yrs)</strong></td>
<td></td>
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<tr>
<td>21-25</td>
<td>17</td>
<td>15</td>
</tr>
<tr>
<td>26-30</td>
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<tr>
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<td>4.4</td>
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<tr>
<td><strong>Gender</strong></td>
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</tr>
<tr>
<td>Female</td>
<td>87</td>
<td>78.8</td>
</tr>
<tr>
<td>Male</td>
<td>23</td>
<td>21.2</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>22</td>
<td>20.2</td>
</tr>
<tr>
<td>Engaged</td>
<td>11</td>
<td>10.1</td>
</tr>
<tr>
<td>Married</td>
<td>76</td>
<td>68.7</td>
</tr>
<tr>
<td>Separated/widowed/divorced</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Emotional load</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minimal</td>
<td>10</td>
<td>8.8</td>
</tr>
<tr>
<td>Below average</td>
<td>5</td>
<td>4.7</td>
</tr>
<tr>
<td>Average</td>
<td>45</td>
<td>40.9</td>
</tr>
<tr>
<td>Above average</td>
<td>50</td>
<td>45.6</td>
</tr>
</tbody>
</table>
4.2.1.2 Highest attained qualification of participant nurses

The participant nurses had different levels of qualification that are also known as cadres. The pie chart (Figure 4.1) shows that 2% (n=2) were enrolled nurses (EN); 60% (n=66) were registered community health nurses who had attained diploma (KRCHN), 37% (n=41) were holders of Bachelor of Science in nursing (BScN) and 1% (n=1) had attained Master of Science in nursing (MScN) degree.

![Pie chart showing qualification of participants](image)

**Figure 4.1: Qualification of participants**

4.2.1.3 Reported Self-concept on empathy

Respondents rated their own empathy alongside pre-determined components of self-concept (Table 4.2). The result showed that the relationship between empathy as a component that improves public image for nurses to promote self-esteem was statistically significant: \( r (109) = -0.12, p=0.02 \) and provides justification for nursing actions; \( r (109) = -0.19, p=0.00 \). Social
awareness didn’t seem to promote self-esteem; \( r(109) = -0.01, p = 0.84 \), however, it provided justification for nurse actions; \( r(109) = 0.12, p = 0.02 \).

**Table 4.2: Relationship between components of self-concept and Empathy**

<table>
<thead>
<tr>
<th>Self-concept on empathy</th>
<th>Statistic label</th>
<th>Improved public image for nurses</th>
<th>Sense of social awareness</th>
<th>Promotion of self-esteem</th>
<th>Justification for nursing action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved public image for nurses</td>
<td>( r )</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sense of social awareness</td>
<td>( r )</td>
<td>-0.022</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>( p )</td>
<td>.660</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promotion of self-esteem</td>
<td>( r )</td>
<td>-.119*</td>
<td>-.010</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( p )</td>
<td>.019</td>
<td>.843</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Justification for nursing actions</td>
<td>( r )</td>
<td>-.187**</td>
<td>-.119*</td>
<td>-.081</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>( p )</td>
<td>.000</td>
<td>.019</td>
<td>.112</td>
<td></td>
</tr>
</tbody>
</table>

*\( p < .05 \). **\( p < 0.01 \); Pearson Correlation = \( r \); df = \( N-2 \)

**4.2.1.4 Nurses encountering empathy related coping challenges**

Participants were requested to indicate whether they encountered challenges and how frequent those challenges were prevalent. The challenges were related to self/other empathy and coping abilities. The responses were; 4% (\( n = 4 \)) reported that they didn’t encounter any challenges, 16% (\( n = 18 \)) encountered challenges less often, 40% (\( n = 44 \)) encountered challenges more often and 40% (\( n = 44 \)) reported that they encountered challenges all the time as shown in figure 4.2.

The main factor contributing to the challenge was shortage of nursing staff that was attributed to higher turn-over rates, excessive demands by the patients and their significant others, absenteeism and allocation of non-nursing duties to nurses. the nurses hinted out that more time was used to
attend to roles that were not core for the nurses. The hospital management boards were blamed for constantly declining to motivate nurses or recruit more nurses following increased turnover rates, turnover tendencies and rampant demotivation.

4.2.1.5 Nurses’ attitude towards empathy training intervention

Participant nurses were asked to indicate their perspectives towards empathy and empathy training intervention in Kenya. Majority of the participants (84%; n=92) reported that empathy training should be integrated in nursing education and professional development plans in nursing practice as a core competency. Although some participants reported that empathy was emotionally burdensome, they recommended that skill mix and benchmarking should be applied in integrating theories of goal attainment and self-determination in daily routines for developing and implementing of the empathy training materials for both pre and in-service nurses. These findings are presented in figure 4.3

Figure 4. 2: Frequency of encountering empathy challenges by the participants
4.2.1.6 The emotional burden in Caring for the sick

Respondents indicated that caring for the sick was emotionally demanding (90%; n=99) and they gave the reason of impaired communication between the care giver and the ailing person and or their significant others or relatives. The expectation on the nurse is seriously high, as reported by 100% of the respondents. Similar response rate was achieved for taking care for the well and health while 78%; n=86 respondents reflected that caring for the persons who are recovering from illness or patients who were in the process of a peaceful death was less emotionally demanding. Caring for one in pain and what causes it and how to relieve or remove it was important knowledge achieved through training to make the right diagnoses, plans and implementation of care and treatment. Empathy helps caring acts to be achievable and fruitful as shown in figure 4.3.

![Figure 4.3: Empathy training – care – emotional load triad](image)

4.2.1.7 Indicators of empathy among nurses

The indicators yielded multiple responses that were categorised in two strata; whether the respondents were sure or not sure whether the indicators were values of empathy. The result indicated that self-awareness (78%; n=86), effective communication (84%; n=92), timely
interventions (33%; n=36), relationship management (90%; n=99) leadership skills (24%; n=26), professional values (46%; n=51), competences in administering best practices (60%; n=66) and skill development (27%; n=30) respondents were sure that these variables were values of empathy.

The information about being sure or unsure is as shown in table 4.3.

Table 4.3: Indicators of empathy among nurses

<table>
<thead>
<tr>
<th>Indicators of empathy</th>
<th>Sure</th>
<th></th>
<th>Not sure</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq (f)</td>
<td>Percent (%)</td>
<td>Freq (f)</td>
<td>Percent (%)</td>
</tr>
<tr>
<td>Self-awareness</td>
<td>86</td>
<td>78</td>
<td>24</td>
<td>22</td>
</tr>
<tr>
<td>Effective communication</td>
<td>92</td>
<td>84</td>
<td>18</td>
<td>16</td>
</tr>
<tr>
<td>Timely interventions</td>
<td>36</td>
<td>33</td>
<td>74</td>
<td>67</td>
</tr>
<tr>
<td>Relationship management</td>
<td>99</td>
<td>90</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Leadership skills</td>
<td>26</td>
<td>24</td>
<td>84</td>
<td>76</td>
</tr>
<tr>
<td>Professional values</td>
<td>51</td>
<td>46</td>
<td>59</td>
<td>54</td>
</tr>
<tr>
<td>Competences in best practices</td>
<td>66</td>
<td>60</td>
<td>44</td>
<td>40</td>
</tr>
<tr>
<td>Skill development</td>
<td>30</td>
<td>27</td>
<td>80</td>
<td>73</td>
</tr>
</tbody>
</table>

4.2.1.8 Rationale for developing and sustaining empathy among nurses

The self-concept was high but the awareness of key principles of empathy was lower than expected. Having based the study on theories of self-determinism and emotional intelligence, it was necessary to allow the respondents to determine their preferred intervention based on how they feel about developing and sustaining empathy in their practice.

4.2.8.1 Rationale for developing empathy among nurses

Rationale for developing empathy in nursing were analysed (figure 4.4). Results showed timely planning for patient care (86%; n=95), improve communication between nurses and patients (96%; n=106), attain professional pride (78%; n=86), improved patient outcomes (92%; n=101) and acquire skills in relationship management (74%; n=81).
4.2.8.2 Rationale for sustaining empathy among the respondents

Respondents indicated that the rationale for sustaining empathy in nursing were that the patients would have better health outcomes (90%; n=99), nurses could have better team spirit towards nursing duties (88%; n=97), empathy promotes gentleness towards strangers and colleagues (83%; n=91), improve nurse-nurse/patient relationships (100%; n=110) and improve therapeutic environments (94%; n=103). The rationales for sustaining empathy are presented in figure 4.5.
4.2.2 Observation of functional empathy attributes

The observational checklist was used to assess functional empathy attributes and competence needs from nurses. The needs analysis of the observed functional attributes of empathy among nurses were compared to post intervention observation results as shown in table 4.4.

Table 4.4: Observational checklist - TNA

<table>
<thead>
<tr>
<th>Observed empathy traits (category)</th>
<th>(n=12) TNA (OC₁)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>F</td>
</tr>
</tbody>
</table>

Personal attributes (Preparedness)

- Begins nursing care on time
  - 2 17
- Creates a welcoming environment
  - 2 17
- Calm but sensitive
  - 1 8
- Actively engages the patient in the intervention
  - 4 33

Professional attributes (Behavioural)

- Demonstrates self confidence
  - 3 25
- Responds respectfully to patients and colleagues
  - 2 17
- Listens carefully and actively
  - 1 8

Interpersonal attributes (Wellbeing)

- Gentleness in administering interventions
  - 3 25
- Effective communication techniques
  - 2 17
- Showing kindness to patients
  - 2 17
- Smile and occasional laughter during care
  - 4 33

TNA = The Needs Analysis

OC = Observation Checklist,
4.2.3 Focus group discussion

The focus group discussions were audiotaped, and notes were also taken by the FGD moderator and assistants. The data was transcribed and coded into themes. The transcribed data was used in demonstrating the qualities of empathy among the nurse respondents.

4.2.3.1 Qualities of empathy

Thematic analysis revealed a set of qualities that the respondents unanimously accepted that were associated with empathy (Table 4.5). The key words identified qualities formed the actual concepts that support the main themes as indicators of empathy. The themes revealed qualities of empathy as gentleness, understanding needs for empathetic concern, kindness, patience, patience, approachable and available. It also included self and social awareness to the needs of self and those entrusted unto nurses’ care.

