

Decreasing stigma and improving therapeutic interventions for psychiatric patients in the

Emergency Department

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Table of Content

<i>Abstract</i> ...	page 5
<i>Chapter 1</i> ...	page 6
Introduction...	page 6
Background and Significance...	page 6
Population...	page 7
Current Nurses' Experiences and Understanding...	page 8
Internal Evidence...	page 9
Problem Statement...	page 9
PICO Statement...	page 10
Search Strategies...	page 10
Synthesis of Evidence...	page 12
Purpose Statement...	page 13
Study Questions...	page 14
<i>Chapter 2</i> ...	page 15
Introduction...	page 15
EBP Model and Conceptual Framework...	page 15
Project Methods...	page 17
Ethics...	page 17
Setting, Organizational Culture, and Participants...	page 17
Intervention...	page 18
Outcome measures...	page 18
Data Collection and Analysis Plan...	page 19

Proposed Budget...page 19

Project Results...page 19

Discussion of Results...page 20

Conclusion...page 20

Chapter 3...page 22

Introduction...page 22

Measured and Potential Impact...Page 22

Financial Impact...page 23

Impact of Current Policy...page 23

Leadership and Innovation...page 24

Sustainability...page 25

Further Application or Research...page 25

Gaps...page 26

Conclusion...page 26

Reference Page...page 28

Appendix A...page 31

Appendix B...page 41

Appendix C...page 42

Appendix D...page 43

Appendix E...page 44

Appendix F...page 45

Appendix G...page 46

Appendix H...page 47

Appendix I...page 48

Appendix J...page 49

Appendix K...page 50

Appendix L...page 51

Appendix M...page 52

Appendix N...page 53

Abstract

Findings suggest that stigma associated with mental illness may be as strong in health care providers as it is in the general public. Research involving non-behavioral health nurses, and medical and nursing students, sought to identify bias and negative attitudes directed toward psychiatric patients in a non-psychiatric setting. Studies were reviewed to determine the effects of educational interventions to teach empathy and increase knowledge related to the pathology of, and treatment modalities for, psychiatric patients. Several scales were used to measure bias/stigma and rate interventions to minimize it. Studies found that healthcare personnel, including nurses, are considered by mental health consumers to be primary contributors to stigma and discrimination against those with mental illness. The studies also discovered that participation in an educational intervention to learn empathy and acquire knowledge about psychiatric patients directly decreased bias. The project utilized the evidence-based practice PRECEDE-PROCEED Model (PPM) supported by Bandura's Social Cognitive Theory (SCT). Combining the PPM with the SCT is supported in the literature as the both rely on learned behavior. Pre- and post-test tools of measure were the Opening Minds Scale for Healthcare Providers, which measures stigma, and the Toronto Empathy Questionnaire, which measures empathy. Out of 80 nurses asked to attend one of the two presentations, a total of 3 participated. With an n of 3, a search for statistical significance was not possible. Descriptive statistics uncovered systemic roadblocks in initiating change. The rigid structure of the ED, the conceptual vision of hospital administration, and a myriad of nursing constructs need to be considered in order to understand the project's outcomes. The plausibility and sustainability of a practice change needs to be measured against the plausibility and sustainability of the status quo.

Keywords: emergency room/department nurse, medical-surgical nurse, psychiatric patient, stigma, bias, empathy, and education

Chapter 1

Introduction

Nurses working in the Emergency Department (ED) often find themselves treating mentally ill patients. There is a level of discomfort associated with treating psychiatric patients for nurses lacking the understanding, skills, and confidence to do the job. This often results in nurse bias directed towards psychiatric patients. It is said we fear that which we do not know. Educating ED nurses about the etiology and pathology of psychiatric illness and exploring ways to decrease stigma and increase empathy when treating psychiatric patients, will be a step forward in helping nurses better manage their delivery of care for the psychiatric population presenting to the ED.

Background and Significance

Can an intervention of educating ED nurses about psychiatric patients and their treatment, translate into less nurse bias related to stigma, and greater empathy directed toward that psychiatric patient population? Can stigma and empathy be measured to substantiate the intervention's outcome? These clinical questions are meaningful as they relate to patient care and outcomes. A look at the background concerning this issue is undertaken by examining the population of ED nurses, identifying interventions to reduce stigma and increase empathy juxtaposed to the current state of practice, and determining outcomes to verify the feasibility and validity of undertaking the intervention.

It might seem odd to talk about nurse stigma toward psychiatric patients as a disease process or in terms of epidemiology, but there is a cause and effect that cannot be denied. Epidemiology is the study of what is visited upon a people. It is the study of distribution and determinants of health related states of events and the application of this study to the control of diseases and other health problems. There are many factors that contribute to the poor physical health of people with severe mental illness (SMI), including lifestyle factors. However, Lawrence and Kisely (2010) find there is increasing evidence that

disparities in healthcare provision contribute to poor physical health outcomes. These inequalities have been attributed to a combination of factors including systemic issues such as the separation of mental health services from other medical health services, and healthcare provider issues including pervasive stigma associated with mental illness. Severe mental illness often robs people of the characteristics we find most endearing in others. If there is one sector of society that should be able to recognize that behaviors that are otherwise seen as signs of a difficult or negative person are actually symptoms of an illness, it would be expected to be the healthcare sector (Lawrence & Kisely).

Population

Findings suggest that stigma associated with mental illness may be as strong in health care providers as it is in the general public (ENA, 2013). Ross et al., (2009), in a literature review identified fear and blame/hostility as the primary negative attitudes of nurses treating patients with mental illness. Eren (2014), using a descriptive cross-sectional design, found nurses lacking in psychiatric ethics resulting from external pressures such as insufficient personnel, excessive workload, working conditions, lack of supervision and in-service training. In response to patients who are agitated, aggressive, impulsive, exhibiting bizarre behavior, or having attempted suicide, nurses attempt to balance patient's needs with securing order in the ward (Eren, 2014), this often results in a paternalist attitude that can lead to unethical behaviors by the nurse. This lack of attention to ethics is translated into neglect, rude/careless behavior, disrespect of patient's rights and human dignity, bystander apathy, lack of proper communication, stigmatization, authoritarian attitude/intimidation, physical interventions during restraint, manipulation by reactive emotions, not asking for permission, disrespecting privacy, dishonesty or lack of clarity, exposure to unhealthy physical conditions, and violation of confidence (Eren, 2014). Plant (2013), using a qualitative investigation of a focus group format, reviewed verbatim transcripts where nurses describe

“struggling with uncertainty”, “seeking resolution and more certainty”, “hopelessness”, and, “blaming” related to “unmovable barriers” when treating psychiatric patients, with “powerlessness” as their overreaching and substantive experience when dealing with psychiatric patients. Dickinson and Hurley (2011), using the Self-Harm Antipathy Scale (SHAS), found that treatments and modalities that fall within the routine scope of non-behavioral health nurses have the ability of forming a therapeutic alliance with the mentally ill patient, when those skills are performed well and with compassion. And in a systematic literature review of adolescents who self-injure, Rissanen, Kylma, and Laukkanen (2011) found that nurse’s concepts about self-injury could be ambiguous, but their attitude directly affected the care they provided. This demonstrates that psychiatric patients are receptive to interactive, caring, and compassionate nurses. Utilizing that readiness of psychiatric patients to respond to positive regard creates opportunity to employ educational interventions to inform non-behavioral health nurses about psychiatric illnesses thereby increasing empathy and decreasing stigma.

Current Nurse Experiences and Understanding

Currently, nurses find themselves with inadequate knowledge or skills to guide their treatment of mental health patients (ENA, 2013). A typical response is to rely on personal experience and peer consensus for patient assessment and planning psychosocial care (MacNeela, Scott, Treacy, Hyde, & O’Mahoney, 2012). The disadvantage of relying on a subjective, largely oral knowledge base is inconsistency in naming and classifying the care strategies (MacNeela, et al., 2012). Van Der Kluit and Goossens (2011) found the most frequently mentioned influencing factor in reducing anxiety and feelings of inadequacy was the availability of knowledge and skills in relation to caring for patients with comorbid mental illness.. Zolnierak and Clingerman (2012) state that non-psychiatric nurses tend to view patients with psychiatric comorbidity negatively and that this has shown to affect nurse’s responsiveness to medical symptoms. Zolnierak and Clingerman (2012) found that nurses feel they lack knowledge, skills,

and support to effectively care for persons with mental illness. The study goes on to state that education and exposure to persons with mental illness can assist nurses to inhibit their negative stereotypes and respond more positively (Zolnierak & Clingerman, 2012). A consistent recommendation is for increased education and professional development to better manage nurse' attitudes towards psychiatric patients (ENA, 2013).

Internal Evidence

There were opportunities to discuss concerns in three major hospitals in the Phoenix metro area. Nurses describe real frustration when working with psychiatric patients. Many nurses have little patience for perceived negative behaviors that they deem volitional on the part of the patient. These behaviors have been interpreted as uncooperative, demanding, rude, hostile, selfish, and attention seeking. These behaviors would be indicative of a difficult, ungrateful patient if they were in the ED or on medical floors for somatic concerns. However, nurses either don't understand the emotional/cognitive component of mental illness, or don't feel the ED or medical floors are the correct place to have to manage those components. This leads to negative comments about, and hostile interactions directed towards, the psychiatric patients. Depending on the diagnoses, nurses have said they feel uneasy and frightened around unpredictable patients such as those with schizophrenia, and impatient, irritated and angry when dealing with patients diagnosed with personality disorders, eating disorders, self-injury, suicide attempts, and especially substance abuse. These attitudes that fuel bias have been described consistently across the hospitals surveyed.

Problem Statement

According to the Emergency nurses Association (ENA, 2013), emergency department caregivers in general do not feel comfortable in providing care for emergency psychiatric patients, which in many cases leads to psychiatric patients receiving inadequate care. When attributing attitudes to mental illness,

Bjorkman, Angelman, and Jonsson (2008) showed that nursing staff in somatic care had more negative attitudes compared with their counterparts in behavioral health. Healthcare personnel, including nurses, are considered by mental health consumers to be primary contributors to stigma and discrimination against those with mental illness (Ross & Goldner, 2009). Stigma can be defined as “the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination in a situation where power is exercised” (Modgill, Patten, Knaak, Kassam, Szeto, 2014). Practitioners in the emergency setting are often the first contact a patient will have with mental health care, and bad experience on this initial mental health contact may lead to long-term problems in which consumers might fear, distrust, or dislike providers, which might interfere with their desire to continue in treatment (Zeller, 2010). There is a need to promote greater therapeutic alliances such as the use of positive regard to reduce the incidence of labeling, and the negative effects this has on a relationship (Dickinson & Hurley, 2011).

