ATATURK UNIVERSITY PUBLICATIONS

Journal of Nursology

Formerly
Journal of Anatolia Nursing and Health Sciences
Official journal of Atatürk University Faculty of Nursing

Volume 27 • Issue 2 • June 2024

EISSN 2822-2954
https://dergipark.org.tr/en/pub/jnursology

Journal of Nursology

Journal of Nursology

ABOUT

Journal of Nursology is a peer reviewed, open access, online-only journal published by the published by Atatürk University.

Journal of Nursology is published quarterly in Turkish and English in March, June, September, and December.

Journal History
As of 2022, the journal has changed its title to Journal of Nursology.

Previous Title
1998-2009
Atatürk Üniversitesi Hemşirelik Yüksekokulu Dergisi
ISSN: 1301-9899

Previous Title
2010-2021
Anadolu Hemşirelik ve Sağlık Bilimleri Dergisi-Journal of Anatolia Nursing and Health Sciences
ISSN: 1309-5471
EISSN: 2687-2498

Current Title
Journal of Nursology
EISSN: 2822-2954

Journal of Nursology currently indexed in Scopus, ESCI, EBSCO, ERIH Plus, CINAHL, DOAJ, CNKI and TUBITAK ULAKBIM TR Index.

All expenses of the journal are covered by the Atatürk University. Processing and publication are free of charge with the journal. No fees are requested from the authors at any point throughout the evaluation and publication process. All manuscripts must be submitted via the online submission system, which is available at https://dergipark.org.tr/en/pub/jnursology. The journal guidelines, technical information, and the required forms are available on the journal's web page.

Disclaimer
Statements or opinions expressed in the manuscripts published in the journal reflect the views of the author(s) and not the opinions of the editors, editorial board, and/or publisher; the editors, editorial board, and publisher disclaim any responsibility or liability for such materials.

Open Access Statement
Journal of Nursology is an open access publication, and the journal's publication model is based on Budapest Access Initiative (BOAI) declara-tion. All published content is available online, free of charge at https://dergipark.org.tr/en/pub/jnursology. The journal's content is licensed under a Creative Commons Attribution-NonCommercial (CC BY-NC) 4.0 International License which permits third parties to share and adapt the content for non-commercial purposes by giving the appropriate credit to the original work.

From January 2022 onwards, content is licensed under a Creative Commons CC BY-NC 4.0 license. The journal's back content was published under a traditional copyright license however the archive is available for free access.

You can find the current version of the Instructions to Authors at https://dergipark.org.tr/en/pub/jnursology/writing-rules

Contact (Editor in Chief)
Nadiye ÖZER
Address: Atatürk University, Faculty of Nursing,
Department of Surgical Diseases Nursing, Erzurum, Turkey
✉ hyodergi@atauni.edu.tr
https://dergipark.org.tr/en/pub/jnursology
☎ +90 442 231 14 48

Contact (Publisher)
Atatürk University
Atatürk University, Yakutiye, Erzurum, Turkey
25240
✉ ataunijournals@atauni.edu.tr
https://bilimseldergiler.atauni.edu.tr
☎ +90 442 231 15 16

Journal of Nursology

CONTENTS

RESEARCH ARTICLES

REVİEW

ATATÜRK ÜNİVERSİTESİ YAYINLARI
ATATURK UNIVERSITY PUBLICATIONS

Research Article *Araştırma Makalesi* DOI: 10.17049/jnursology.1507481

Role-Play Based Gamification for Communication Skills and Nursing Competence in Internal Medicine Nursing

İç Hastalıkları Hemşireliğinde İletişim Becerileri ve Hemşirelik Yetkinliğine Yönelik Rol Oynamaya Dayalı Oyunlaştırma

Huri Deniz KARCI[1]
Nilay BEKTAŞ AKPINAR[2]
Ulviye ÖZCAN YÜCE[3]

[1]Ankara Medipol University, Faculty of Communication, Ankara, Turkey
[2]Ankara Medipol University, Faculty of Health Sciences, Department of Nursing, Ankara, Turkey
[3]Osmaniye Korkut Ata University, Faculty of Health Sciences, Department of Nursing, Osmaniye, Turkey