Table 4.5: Qualities of empathy

<table>
<thead>
<tr>
<th>Category</th>
<th>Themes</th>
<th>Keywords</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualities of Empathy</td>
<td>Gentleness</td>
<td>Reassuring communications, Gentle during nursing interventions, pre-medication, timely analgesia</td>
</tr>
<tr>
<td></td>
<td>Understanding</td>
<td>Active listening, accurate social imagination, positive gestures</td>
</tr>
<tr>
<td></td>
<td>Kindness</td>
<td>Calm caring, ready, available, spirited and a forgiving</td>
</tr>
<tr>
<td></td>
<td>Patience</td>
<td>Calm, slow but sure, ensures clarity of instructions before proceeding to deliver care</td>
</tr>
<tr>
<td></td>
<td>Friendliness</td>
<td>Encourages unity, gender responsive, friendly, aware of healthcare needs, standards, and interventions</td>
</tr>
<tr>
<td></td>
<td>Approachable</td>
<td>Friendly, social, welcoming and ready to help</td>
</tr>
<tr>
<td></td>
<td>Available</td>
<td>Punctual, intrinsically motivated, energetic and no (or minimalistic) turn-over intentions</td>
</tr>
</tbody>
</table>
4.2.3.2 Levels of empathy in nursing practice

Qualities that determine the status of empathy are diverse and the assessment can be spurious but with a predetermined criterion, an approximate status can be derived. The empathy demonstrated as competences were assigned three levels; novice, competent and expert. The assigned levels were conceptualised for description (table 4.6). Novice is assigned to nurse trainee eager to learn but occasionally is argumentative, inconsistent in practice and silently portrays a resistant behaviour which may be sometimes interpreted as rudeness. Such a competence mix can ensure continued development by recognising the gaps and intervening through capacity building and professional development plans.

Table 4. 6: Levels of empathy in nursing practice

<table>
<thead>
<tr>
<th>Status</th>
<th>Indicators</th>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incompetent</td>
<td>Argumentative</td>
<td>Nursing staff with least positive experience for adaptation and motivation</td>
</tr>
<tr>
<td></td>
<td>Inconsistent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Resistant behaviour</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not interested</td>
<td></td>
</tr>
<tr>
<td>Competent</td>
<td>Good Listener</td>
<td>Nursing staff with positive experience, adaptive and has the right motivation</td>
</tr>
<tr>
<td></td>
<td>Reliable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Amiable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Available</td>
<td></td>
</tr>
<tr>
<td>Expert</td>
<td>Gentle</td>
<td>Nursing staff with highly positive experience, adaptation skills and intrinsic motivation</td>
</tr>
<tr>
<td></td>
<td>Strong</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Humble</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Compassionate</td>
<td></td>
</tr>
</tbody>
</table>
4.3 Pre and post empathy training intervention evaluation

4.3.1 Demographic characteristics of the participants

The demographic characteristics were analysed (Table 4.1). The analysis indicated that 15% (n=58) were aged between 21-25 years, 17.4% (n=67) were aged between 26-30 years, 21% (n=81) were 31-35 years old, 24.1% (n=93) aged between 36-40 years, 10.6% (n=41) were between 41-45 years, 7.5% (n=29) were 46-50 years old and 4.4% (n=17) were above 50 years old. The mean age of the respondents was 33.41 (±1.64) years.

The gender distribution showed that females nurses were more than males nurses (78.8%; n=304, 21.2%; n=82%). Results about marital status indicated that 20.2% (n=78) were single, 10.1% (n=39) were engaged, 68.7% (n=265) were married and 1% (n=4) of the respondents were separated from partner or spouse.

To establish a relationship between gender and marital status with empathy, the perceptions were that empathy was perceived to have minimal (8.8%; n=34), below average (4.7%; n=18), average (40.9%; n=158) and above average (45.6%; n=179) emotional load.

The relationship between gender and empathy load was statistically significant t(385) = -41.18, p=0.00. The relationship between marital status of the respondents and their perception of empathy as an additional emotional load was statistically significant t(384) = -10.67, p=0.00.
Table 4. 7: Demographic Characteristics

<table>
<thead>
<tr>
<th>Demographic Variables</th>
<th>Freq</th>
<th>Percent</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (yrs)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21-25</td>
<td>58</td>
<td>15.0</td>
<td>Mean: 33.41</td>
</tr>
<tr>
<td>26-30</td>
<td>67</td>
<td>17.4</td>
<td></td>
</tr>
<tr>
<td>31-35</td>
<td>81</td>
<td>21.0</td>
<td>(±1.64)</td>
</tr>
<tr>
<td>36-40</td>
<td>93</td>
<td>24.1</td>
<td></td>
</tr>
<tr>
<td>41-45</td>
<td>41</td>
<td>10.6</td>
<td></td>
</tr>
<tr>
<td>46-50</td>
<td>29</td>
<td>7.5</td>
<td></td>
</tr>
<tr>
<td>&gt;50</td>
<td>17</td>
<td>4.4</td>
<td></td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>304</td>
<td>78.8</td>
<td>Gender and emotional load</td>
</tr>
<tr>
<td>Male</td>
<td>82</td>
<td>21.2</td>
<td>(t(384) = -41.18, p=0.00).</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>78</td>
<td>20.2</td>
<td>Marital status and emotional load</td>
</tr>
<tr>
<td>Engaged</td>
<td>39</td>
<td>10.1</td>
<td>(t(384) = -10.67, p=0.00).</td>
</tr>
<tr>
<td>Married</td>
<td>265</td>
<td>68.7</td>
<td></td>
</tr>
<tr>
<td>Separated/widowed/divorced</td>
<td>4</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christian</td>
<td>385</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td><strong>Emotional load</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minimal</td>
<td>34</td>
<td>8.8</td>
<td>Age and emotional load</td>
</tr>
<tr>
<td>Below average</td>
<td>18</td>
<td>4.7</td>
<td>(t(384) = 1.32, p=0.19).</td>
</tr>
<tr>
<td>Average</td>
<td>158</td>
<td>40.9</td>
<td></td>
</tr>
<tr>
<td>Above average</td>
<td>176</td>
<td>45.6</td>
<td></td>
</tr>
</tbody>
</table>
4.3.2 Factors influencing development of empathy among nurses

Dependent variables of the study model were explained as factors and indicators that have a locus in empathy for nurses. The baseline means ($M_b$) and end-line means ($M_e$) were statistically compared using a paired samples t-test (sig. p=<0.05).

4.3.2.1 Factors that favour development of empathy among nurses

The knowledge scores about factors that favoured development of empathy was analysed and showed a significant improvement following training (Table 4.7). Knowledge on mentorship programs and activities improved from good to excellent ($M_b=0.64$, $M_e=0.98$), $t(384)=-13.32$, $p=0.00$) following training. The knowledge on willingness to show empathy improved significantly ($M_b=0.46; M_e=0.90$), $t(384)=-15.43$, $p=0.00$). Knowledge of empathy as a social norm achieved a significantly significant improvement from low to high; ($M_b=0.35$, $M_e=0.86$), $t(384)=-17.36$, $p=0.00$). Friendly ways scores improved from low to very high ($M_b=0.48$, $M_e=0.85$), $t(384)=-11.36$, $p=0.00$). Positive attitudes towards empathy showed statistically significant improvement from baseline ($M_b=0.56$) to end-line ($M_e=0.78$), $t(384)=-6.54$, $p=0.00$).

Table 4.8: Factors that favour development of empathy among nurses

<table>
<thead>
<tr>
<th>Factor</th>
<th>$M_b$</th>
<th>$M_e$</th>
<th>$t$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mentorship role model</td>
<td>0.64</td>
<td>0.98</td>
<td>-13.315</td>
<td>.00</td>
</tr>
<tr>
<td>Willingness to show empathy</td>
<td>0.46</td>
<td>0.90</td>
<td>-15.426</td>
<td>.00</td>
</tr>
<tr>
<td>Empathy as a social norm</td>
<td>0.35</td>
<td>0.86</td>
<td>-17.359</td>
<td>.00</td>
</tr>
<tr>
<td>Showing friendliness</td>
<td>0.48</td>
<td>0.85</td>
<td>-11.361</td>
<td>.00</td>
</tr>
<tr>
<td>Positive attitudes towards empathy</td>
<td>0.56</td>
<td>0.78</td>
<td>-6.544</td>
<td>.00</td>
</tr>
</tbody>
</table>
4.3.2.2 Factors that hinder development of empathy among nurses

The knowledge on the factors that hinder development of empathy was analysed (Table 4.8). Knowledge about high workload and exhaustion score improved from good ($M_b=0.70$) to excellent ($M_e=1.0$), with the improvement showing a statistically significant relationship $t(384) = -12.94$, $p=0.00$. The knowledge on exploitation of individuals by colleagues or dependants for showing empathy improved significantly ($M_b=0.48$, $M_e=0.84$) $t(384) = 10.94$, $p=0.00$) after training. Knowledge on prejudice of members of the public towards nursing improved from low to above average ($M_b=0.42$, $M_e=0.70$) and the improvement was statistically significant $t(384) = -7.83$, $p=0.00$.

Knowledge about harsh working environment improved from average to excellent ($M_b=0.58$, $M_e=0.98$) $t(384) = -14.76$, $p=0.00$) after training. Knowledge on vulnerability for social injury had a substantive positive change from very low ($M_b=0.14$) to high ($M_e=0.82$) the indicative scores were statistically significant $t(384) = -24.20$, $p<0.05$). Knowledge attainment on lack of interest in developing empathy was statistically significant ($M_b=0.57$, $M_e=0.96$), $t(384) = 14.13$, $p=0.00$

Table 4.9: Factors that hinder development of empathy among nurses

<table>
<thead>
<tr>
<th>Factor</th>
<th>$M_b$</th>
<th>$M_e$</th>
<th>$t$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>High workload and exhaustion</td>
<td>0.70</td>
<td>1.00</td>
<td>-12.94</td>
<td>.00</td>
</tr>
<tr>
<td>Exploitation for showing empathy</td>
<td>0.48</td>
<td>0.84</td>
<td>-10.94</td>
<td>.00</td>
</tr>
<tr>
<td>Prejudice towards nurses</td>
<td>0.42</td>
<td>0.70</td>
<td>-7.83</td>
<td>.00</td>
</tr>
<tr>
<td>Harsh working environment</td>
<td>0.58</td>
<td>0.98</td>
<td>-14.76</td>
<td>.00</td>
</tr>
<tr>
<td>Fear for vulnerability for injury</td>
<td>0.14</td>
<td>0.82</td>
<td>-24.20</td>
<td>.00</td>
</tr>
<tr>
<td>Lack of interest to develop empathy</td>
<td>0.57</td>
<td>0.96</td>
<td>-14.13</td>
<td>.00</td>
</tr>
</tbody>
</table>
4.3.3 Factors influencing sustainability of empathy among nurses

4.3.3.1 Factors that favour sustainability of empathy among nurses

The scores on awareness about factors that favour sustainability of empathy were analysed (Table 4.9). Analysis showed a statistically significant increase in the knowledge scores. Compassion among nurse colleagues increased from high to excellent \((M_b=0.88, M_e=1.00)\), \(t(384) = -7.22, p<0.05\). Knowledge of maintaining a positive attitude on empathy improved from above average to excellent \((M_b=0.64, M_e=1.00)\). The change was statistically significant \(t(384) = -7.22, p=0.00\).