PICO

This leads us to the relevant PICO question: For non-behavioral health nurses caring for psychiatric patients in the Emergency Department (P), how does education on disease etiology, pathology, treatment modalities, and the use of empathy (I), compared to current practice (C), affect nurse stigma and empathy toward those psychiatric patients (O)?

Search Strategies

The initial search strategy involved the concept of ED nurses interacting with the mental health population, and the attempt to identify barriers between them and find ways to improve the interaction between the two groups. The search was driven by the desire to determine an appropriate educational intervention to reduce nurse stigma and increase nurse empathy towards the psychiatric patient in the ED setting. To some extent, the search moved the focus of an educational intervention between understanding

the pathology and treatment of a psychiatric diagnosis to reduce stigma, and understanding empathy's role in reducing bias.

Databases searched were the Cumulative Index of Nursing and Allied Health Literature (CINAHL), the Psychological Information database (PsychINFO), and Public/Publisher Medline (PubMed). Key words used in the search were *emergency room/department nurse, medical-surgical nurse, psychiatric patient, mentally ill, stigma, empathy, bias, and education*. Initially the filters were set broadly to get a sense of what was out there. Ultimately limits were set for research articles, peer review, systematic review, journal articles, English language, and articles published since 2010.

The CINAHL search results for *nurse* yielded 48,601 results. *Emergency room nurse* yielded 11,288 and *medical surgical nurse* yielded 3,971. *Etiology* yielded 285,190 results, *intervention* yielded 125,865 results, and *education* yielded 6,981 results. The combination of *education and intervention* yielded 239 results. The term *psychiatric patient and nurse ratio* yielded 3,536 results. Unfortunately a proper combining of terms what not done appropriately in CINAHL.

PsychINFO had larger yields. Broadly, *patient* yielded 576,832 results while *psychiatric patient* yielded 1810 results. *Psychiatry and bias* yielded 5484 results. *Nurse and emergency room* yielded 179 results while *nurse and emergency department* yielded 553 results. The term *psychiatric symptoms* yielded 17,215 while *psychiatric and symptoms* yielded 64,849. *Empathy* yielded 19,383 and *mental illness and empathy* yielded 192. *Nurse* yielded 51,957 results, *medical nurse* yielded 14,913 results, and *bias and (scale or measure) and nurse* yielded 49 results. *Bias and (rating or measure) and mentally ill* yielded 1 result. *Education and reducing and bias* yielded 170 results.

PubMed yielded 5,148,879 for *patient*, 229,092 for *psychiatric and patient*, and 996 for *psychiatric patient*. *Bias and (measure or scale)* yielded 21,828 while *bias and (measure or scale)* within the last 5 years yielded 8,084. *Nurse and stigma and education* yielded 219 results while *nurse and stigma and*

mental health yielded 142 results and *nurse and bias and mental health* yielded 71 results. More than three terms would yield little, as with *empathy and impact and bias and stigma* yielding 1 result, or no results. *Nurse and Bias* yielded 1,857 results but when the filters *randomized control trial or systematic review or meta-analysis and last 5 years* was applied that number came down to 131 results. The implementation of multiple filters often brought the yield down to zero.

Synthesis of Evidence

Ten studies were selected for review with a range of level of evidence from I to VI (Appendix A). There was 1 Systematic Review (SR), 1 well designed Randomized Control Trial (RCT), 1 Quasi-experimental design (QE), 4 Cohort Studies (CS), 1 Integrative Review (IR), and 2 Single Descriptive or Qualitative Studies (SD/Q). The studies' demographics (Synthesis table, Appendix B) reflected moderate homogeneity as it applies to nurses with four of the ten studies having specifically sampled nurses. The homogeneity of two articles pertained to medical students. The four remaining articles demonstrated heterogeneity, with three pertaining to healthcare providers, and one pertaining to the population at large. The settings of hospitals, clinics, universities, and the community encompassed the ten studies with four of the ten studies having multiple settings. Four studies were found to have good validity, one had acceptable validity, and one had fair validity. Reliability was found to be excellent in two studies, good in four studies, and fair in one study. Overall, generalizability was limited to poor. Only one study determined it had good generalizability.

The findings pertained to the following themes; bias (focus of 5 studies), stigma (focus of 4 studies), negative attitudes (focus of 3 studies), stereotyping (focus of 2 studies), empathy (focus of 3 studies), and knowledge and skills deficits (focus of 3 studies) among healthcare providers, along with one study measuring attitudes towards using EBP. Overall, decreases in negative attitudes, stigma, and bias, and an increase in empathy were found in the studies that pertained to those topics. Only 1 study suggested an

increase in stigma and stereotyping as it relates to social distancing of patients diagnosed with schizophrenia. Two studies looked at rating scales or measures to determine effectiveness of interventions to increase empathy and decrease negative attitudes and bias, while one rated a scale to determine attitudes toward the use of EBP. The theoretical frameworks were identified accordingly; 7 articles utilized Bandura's Self-efficacy Model, 2 used Wagner's Chronic Care Model, and 1 used Meyer's Minority Stress Model.

The studies relied on questionnaires, pre- post-tests, empathy scales, narrative synthesis, structured engagement, and specifically the Likert scale, Kuger & Casey Qualitative Analysis, and the Implicit Association Test (Appendix A). ANOVA, MANOVA, Chi-Square tests, paired t-tests, Mann-Whitney U test, Wilcoxon Signed-Rank Test, Bartlett's test of Sphericity, Chronbach's Alpha test, Confidence Intervals, and Inter-Rater Reliability were all utilized in the studies.

We can conclude that educational interventions to create awareness of psychiatric etiology, pathology and treatment modalities do have a positive impact on stigma and empathy. The research describes real-time changes of decreased stigma and increased empathy and confidence on the part of nurses following educational programs. Measures exist that can accurately assess stigma and empathy. These measures not only provide proof of bias, they validate the success of interventions based on positive results. Educational interventions to help nurses understand a psychiatric patient's experience has empowered nurses to provide care with increased confidence and understanding, thereby decreasing stigma and increasing empathy.

Purpose Statement

Psychiatric patients in crisis are utilizing EDs at an increasing rate. The nurses they encounter are faced with delivering treatment that is based on knowledge the nurses feel they lack, and understanding and empathy the nurses struggle to conceptualize. The purpose of this paper was to determine if educating

ER nurses on the etiology and pathology of psychiatric symptoms, treatment modalities, along with the positive effects of empathy, would affect nurse stigma and empathy towards the mentally ill.

Study Questions

This project hoped to answer the following questions. Can stigma directed towards psychiatric patients be reduced through education? It was hoped that education describing the experience of the mentally ill and highlights misconceptions about the disease process would accomplish this. Can empathy for psychiatric patients be engendered or increased as a result of an educational intervention? Learning about the cause and onset of certain diseases and gaining a better understanding of criteria for a diagnosis may release the psychiatric patient of unfair judgments made against him or her as a result of increased empathy and awareness on the part of the nurses. Finally, though not officially measured, would participation in the educational presentation offer a tool for nurses to better manage frustration and anxiety that often occurs when treating psychiatric patients in the ED? It was hoped that this would be a byproduct of the presentation, as emergency department nurses deserve every helping hand they can get in the execution of their duties.

Chapter 2

Introduction

The intervention was a PowerPoint presentation entitled “The tool of empathy and knowledge to help decrease stigma and treat psychiatric patients in the ED” (Appendix I). Measuring the impact on nurse stigma and empathy toward psychiatric patients, and changes as a result of participating in the intervention, was the focus of the project. Nevertheless, teaching ED nurses about psychiatric patients so that they are better equipped to treat this population was a corresponding goal. The intervention will be appraised within this chapter to describe its foundation in the PRECEDE-PROCEED evidence based practice model and the correlating conceptual framework of Bandura’s Social Cognitive Theory. Project methods (approval, setting, participants, outcomes, and analysis) and results will also be examined.

EBP Model and Conceptual Framework

The Evidence-Based Practice (EBP) model selected to guide this project was the PRECEDE-PROCEED Model (PPM) (Appendix C). Strictly, PRECEDE stands for Predisposing, Reinforcing, and Enabling Constructs in Educational/Environmental Diagnosis Evaluation and PROCEED stands for Policy, Regulatory, Organizational, Constructs, Educational, Environmental, and Developmental, as described by Raingruber (2014). The model is a product of John Hopkins University and was developed to teach health promotion to their students. It’s a tool for designing, implementing, and evaluating health behavior change programs and is considered a behavioral change intervention (Raingruber, 2014). Its application relies on the concept that the participants must assess their own needs and priorities. It uses approaches to planning that encourages individual and group involvement and participation. This was fundamental in adopting PPM to initiate and maintain buy-in from the nurses who participated in the intervention. It also included nurse participation in describing the problem and the need for solutions, rather than telling the nurses what they need and

mandating a particular intervention. When the need for change is verified by nurses the likelihood of a successful intervention and improved outcomes is greatly enhanced. There are nine steps involved in PPM. The first step was to conduct a social assessment of the population to identify their own needs as it related to the problem. Internal and external evidence has suggested the nurses' needs confirm step one, and should give the nurses shared authorship to the intervention. Step two used statistics and surveys to gauge the effect of the problem on the nurse population. Step three was a behavioral and environmental assessment to identify factors that contribute to the problem. Step four identified predisposing factors that provide rationales for behavior, "Why do nurses struggle with negative feelings when it comes to the psychiatric patients in their care?" Step five provided interventional strategies and identified policies, resources, and circumstances that influenced the intervention. Step five also considered barriers that would possibly be encountered such as space for the intervention, time involved, and staff commitment. Steps six through nine coalesced to determine the likelihood of change and evaluations of outcomes related to predisposing, reinforcing, enabling, behavioral, and environmental factors.

The theory underpinning the PPM was Bandura's Social Cognitive Theory (SCT) (Appendix D). Several studies link the PPM to SCT as it relies on learned behavior. The theory suggests that people learn by noticing the benefits of actions that they observe other people performing (Raingruber, 2014). Raingurber (2104) lists the six components of SCT as Reciprocal determination, Behavioral capability, Expectations, Self-efficacy, Observational learning, and Reinforcements. The hoped for change in interactions between ED nurses and their psychiatric patients would address the components of SCT. It was hoped for that nurses would see how they influence, and are influenced by their work environment. Their capabilities and expectations would change and they would better incorporate self-efficacy that is then observed and utilized by their peers.