ABSTRACT

Objective: This study aims to the effect of role-play-based gamification on the analysis of symptoms in Internal Medicine Nursing, decision making, administration of appropriate nursing care, and the communication skills of nursing students.
Methods: The study was designed in participatory action research as a qualitative design. In the action research, gamification elements were constructed on a role-play performance of the students in Nursing Department at a private university in Ankara-Türkiye. A gamification based on systems role play was performed for students taking the internal medicine nursing course (n=10). Checklists for each system regarding the selection and use of equipment appropriate for nursing interventions have been added to the games. At the end of the semester they were asked to evaluate this intervention via qualitative interview. In the in-depth interviews, data were collected by asking the students 9 unstructured open-ended questions prepared by the researchers. Data analysis was carried out by hand coding by the researchers. Codes were created from the research objectives based on Werbach's D6 Model for gamification design.
Results: The qualitative analysis revealed six major themes (i) Defining Business Goals (ii) Delineating Target Behaviors (iii) Describing Players (iv) Devising Activity Loops (v) Deploying Tools (vi) Not forgetting the fun. In these themes, students stated that by using game elements in lessons, it became easier to remember and apply theoretical knowledge about internal medicine nursing, improved their practical skills, time management skills and critical decision-making abilities, and that they better understood the importance of effective communication within the team. Additionally, students stated that the experience of learning the basic aspects of internal diseases, which are difficult to learn in theory, became fun with the gamification technique.
Conclusion: The use of gamification, students learned nursing care and communication skills related to Internal Medicine Nursing education in a motivated and more permanent manner.

Keywords: Communication, education, gamification, nursing student

ÖZ

Amaç: Bu çalışma, rol-play temelli oyunlaştırmanın İç Hastalıkları Hemşireliğinde semptomların analizi, karar verme, uygun hemşirelik bakımının yönetimi ve hemşirelik öğrencilerinin iletişim becerileri üzerindeki etkisini amaçlamaktadır.
Yöntemler: Katılımcı eylem araştırması olarak tasarlanan araştırma, Ankara'da bulunan özel bir üniversitenin Hemşirelik Bölümünde İç Hastalıkları dersini alan öğrenciler (n=10) ile rol yapma üzerine gerçekleştirildi. Oyunlara hemşirelik girişimlerine uygun ekipmanın seçilmesi ve kullanılmasına ilişkin her sistem için kontrol listeleri eklenmiştir. Dönem sonunda öğrencilerden oyunlaştırma ile sürdürülen öğrenme süreçlerini nitel görüşme yoluyla değerlendirmeleri istendi. Derinlemesine görüşmelerde öğrencilere araştırmacılar tarafından hazırlanan 9 adet yapılandırılmamış açık uçlu soru sorularak veriler toplandı. Verilerin analizi araştırmacılar tarafından elle kodlama yapılarak gerçekleştirilmiştir. Oyunlaştırma tasarımı için Werbach'ın D6 Modeli temel alınarak araştırma hedeflerinden kodlar oluşturulmuştur.
Bulgular: Niteliksel analiz altı ana temayı ortaya çıkardı: (i) İş Hedeflerini Tanımlamak (ii) Hedef Davranışları Tanımlamak (iii) Oyuncuları Tanımlamak (iv) Etkinlik Döngüleri Tasarlamak (v) Araçları Yerleştirmek (vi) Eğlenceyi unutmamak. Bu temalarda öğrenciler derslerde oyun unsurlarının kullanılmasıyla İç Hastalıkları Hemşireliği ile ilgili teorik bilgilerin hatırlanması ve uygulanmasının kolaylaştığını, pratik becerilerinin, zaman yönetimi becerilerinin ve kritik karar

Geliş Tarihi/Received: 20.04.2023
Revizyon Tarihi/Revised 12.01.2024
Kabul Tarihi/Accepted: 19.02.2024
Yayın Tarihi/Publication Date: 25.06.2024

Sorumlu Yazar/Corresponding author:
Ulviye ÖZCAN YÜCE
E-mail: ulviyezcan6@gmail.com

Cite this article: Karcı H.D, Bektaş Akpınar N, Özcan Yüce U. Role-Play Based Gamification for Communication Skills and Nursing Competence in Internal Medicine Nursing.. *J Nursology*. 2024;27(2):88-100.

verme becerilerinin geliştiğini, ekip içinde etkili iletişimin sağlanması konusunun önemini daha iyi anladıklarını ifade etmişlerdir. Ayrıca öğrenciler teoride öğrenilmesi zor olan iç hastalıklarının temel yönlerini öğrenme deneyiminin oyunlaştırma tekniği ile eğlenceli hale geldiğini ifade etmişlerdir.