Scores indicating change of knowledge on contribution of continued professional development in sustaining empathy had a small increase from high \((M_b=0.70)\) to very high \((M_e=0.88)\). The change was actually statistically significant \(t(384) = 6.30, p<0.05\). Indicative scores for the knowledge about recognizing and rewarding empathy champions in nursing practice had a minimal change from above average to good \((M_b=0.64, M_e=0.72)\), but the change was statistically significant \(t(384) = 2.41, p=0.02\). Knowledge change on receiving empathy from peers showed statistically significant increase \((M_b=0.42, M_e=0.64)\) \(t(384) = 5.50, p<0.05\)

Table 4.10: Factors that favour sustainability of empathy among nurses

<table>
<thead>
<tr>
<th>Factor</th>
<th>(M_b)</th>
<th>(M_e)</th>
<th>(t)</th>
<th>(p)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compassion among nurse colleagues</td>
<td>0.88</td>
<td>1.00</td>
<td>-7.22</td>
<td>.00</td>
</tr>
<tr>
<td>Maintaining positive attitude towards empathy</td>
<td>0.64</td>
<td>0.92</td>
<td>-9.70</td>
<td>.00</td>
</tr>
<tr>
<td>Continued professional development</td>
<td>0.70</td>
<td>0.88</td>
<td>-6.30</td>
<td>.00</td>
</tr>
<tr>
<td>Recognise and reward empathy champions</td>
<td>0.64</td>
<td>0.72</td>
<td>-2.41</td>
<td>.02</td>
</tr>
<tr>
<td>Peer oriented empathy systems</td>
<td>0.42</td>
<td>0.64</td>
<td>-5.50</td>
<td>.00</td>
</tr>
</tbody>
</table>
4.3.3.2 Factors that hinder sustainability of empathy among nurses

The scores on awareness about factors that hinder sustainability of empathy were analysed (Table 4.10). Burn-out syndrome was attributed to mental and social fatigue among nurses as a factor that hindered sustainability of empathy. Respondents’ knowledge scores on burn-out as a negatively influencing factor improved from below average ($M_b=0.44$) to high ($M_e=0.84$) and the improvement was statistically significant $t(384)=-7.22, p=<0.05$. The knowledge on lack of advocates for empathy or empathy champions improved from above average ($M_b=0.60$) during baseline to moderately high ($M_e=0.72$), $t(384)=-33.54, p=<0.05$ following training.

Scores attained from knowledge on demotivation of individual respondents to develop empathy due to previous negative experiences from empathy improved from very low ($M_b=0.18$) to above average ($M_e=0.60$) and significantly significant $t(384)=-12.79, p=0.00$. Scores on knowledge about negative attitude towards empathy received least improvement. Score recorded an extremely low baseline knowledge score ($M_b=0.15$) which improved to below average ($M_e=0.48$). However, the change was significantly significant $t(384)=10.59, p=0.00$.

**Table 4.11: Factors hindering sustainability of empathy**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Mb</th>
<th>Me</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burn-out or mental and physical fatigue</td>
<td>0.44</td>
<td>0.84</td>
<td>-12.06</td>
<td>0.00</td>
</tr>
<tr>
<td>Lack of advocates for empathy</td>
<td>0.60</td>
<td>0.72</td>
<td>-3.54</td>
<td>0.00</td>
</tr>
<tr>
<td>Demotivation from negative experiences</td>
<td>0.18</td>
<td>0.60</td>
<td>-12.79</td>
<td>0.00</td>
</tr>
<tr>
<td>Negative attitudes towards empathy as an emotional burden</td>
<td>0.15</td>
<td>0.48</td>
<td>-10.59</td>
<td>0.00</td>
</tr>
</tbody>
</table>
4.3.4 Cumulative factors analysis of empathy among nurses

The influence of individual variables (predicting factors) on empathy were analysed (Table 4.12). The influence and sources of influences were as follows: patients’ health benefits (direct; 0.30, indirect=0.34 and total effect 0.72), nurses’ professional benefits (direct; 0.36, indirect=0.34 and total effect 0.70) professional mentorship (direct; 0.32, indirect=0.21 and total effect 0.53), personal values (direct; 0.38, indirect=0.24 and total effect 0.62) extrinsic motivation to empathise (direct; 0.41, indirect=0.17 and total effect 0.58), opportunities to show empathy (direct; 0.41, indirect=0.39 and total effect 0.80), extrinsic motivation (direct; 0.30, indirect=0.22 and total effect 0.52), multiple intelligences (direct; 0.22, indirect=0.29 and total effect 0.51) social awareness (direct; 0.36, indirect=0.34 and total effect 0.70), relatedness (direct; 0.41, indirect=0.39 and total effect 0.80). Further factor analyses are presented in tables 4.13 and 4.14.

Table 4.12: Factors and their influence sizes on empathy

<table>
<thead>
<tr>
<th>Factor</th>
<th>Influence on empathy</th>
<th>Source of influence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Direct</td>
<td>Indirect</td>
</tr>
<tr>
<td>Patients’ outcomes</td>
<td>0.38</td>
<td>0.34</td>
</tr>
<tr>
<td>Nurses’ outcomes</td>
<td>0.36</td>
<td>0.34</td>
</tr>
<tr>
<td>Professional Mentorship</td>
<td>0.32</td>
<td>0.21</td>
</tr>
<tr>
<td>Personal values</td>
<td>0.38</td>
<td>0.24</td>
</tr>
<tr>
<td>Extrinsic motivation</td>
<td>0.41</td>
<td>0.17</td>
</tr>
<tr>
<td>Opportunities to empathise</td>
<td>0.41</td>
<td>0.39</td>
</tr>
<tr>
<td>Intrinsic motivation</td>
<td>0.30</td>
<td>0.22</td>
</tr>
<tr>
<td>Multiple intelligences</td>
<td>0.22</td>
<td>0.29</td>
</tr>
<tr>
<td>Social awareness</td>
<td>0.36</td>
<td>0.34</td>
</tr>
<tr>
<td>Relatedness</td>
<td>0.41</td>
<td>0.39</td>
</tr>
</tbody>
</table>
Table 4. 13: Exploratory factor analysis

<table>
<thead>
<tr>
<th>Factor dimension</th>
<th>Factor loading</th>
<th>Eigen value</th>
<th>% variance explained</th>
<th>Reliability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Observable characteristics [OC]</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Professional conduct</td>
<td>0.93</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Effective communication</td>
<td>0.821</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Being kind to others</td>
<td>0.784</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Gender responsiveness</td>
<td>0.669</td>
<td>4.521</td>
<td>10.256</td>
<td>0.875</td>
</tr>
<tr>
<td>5. Having a warm smile</td>
<td>0.657</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Honest to peers and strangers</td>
<td>0.623</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Factors that favoured development of Empathy [FFD]</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Mentorship role model</td>
<td>0.848</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Willingness to show empathy</td>
<td>0.785</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Empathy as a social norm</td>
<td>0.706</td>
<td>3.214</td>
<td>8.942</td>
<td>0.89</td>
</tr>
<tr>
<td>4. Showing friendliness</td>
<td>0.544</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Positive attitudes towards empathy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Factors that hindered development of Empathy [FHD]</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. High workload and exhaustion</td>
<td>0.884</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Exploitation for showing empathy</td>
<td>0.840</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Prejudice towards nurses</td>
<td>0.788</td>
<td>3.126</td>
<td>7.986</td>
<td>0.84</td>
</tr>
<tr>
<td>4. Harsh working environment</td>
<td>0.754</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Fear for vulnerability for injury</td>
<td>0.691</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Lack of interest to develop empathy</td>
<td>0.634</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Factors that favoured sustainability of Empathy [FFS]</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Compassion among nurse colleagues</td>
<td>0.89</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Maintaining positive attitude towards empathy</td>
<td>0.823</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Continued professional development</td>
<td>0.825</td>
<td>2.495</td>
<td>7.416</td>
<td>0.8</td>
</tr>
<tr>
<td>4. Recognize and reward empathy champions</td>
<td>0.796</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Peer oriented empathy systems</td>
<td>0.684</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Factors that hindered sustainability of Empathy [FHS]</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Burn-out or mental and physical fatigue</td>
<td>0.836</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Lack of advocates for empathy or champions</td>
<td>0.741</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Demotivation from negative experiences from empathy</td>
<td>0.679</td>
<td>2.158</td>
<td>6.56</td>
<td>0.783</td>
</tr>
<tr>
<td>Negative attitudes towards empathy due to prior negative experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total variance explained: 41.16; Kaiser-Meyer-Olkin Measure of sampling adequacy=0.842</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 4.14: Presentation of pre and post intervention evaluation

<table>
<thead>
<tr>
<th>OC</th>
<th>Observable Characteristics of empathy</th>
<th>Mean- B</th>
<th>Mean- E</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Professional conduct</td>
<td>0.38</td>
<td>1</td>
<td>-25.02</td>
<td>0.00</td>
</tr>
<tr>
<td>2.</td>
<td>Effective communication</td>
<td>0.42</td>
<td>1</td>
<td>-23.07</td>
<td>0.00</td>
</tr>
<tr>
<td>3.</td>
<td>Being kind to others</td>
<td>0.09</td>
<td>0.96</td>
<td>-47.68</td>
<td>0.00</td>
</tr>
<tr>
<td>4.</td>
<td>Gender responsiveness</td>
<td>0.16</td>
<td>0.9</td>
<td>-30.98</td>
<td>0.00</td>
</tr>
<tr>
<td>5.</td>
<td>Having a warm smile</td>
<td>0.1</td>
<td>0.88</td>
<td>-33.98</td>
<td>0.00</td>
</tr>
<tr>
<td>6.</td>
<td>Honest to peers and strangers</td>
<td>0.06</td>
<td>0.64</td>
<td>-20.95</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**FFD**
Factors that favoured development of Empathy

| 1. | Mentorship role model                | 0.64   | 0.98   | -13.32 | 0.00 |
| 2. | Willingness to show empathy          | 0.46   | 0.9    | -15.43 | 0.00 |
| 3. | Empathy as a social norm             | 0.35   | 0.86   | -17.36 | 0.00 |
| 4. | Showing friendliness                 | 0.48   | 0.85   | -11.36 | 0.00 |
| 5. | Positive attitudes towards empathy   | 0.56   | 0.78   | -6.54  | 0.00 |