Project Methods

Ethics

IRB submission was approved on September 15, 2015 (Appendix E). This process maintains human subject protection through inclusion and exclusion criteria, ensuring vulnerable populations are identified and protected. Recruitment methods, risks to participants, privacy and confidentiality, and consent procedures are also part of the IRB approval process. Since the presentation occurred at the hospital where the ER nurses work, special attention was paid to explaining how privacy and confidentiality was to be maintained. It was also made clear that choosing to participate or choosing to not participate would have no bearing on their employment standing. Recruitment entailed posters placed in the ER break room with corresponding flyers (Appendix F). A general email was sent to all nurses in the ER inviting them to participate anonymously with no response to the email required (Appendix G).

Setting, Organizational Culture, and Participants

The setting was the emergency department at a level one trauma center and teaching hospital in Phoenix, Arizona. Permission was obtained from the hospital's Evidence Based Practice Board (Appendix H). The presentation was located in another part of the medical center and on a different floor from the ED. This particular medical center has shown its dedication to a culture of competence across the entire organization. Less than optimal performance outcomes are seen as opportunities for learning. Actual errors are met with education and mentoring with resulting competencies assessed and reinforced. This particular setting is a Magnet hospital where continuing education is valued and supported. This project benefited from an emergency room administration that enthusiastically welcomed the intervention and actively supported its evolution. The participants were ED nurses treating psychiatric patients. Their desire to learn and be a part of the intervention was evident. Gratitude was the major theme expressed by the nurses. Mutual respect allowed for an open and honest exchange.

Intervention

This project was an educational intervention (Appendix I) for nurses treating psychiatric patients in the emergency department. It gave information on the causes of certain mental illnesses to demonstrate that emotional, physical, and sexual trauma, are often part of the history of the mentally ill. It was hoped that this, along with information on inherited traits and brain chemistry, engendered some understanding of the innocence of patients in creating their circumstance. The patient experience was discussed as it related to why certain behaviors manifest. Behaviors were discussed in terms of being criteria and often time non-volitional on the part of the patient. Myths were discussed in the attempt to mitigate stigma. Cognitive empathy was discussed in the hope of increasing empathy as a tool for an overworked nursing staff. Stigma and empathy was measured pre- and post-test.

Outcome Measures

The Toronto Empathy Questionnaire (TEQ) (Appendix J) was used to measure empathy. Item-remainder coefficients were sound, ranging from .36 - .59; internal consistency was also good, Cronbach's $\alpha = .85$. In a second EFA of the 16-item TEQ, the first five eigenvalues were 5.23, 1.43, 1.13, 1.06 and 0.93. There is a discontinuity between the first and second factor, consistent with a uni-dimensional structure. Factor coefficients are reported where the items were forced to load upon a single factor, ranging from .42 to .65 (mean = .53, SD = .08). This analysis yielded four items with loadings above .60, an indication that the factor is reliable regardless of sample size (Spreng, McKinnon, Mar, & Levine, 2009).

The Opening Minds Scale for Health Care Providers (OMS-HC) (Appendix J) was used to measure stigma. The initial testing OMS-HC scale showed good internal consistency, Cronbach's $\alpha = 0.82$ and satisfactory test-retest reliability and intra-class correlation = 0.66 (95% CI 0.54 to 0.75). The OMC-HC

was only weakly correlated with social desirability, indicating that the social desirability bias was not likely to be a major determinant of OMS-HC scores (Modgill, et al., 2014).

Data Collection and Analysis Plan

All data was collected at the first presentation. The second presentation had no participants. Data was kept locked with the facilitator having the only key. With the participation of just 3 nurses, statistical significance was not reached. A Wilcoxon Matched-Paired Signed Rank Test was going to be used for analysis of the sample pre- and post-test. With an n less than 30 it seemed appropriate to use this non-parametric test. Ultimately it was decided that an n of 3 was too small for even the Wilcoxon Matched-Paired Signed Rank Test. Therefore, descriptive statistics were used to describe the sample and outcome variables.

Proposed Budget

Minimal expense was required in funding the project. Copies of flyers and posters announcing the presentation along with copies of the measuring tools were the only expense. The entire cost was under \$50.00.

Project Results

Three study questions were initially asked. Can stigma directed towards psychiatric patients be reduced through education, can empathy for psychiatric patients be engendered or increased as a result of an educational intervention, and will participation in the educational presentation offer a tool for nurses to better manage frustration and anxiety that often occurs when treating psychiatric patients in the ED? Statistically, we cannot answer these questions. The 3 participants all had experience working with psychiatric patients and had friends or family members with a mental health diagnosis. This information was obtained via the demographic questions. OMS-HC had a possible score of 20-100 with higher numbers correlating with greater stigma. TEQ had a possible score of 0-64 with higher numbers

correlating with greater empathy. Participant n-1 had a decrease in stigma from 32 to 30 and no change in her empathy score of 61. Participant n-2 had a decrease from 51 to 50 and no change in her empathy score of 44. Participant n-3 actually had an increase in stigma from 48 to 50 but an increase in empathy from 56 to 54. See Appendix N (demographics, empathy: Epre/Epost, stigma: Spre/Spst). The project would have been greatly enhanced if ED nurses with no psychiatric experience, either professionally or personally, had participated. Having that participation would have better shown the value of education and its impact on stigma and empathy.

Discussion of Results

Taking perspective of another persons experience reflects a cognitive empathy which often overlaps with affective empathy (Spreng, et al., 2009). The TEQ measures both cognitive empathy such as assessment of emotional state, the ability to infer and predict, or pro-social helping behaviors, and affective empathy such as emotional contagion or sympathetic arousal (Spreng, et al.). The OMS-HC measures components of stigma such as perceived stigma, self-stigma, or social distancing (Modgill, et al., 2014). Though higher scores relate to greater empathy and stigma respectively, data analysis for this project confines itself to changes in scoring rather than in identifying what a pre-intervention score means in terms of a persons behavior. It might be stated that results are hard to come by when only 3 ED nurses participated in the educational presentation. However, we in psychiatry understand that much can be derived from what doesn't happen in a given situation, as can be derived from what does happen. Subsequently, a review of why nurses failed to participate is essential going forward. A better understanding of time constraints, workflow, workload, and level of administrative support is needed.

Conclusion

We need to adapt the way in which to deliver educational programs to ED nurses. Their often chaotic schedule seems to prohibit an educational intervention set at a specific time. It might make sense to

provide a video presentation or a voice-over PowerPoint presentation that individual nurses could access at their leisure. The facilitator could give contact information to allow for questions to be answered. What would be missing though is the human connection that is the essence of a therapeutic intervention for psychiatric patients. Remembering Bandura's Social Cognitive Theory that suggests learning comes from observation, we may find that the didactic is diminished in its power and meaning if done via electronic media. Perhaps the facilitator has designed his own fate by accepting the title of facilitator instead of educator. Godsey (2015) suggests that teachers are moving from "content experts" to "curriculum facilitators" as we utilize technology to present course instruction in the 21st century. As for this facilitator, the experience of personally educating the nurses that participated in the presentation was moving. Gauging interest, attention, and the mood of the class allowed for an immediate assessment of understanding that informed the effectiveness of instruction at that moment and the nurses corresponding needs. This is the essence and power of behavioral health nursing. Oftentimes information needs an advocate, a message needs an interpreter, and the moment needs to be shared.

Chapter 3

Introduction

There may be nothing more unfulfilling or disappointing as a missed opportunity, especially when it was hoped for rather than a surprising knock at your door. To frame the outcome of this project as a missed opportunity, however, neither honors the work nor describes the reassessment of needs. ED nursing is a complex undertaking. The skills are taxing, the knowledge is simultaneously broad and focused, the environment is energized, and the milieu responds in kind. The question may be, is it right to try and change the focus, style, and behavior of nurses working in the ED? It would seem that they work and behave as they do because it facilitates better outcomes for emergencies in general? In the desire to improve psychiatric patient experiences and outcomes in the ED, we may have targeted the wrong issue. It's possible we need to make structural changes that leave our hard working ED nurses be and create different emergency care options for psychiatric patients. Discovery happens as a result of seeking answers and the answers present themselves organically. If the answers aren't acceptable to us, it may be a measure of the question. Forcing answers hardly bodes well for the uptake or sustainability of policies.

What happened with this particular project? What did it give us and what did it withhold? Where do we go next? One thing is certain, we have opened a door and we have walked through it. Perhaps an opportunity missed becomes an opportunity created.

Measured and Potential Impact

The measured impact was minimal at best. If nothing more is done with regard to this project, the ED nurses at this practice site will have benefited nothing. They will utilize the same interactions and interventions they have always used when treating psychiatric patients. The PICO question will not resonate and will be unanswered as we are left with "(C) compared to current practice" in the final

analysis. This is not to say that ED nurses will not learn therapeutic interactions in the course of their experiences. It also is not to say that personal stigma and empathy levels will remain stagnate without this intervention. In terms of this project, however, its usefulness will not be enjoyed by the nurses, imparted to the patients, nor implemented by the department.

Potentially, nurses may be able to avail themselves of this educational intervention individually to gain knowledge that they feel might be useful. After all, the project was meant as a tool to help unfamiliar nurses engage with psychiatric patients. Nurses often adjust their skills based on evidence-based practice to adopt better ways to do a job or better tools with which to do them. Even though the presence of a facilitator would provide an opportunity for enhancement of the education, the tool itself stands on it's own to provide the needed content.

Financial Impact

If we think in terms of a strict cost-benefit analysis, the minimal cost of this intervention pales in comparison to the potential benefit. The presentation is completed and need only be viewed by staff to effect change. It could be argued that the benefit of having more ED nurses capable and willing to apply therapeutic interventions, minimizing stigma and employing empathy, would have untold financial benefits as patients would more frequently be deescalated in the ED and triaged more effectively.

Impact of Current Policy

As project facilitator, there were many walk-throughs of the ED to talk about the upcoming educational presentation. Beyond individual praise and verbal gratitude from some at the onset of this project, hospital support was limited to nurse access via email and permission to place posters, and flyers in the break room. Concerns over a mere 3 participants at the first intervention were expressed to supervisors, managers, and the director of the ED along with the research department at the hospital.