Sonuç: Oyunlaştırma kullanımıyla öğrenciler İç Hastalıkları Hemşireliği eğitimine ilişkin hemşirelik bakımı ve iletişim becerilerini motive edici ve daha kalıcı bir şekilde öğrenmişlerdir.

Anahtar Kelimeler: İletişim, eğitim, oyunlaştırma, hemşirelik öğrencisi

INTRODUCTION

Today, nursing students need to acquire and improve higher-order skills and competencies such as critical thinking, problem solving, stress management, creativity and so forth[1] which keeps nursing students away from a teacher-centered instruction model and leads them into a rather student-centered learning environment.[2] For this reason, nursing education involves cognitive, sensory and psychomotor learning areas to help students experience professional roles which they must use in their profession after graduation.[3] Besides, they clearly seem to demand learning confusing nursing skills and notion in a different way from traditional methods in such an information age. In an era of a quite rapid growth in technological advancements nursing students do not find passive learning by traditional teaching methods sufficient.[3,4]

In our era in which education and training activities have been undergoing change depending on today's needs, the usage of gamification in education is rather at issue recently. The use of games in the field of education today is called 'game'- 'serious game'.[5] The usage of gaming elements in out-of-game contexts, "gamification" stated in other words, is strongly recommended due to its contribution to the improvements of effective communication, problem solving, creativity and interpersonal communication.[6] The usage of gamification in nursing education has emerged resulting from students' need to improve clinical practice skills.[7] The use of the gamification method as a teaching model in nursing was first introduced by Dewey and Gestalt theorists at the beginning of the 20th century. Today, game-based learning is still in its infancy in the field of nursing.[8,9] A recent model which integrates game elements into learning is Werbach D6. The model was developed by Werbach and Hunter[10] firstly as a three-dimensional pyramid of game elements consisted of dynamics, mechanics and components and was advanced later into six-phase process as defining business goals, delineating target behaviors, devising activity loops, deploying tools and don't forget the fun. In terms of the features of the model (Figure 1) it seems possible to be applicable in nursing education.[10]

Gamification in nursing education could help a student engage in active learning; acquire principle nursing skills such as collaboration, empathy, communication, creativity, critical thinking, and problem solving more easily; learn depending on his or her individual pace; and meet necessities such as revision, testing the notion, getting feedback, being approved and socializing. [1,11-14]

Figure 1. The Werbach D6 Model[10]

On the other hand; gamified learning in teaching of professions, which are fundamentally based on human life such as health so on, would be rather effective if it was particularly based on role-play. Role-playing method in learning gives a chance to students and all kinds of trainees to gain specific skills such as problem solving, a management of stress, crisis and time, risk-taking, critical thinking.[2,15,16] Because role-play provides learners with the opportunity to analyze specific life situations in case studies, they could have self-awareness and self-discovery in these situations. They can evaluate their knowledge and capabilities or lack in information or professional and personal development. Therefore; role-play is not only a fun activity opposite to general superficial perspective.[15] Such a technique develops learners' empathy within emotional intelligence.[17]

Although the contributions of gamification-based learning are known, there are very few studies on this topic in the literature. Boada et. Al[18] reported this method contributed to the rise of knowledge, skills and motivation level in students during the game which was developed for cardiac resuscitation.[18] Johnsen et al.[19] concluded that the game,

which was introduced to nursing students in order to improve problem solving and clinical decision making skills in the care of individuals with Chronic Obstructive Pulmonary Disease, was helpful and enjoyable.[19] Del Blanco et al.[20] reported the students, who had not been experienced in operating room before, were less afraid of making mistake and exhibited a more collaborative attitude thanks to game-based learning.[20] In the research by Biyik and Caliskan[14], the fact that game-based artificial reality (AR) application was supportive for nursing students in tracheostomy practice training and gaming application will be helpful was stated.[14]

As gamification is originally based on some certain communication elements and skills, the communication way during nursing skills teaching was given a particular importance in the current study. Besides, because Internal Medicine Nursing involves quite specific systems such as neural system, cerebrovascular cases, diabetics, etc., gamification was found to be promising in terms of giving students the chance to practice. Because of these reasons, role-play seems to be functional in order to apply more realistic and detailed situations, treatment simulations, detection of Internal Medicine systems diseases, nursing care skills and communication skills in simulated dialogues and storytelling. So, the study was constructed on gamification based on role play.