**FHD**
Factors that hindered development of Empathy

| 1. | High workload and exhaustion         | 0.7    | 1      | -12.94 | 0.00 |
| 2. | Exploitation for showing empathy     | 0.48   | 0.84   | -10.94 | 0.00 |
| 3. | Prejudice towards nurses             | 0.42   | 0.7    | -7.83  | 0.00 |
| 4. | Harsh working environment            | 0.58   | 0.98   | -14.76 | 0.00 |
| 5. | Fear for vulnerability for injury    | 0.14   | 0.82   | -24.20 | 0.00 |
| 6. | Lack of interest to develop empathy  | 0.57   | 0.96   | -14.13 | 0.00 |

**FFS**
Factors that favoured sustainability of Empathy

| 1. | Compassion among nurse colleagues    | 0.88   | 1      | -7.22  | 0.00 |
| 2. | Maintaining positive attitude towards empathy | 0.64 | 0.92 | -9.70 | 0.00 |
| 3. | Continued professional development   | 0.7    | 0.88   | -6.30  | 0.00 |
| 4. | Recognize and reward empathy champions | 0.64 | 0.72 | -2.41 | 0.02 |
| 5. | Peer oriented empathy systems        | 0.42   | 0.64   | -5.50  | 0.00 |

**FHS**
Factors that hindered sustainability of Empathy

| 1. | Burn-out or mental and physical fatigue | 0.44 | 0.84 | -12.06 | 0.00 |
| 2. | Lack of advocates for empathy or champions | 0.6    | 0.72 | -3.54  | 0.00 |
| 3. | Demotivation from negative experiences from empathy | 0.18 | 0.6  | -12.79 | 0.00 |
| 4. | Negative attitudes towards empathy due to prior negative experience | 0.15  | 0.48 | -10.59 | 0.00 |
4.3.5 Observable empathy-related characteristics

The awareness of observable characteristics related to empathy (Table 4.11) was analysed. The improvement on individual variables was substantive as indicated by the mean scores. The knowledge score means [baseline means ($M_b$) and end-line means ($M_e$)] were statistically compared using a paired samples t-test. Professional conduct score improved from low to high ($M_b=0.38$, $M_e=1.00$), $t(384)=-25.02$, $p=0.00$). The knowledge on effective communication improved significantly ($M_b=0.42$, $M_e=1.00$), $t(384)=-23.07$, $p=0.00$) after training. Knowledge on showing kindness to colleagues and clients improved from very low to high ($M_b=0.09$, $M_e=0.96$), $t(384)=-47.69$, $p=0.00$).

Similarly, knowledge on gender responsiveness had a significant improvement from very low to very high ($M_b=0.16$, $M_e=0.90$), $t(384)=-30.98$, $p=0.00$). Knowledge about having a warm smile showed statistically significant improvement from very low during baseline to high ($M_b=0.10$, $M_e=0.88$), $t(384)=-33.98$, $p=0.00$) after training. Knowledge on honesty improved substantively as shown by the significant change in mean scores ($M_b=0.06$, $M_e=0.64$), $t(384)=-20.96$, $p=0.00$).

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>$M_b$</th>
<th>$M_e$</th>
<th>$t$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional conduct</td>
<td>0.38</td>
<td>1.00</td>
<td>-25.02</td>
<td>.00</td>
</tr>
<tr>
<td>Effective communication</td>
<td>0.42</td>
<td>1.00</td>
<td>-23.07</td>
<td>.00</td>
</tr>
<tr>
<td>Being kind to others</td>
<td>0.09</td>
<td>0.96</td>
<td>-47.68</td>
<td>.00</td>
</tr>
<tr>
<td>Gender responsiveness</td>
<td>0.16</td>
<td>0.90</td>
<td>-30.98</td>
<td>.00</td>
</tr>
<tr>
<td>Having a warm smile</td>
<td>0.10</td>
<td>0.88</td>
<td>-33.98</td>
<td>.00</td>
</tr>
<tr>
<td>Honest to peers and strangers</td>
<td>0.06</td>
<td>0.64</td>
<td>-20.95</td>
<td>.00</td>
</tr>
</tbody>
</table>
Table 4.16: Observational checklist - PETIOC

<table>
<thead>
<tr>
<th>Observed empathy traits (category)</th>
<th>PETI (OC\textsubscript{2})</th>
<th>(n=12)</th>
<th>Yes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>F</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>Personal attributes (Preparedness)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Begins nursing care on time</td>
<td></td>
<td>10</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>Creates a welcoming environment</td>
<td></td>
<td>7</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>Calm but sensitive</td>
<td></td>
<td>8</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>Actively engages the patient in the intervention</td>
<td></td>
<td>11</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Professional attributes (Behavioural)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrates self confidence</td>
<td></td>
<td>11</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Responds respectfully to patients and colleagues</td>
<td></td>
<td>12</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Listens carefully and actively</td>
<td></td>
<td>9</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>Interpersonal attributes (Wellbeing)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gentleness in administering interventions</td>
<td></td>
<td>11</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Effective communication techniques</td>
<td></td>
<td>11</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Showing kindness to patients</td>
<td></td>
<td>12</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Smile and occasional laughter during care</td>
<td></td>
<td>12</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

\textbf{PETIOC}_{2} = \text{Post Empathy Training Intervention Observation Checklist},
4.3.6 Triangulation of key research findings

During the study process, three reliable findings emerged from the research. The study revealed that the issue of empathy role strain between nurses and patients exist; nurses experience difficulties in providing, showing an offering empathy before empathy training intervention as shown in figure 4.6

**The needs analysis – Nurses experienced difficulties in empathy**
- Significant deficiencies in empathy knowledge and skill among nurses and this gap was indicative of an empathy training intervention
- Focus group discussion identified indicators of empathy in nursing
- Observation identified skill performance gaps in clinical-empathy

**Empathy training intervention**

**Development of empathy for nurses**
- Motivation of nurses to determine their own course in empathy development
- Integrating Imogene king theory of goal attainment in empathy
- Empowering nurses to discover their emotional intelligence for social and professional management

**Sustaining empathy in nursing**
- Integrating models of nursing care in empathy
- Continued professional support
- Institutional support for nurses to remain relevant in their roles

Figure 4.6: Triangulation of results from both phases of the research
4.3.7 Results of the Hypotheses tests

The three hypotheses were tested at 95% confident interval and the following findings were arrived at 0.05 significance level using a t-test. First hypothesis stated that nurses in Kenya experience significant challenges in integrating clinical empathy in nursing care of patients thus increasing turn-over intentions by nurses.

Findings of the empathy needs analysis provided evidence; when empathy challenges were prevalent, turn-over intentions increased significantly from 0.2 ± 0.03; to 0.4 ± 0.03; (n=384; df=384) but following empathy training interventions, the turn-over intentions reduced to 0.00 ± 0.03; p=0.001. therefore, there was significantly increase turn-over intentions among nurses in Kenya when empathy is strained.

The second hypothesis stated that empathy training intervention has significant influence on developing empathy knowledge and skill performance in nursing practice among nurses in Kenya. The results from this study indicated a significant positive change in knowledge and skills (0.4 ± 0.02 to 0.8 ± 0.07; p=0.001. there was adequate evidence to suggest that the empathy knowledge attainment and behavioural demonstration of empathy skill by the respondents was a positive contribution to empathy integration in nursing practice.

The third hypothesis stated that there is a statistically significant relationship between knowledge attainment and empathy training intervention among nurses in Kenya. Hypothesis tests conducted at 0.05 alpha level showed that the relationship was significant and positive; 0.4 ± 0.03; to 0.9 ± 0.03; (n=384; df=384). The knowledge change showed a very positive contribution to empathy among nurses and it also improved the caring behaviours that are related to empathy and altruism
4.4 Summary of the findings

This research was very successful and relevant to caring behaviors among nurses and to nursing profession. The findings are presented as per the research objectives. The first objective was to determine the empathy training needs among nurses in Kenya. The findings confirmed that there existed knowledge and skill gaps that required intervention. The intervention was developed and implemented. The second objective was to establish the rationale for developing and sustaining empathy among nurses in Kenya.

The findings confirmed that the respondents (nurses) were able to give rational implication that warranted implementation of the training intervention module. The third objective was to determine and apply the most appropriate training strategies and resource materials for training empathy among nurses in Kenya. The study confirmed that there were no available resources as yet but a training module for continued professional development was developed and implemented. The fourth objective was to analyze the effect of empathy training intervention on empathy knowledge and skills in nursing practice among nurses in Kenya. The results indicated that the effect size was significant, and the participants showed a lot of interest in the progression of empathy as a core competence and a caring behavior in nursing practice. All the three hypotheses were tested, and the relationships between the variables were significant.
CHAPTER FIVE: DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

The goal of this study was to develop and implement an empathy training manual for nurses using constructivist approach and pragmatic paradigm of inquiry. Analysis of obtained data from needs analysis among nurses resulted in the development of interventions that are specific to Kenyan nursing practice and healthcare environment. The interplay of various factors and approaches made the entire research process very practical at different levels of nursing practice and diverse self and social conditions under which empathy is developed, sustained and applied in everyday nurse-patient interactions in Kenya.

In this chapter, the conceptualised variables of the conceptual model and the training manual components are discussed regarding the specific research questions that guided the study. The main questions that guided this study explored the empathy training needs of nurses on the knowledge and skill concepts that formed variables of the empathy development and sustainability conceptual model. Reflections on current findings that aim to place the training manual concepts model within the context of existing literature are presented. In addition, the significance of the current findings and their potential contributions to professional nursing knowledge is presented.

The chapter is organized into sections that comprise of demographic characteristics, self-concept, indicators of empathy, observable characteristics of empathy in nursing practice, rationalization of development and sustainability of empathy, factors influencing development and factors influencing sustainability of empathy among nurses, conclusion and recommendations are presented.
5.2 Demographic characteristics of participants

This study presents a relatively young nursing workforce with individuals who have a high self-concept and a true conviction to the professional values. The age distribution showed positive skew with a mean age of 33.41 years. Contrary to this result regarding age is AACN (2010) report which indicated that majority of nurses in practice were 50 years or older. These findings indicate that a relatively young group of nurses could benefit from empathy training due to their potential in professional development and positive influence from new achievements for nursing profession. The lower age group is reflective of the national workforce of young people across the Kenyan job markets.