Another email was sent by management to nurses encouraging them to attend a second presentation. No other action was taken. The director would not consider allowing nurses to attend while on the clock. As a result, there were no participants at the second presentation.

The site of this presentation is a large level I trauma center, the flagship hospital of a large multi-state system with a Magnet designation. Prior to the presentations, the hospital was in the process of recertification to receive Magnet designation for another 5 years. This was the only time hospital personnel approached this facilitator to ask that I speak with Magnet appraisers to discuss my project. Looking back, it seems there may have been some policy related to magnet status that could have mandated more support after they left. Prior to the Magnet visit, phrases like, “creating a culture for best patient outcomes”, “promoting education”, “forging collaborative working relationships”, and “positive relationships among different departments and disciplines” were bandied about ad nauseam via posters, emails, and on site visits by administrators. Afterward, the energy dissipated along with the interest.

Leadership and Innovation

As a doctoral student, one discovers how important it is to be an active part of the healthcare system on behalf of the patients they serve. Change is no longer left up to an anonymous cast of powerful, entrenched individuals. The opportunity to independently choose a project planted the seed of leadership and innovation. Autonomy allowed for ownership, which truly ignited the process. This facilitator had personally witnessed a dysfunctional treatment protocol for psychiatric patients in the ED. The negative impacts of non-therapeutic interventions by unsupported, well meaning nurses on psychiatric patients were clearly seen by the behavioral health staff and this facilitator. A theory was developed by this facilitator to explain why ED nurses develop negative attitudes toward psychiatric patients. The idea of addressing stigma and introducing education and empathy as a tool came from

internal evidence and facilitator observation. Moving this project forward needed leadership and innovation. These precepts were informed and supported by the DNP curriculum and resulted in a worthy and important intervention. Negotiating barriers was a function of believing in the value of the project, imparting that value to stakeholders, and demonstrating commitment to the project.

Sustainability

We need to reassess the commitment to change protocols for psychiatric patients in the ED. The question may be one of assessing the sustainability of the status quo. Most research points to the inability to maintain current systems to care for the increasing numbers of psychiatric patients coming to our emergency departments. Salinsky and Loftis (2007) found that sixty percent of ED doctors believe that increases in psychiatric patients in the ED have a negative impact on access to emergency medical care for all patients. Internally, some nurses have expressed concerns that improving care and nursing skills for psychiatric patients will open the door to more psychiatric patients and added expectations of ED nurses. The project cannot sustain itself if the mindset of the ED is one where psychiatric patients are seen as problematic and better served in a separate (but equal?) area. What is the context in which this project will be applied? Before we assess the sustainability of this project, we must assess the future commitment of emergency departments to treat psychiatric patients.

Further Application or Research

It is unlikely that we will see a drastic change in the way emergency care is delivered to psychiatric patients. Due to the high level of medical comorbidities, it is unreasonable and unethical to separate psychiatric patients into “jerry-rigged” psychiatric holding sections in the ED. Psychiatric patients will, for now, continue to seek help in emergency departments. More research, though underscoring, will not add to the understanding of the problem. Therefore, further application of this project should be the current focus. Modifications should be made that allow for distribution of the project in a

manner that allows for maximum access. Content should be evaluated to assure clarity in the absence of a helpful facilitator. Perhaps the presentation could be included in the mandatory learning modules that nurses currently participate in. The education department should be elicited to help in formatting the presentation to fit the standards currently held for other learning modules. In the face of what is, we need to work with what we have.

Gaps

Any gaps in the literature, practice, or policy, needs to be discussed under 2 subheadings. For purposes of educating nurses and affecting patient outcomes, there are no gaps that suggest the intervention would be problematic or ineffective. Any improvement in nurses' understanding related to psychiatric patients will have positive results for nurses and patients alike. In terms of the doctoral requirements to apply a tool to measure significance of the intervention, gaps could be identified. The validity and reliability of tools used to measure stigma and empathy are varied. Alterations in the TEQ, which had high internal consistency, were made in an attempt to improve construct validity. It was not made clear if these changes had any effect. OMS-HC scale showed good internal consistency, satisfactory test-retest reliability and intra-class correlation (Modgill et al., 2014), but findings varied in relation to using the 15-item Likert scale or the 20-item Likert scale. Comparative superiority led to choosing the TEQ and the OMS-HC rather than other tools.

Conclusion

Unable to be measured statistically, the impact of the project may lie in the potential that waits inside the unseen intervention. Or it's possible the impact of the project lies in its appropriateness for use in an emergency department system that is dysfunctional in its protocols for treating psychiatric patients. It comes down to asking the right questions to better ascertain the landscape we will be functioning in. Adjusting the question. It is the essence of discovery, which requires humility of ego to

alter our vision in order to better serve our patients. It's possible that this project's intervention is misplaced. Perhaps ED nurses are fighting an uphill battle when they are asked to manage patient's behaviors. Perhaps they are being diverted from their primary roles. It's possible that assigned behavioral health staff should work in consort with the medically minded ED nurses to better serve the psychiatric patient population. Ultimately though, this facilitator expects there is value in all nurses expanding their knowledge and skills to holistically treat the patient in front of them. We should counter the internally fragmented state of mind of the psychiatric patient with a coalesced set of skills contained in the one nurse that touches the patient.

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Appendix A

Citation	Conceptual Framework	Design/Method	Sample/Setting	Major Variables & Definitions	Measurements	Data Analysis	Study Findings	Decision For Use
<p>Aarons, G.A. (2010). Psychometric Properties and U.S. National Norms of the Evidence-Based Practice Attitude Scale (EBPAS)</p> <p>U.S.A.</p> <p>Funding: NA</p> <p>Bias: none</p>	<p>Bandura: Self Efficacy model</p>	<p>Survey design based on the MHCS</p> <p>Purpose: To assess mental health provider’s attitudes toward adopting EBP</p>	<p>N: 1,089 CLN 100 CL, 75 cities, 26 states. n: DG: CAU-70.5% AA-7.6%, H-1.8%, AS-1.8%, NT-0.3%, O-4.8%. SE:</p> <p>IN: Sites with 5 or more CLN, Off-site and SCH access to CLN</p> <p>AT:0</p>	<p>IV: EBPAS 15 item LS</p> <p>DV1: p< .05, SS for all factor loading. DV2: CFA supported SOFM of .91 to .67, finding EBPAS = .74</p>	<p>EBPAS 15 item, 5 point LS</p>	<p>LOS: CFA supported SOFM.</p> <p>R CE = .91-.67 (total scale = .74)</p>	<p>More positive attitudes toward adopting EBP COR with > organizational support. Norms provide reference point for future research. > need to link attitude with fidelity to use EBP.</p>	<p>LOE: IV</p> <p>STR: Large, nationwide, DIS, moderate to excellent reliability, good G. CON with previous ST</p> <p>WE: Speculative findings of lower scores for African American, Latino, and “Other”.</p>

Key: AA- African American, ANOVA- Analysis of Variance, AR- age range, AS- Asian American, AT- attrition rate, BTS- Bartlett’s Test of Sphericity, CAU- Caucasian, CAMI- Community Attitudes towards the Mentally Ill scale, CBA- Cronbach’s Alpha, CE- Coefficient/s, CI- confidence interval, CFA- Confirmatory Factor Analysis, CFI- Comparitive Fit Index, CL- Clinic/s, CLN- Clinician/s, COCO- Correlation Coefficient, COI- Conflict of Interest, CON- Congruent, COR- Correlate/tion, CR- Criteria, CS- chi-square analysis/test, DG- demographics, DI- Diverse, DV- dependent variable, EBP- Evidence-Based Practice, EBPAS- Evidence-Based Practice Attitude Scale, EFA- Exploratory Factor Analysis, EPPS- Edwards Personal Preference Schedule, EX- exclusions, F- female, FA- Factor Analysis, FS- feasibility, G- Generalizability, GFI- Goodness of Fit Index, H- Hispanic, HA- Harm, HCP- Health Care Professional/s, HET- Heterogeneity, HOM- Homogeneity, IAT- Implicit Association Test, IN- inclusions, IRI- Interpersonal Reactivity Index, IRR- Inter-Rater Reliability, IV- independent variable, JSE- Jefferson Scale of Empathy, KMO- Kaiser-Meyer-Olkin, LM- Limitations, LOE- level of evidence, LOS- Level of Significance, LS- Likert Scale, M- male, MANOVA- Multivariate Analysis of Variance, MHCS- Mental Health Clinicians Survey, MI- Mental Illness/Mentally Ill, MOTES- Measure of Orientations Toward Empathic and Sympathetic care, MWU- Mann-Whitney U test, N- sample size (people), n- sample size (studies), NA- not applicable, NHMRC- National Health and Medical Research Council, NIHR- National Institute for Health Research, NT- Native American, PCA- Principal Component Analysis, PP- Pre- and Post-test, Q- Quality, QL- qualitative study, QN- quantitative study, R- reliability, RCT- randomized control trial, RMSEA- Root Mean Square Error of Approximation, r/t- related to. S- Sample, SAS- Statistical Analysis Software, SCH- Scheduled, SD- Standard Deviation, SE- Setting, SOFM- Second-Order Factor Model, SOH- Simulation of Hallucinations, SR- Systematic Review, SRM- Standardized Response Means, SS- Statistically Significant, ST- Study/s, STR- strengths, SYN- Synthesis, t- t-test, U- university, WE- weaknesses, WSR- Wilcoxon Signed-Rank Test, >- Increase/greater than, <- decrease/less than