AIM

Thus, this study aims to the effect of role-play based gamification on the analysis of symptoms in internal medicine nursing, decision making, administration of appropriate nursing care, and the communication skills of nursing students.

METHODS

Design and Setting

The study was designed in participatory action research, which is extensively used by teaching researchers, teachers and lecturers as a qualitative design. In the action research, gamification elements were constructed on a role-play performance of the students in Nursing Department at a private university in Ankara-Turkey, which was founded in 2019 and opened with the contingent of 10 Nursing students. Action research aims to explore a problem of the field or course in order to bring a solution by employing specific practices with the participation of students and lecturers. So, present study also aimed to develop Nursing students' internal medicine nursing skills by contributing their communication skills, as well. A gamification based on systems role play was performed for students taking the internal medicine nursing course. There were check lists for each system. At the end of the semester and after the final exam, they were asked to evaluate this intervention via qualitative interview. Behind the explorative qualitative method the constructivist paradigm was stimulated to bring an evaluation to the research subject resulting from the participants' views.[21] The qualitative method of the current study was based on the SRQR (the Standards for Reporting Qualitative Research) by O'Brien et al.[22] Therefore; whether the students were able to achieve acceleration in learning thanks to the use of gamification as a communication tool in nursing courses was researched.

The Action Research Process

An action research process follows certain phases starting with problem identification, data collection, data analysis, preparation of action plan and application and evaluation of the results. If the process requires any new action, all the process is renewed and tries again. So, presents study follows those steps:

Firstly, the problem was identified as Nursing students' need for a comprehensive and playful environment which will feed their learning and communication abilities applicable to real-life cases. The gamification action during course was conducted by the second author, who was Internal Medical Nursing lecturer. The first author observed the communication way and skills to improve nursing skills in the classroom as a communication researcher and a contributor to the communication part when necessary. For each system (cardiovascular, respiratory, endocrine, oncology, renal, nervous, musculoskeletal, immune and hematological system with fluid-electrolyte, acid-base imbalances and shock) given in the internal medicine nursing course, gamification was applied to provide the best nursing care with evidence-based practices and without complications. In these mini-games, a game lasted about 40 minutes, focusing on the tasks to be done for each role. For example; the game progresses starting with the admission of the individual diagnosed with Type 2 diabetes mellitus to the clinic. Students can perform a physical examination of the patient regarding the nursing role, anamnesis, analyze the symptoms related to the disease, nursing care, include the patient and his family in care, make quick and accurate decisions for emergencies, and communicate effectively and accurately while doing all these processes. Choosing and using the appropriate equipment for nursing interventions is one of the contents of the game. A scoring system has been added to the games to increase its playability, and sometimes to complicate the cases and to develop complications in the patient. Each mini-game was made only once. All simulations were analyzed by the

lecturer and the classmates after the game. The game was held in the nursing laboratory between 11:00 and 13:30 on Thursdays every week. The 10 students who took the course were divided into groups in different roles each week. Within the scope of the study aim, the construction of Werbach D6 Model of the role-play based gamification was embedded in such way:

According to the first step of the model, the goals were identified as 'to gain İnternal Medicine Nursing skills' and 'to gain effective communication skills in Internal Medicine Nursing. Role-play was decided as the basis of that construction.

Secondly, some specific behaviors were delineated as target learning outcomes. Each mini-game based on role-play targeting Internal Medicine Nursing care and communication skills were evaluated some criteria on whether they could use what they learned theoretically in that course and what kinds of effective communication strategies they focused on. Besides, the students' Nursing practices in their roles were restricted with certain time limitations.

Thirdly, in every mini-game of a certain Internal Medicine disease, the students were delivered some roles with detailed descriptions by the lecturer. For example; "Student C, you are a patient at the age of 55 bearing cardiovascular risks coming to the hospital to see the doctor and also have panic attack" or "Student E, you are a very young and junior nurse while you, Student A, are a well-experienced nurse". During these role-delivery the students were observed to have fun a lot. Their nursing skills such as detecting urgencies and communication skills on how they behave patients and other team members had been crucially planned during course plan by the lecturer and evaluated as criteria during the in class activity. The roles were basically delivered as patient, nurse, doctor, patient's relatives, head nurse.

Next, activity loops were devised depending on certain determinants like timing, starting and ending points. Some motivators such as best nurse rosette were presented to see whether particularly nurse role-players are more willing to act or not. And at the end of each loop of participation, they were told right or wrong. Additionally, a symbolic badge was given as a reinforcement to ensure motivation. For example, a patient diagnosed with type 2 diabetes receives treatment in the clinic. This patient's fasting plasma glucose was given as 180 mg/dl. The evaluation of these limits by the student who played the role of a nurse was a point.