The results of this study showed that there were more female nurses compared to male nurses; in a ratio of 3 to 1. Although it seems an improvement from the times when nursing was considered a woman’s profession. This finding is consistent to Cook-Krieg, (2011) who argued that men have a challenge in choosing nursing as a career because nursing involves vulnerability and values that are considered feminine. Further insights into male population in nursing indicate that although there is increasing males in nursing profession, majority prefer pursuit of specialties that are acceptable as more masculine in nature, such as anaesthesia and psychiatric nursing (Prideaux, 2010). In specialties in nursing profession embraces social awareness in care; however, empathy is viewed as a more powerful communication skill than a social trait with vulnerable qualities (Meadus & Twomey, 2011). Empirical evidence points at paradigm change that nursing, the so-called female-dominated field of opportunities is being exploited by males Regardless of increase in number of males in nursing profession, female nurses are reportedly able to show empathy better than male nurses (Cook-Krieg, 2011).
5.3 Self-concept

Self-concept has a direct influence in empathy in that it demonstrates the urge for innovative solutions that are self-satisfying as an individual pursues universal values of peace, human dignity, gender equality, non-violence engagements and non-discrimination to patients and colleagues. High self-concept was reported in this research whereby, majority of the participating nurses had relatively high levels of self-concept. Although it was a simple self-reflection exercise, participants showed consistency in maintaining that they held themselves and colleagues in high regard. These findings are consistent with research conducted by Baron and Wheelwright, (2004) reported that professionals in fields where caring for individuals or groups forms the core competence and reference, and therefore, such high self-concept is expected from such professionals.

This understanding that springs from higher levels of self-concept is also related to the mood or affective components of an individual. It also enables persons to create interpersonal relationships without a concern for keeping and maintaining own self-identity. These skills are the basis for understanding self-feelings and allow the prediction of his or her future behaviour (Howe, 2016). The current research has indicated that nursing care is a goal that requires being coupled with attainment of empathy goals as well. High self-concept can be further interpreted as an indicator of nurses’ confidence as she provides nursing care to the patients. The sociability and interpersonal perspectives in empathy are so interdependent that nurse-patient relationships have been viewed as the basis upon which moral foundation of nursing practice is established (Song, Colosante and Malti (2017).
5.4 Indicators of empathy

The indicators of empathy that were identified in this study were awareness, gentleness, communication, wellbeing, predictability, kindness and gender sensitivity. These qualities were consistent to those described earlier in empathy factor analysis results namely social self-confidence, (gentleness and kindness), calmness, sensitivity and non-conformity (Johnson, Cheek and Smither, 2013). The awareness and skill indicators have proven essential in developing and sustaining empathy. These findings are consistent to literature sources (Theodosius, 2008) that identifies empathy as a continuous variable that have qualities of being calm, gentle, understanding, availability and are ready to engage in an informative conversation with the patients.

The needs analysis results of this study show that the training curriculum for nurses did not explicitly identify empathy as a trainable competence but an in-born trait that some people have easier time showing empathy than others. The respondents didn’t know that consistency in developing and showing or offering empathy would be greatly influenced by work related challenges like workload and vulnerability; but aggravated by personal emotional strength. Non-conforming is specifically responsible for accuracy in person’s perception If the perception of a phenomena is accurate, the behavioral characterization can be expected to be consistent (Baron-Cohen, 2012).

In the self-concept perspectives, this study suggests that self-concept can be converted into self-awareness and empathetic concern. Therefore, in nursing, where caring forms the core competence and reference, such high self-concept is expected from the professionals (Baron-Cohen & Wheelwright, 2004). Behavioural characteristics stem from self-concept and avowal to serve is a
complimentary value in identifying with a profession. Furthermore, self-concept is more basic part of personality that it is a part of emotionality (Parr & Waller, 2007).

This study established that training guides and syllabus didn’t recognise empathy as a trainable skill. There were no learning experiences designated to train empathy in the entire training curriculum. While settings expected learning outcomes and exit competences should be consistent with learner needs; we should therefore not expect learners to exhibit behaviours that are not allocated in their prescribed curriculum. The justification for training empathy is evidence based. The road map to sustainable empathy is entirely based on professional commitment to continuously linking empathy competency training to improved health and wellness outcomes. This study was informed by the nurses’ need for empowerment in empathy because it was believed to improve nurses’ professional outcomes and patients’ health rewards. Healthcare development has been mandated the professional responsibility which embeds competency assessment and assurance into professional practice (Gitonga, Gatere, Karani, and Wakapa 2014). Further, evidence suggests that nursing is an emotionally intense profession and nurses should be empowered with relationship management (Morrison, 2012).

Regarding empowering nurses on empathy, American College of Healthcare Executives (ACHE, 2014) recommends that healthcare professionals should be empowered but not micromanaged, sponsored to serve as role models, allowed to manage their own scale of innovation, trusted without being prejudiced, and be positively challenged rather than being marginalized. Therefore, empathy training should be considered in all capacities to empower both the nurse and the client (Cunico, Sartori, Marognoli and Meneghini, 2012). Developing empathy among nurses, colleagues and patients was considered a pre-requisite factor for developing social skills and empathy. These findings are consistent to Ozcan et al. (2010) who recommended that empathy
should be taught, trained and sustainability strategies informed by continuous professional development and retraining.

5.5 Rationalizing training interventions for empathy

Providing a rationale for our interventions is a good practice. It is not accurate to intervene without supporting evidence from needs and recognition of the benefits related to the intervention. This study presented to the respondents an intention to engage them in an empathy empowerment process. Study results showed that the participants were aware that such an empowerment would be essential in their practice. The empowerment was in form of a training to promote institutional capacity, as recommended by Ministry of Health (2016) strategic policies for health care.

Majority of the study participants realised that empathy training intervention would improve health outcomes for patients and promote professional wellness and success for nurses. These findings are consistent with study conducted to review rationales for effective interventions for empathy in care delivery intuitions (McGuire, 2008) which indicated a rationalized process achieves better outcomes than those that are not rationalised. This understanding for intervention in empathy is consistent to Song, Colosante and Malti (2017) who in their research reported that individuals with better emotional identification, motivational preparation, self-interest regulation and empathy in their practice tend to offer empathy in a much easier manner that those that do not have such opportunities about empathy. Findings from this study further demonstrate that when an interventional program is intended, it should be provided with a rationale, a justifiable reason and should address specific needs of the target population. The intervention for developing empathy was in accordance with the professional commitment to promote awareness and prepare champions of empathy among nurses.
5.6 Observable characteristics related to empathy

Empathy is a life skill that can be characterized into observable and non-observable characteristics. The more relevant of the characterizations of empathy are those that can be observed; these are behavioural and social interactionism skills. Results of this study indicate that application or integration of goal of nursing as a transaction process requires a degree of psycho-social perspectives. Observable empathy characteristics were equivalent to indicators of empathy as values of professional conduct of nurses in their professional duties. These findings are consistent to studies conducted by Ozcan and colleagues (2010) which revealed that empathy can is comprised of observable values and that empathy competences can be successfully learned and therefore should be taught or trained.

Non-observable characterizations of empathy (mainly physiological) were not measured or subject to manipulation in the current research and therefore not explained in this study. Empirical evidence however, suggests that empathy can be influenced by physiological and biochemical molecules, for instance, oestrogen hormone increases tendencies to empathise and demonstrate empathic concerns (Domes, Heinrichs, Michel, Berger and Herpertz 2006). Hormonal and psychological status like emotional intelligence was not measured as well as was intrinsic motivations to empathy. Although intrinsic influence of empathy was not measured, it would be inappropriate to conclude that their influence is negligible.

This study established that observable characteristics of empathy help in determining whether or not people are influenced by their motives of connecting to others; especially to strangers. This result is consistent to evidence which suggested that, among the many benefits of empathy has in therapeutic relationships, the most practical for nurses are awareness and practice to ensure that;
empathy connects people and generates emotional intelligence about developing innovations for better health outcomes (Eisenberg and Liew, 2009). In addition, empathy encourages understanding of self-worth, worth for others and communicate that understanding for better relationships (Gehres, 2011).

Results of this study indicated that showing kindness to others, being honest and sensitive to them is advantageous in establishing trusting therapeutic relationships between nurses and patients. This finding is consistent with Song et al., (2017) who argues that when nurses show empathy, they achieve benefits for themselves and for their patients. Further, evidence suggests that empathy heals, helps build trust among members of a team and closes the communication loop (Eisenberg and Liew, 2009).

5.7 Factors influencing development of empathy among nurses

5.7.1 Factors and their influence size

A variety of factors had an effect (influence) on development and sustainability of empathy. The largest influence was that exerted by relatedness of an action to empathy and opportunities to develop empathy. Actions and their relatedness to empathy was considered vital because persons relate what they do, to what they are trained to do. The opportunities to develop a competence plays a vital role of what the overall development achieves. Evidence suggests that individuals should offer empathy to others (Song, Colosante and Malti (2017).

This study also found out that the lowest effects were exerted by intrinsic motivation, peer influence and multiple intelligences. These factor influences were used as components of the intervention program to stimulate the respondents into continuous self-evaluation on empathy development and sustenance processes.
5.7.2 Factors that favour development of empathy

Awareness of conditions that favour development of empathy was initially below average. On a substantially high. Study showed that availability of role models and willingness of the respondent to develop empathy were highest ranking favourable factors. These results were consistent to Ross and Hillborn (2008) who found out that developing empathy can positively be influenced by positive mentoring by role models and able mentors. Further evidence showed that the emotional behaviour is intrinsically controlled (Hatfield, Cocioppo and Rapson 1994). These results indicate that professional commitment to the promise that nurses will ensure continuity of developing empathy as a personal ethical responsibility can be made a reality in nursing.

5.7.3 Factors that hinder development of empathy

Conditions that hinder development of empathy have been consistent during the entire process of this study. Development of empathy was hindered by high workload assigned to the nurses; mentors and mentees, highly experienced and novices, males and females in nursing practice in Kenya. This result is consistent to research findings presented as conference proceedings by Hamilton (2008) indicating that training emotional and social connections is not an easy task. Although the best practice is to inculcate empathy within the schedules for nurses, the high demand on the nurse makes it almost humanly impossible to have consistency in empathy. Referring to consistency, the findings of this study are similar to findings of Reynolds and Scott (2000) who found out that nurse leaders and managers usually link new concepts to existing healthcare protocols. High demand for nurses’ attention may hinder development of empathy.