Citation	Conceptual Framework	Design/Method	Sample/Setting	Major Variables & Definitions	Measurements	Analysis	Findings	Decision For Use
<p>Ando, S. (2011). The simulation of hallucinations to reduce the stigma of schizophrenia: A systematic review U.K. Funding: NIHR program grants for Applied research. So. London and Maudsley NHS Foundation Bias: No COI declared. Second author is funded through unrestricted scholarship: GlaxoSmithKline International Scholarship Charitable Trust</p>	<p>Bandura: Self-efficacy model</p>	<p>SR Meta-Ethnographic Synthesis. Purpose: To determine effects of SOH on attitudes regarding patients with schizophrenia</p>	<p>N: 10 studies; 143, 150, 112, 127, 504, 94, 579, 10, 27, 8. DG: SE: IN: ST creating experience of auditory, visual, olfactory, or tactile hallucinations with aim of < stigma. Data-based ST r/t stigma related outcomes, harm or distress. EX: ST with simulation of hallucinations for therapeutic purposes. AT: 0</p>	<p>SOH in minutes, listed by 10 N ST: IV1: 16min IV2: 4.5min IV3: 4.5min IV4: 16min IV5: 4.5min IV6: 4.5min IV7: 4min IV8: 4.5min IV9: 4.5min IV10: 4.5min DV1: > in desire for social distancing. DV2:SS> in empathy DV3: < in negative attitudes</p>	<p>Tabular presentation of narrative SYN. SYN of the standardized mean difference was inappropriate.</p>	<p>LOS: 2 RCT met all Q CR. 2 RCT met 3 out of 6 Q CR.</p>	<p>Created insider perspective which > empathy and respect. desire for social distancing > which may not pertain to the nurse-patient relationship. Negative attitudes <.</p>	<p>LOE: I STR: IRR was high. WE: initial screening done by 1 researcher. Meta-Analysis precluded r/t HET. No HA identified but potential harm if participants have current or prodromal psychotic illness.</p>

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Citation	Conceptual Framework	Design/Method	Sample/Setting	Major Variables & Definitions	Measurements	Analysis	Findings	Decision For Use
Hojat, M. (2011) Empathic and Sympathetic Orientations Toward Patient Care: Conceptualization, Measurement, and Psychometrics U.S.A. Funding: None Bias: None	Bandura: Self Efficacy model	Design: Conceptual, measured, psychometric. Purpose: To develop instruments for measuring empathic and sympathetic orientations in patient care and to provide evidence in support of their psychometrics.	N= 201 DG: 3rd year medical students SE: Jefferson Medical College IN: EX: AT: 57	IV1: JSE IV2: IRI IV3: MOTES DV1: mean (+SD) = 13.7 (+2.4) for empathic orientation DV2: mean (+SD) = 9.2 (+3.2) for Sympathetic orientation	JSE IRI MOTES Confirmed construct validity through FA. LS. Two-way MANOVA. ANOVA. Duncan Multiple Range Test.	Principal component factor by varimax rotation, contrasted groups	Empathic orientation is significantly associated with scores of validity, conceptually relevant measure (JSE) of empathy. Outcomes progressively better as a function of > empathy.	LOE: IV STR: participation voluntary, anonymous, with no compensation. SS for empathy on JSE scale WE: Not SS for empathy on IRI scale. Included only 3 rd year medical students. HA: None

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Citation	Conceptual Framework	Design/Method	Sample/Setting	Major Variables & Definitions	Measurements	Analysis	Findings	Decision For Use
<p>MacNeela, P. (2012). A Risk to Himself: Attitudes Toward Psychiatric Patients and Choice of Psycho- social Strategies Among Nurses in Medical-Surgical Units.</p> <p>Ireland</p> <p>Funding: None</p> <p>Bias: None</p>	<p>Bandura: Self Efficacy model</p> <p>Peplau’s inter- personal Relationship theory</p>	<p>Qualitative. Multi-method design; Think aloud decision-making task and Critical Incident Interview</p> <p>Purpose: To use “think-aloud” decision making and critical incident interviewing to assess nurses’ process for described interventions</p>	<p>N=13</p> <p>DG: F, work experience; 3 nurses < 5 yrs 4 nurses 6-9 yrs 6 nurses > 10yrs</p> <p>SE: 2 acute care hospitals in Ireland (1urban-7 nurses, 1 rural-6 nurses)</p> <p>AT: 0</p>	<p>IV: Think aloud decision-making task and critical incident interview</p> <p>DV: Identifica- tion of interventions</p> <p>DV1: Reassurance</p> <p>DV2: Structured engagement</p> <p>DV3: Encourage- ment</p>	<p>Risk Attitude</p> <p>Vulnerability Attitude</p> <p>Reassurance</p> <p>Encouragement</p> <p>Structured engagement</p>	<p>NVivo7 data analysis: 4 parts; Thematic analysis. Directed content analysis. Comparison of thematic analysis in context of the critical incident inter- views. Content analysis.</p>	<p>Attitudes of the nurses were not person- centered suggesting Stereotyped rather than specialized understand- ing. Inauthentic relationship building on the part of the nurses r/t feelings of danger and unpredicta- bility.</p>	<p>LOE: VI</p> <p>STR: Compatible with other nursing research.</p> <p>WE: Findings from 1 patient scenario= limited transferability.</p> <p>HA: None</p>

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Citation	Conceptual Framework	Design/Method	Sample/Setting	Major Variables & Definitions	Measurements	Analysis	Findings	Decision For Use
<p>Modgill, G. (2014). Opening minds stigma scale for health care providers (OMS-HC): examination of psychometric properties and responsiveness</p> <p>Canada Funding: Mental Health Commission of Canada (MHCC) and a grant from Health Canada. Bias: Possible COI; 2 researches and 1 professor are associated with MHCC.</p>	<p>Bandura: Self Efficacy model</p>	<p>Secondary Analysis of Data; Evaluative ST</p> <p>Purpose: To measure stigma in HCP populations and evaluate anti-stigma programs.</p> <p>ST approved by the Conjoint Health Research Ethics Board at the U of Calgary.</p>	<p>N=1,523 HCP n=12 DG: Women 77.4%, MDs 41.5% Nurses 17% Medical students 13.4% Allied health students 14%</p> <p>SE: IN: AT:</p>	<p>IV: Opening Minds Stigma scale for Health Care Providers</p> <p>DV1: < in overall mean 6.6% DV2: < in negative attitude 7.9% DV3: < in disclosure and help-seeking 7.1% DV4: < in social distancing 4.2%</p>	<p>20 and 15 IT scale with 3 sub-scores for Attitudes, Disclosure and Help-Seeking, and Social Distancing. CBA CE with paired t and effect sizes and SRM. Matched PP surveys. One-way ANOVA, Post-hoc Tukey’s test. LS</p>	<p>EFA favored a 3-factor structure accounting for 45.3% of variance With overall internal consistency rated as Acceptable for all versions (> 0.65) Eigenvalue – one procedure, PCA, BTS, KMO, Parallel analysis, STATA software</p>	<p>OMS-HC is an accurate and reliable tool to measure stigma among HCP and to measure the effectiveness of anti-stigma programs.</p>	<p>LOE: IV STR: S size adequate, acceptable construct validity and a meaningful EFA. WE: small number PP unsuccessful r/t participants having to recall ID numbers. The self-report nature of ST. Sociodemographic information missing for some participants.</p> <p>HA: none</p>

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Citation	Conceptual Framework	Design/Method	Sample/Setting	Major Variables & Definitions	Measurements	Analysis	Findings	Decision For Use
<p>Morris, R. (2011). Is the Community Attitudes towards the Mentally Ill scale valid for use in the investigation of European nurses' attitudes towards the mentally ill? A confirmatory factor analytical approach.</p> <p>Europe</p> <p>Funding: The European Commission</p> <p>Bias: None</p>	<p>Wagner: Chronic Care Model</p>	<p>CFA</p> <p>Purpose: To assess the construct validity of applying the CAMI scale to nurses.</p>	<p>N= 858 (69.3% Response rate) DG: F 66%, M 34% Mean age 40 Average level of education 18yrs SE: 6 countries in Europe, 6 psychiatric hosp. 9 acute care hosp. 5 clinics. IN: Scale had to be translated and validated into other languages. Scale had to have been previously used with some level of consistency. Scale included a community focus. Scale had tools previously validated for use.</p>	<p>IV: CAMI and modified CAMI.</p> <p>DV1-3: > 0.9 cut off point desired DV1: CFI > 0.9 DV2: GFI > 0.9 DV3: adjusted GFI > 0.9</p> <p>DV4: RMSEA = 0.054 indicating a good fit</p>	<p>CFA using maximum likelihood estimation in AMOS7 software. Normed x2 GFI, CFI, RMSEA. Expectation Maximization Algorithm. The following tools were excluded: Mental Illness Attitude Scale (MIA), Opinions about Mental Illness Scale (OMI), and Attitudes towards Mental Illness scale (AMI).</p>	<p>Skewness >2, and Kurtosis >7 = non-normality. CS</p>	<p>Would the CAMI scale, which was designed to measure the attitudes of lay people and the community towards the MI, translate to nurses. A modified CAMI scale was found more appropriate for measuring nurses' attitudes towards patients with MI.</p>	<p>LOE: IV STR: Modified CAMI had good validation. CFI, GFI and adjusted GFI scores at or above cut off point of 0.9. RMSEA at .054 inferred a good fit.</p> <p>WE: Majority % of participants were psychiatric nurses, which does not affect the study's purpose of validating the scale but may effect the findings of the scale.</p>

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Citation	Conceptual Framework	Design/Method	Sample/Setting	Major Variables & Definitions	Measurements	Analysis	Findings	Decision For Use
<p>Ozcan, C.T. (2012). The effect of a structured empathy course on the students of a medical and a nursing school</p> <p>Turkey</p> <p>Funding: Unknown Bias: None</p>	<p>Bandura: Self Efficacy model</p>	<p>PP Quasi-experimental design.</p> <p>Purpose: To determine if a structured empathy course can increase empathy skills and empathy tendencies.</p>	<p>N= 226</p> <p>DG: First year medical (143) and nursing (83) students. AR 19-20. M=143, F=83</p> <p>SE: University in Ankara, Turkey</p> <p>AT: 31</p>	<p>IV: Structured Empathy course</p> <p>DV1: Empathic Communication Skills Scale; 141.72 (+21.66) > to 169.42 (+28.82)</p> <p>DV2: Empathic Tendency Scale; 70.94 (+ 8.93) > to 73.73 (+10.49)</p>	<p>Empathic Communication Skills (ECSS) scale. Empathic Tendency Scale (ETS). LS.</p>	<p>CBA = 0.88 COCO $r=$ 0.82 compared to EPPS scale with COCO $r=$ 0.68. COR analysis, WSR, MWU.</p>	<p>An > in empathic skills and empathic tendencies. Students can learn empathic process on a cognitive level LM: Findings based on self-reporting. First year students only, undetermined G to all students.</p>	<p>LOE: III</p> <p>STR: Strong positive > in scores for both men and women. > in empathy skills over 4 years</p> <p>WE: Weak longitudinal focus. Self-reporting. Only 1st year medical and nursing students</p>

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Citation	Conceptual Framework	Design/Method	Sample/Setting	Major Variables & Definitions	Measurements	Analysis	Findings	Decision For Use
<p>Plant, L.D. (2013). Emergency Room Psychiatric Services: A Qualitative Study of Nurses' Experiences</p> <p>U.S.A.</p> <p>Funding: None</p> <p>Bias: None</p>	<p>Meyer's Minority Stress Model</p> <p>MMSM applies as the psychiatric patient experience of stressors r/t expectations of rejection, concealment, and internalized stigma, along with the intervention of a supportive nurse affecting a more positive outcome.</p>	<p>Qualitative Study of literature reviews including 1 RCT.</p> <p>Qualitative investigation used a focus group format.</p> <p>Purpose: To elicit ER nurses' perspectives on their experiences with psychiatric patients, relating their knowledge, skills and competence to their attitudes such as bias.</p>	<p>N= 10</p> <p>DG: 4-32 years of experience.</p> <p>Education: Diploma-1 Associate degree-5 Bachelor degree- 3 Masters degree- 1</p> <p>SE: Medium-sized community hospital in the Northeast.</p> <p>IN: RNs in the ER with at least 6 months experience working with psychiatric patients.</p> <p>AT: 0</p>	<p>IV: ER Nurses Attitudes r/t powerlessness, struggling with uncertainty, seeking resolution and more certainty, blaming, and hopelessness when caring for the MI</p> <p>DV: Powerlessness was the over-reaching theme.</p>	<p>Krueger and Casey's qualitative analysis.</p>	<p>Transcripts were coded to identify meaningful words and phrases. Powerlessness was the major theme with sub-themes of blaming, immovable barriers, struggling with uncertainty, and seeking resolution.</p>	<p>Nurses described a desire for a nurse educator to assist them in gaining knowledge to care for psychiatric patients. Role ambiguity is associated with < understanding and clinical interaction with psychiatric patients</p>	<p>LOE: II</p> <p>STR: Consistent findings of ER nurses discomfort r/t lack of knowledge and education leading to avoidance, incorrect assessments, and poorer outcomes for psychiatric patients</p> <p>WE: \$30 compensation for participation. 41% participation of ER nurses. Less than 5 participants in each group.</p>

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Citation	Conceptual Framework	Design/Method	Sample/Setting	Major Variables & Definitions	Measurements	Analysis	Findings	Decision For Use
Teal, C.R. (2010). When Best Intentions Aren't Enough: Helping Medical Students Develop Strategies for Managing Bias about Patients U.S.A. Funding: Bias: No COI	Grounded Theory Bandura: Self Efficacy model	Grounded theory Purpose: To test an educational intervention to promote group-based reflection about implicit bias.	N= 72 DG: 3 rd year medical students SE: medical school AT: 0	IV: Discussion sessions entitled "Best Intentions" DV1: > in applying multi-faceted strategies to manage bias; 10.4% to 16%. DV2: 67% identified Alternative strategies for managing bias.	IAT. CS	CS of Pre-post-session strategy distribution 27.93, p<0.01 for > in reflection and debriefing of 67% of students.	67% of students employed or developed different strategies for managing bias	LOE: VI STR: Shifts in strategies were directly correlated to the group sessions. WE: Only 3 rd year med students. Small sample. Open-ended questions = labor intensive analysis.

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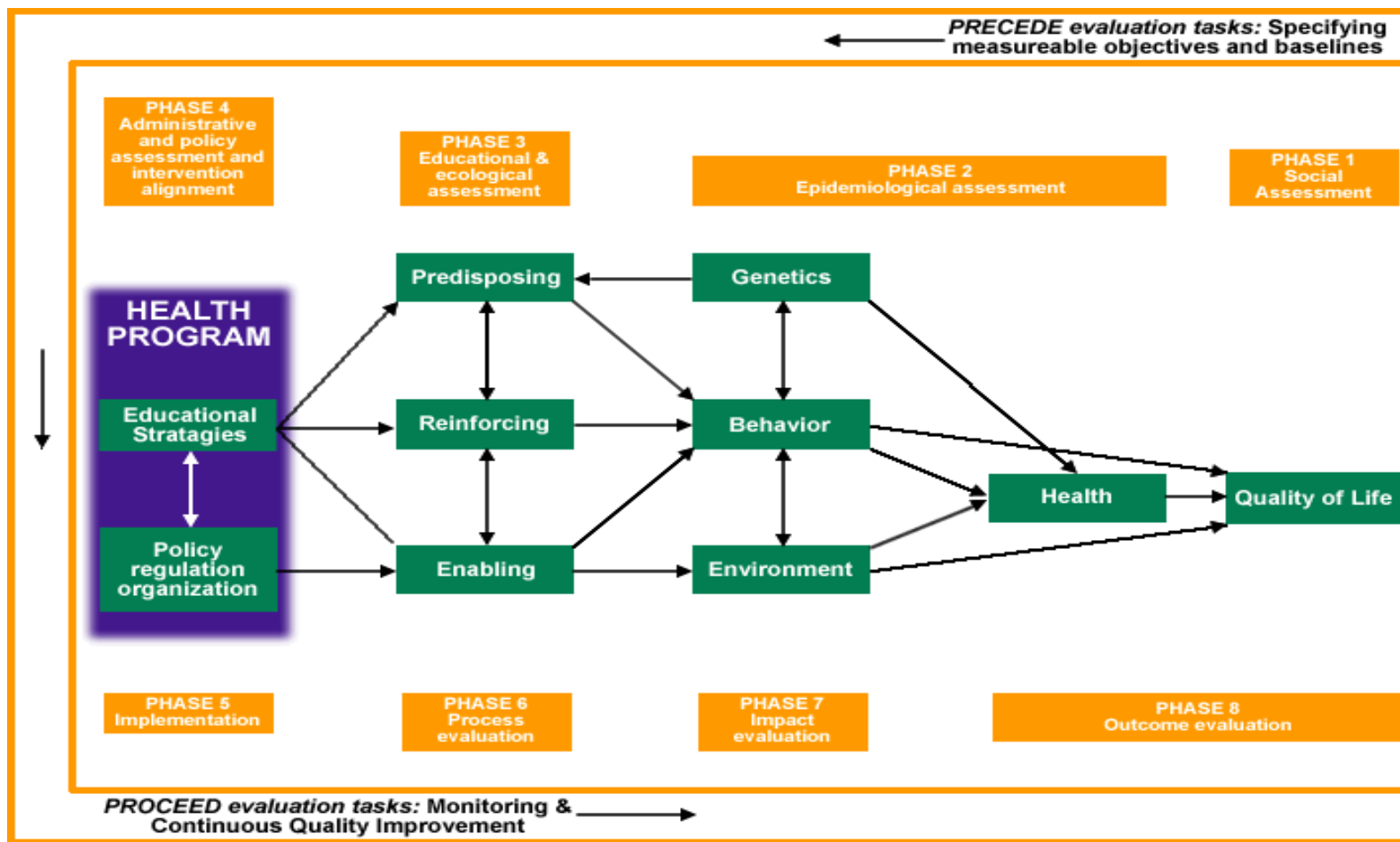
Citation	Conceptual Framework	Design/Method	Sample/Setting	Major Variables & Definitions	Measurements	Analysis	Findings	Decision For Use
<p>Van Der Kluit, M.J. (2011). Factors Influencing Attitudes of Nurses in General Health Care Toward Patients with Comorbid Mental Illness: An Integrative Review</p> <p>Netherlands</p> <p>Funding:</p> <p>Bias: No COI</p>	<p>Wagner: Chronic Care Model</p>	<p>Integrative Literature Review</p> <p>Methodology for the assessment of quantitative and qualitative studies as described by Polit and Beck (2008).</p> <p>Purpose: A review of literature to elucidate the factors influencing attitudes of general health care nurses towards patients with comorbid MI.</p>	<p>n= 15 articles (10 QN, 5 QL).</p> <p>DG: Multi SE: Multi</p> <p>IN: Primary research articles. Published between 1989 and 2009. Addressing attitudes of General Healthcare nurses caring for psychiatric patients. Describing influencing factors.</p> <p>AT: 2 out of 17 articles disqualified.</p>	<p>IV: med/surg nurses' attitudes towards patients with co-morbid MI</p> <p>DV: Knowledge and skills, professional experience, experience with MI patient population, holistic nursing vision, works satisfaction, support, Personality, personal experience with MI, age and gender, ethnicity, religion</p>	<p>Semi-structured interviews, focus groups, individual interviews, descriptive QL. LS, Opinions about MI scale, Depression Attitude Questionnaire, Suicide Opinion Questionnaire, Understanding of Suicide Attempt Patients Scale.</p>	<p>Multi-regression analysis</p>	<p>Positive influencing factors include knowledge and skills, education level, professional experience, nurses' experience dealing with psychiatric patients, holistic nursing vision, support, satisfaction at work, personal experience, age, and religion.</p>	<p>LOE: V</p> <p>STR: Solid methodology for the assessment of the QL and QN articles.</p> <p>WE: great diversity of studies of many cultures facilitating a broad spectrum which tends to hamper comparisons. Some instruments used had poor quality and some articles lacked empirical data.</p>