However, empathic behaviour can reduce mental and physical load on the nurse. This study reported other factors that hindered development of empathy; these includes lack of interest from
participants due to possible exploitation and a sense of social vulnerability. Participants described that they had witnessed some incidences where those nurses that showed a lot of concern for patients were allocated more roles and received several requests from colleagues to cover for them. This was perceived as exploitative behaviour that discouraged others from being comfortable in showing empathy.

5.8 Factors influencing sustainability of empathy among nurses

5.8.1 Factors that favour sustainability of empathy

This study revealed that several factors favoured sustainability of empathy among nurses. The awareness levels were initially good but after interventions, the scores showed a considerable improvement. Sustainability of empathy was highly favoured by compassion among nurse colleagues and maintaining a positive attitude towards self and towards others. Research evidence suggest that positive attitude towards what people do gives them longevity in maintaining the beauty of their profession (Fitzpatrick, 2014).

This study discovered that capacity building on empathy through continued professional development equips the nurse with most current social and professional competences to meet the evolving healthcare needs of a diversified population. Social competence is also an important value for patients. Training provides a chance to improve the social environment for sustaining empathy. Research has indicated that promoting self-awareness and affective social competence determines sustainability of nursing empathy (Goleman, 2006). This study shows that creating a compassionate societal and institutional culture plays a pivotal role in sustaining empathy. These findings mean that if all these contributing factors are implemented, sustaining empathy would be much easier than it seems.
5.8.2 Factors that hinder sustainability of empathy

Several factors were associate with influences that hindered sustainability of empathy among nurses in Kenya. The initial levels of awareness were very low with an average improvement after training. The study showed that sustainability of empathy is hindered by mental and social fatigue, lack of empathy champions and negative attitude towards empathy. These results agree with studies by Gehres (2009) which reported initial challenges to sustaining empathy were emotional loads related to nursing roles. Research evidence suggest that vicarious trauma from intense emotional injury discourages care providers into maintaining the empathetic behaviours (Sabo, 2011).

Results of this study pointed out that empathy development and turnover challenges of nurses with the claims that they were being trivialised, ignored, their empathy motives were potentially subject to misinterpretation. of the motives to empathy and vulnerability to social – emotional injury hindered sustainability of empathy. This study has confirmed that sustaining empathy requires multiple interactions between the institutional culture, healthcare delivery team and significant others to be successful.

5.9 Conclusion

The findings from this research posits that a multi-stage triangulation can yield rich data and high internal consistency index. We therefore conclude that empathy is an observable and a trainable life skill. Understanding self-limitations of empathy competences is the first step of planning for an intervention. Needs assessment provides important rationales for closing the gaps identified among nurses. Training interventions in developing and sustaining empathy yielded significant knowledge attainment. Empathy among nurses is a trait that is increasingly responsible for
cultivating altruistic qualities that enable nurses to meet professional and social expectations. The expectations involve delivering high quality nursing care without necessarily suffering from emotional or social fatigue.

This study concludes that developing and sustaining empathy competences is possible. The social awareness and relationship management should not be forced unto nurses or unto clients. Nurses should be provided with opportunities to develop their empathy in the style that conforms to nursing practice. The patients and significant others should be empowered to embrace empathy as a desirable social trait. The public should learn to show empathy to nurses and to fellow citizens, care givers, dependants, friends and strangers.

5.10  Recommendations

This research makes the following recommendations that present opportunities to develop and sustain empathy among nurses in nursing practice.

Nursing education and administration recognizes that nursing roles are multidimensional and an on-going commitment to develop and maintain professional competence in the nursing practice is essential. Nurse training institutions should develop their own policies and mechanisms that actively advocate for inclusion of empathy in the training curriculum to ensure that empathy is an exit competence.

5.10.1  Recommendations for empathy - best practices in nursing

This needs analysis found out that training materials and the nursing curriculum did not have specified learning experiences that are designed to developing empathy for nurses.

i) Include the recommended empathy training outline in the curriculum for nurses.
ii) Promote empathy through professional development plans and implementation in training

iii) Establish a NCK committee to spearhead empathy in nursing profession

iv) Establish a national empathy index for nurses

v) Establish threshold targets for comparative empathy among nurses in Kenya

5.10.2 Recommendations for the hospital management boards

The study established that a major setback in developing and sustaining empathy was lack of institutional support and champions for empathy. The study also established that nurses felt that their empathy training needs had been ignored or trivialised in several occasions. The study also observed that hospital managements didn’t adhere to the patient-nurse ratios as recommended by the regulator of nursing practice in Kenya

i) The management boards in Kenya should take a leading role in championing for empathy

ii) The hospital managements should establish an empathy specific continuous professional development program where opportunities to train empathy competencies can be provided to nurses.

iii) The hospital boards should to adhere to realistic nurse-patient ratios as recommended by the NCK so that nurses are not overwhelmed by physicality of delivering nursing care and deteriorate on emotionality and value delivery of care.

5.10.3 Recommendations for the schools of nursing

The study established that the curriculum for training nurses at all levels didn’t have expected learning experiences specific to empathy.
i) This study recommends that the schools of nursing should adjust their course/unit implementation matrices to accommodate empathy training in pre-service nurses’ training.

ii) The curriculum review should include learning experiences for empathy training skills compatible with nursing practice.

5.10.4 Suggestions for Further Research

This study was carried out among nurses only in the four hospitals in Kenya. The respondents unanimously agreed that capacity building was required for empowering nurses in developing and sustaining empathy in nursing practice.

i) This study recommends that a comparative analysis among healthcare providers, is conducted among doctors, clinical officers, nutritionists, radiology technologists in Kenya to establish their development and sustainability of empathy.

ii) The researcher suggests a replication of this study using other dependent variables such as; empathy among persons in other professions and the public.

iii) The study recommends that a feasibility analysis is conducted to analyse the training curricula in nursing and develop a structured checklist to train empathy skills.
ANNEX: Empathy Training Manual for Nurses

DEVELOPMENT AND SUSTAINABILITY OF EMPATHY IN NURSING PRACTICE

By

Pius Gitonga Gervasioh

Contributors

Prof. A. Karani, Dr. S. Kimani, Dr. J. Mwaura and Dr. M. Wagoro

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DEVELOPMENT AND SUSTAINABILITY OF EMPATHY IN NURSING PRACTICE

Introduction

The reason for developing this training was the motivation of Edwin Rutsch to build a culture of empathy and compassion. Pius Gitonga is the principal investigator for this research and believes that fostering empathy competence in nursing practice is important because it helps to resolve nurse-nurse – nurse-patient role/relationship conflicts that may arise and improve the professional social connection between them. Furthermore, it leads to a broader awareness and more openness to new insights in therapeutic environments. Research has confirmed that showing and offering empathy to each other and showing empathy concern leads to conflict resolution and a better connection between individuals (Gordon 2012).

Indeed, fostering empathy is important in nursing practice because it reduces emotional exhaustion, burn-out, prejudice and discrimination, negligence and increases the will of nurses to help persons who are in need (Dixon, 2011; Gordon, 2012; Davis, 1980; Eisenberg & Miller, 1987). In other words, empathy is a building block for a better society. The main goal of this training is that the nurse participants can apply the learning materials from this training in real life situations to be able to be empathic with themselves as with others. The target group of this training concerns 21+ adults with different ethnical backgrounds. This empathy training is based on the insights of Imogene King goal attainment theory and transaction process (King, 1990).

King (1990) defines empathy as: strategies and means that empower nurses with skill and confidence for entering the perceptual world of the other and becoming truly sensitive, moment by moment, to the changing felt meaning which flow in this other person, to the fear or tenderness or rage or confusion or whatever the other person is experiencing. It means to temporarily living
in the others perceptual world and moving in it delicately without making judgments; it means sensing meanings of which the other is scarcely aware, but not trying to uncover totally unconscious feelings because this can be to be threatening. It includes communicating your sensing’s of the person’s world as you look with fresh and un frightened eyes at elements of which he or she is fearful. It means frequently checking with the other person as to the accuracy of your sensing’s and being guided by the responses that you receive. You are a confident companion to the person in his inner world. This way the other person can experience the personal meanings more fully and move forward in the positive experiencing.

Further insights from Rogers (1982) implies that, in order to empathize with others, it is important to show unconditional positive regard, listen accurately and be able to take the perspective of others. Unconditional positive regard means to not judge others but to accept them for who they are, both positive and negative sides and to acknowledge that they all are self-determining individuals. Showing unconditional positive regard towards others is important because it gives them the knowledge that they are just as important as everybody else and they are more likely to think “if he isn’t judging me and allows me for who I am, I am maybe not that strange person I always thought I was”. People who receive unconditional positive regard are more likely to show it towards themselves and start to empathize more with themselves.

**Background of empathy training for nurses**

Empathy can be described as temporarily taking the role of the other and seeing the other from his or her internal frame of reference (Baron, Eagle & Wolitzky, 2009). In recent years, empathy has been one of the most popular topics in the field of clinical psychology, medicine and nursing. To gain better understanding new studies concerning neuroscientific, developmental and social side
of empathy have been conducted. Empirical evidence has showed that empathy is rather a multidimensional construct and can be divided into two concepts: cognitive empathy and affective (emotional) empathy. Cognitive empathy can be subdivided into perspective taking and fantasy as well as affective empathy can be subdivided into empathic concern and personal distress. However, as empathy is a quite complex process it has not been fully agreed whether cognitive and affective systems exist at all and if they do whether they interact or work as two separate systems.

Despite all the different types and science concerning empathy it would be very important to understand what roles do personal attributes play in the process of empathy, what are the qualities and indicators of empathy in nursing, how does mentoring and empowering nurses on self-empathy needs analysis, what characteristics affect the development of empathy and how loneliness or personal distress influence empathy is so much attention to this crucial process. However, the focus of this training is improving clinical experience for patients through developing and sustaining clinical empathy. Clinical empathy is one of the most important skills in developing effective skills in therapeutic communication, social connection and developing trusting relationships between nurses and their patients.