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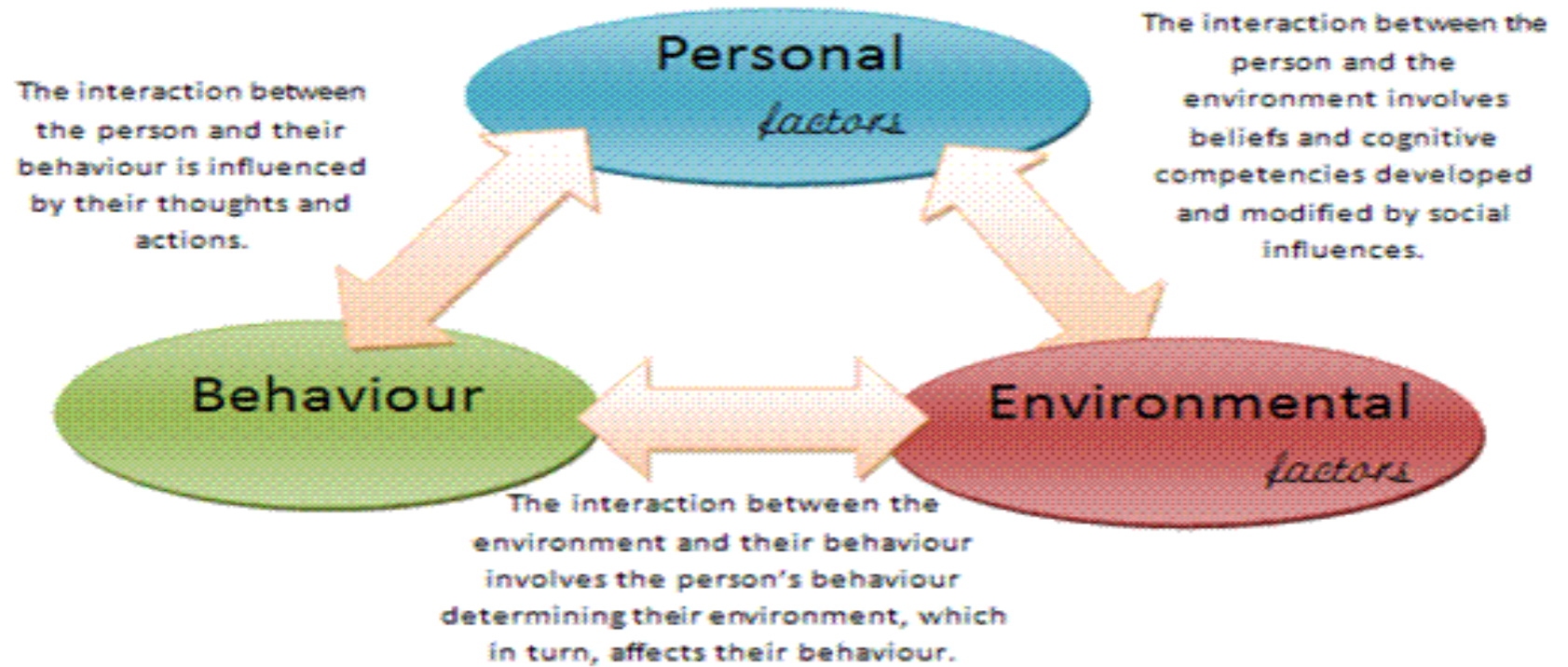
Appendix B

	Aaron	Ando	Hojat	MacNeela	Modgill	Morris	Ozcan	Plant	Teal	Van Der Kluit
Year	2010	2011	2011	2012	2014	2011	2012	2013	2010	2011
Country	U.S.A.	U.K.	U.S.A.	Ireland	Canada	Europe	Turkey	U.S.A.	U.S.A.	Netherlands
Level of evidence	IV	I	IV	VI	IV	IV	III	II	VI	V
Independent Variables										
Empathy Scale			X		X	X				
Empathy Course		X					X		X	
Assessing Bias		X	X	X	X	X	X	X	X	X
Knowledge/Skills				X				X		X
Attitudes r/t EBP	X									
Dependent Variables										
Changes in Empathy		X	X			X	X		X	
Changes in Bias		X	X				X		X	
Awareness of Bias									X	X
Factors of Bias				X						X
Support for EBP use	X									
Heterogeneity	X	X			X		X			
Homogeneity			X	X*		X*		X*	X	X*
Validity			++		++	++		++	++	+
Reliability	+++	+++			++	++		++	++	+
Generalizability	++	-	-	-		-	--			
Settings										
University		X	X		X		X		X	
Hospital				X	X	X		X		X
Clinic	X	X			X	X				X
Community		X								
Interventions										
Teaching Empathy			X	X			X		X	
Empathy Survey						X		X	X	X
Assessing current empathy, bias and negative attitudes		X	X	X	X	X	X	X	X	X
Teaching Skills		X		X			X		X	
Assessing knowledge and skills	X		X	X			X	X	X	X
Assessing/Creating Scales	X	X	X		X	X				X
Outcomes										
Changes in Empathy		>	>	>			>		>	
Changes in Bias		<	<				<		<	
Changes in Knowledge/Skills	>	>	>	>			>		>	
Rating of Scales	+++				+++	+++		++		+++

Appendix C



Appendix D



Appendix E



EXEMPTION GRANTED

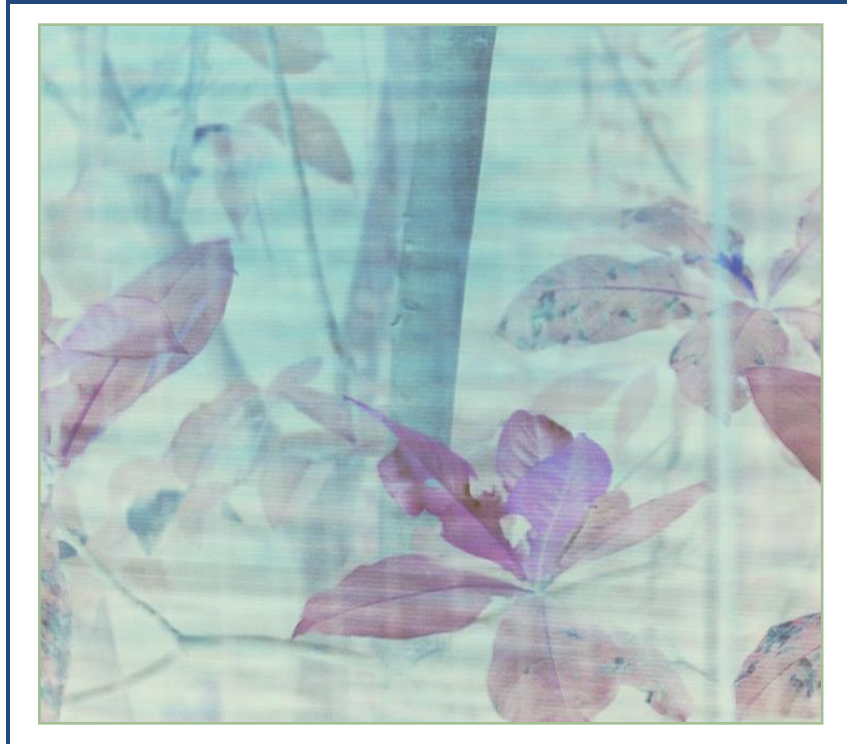
Ann Guthery
 CONHI - DNP
 602/496-0794
 Ann.Guthery@asu.edu

Dear Ann Guthery:

On 9/15/2015 the ASU IRB reviewed the following protocol:

Type of Review:	Initial Study
Title:	An Educational Intervention to Mitigate Stigma and Increase Empathy in Nurses Toward Psychiatric Patients in the Emergency Department
Investigator:	Ann Guthery
IRB ID:	STUDY00003167
Funding:	None
Grant Title:	None
Grant ID:	None
Documents Reviewed:	<ul style="list-style-type: none"> • Permission to use OMS-HC, Category: Other (to reflect anything not captured above); • Recruitment email, Category: Recruitment Materials; • Letter of Support-BUMCP.pdf, Category: Off-site authorizations (school permission, other IRB approvals, Tribal permission etc); • Consent documentation, Category: Consent Form; • Toronto Empathy Questionnaire, Category: Measures (Survey questions/Interview questions /interview guides/focus group questions); • recruitment flyer, Category: Recruitment Materials; • Opening Minds Scale for Health Care Providers, Category: Measures (Survey questions/Interview questions /interview guides/focus group questions); • Permission to use TEQ, Category: Other (to reflect anything not captured above); • HRP-

Appendix F

The tool of empathy to help manage stress and frustration**ER NURSES**

**An educational intervention to describe the etiology and presentation of psychiatric symptoms and behaviors seen in the ER
*An Arizona State University Research Study***



A DNP project by Ray Hippe, RN, BSN

I am seeking voluntary participation in an educational intervention to describe the experience of psychiatric patients in the ER, reasons for their behaviors, and helpful ways to better understand and engage with this population. Stigma and empathy will be addressed as it pertains to giving nurses pathways to decrease their frustration and stress while validating the difficult task of caring for this population. The educational intervention will take no more than 90 minutes and will occur at various times and dates in late October and early November. No signing up required. For purposes of measurement, 2 short questionnaires will be given before and after the educational presentation. You must be 18 years or older to participate in this study. Please feel free to contact me with any questions: Ray Hippe, 480-252-0481-c, ray.hippe@asu.edu

Appendix G

**An Educational Intervention to Mitigate Stigma and Increase Empathy in Nurses
Toward Psychiatric Patients in the Emergency Department**

Date: September 1, 2015

Dear Participant:

I am a graduate student under the direction of Professor Ann Guthery, PhD, RN, PMHNP-BC in the College of Nursing and Health Innovation at Arizona State University.

I am inviting you to participate in an evidence based educational program to see if an educational intervention regarding psychiatric illness and it's etiology and presentation can reduce stigma and increase empathy in emergency room nurses caring for psychiatric patients. This will involve participating in an educational class about causes and symptoms of mental illness and completing a survey before and after the class. The total time required to listen to the educational presentation and complete the questionnaires will be approximately 60 minutes. The program will be scheduled as a 10-15 minute session to complete 2 questionnaires before a 30 minute long educational segment, followed by another 10-15 minute session to fill out the 2 questionnaires again. There will be additional time allowed to answer any questions you may have. For project purposes, a measurement of stigma and empathy will inform the impact of the educational intervention. For the nurses participating, the goal is to increase understanding and awareness of psychiatric presentations and develop ways to manage anxiety and frustration when caring for the mentally ill population.

Your participation in the evaluation of the program is voluntary. If you choose not to participate or to withdraw from the program at any time, there will be no penalty. Participation in this study will not affect your treatment at Banner-University Medical Center Phoenix. All identification of participants will be coded so that the questionnaires cannot to be identified with, or ascribed to, any individual. You must be 18 years of age or older to participate in this program.

Responses to the questionnaires will be used to evaluate the effectiveness of the education on nurse stigma and empathy. There is no known risk greater than those that are associated with everyday types of activity.

Your responses on the questionnaires will be anonymous and will be identified only by a number-color combination (e.g. favorite month, favorite color, favorite age so far: October, blue, 19= 10blue19) that will not be connected to your name or other personal identifying information. The results of this study may be used in reports, presentations, or publications, but your name will not be known or used.

If you have any questions concerning this program, please contact the following team members: **Ray Hippe, RN, BSN at ray.hippe@asu.edu or (480) 252-0481- cell.**

Ann Guthery, PhD, RN, PMHNP-BC at ann.guthery@asu.edu.

Listening to the educational program regarding psychiatric illness' etiology and presentation, and finishing the pre education and post education survey will be considered your consent to participate.

Sincerely,

Ray Hippe, RN, BSN

Ann Guthery, PhD, RN, PMHNP, B.C.

Appendix H



1111 East McDowell Road
Phoenix, AZ 85006
(602) 839-6989 Office
www.bannerhealth.com

July 22, 2015

Re: Ray Hippe DNP Project Proposal

To Members of the Review Panel,

I am writing to express my support for the DNP project conducted by Ray Hippe. This project seeks to conduct an educational intervention with Banner – University Medical Center Phoenix Campus emergency room nurses assess empathy and stigma of behavioral health patients, before and after the education. The goal of the education is to reduce bias by increasing empathy and decreasing stigma, each measured by validated instruments.

According to the Emergency Nurses Association (ENA), emergency department caregivers in general do not feel comfortable in providing care for emergency psychiatric patients, which in many cases leads to psychiatric patients receiving inadequate care. When attributing attitudes to mental illness, studies showed that nursing staff in somatic care had more negative attitudes compared with their counterparts in behavioral health. Healthcare personnel, including nurses, are considered by mental health consumers to be primary contributors to stigma and discrimination against those with mental illness. Findings suggest that stigma associated with mental illness may be as strong in health care providers as it is in the general public. More troubling is that the ENA found that non-psychiatric nurses tend to view patients with psychiatric comorbidity negatively and that this has shown to affect nurses' responsiveness to medical symptoms. Outcomes of increased empathy have proven to be effective, and research has shown that patients respond to it.

The proposed intervention will help emergency department nurses describe the etiology, pathology, and therapeutic treatment modalities concerning psychiatric patients and their particular diagnoses, as they present in the emergency department. The implications include increasing communication between nurses and patients and improving holistic care.

We welcome the opportunity to advance nursing education and professional nursing practice within our Magnet®-designated facility. We will expect Ray to present outcomes of his project upon completion of his implementation and analysis.

If I can be of any further assistance, please don't hesitate to contact me.

Sincerely,

A handwritten signature in cursive script that reads 'Lesly A. Kelly'.

Lesly A. Kelly
RN Clinical Research Program Director
Banner – University Medical Center Phoenix Campus

Appendix I

The tool of empathy and knowledge to help manage psychiatric patients in the ER

...or, I'm a great ER nurse but this population really gets under my skin

What I'm not asking of you

- To put yourself at risk
- To like a particular patient
- To understand every patient
- To be a doormat
- To be nice

What I am asking of you

- Be bold (The natural character of an ER nurse)
- Breathe: Take the time YOU need.
- Challenge yourself... to expand your capacity to employ therapeutic interactions if it empowers and it will make you feel good

Statistics

Perpetrators of Violent Crimes in U.S. in 2012

Category	Percentage
White	55%
Black	35%
Hispanic	10%

Appendix J



Opening Minds Scale for Health Care Providers (OMS-HC)

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. I am more comfortable helping a person who has a physical illness than I am helping a person who has a mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. If a person with a mental illness complains of physical symptoms (e.g., nausea, back pain or headache), I would likely attribute this to their mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. If a colleague with whom I work told me they had a managed mental illness, I would be just as willing to work with him/her.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. If I were under treatment for a mental illness I would not disclose this to any of my colleagues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I would be more inclined to seek help for a mental illness if my treating healthcare provider was not associated with my workplace.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I would see myself as weak if I had a mental illness and could not fix it myself.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I would be reluctant to seek help if I had a mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Employers should hire a person with a managed mental illness if he/she is the best person for the job.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I would still go to a physician if I knew that the physician had been treated for a mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. If I had a mental illness, I would tell my friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. It is the responsibility of health care providers to inspire hope in people with mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Despite my professional beliefs, I have negative reactions towards people who have mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. There is little I can do to help people with mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. More than half of people with mental illness don't try hard enough to get better.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. People with mental illness seldom pose a risk to the public.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. The best treatment for mental illness is medication.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I would not want a person with a mental illness, even if it were appropriately managed, to work with children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Healthcare providers do not need to be advocates for people with mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I would not mind if a person with a mental illness lived next door to me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. I struggle to feel compassion for a person with mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix K

Below is a list of statements. Please read each statement carefully and rate how frequently you feel or act in the manner described. Circle your answer on the response form. There are no right or wrong answers or trick questions. Please answer each question as honestly as you can.

		Never	Rarely	Sometimes	Often	Always
1.	When someone else is feeling excited, I tend to get excited too	0	1	2	3	4
2.	Other people's misfortunes do not disturb me a great deal	0	1	2	3	4
3.	It upsets me to see someone being treated disrespectfully	0	1	2	3	4
4.	I remain unaffected when someone close to me is happy	0	1	2	3	4
5.	I enjoy making other people feel better	0	1	2	3	4
6.	I have tender, concerned feelings for people less fortunate than me	0	1	2	3	4
7.	When a friend starts to talk about his\her problems, I try to steer the conversation towards something else	0	1	2	3	4
8.	I can tell when others are sad even when they do not say anything	0	1	2	3	4
9.	I find that I am "in tune" with other people's moods	0	1	2	3	4
10.	I do not feel sympathy for people who cause their own serious illnesses	0	1	2	3	4
11.	I become irritated when someone cries	0	1	2	3	4
12.	I am not really interested in how other people feel	0	1	2	3	4
13.	I get a strong urge to help when I see someone who is upset	0	1	2	3	4
14.	When I see someone being treated unfairly, I do not feel very much pity for them	0	1	2	3	4
15.	I find it silly for people to cry out of happiness	0	1	2	3	4
16.	When I see someone being taken advantage of, I feel kind of protective towards him\her	0	1	2	3	4

Appendix L

Preview

7/15/15, 7:39 AM



Date: Wednesday, July 15, 2015 7:16 AM
From: Scott B. Patten <patten@ucalgary.ca>
To: rayhippe@cox.net <rayhippe@cox.net>
Cc: Stephanie Knaak (sknaak@mentalhealthcommission.ca) <sknaak@mentalhealthcommission.ca>
Subject: RE: Permission to use OMS-HC

Please feel free to use it.
Most of the psychometric data is available from these two papers:

www.biomedcentral.com/1471-244X/12/62
www.biomedcentral.com/1471-244X/14/120

I am copying this to Stephanie Knaak at the Mental Health Commission of Canada, who keeps track of its use.

Scott

-----Original Message-----

From: rayhippe@cox.net [rayhippe@cox.net]
Sent: Tuesday, July 14, 2015 2:21 PM
To: Scott B. Patten
Subject: Permission to use OMS-HC

Dear Sir,

My name is Ray Hippe. I am trying to obtain permission to use the Opening Minds Scale for Health Care Providers (OMS-HC) for my graduate program project. I am at a loss in determining who the author is and thought that maybe you could help me find that out. Thank you for your time and consideration.

Ray Hippe, RN, BSN

Appendix M

Preview

7/13/15, 8:32 PM



Date: Monday, July 13, 2015 10:43 PM
From: Nathan Spreng <nathan.spreng@gmail.com>
To: rayhippe@cox.net
Subject: Re: Permission to use the TEQ

Thank you for your interest.

You are welcome to use and reproduce the Toronto Empathy Questionnaire for non-commercial research and educational purposes without seeking my written permission. Distribution must be controlled, meaning only to the participants engaged in the research or enrolled in the educational activity. Any other type of reproduction or distribution of the TEQ is not authorized without my written permission. The original Journal of Personality Assessment paper should be referenced in any resulting publication or report.

Best,
Nathan Spreng

On Mon, Jul 13, 2015 at 7:07 PM, <rayhippe@cox.net> wrote:

Dear R. Nathan Spreng,

My name is Ray Hippe. I am currently enrolled at Arizona State University working toward my DNP in psychiatry. I am working on an educational intervention for the nurses giving care to psychiatric patients in our emergency department. I would like to measure empathy using the Toronto Empathy Questionnaire and am wondering who I might speak with to attain permission to use the scale. I have seen your name attached to information about the scale and am thinking that perhaps you are the author of the scale. I can imagine that you are a very busy man so if you took the time to direct me, I would be grateful. Thank you for your time and consideration.

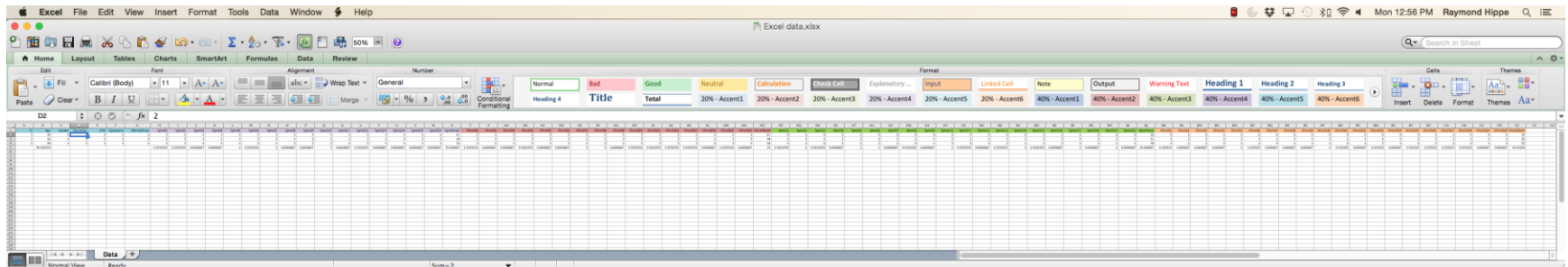
Sincerely, Ray Hippe, RN, BSN

--

R. Nathan Spreng, PhD
Assistant Professor
Rebecca Q. and James C. Morgan Sesquicentennial Faculty Fellow
Laboratory of Brain and Cognition
Department of Human Development
Martha Van Rensselaer Hall G62C
Cornell University, Ithaca, NY 14853
p: 607-255-4396
e: nathan.spreng@gmail.com; rns74@cornell.edu
w: <http://lbc.human.cornell.edu>

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Appendix N



The screenshot displays a Microsoft Excel spreadsheet with the following data:

	A	B	C	D	E	F	G
1	ID	Age	Gender	Education	shift	Experience	MentalIllness
2	1	30	1	2	2	1	1
3	2	32	1	1	1	1	1
4	3	44	1	1	1	1	1
5		35.333333					
6							
7							

The status bar at the bottom of the window indicates 'Normal View', 'Ready', and 'Sum=2'.