This training is aimed at promoting social competences that foster development and sustainability of empathy among nurses in Kenya. Nursing practice has a pivotal role in health of our communities. Empathy in nursing is a precursor for better health outcomes and therapeutic relationships among nurses and their clientele. The training needs assessment indicated that nurses needed to train on empathy. Deci & Ryan, (2000) argued that empathy is a very powerful and essential communication skill that is often misunderstood and underused. It would not be appropriate at all if nurses continued to misunderstand and/or underuse empathy in nursing actions.
We, the authors of this manual, envision that nurses will consistently apply empathy in their daily practice. It is recommended hereunto that nursing practice will consistently ensure that every and actually all interpersonal human connections in therapeutic settings are socially acceptable and professionally sound. In interpersonal connections, self-awareness, social awareness, recognition of knowledge and skill needs through needs analysis and effective relationship management are key principles in developing and sustaining those connections. Training needs assessments showed that empathy was not being trained to nurses; national and county investments have been directed to new treatment regimens and case management protocols.

The needs assessment observed that the nursing curriculum and professional development plans were not aimed at developing empathy. Knowledge on empathy among nurses was found to be low. Therefore, there is need to provide training opportunities to nurses. The empathy training initiative is an interventional strategy to meet the nurses’ needs as aforementioned. The initiative is informed by the ideology that indicated empathy skills are teachable, learnable and have tangible benefits for both nurses and patient (Ioannidou & Konstantikaki, 2008). In developing empathy, the motivation is to ensure that we understand what empathy is and define the sphere within which empathy is practical. In sustaining empathy, we intended to identify champions and mentors within nursing practice for them to maintain the activities within the identified sphere in promoting empathy.

**Justification for empathy training intervention for nurses**

Empathy has been reported to be an essential competence in promoting human relationships. The best way to develop empathy is through training, practice and retraining. Improved knowledge on empathy is associated with possible application into nursing practice. When nurses are trained on empathy nurse-patient relationships have been associated with better health outcomes.
**Empathy intervention as part of improving nursing care outcomes**

Empathy is essential in improving nursing and health care outcomes. Empathy Project will be established within that premise. We intend to empower institutions to establish functional training systems; such that can assess training needs, plan and implement training, manage its human resources, monitor and evaluate training, develop and disseminate training standards and guidelines, and design and develop training curricula and materials. This programme will establish personnel and resources for empathy development and sustainability in nursing profession in Kenya. This training is intended for two days as a professional development plan [PDP] in a face-to-face setting. The activities of the first day are theoretical and skill demonstration while those of the second day are skill application and overall training evaluation.

**Scope of the empathy training intervention**

The empathy training intervention manual is intended to support nurses in deeper integration of empathy in nursing practice. This manual proposes a supportive practice environment, nurses experience success, challenges, guidance and support in the practice of empathy. and seeing our world empathically. Throughout our time together we will acquire knowledge and skills so as to increase our capacity for integrating empathy, learn to focus our awareness, and develop the ability to work with our own capabilities and humanity, in real-time situations requiring empathy.

Feelings and needs are the focus of empathy, so our relationship to them directly influences the quality and depth of our empathy. At this intensive, through practice and exercise, we will broaden and enrich our understanding and experience of these life energies thereby deepening our practice of empathy. Throughout the training, we will build on what we already know and what is practical to nurses’ role-relationships. We envision ensure sustainable empathy into our daily lives.
• **Needs assessment** - confirmed that training was the indicated intervention and established a baseline against which future progress can apply as a reference.

• **Consensus building** – is a process that engaged stakeholders to develop training strategies, take ownership of the program, and commit to its success.

• **Resource planning** – the empathy project upon full adoption will require organisation and support in the following resources.
  
  o Establishing financial stability – remuneration, commodities, and research
  o Developing human resources for health
  o Maintaining physical resources
  o Developing and implementing instructional tools for empathy

**Linking empathy training to on the Job nursing practice**

Linking training to subsequent practice of empathy reinforces the goal of empathy training, which is to improve nurse’s performance at the workplace.

**The prerequisites that strengthen empathy are:**

• **Institutional commitment** - The institution is supportive of the participant’s training and will provide opportunities for applying newly acquired empathy skills. This includes restructuring work, as needed, to support nurses in practicing empathy, as well as to reward improved empathy competence.

• **Effective mentorship** – training empathy requires providing coaching and mentoring in ensuring that nurses show and offer empathy effectively.
• **Personal drive and commitment** - The nurse is willing to learn and to apply new skills on the job on a continuous basis.

**Learning goal and outcomes of the training**

**Goal of the training**

By the end of the training, the participant will be able to explain abilities related to development and sustainability of empathy among nurses in Kenya.

**Learning outcomes of the training**

*By the end of this training, the participant will be able to;*

i) Describe the indicators of empathy as an adaptive human functioning behaviour among nurses

ii) Describe abilities that are related to identifying, understanding and intervening to solve empathy – related challenges among nurses providing nursing care in Kenya.

iii) Describe the process to develop personal and social emotional competences among nurses

iv) Discuss the challenges that influence the
   a. Abilities to identify and intervene to emotional problems
   b. Adaptive human functioning in healthcare
   c. Development of personal and social emotional competences
DEVELOPING SUSTAINABLE EMPATHY IN NURSING PRACTICE

Empathy for Nurses

(COURSE OUTLINE)

By

Pius Gitonga Gervasioh

Contributors

Prof. A. Karani, Dr. S. Kimani, Dr. J. Mwaura and Dr. M. Wagoro

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DEVELOPING SUSTAINABLE EMPATHY FOR NURSES 45 HOURS

Unit purpose: To equip the learner with knowledge, skills and attitudes on empathy in nursing

Expected learning outcomes

By the end of the unit, the learner will be able to:

1. Explain the principles and concepts of empathy in nursing practice
2. Describe the processes of developing empathy skills
3. Apply empathy skills in nursing practice
4. Apply the concept of sustainability of empathy competence in nursing practice

Unit Content

Empathy: Definition, historical perspectives of empathy, classification, cognitive empathy, emotive empathy, empathetic concern, emotional contagion, professional empathy in nursing; process of developing empathy, self-concept, social awareness, self-judgement, relationship management, empowering care targets, revitalising from positive empathy, apply empathy skills; gentleness, kindness, patience, calmness, listening skills, positive attitude towards empathy, conducive hospital environment for empathy, professional responsibility in developing and sustaining empathy; evaluate characteristics of empathy; self-evaluation, peer evaluation, institutional evaluation, empathy audit.

Teaching Methods

Lectures, tutorials, group discussions, self-directed learning, individual and assignments

Teaching and learning resources

Lecture notes, Textbooks, Journals, LCD projectors, e-resources

Methods of Unit Assessment

Continuous Assessment Test (CAT) 30 %; End of Semester Examination (ESE) 70 %
Core reading materials


Recommended reference materials

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PMid:19631488http://dx.doi.org/10.1016/j.pec.2009.06.012


APPENDICES

Appendix I: Information Sheet for Participants

My name is Mr. Pius Gitonga a student in the School of Nursing Sciences at the University of Nairobi; Kenya. I am conducting a research to establish the training needs assessment for nurses on empathy whose title is: “Development and Sustainability of Empathy among nurses in Kenya”

**Risks:** There are no actual or potential risks associated with participating in this study.

**Objectives:** The study will determine the empathy training needs for caring or related behavioural characteristics among nurses in Kenya. Identify the factors that influence development of empathy, identify the factors that influence sustainability of empathy, and implement a training intervention to promote development of sustainable empathy knowledge and skills among nurses in Kenya.

**Confidentiality:** All information you provide will be treated with utmost anonymity. Your name will be only at the consent form for proof of existence of respondents and in ethical approval protocols. Your name will not appear on the questionnaire or in the study results. Therefore, it will not be possible for you to be identified in reporting of information you will have provided. Participants in focus group discussion will be issued a group and individual numbers which are not recognisable in data presentation.

**Benefits:** This study provides learning resources for developing empathy for nurses. The results will be used for academic purposes and as evidence to support recommendations.

**Participation:** If you agree to voluntarily participate in the study, you will be required to give a signed consent. The entire process may take approximately 15 minutes.

**Contact details for the research**

Name of researcher : Mr. Pius Gitonga  
Contacts : 0729301700  
Chair of KNH/UON-ERC : Prof. A. N. Guantai  
Contacts : Tel: (254-020) 2726300-9 Ext 44355
Appendix II: Consent to Participate in Self-Administered Questionnaire

I have read and understood the information provided in the information sheet. I have had an opportunity to ask questions about my participation and I am aware that it is a purely voluntary participation exercise without any danger associated with this research process/questionnaire.

I understand that there is no actual or potential risk involved in giving information in this study.

I understand that I have the right to withdraw from this study at any stage, in case I wish to, without giving any reason(s).

My privacy is and will be held in confidence as an anonymous respondent of this study.

I agree to participate in this study.

Signature of participant: ________________________________

Signature of researcher: ________________________________

Date: ________________________________

Contact details for the research

Name of researcher : Mr. Pius Gitonga
Contacts : 0729301700 or [piusgvg@gmail.com]
Chair of KNH/UON-ERC : Prof. A. N. Guantai
Contacts : Tel: (254-020) 2726300-9 Ext 44355
Appendix III: The Needs Assessment Questionnaire for the Respondents

Title of the study:

_Development and sustainability of empathy among nurses in Kenya”_

**INSTRUCTIONS**

a) Do not write your name in this questionnaire
b) Give sincere/honest responses to all the questions
c) Use appropriate indications to show your answer.
   • Place a tick or write sentences where appropriate.
d) If you have participated in this study, do not participate for a second time

DATE OF DATA COLLECTION __________/_____________/__________

**SECTION I – DEMOGRAPHIC AND SOCIAL INFORMATION**

1. Indicate your gender
   a) Male  □  b) Female □

2. Indicate your age bracket in years
   a) 21-25 □
   b) 26-30 □
   c) 31-35 □
   d) 36-40 □
   e) 41-45 □
   f) 46-50 □
   g) ≥ 51 □
3. Indicate your marital status
   a) Single □
   b) Engaged □
   c) Married □
   d) Divorced □
   e) Widowed □

4. Indicate your religious affiliation
   a) Christian □
   b) Muslim □
   c) Hindu □
   d) None □
   e) Other: [specify]…………………………………………………

SECTION II – PROFESSIONAL INFORMATION

5. Indicate your highest attained qualification in nursing
   a) Certificate □
   b) Diploma □
   c) Degree □
   d) Other: [specify]……………………………………………………

6. Indicate the extent at which empathy affects your daily plans and actions as a nurse?
   a) Minimally □
   b) Below average □
   c) Average □
   d) Above average □
7. In a scale of 1 – 10, rate your empathy level by placing a tick (✔) on the grid below

<p>| | | | | | | | | | | |</p>
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<thead>
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<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

8. Indicate your concept on what empathy can achieve for nurses
   a) Improve public image for nurses
   b) Creates a sense of social awareness
   c) Promotes self-esteem
   d) Provides a validated rationale for nursing actions

9. How often do you encounter empathy specific challenges when caring for patients?
   a) Not at all
   b) Less often
   c) More often
   d) Always

10. Does the training for nurses adequately develop empathy?
    a) Yes
    b) No
    c) Don’t know

11. What suggestion do you have for empathy in nursing?
    a) Empathy training
    b) Patient education
    c) Don’t know
Appendix IV: Consent to participate in Focus Group Discussion

Introduction
The purpose of this focus group discussion and the nature of the questions have been explained to me. I consent to take part in this focus group discussion to share my views and opinions about empathy in nursing practice, I have been informed that this discussion will be done at no cost to me. I also consent to be tape-recorded during this focus group discussion. My participation is voluntary. If I decide not to participate at any time during the discussion, my decision will be respected.

Confidentiality
None of my experiences or thoughts will be shared with anyone else outside this project. The information that I provide during the focus group will be grouped with answers from other members of the group so that I cannot be identified.

Benefits
I understand there will be no payment for participation, but I will be provided with refreshments, snacks and my fare will be catered for, for transport to the discussion and back to my home after the discussions.

I have been informed that if I have any questions I can contact Mr. Pius Gitonga on Telephone 0729 301 700 or email: piusgyg@gmail.com.

Participant Signature---------------------------Date .................................................................

Witness Signature -------------------------- Date .................................................................
Appendix V: Focus Group Discussion Introduction Guide

Title of study:

*Development and Sustainability of Empathy among Nurses in Kenya*”

Opening remarks – Welcome to this discussion

Thank you for volunteering to take part in this focus group discussion. You have been requested to participate because your point of view on empathy is important to this study. I realize you had to create time from your busy schedules and I really appreciate you for your time.

**Introduction:** This focus group discussion is designed to assess your current thoughts and feelings about the factors that promote or hinder development and sustainability of empathy among nurses in nursing practice. The focus group discussion will take one hour. I request you to allow us to tape-record the discussion to facilitate analysis.

**Anonymity:** Despite the discussion being taped, I would like to assure you that your views in the discussion will be anonymous. The tapes will be kept safely in a locked facility until they are transcribed word for word, then they will be destroyed. The transcribed notes of the focus group will contain no information that would allow individual subjects to be linked to specific statements.

**Discussion rules**

a) The most important rule is that only one person speaks at a time. There may be a temptation to jump in when someone is talking but please wait until they have finished.

b) There are no right or wrong answers

c) You do not have to speak in any particular order

d) You do not have to agree with the views of other people in the group

OK, let’s begin!
Appendix VI: Interview guide for Focus Group Discussion

Title of study:

*Development and Sustainability of Empathy among Nurses in Kenya*”

Introductory question

I am just going to give you a couple of minutes to share your experience about among nurses in their place of work. Is anyone ready to share his or her experience?

Questions about empathy in nursing practice

1. What is empathy?
2. What are the indicators of empathy?
3. What is the rationale for developing empathy among nurses?
4. What is the rationale for sustaining empathy among nurses?
5. What should be the intervention for nurses to develop and sustain empathy?

Conclusion question

What else would you like to say about empathy in nursing practice?

------------------------------------------------- END ------------------------------------------------------
## Appendix VII: Empathy in Nursing Practice Observation Checklist

<table>
<thead>
<tr>
<th>Category</th>
<th>Response</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>Personal attributes (Preparedness)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well prepared for nursing care</td>
<td></td>
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<tr>
<td>Begins nursing care on time</td>
<td></td>
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<tr>
<td>Creates a welcoming environment</td>
<td></td>
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<tr>
<td>Calm but sensitive</td>
<td></td>
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<tr>
<td>Actively engages the patient in the intervention</td>
<td></td>
<td></td>
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<tr>
<td><strong>Professional attributes (Behavioural)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrates self confidence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responds respectfully to patients and colleagues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Listens carefully and actively</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speaks about care with confidence and authority</td>
<td></td>
<td></td>
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<tr>
<td>Able to admit error or self insufficiency</td>
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<td></td>
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<tr>
<td><strong>Interpersonal attributes (Wellbeing)</strong></td>
<td></td>
<td></td>
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<tr>
<td>Gentleness in administering interventions</td>
<td></td>
<td></td>
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<tr>
<td>Effective communication techniques</td>
<td></td>
<td></td>
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<tr>
<td>Showing kindness to patients</td>
<td></td>
<td></td>
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<tr>
<td>Smile and occasional laughter during</td>
<td></td>
<td></td>
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<tr>
<td>Socially acceptable cues</td>
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<tr>
<td><strong>Total</strong></td>
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</tbody>
</table>

.................................................. End ..........................................
Appendix VIII: Pre-Post Training Questionnaire

Title of study:

*Development and sustainability of empathy among nurses in Kenya*

INSTRUCTIONS

a) Do not write your name in this questionnaire

b) Answer all the questions

c) Place a tick or circle alongside your preferred answer.

d) You may indicate one or more selections depending on how they relate to the question

Date of taking the quiz __________/____________/__________

1. Identify observable empathy related characteristics among nurses

   a) Conduct themselves professionally

   b) Provides simple and clear communication to patients and colleagues

   c) Shows kindness to others more easily

   d) Recognises gender needs and promotes gender equality

   e) Has a ready and warm smile

   f) Honest to peers and strangers
3. Indicate how the following factors influence empathy

<table>
<thead>
<tr>
<th>S/N</th>
<th>Influence</th>
<th>Direct</th>
<th>Indirect</th>
<th>Source of influence</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Patient outcomes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b)</td>
<td>Nurse outcomes</td>
<td></td>
<td></td>
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<tr>
<td>c)</td>
<td>Professional mentorship</td>
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<td></td>
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<tr>
<td>d)</td>
<td>Personal values</td>
<td></td>
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<tr>
<td>e)</td>
<td>Extrinsic motivation</td>
<td></td>
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<tr>
<td>f)</td>
<td>Opportunities to show empathy</td>
<td></td>
<td></td>
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<tr>
<td>g)</td>
<td>Extrinsic motivation</td>
<td></td>
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<tr>
<td>h)</td>
<td>Multiple intelligences</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i)</td>
<td>Social awareness</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>j)</td>
<td>Relatedness</td>
<td></td>
<td></td>
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</tbody>
</table>

4. Observable characteristics related to empathy

<table>
<thead>
<tr>
<th>S/N</th>
<th>Characteristic/Indicators</th>
<th>Y</th>
<th>N</th>
<th>DK</th>
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</thead>
<tbody>
<tr>
<td>a)</td>
<td>Professional conduct</td>
<td></td>
<td></td>
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<tr>
<td>4</td>
<td>Effective communication</td>
<td></td>
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<tr>
<td>5</td>
<td>Being kind to others</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>6</td>
<td>Gender responsiveness</td>
<td></td>
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<tr>
<td>7</td>
<td>Having a warm smile</td>
<td></td>
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<tr>
<td>8</td>
<td>Honest to peers and strangers</td>
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</tbody>
</table>
5. Factors that favour development of empathy in nursing

<table>
<thead>
<tr>
<th>S/N</th>
<th>Factor</th>
<th>Y</th>
<th>N</th>
<th>DK</th>
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<tbody>
<tr>
<td></td>
<td>a) Mentorship role model</td>
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<tr>
<td>9</td>
<td>Willingness to show empathy</td>
<td></td>
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<tr>
<td>10</td>
<td>Empathy as a social norm</td>
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<tr>
<td>11</td>
<td>Showing friendliness</td>
<td></td>
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<tr>
<td>12</td>
<td>Positive attitudes towards empathy</td>
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</table>

6. Factors that hinder development of empathy in nursing

<table>
<thead>
<tr>
<th>S/N</th>
<th>Factor</th>
<th>Y</th>
<th>N</th>
<th>DK</th>
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<tbody>
<tr>
<td></td>
<td>a) High workload and exhaustion</td>
<td></td>
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<tr>
<td>13</td>
<td>Exploitation for showing empathy</td>
<td></td>
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<tr>
<td>14</td>
<td>Prejudice towards nurses</td>
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<tr>
<td>15</td>
<td>Harsh working environment</td>
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<td>16</td>
<td>Fear for vulnerability for injury</td>
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<td>17</td>
<td>Lack of interest to develop empathy</td>
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</table>
8. Factors that favour sustainability of empathy in nursing

<table>
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<tr>
<th>S/N</th>
<th>Factor</th>
<th>Y</th>
<th>N</th>
<th>DK</th>
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<tbody>
<tr>
<td>a)</td>
<td>Compassion among nurse colleagues</td>
<td></td>
<td></td>
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<tr>
<td>18</td>
<td>Maintaining positive attitude towards empathy</td>
<td></td>
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<tr>
<td>19</td>
<td>Continued professional development</td>
<td></td>
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<tr>
<td>20</td>
<td>Recognize and reward empathy champions</td>
<td></td>
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<td>21</td>
<td>Peer oriented empathy systems</td>
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9. Factors that hinder sustainability of empathy in nursing

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<th>S/N</th>
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<th>DK</th>
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<tbody>
<tr>
<td>a)</td>
<td>Burn-out or mental and physical fatigue</td>
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<td>22</td>
<td>Lack of advocates for empathy</td>
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<tr>
<td>23</td>
<td>Demotivation from negative experiences</td>
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<tr>
<td>24</td>
<td>Attitudes towards empathy as an emotional burden</td>
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</tbody>
</table>
Appendix IX: Ethical Approval – KNH/UON
Appendix X: Ethical Approval – KNH/UON
Appendix XI: Registration Certificate – KNH – Surgical services division
Appendix XII: Registration Certificate – KNH - Medical services division
Appendix XIII: Approval – KNH – Surgical services division
Appendix XIV: Approval – KNH – Medical services division
Appendix XV: Research Permit – NACOSTI
Appendix XVI: Research Authorization – NACOSTI
Appendix XVII: Approval – Tenwek hospital
Appendix XVIII: Approval – Meru teaching and referral hospital
Appendix XIX: Approval – Embu county referral hospital
Appendix XX: Publications


Online – ISSN 2411- 2933, Print ISSN 2411-3123


Appendix XXI: Research article
Appendix XXII: Research article
Appendix XXIII: Research article
Appendix XXIV: Anti-plagiarism test result
... The End ...