Or there was a scoring system for providing proper education to a patient diagnosed with hypertension. A checklist was prepared for each case. Each game including certain Internal Medicine disease treatment with different theme was repeated in different roles and simulations.

The most fundamental factor of gamification of this practice according to our study was the part of deploying tools because the method to practice gamification in this sample was oriented from role-play in order to achieve nursing and communication skills with more realistic cases. Each role was based on a different case; namely a story.

Finally, as not the mere aim of role play but a very important factor to motivate students to learn the targets of the courses, fun was not excluded from practices. Because of the fun effect, games are known to be functional and effective, which attracts students. The sample students of the study added humorous dialogues to their roles during mini-games.

Data Collection

Although face-to-face interview was firstly intended after all 10 students showed consent, open-ended internet interview form using an interview guide consisting of unstructured open-ended questions24 was used as a data collection tool because 2 of the participants were caught by COVID-19 virus. Because not so big sample was included, the same interview technique was wanted to follow with all the participants. The in-depth interview form included 9 open-ended and unstructured questions, which did not use any manipulative or directive tactics effective on the participants. Any confusing statement was avoided by following a step-by-step path from simple questions to the deeper. The structure in forming questions was based on Kevin Werbach's D6 Model for gamification design, which was particularly recommended for education.10 This model had also been based on the gamification design which formed the Nursing course schedule. As Werbach's D6 steps were followed in designing the course elements and provide a more interactive and functional communication approach to perform nursing tasks, the interview questions were consisted depending on those steps. The interview questions (Table 1). The gamification intervention was carried out by the instructor teaching the internal medicine nursing course. The first author supported the communication part during the gamification. The first author and the second author did not collect the data because they carried out the gamification and knew the students. Therefore, the last author collected the data. The last author was the researcher who conducted the interview part as an objective eye from a different university, who was not familiar with ant participants in the focus group. Including multiple observers in the intervention and interview part provided a triangulation in terms of the reliability and validity in findings.

Table 1. The In-depth-Interview Questions

1. What systems were constructed in the frame of gamification activities in your Internal Medicine Nursing class?
2. What learning outcomes towards these systems do you think you acquired?
3. What differences in the communication skills you used in your nursing team attracted your attention?
4. What nursing skills (in nursing care, knowledge, analysis, etc.) in the systems you learned in Internal Medicine Nursing class do you think you acquired after involving in gamification activities?
5. What roles did you have during games?
6. How many types of patients did you perform nursing care on?
7. During the analysis of patients' symptoms, what kind of differences did you experience in your management after the gaming activities?
8. In which phases of the games in Internal Medicine Nursing class did you particularly have fun?
9. Which of the stories based on the games that were practiced in Internal Medicine Nursing class remained most strongly in your mind?

Data Analysis

Not any software program was used in coding or transcription process. The researchers read the word recordings of the interviews independently. For content analysis; The students' statements were recorded as a word file by the last author, and all study data were stored for confirmability.

To conceptualize the written statements within the scope of the transferability principle, all researchers independently read and conceptualized the responses. Codes were categorized into umbrella themes and subthemes. First, codes were generated from the research aims based on Werbach's D6 Model for gamification design. The raw data were interpreted depending on those criteria. On the other hand; umbrella themes and subthemes were created on the basis of critical points in D6 Model. In present study, the action research data, which was achieved through Nursing students involved in role-play game design action during the internal medicine nursing course, were analyzed using the descriptive analysis method to describe and explain participants' experiences and identify emerging themes and subthemes, without using any software program.

Various strategies could be employed for the validity and reliability of qualitative research data analysis. These strategies involves credibility, transferability, dependability, and confirmability. The research results were examined through these four strategies. In terms of credibility, present study included the diverse opinions, perspectives, and experiences of the participants on the subject. Participants who have different nursing and communication skills and characteristics were also included in the action research. Regarding transferability, the purposive sampling method was used to determine the participants' relevancy to the research topic. Accordingly, the results part of the study directly presents the participants' statements. To ensure dependability and prevent research bias, the researchers independently reviewed the recordings of the data obtained from the participants. For descriptive analysis, participants' statements were recorded by the researchers in both audio and written text formats, and for confirmability, all data documents of the study were stored.

Ethics Statement

Firstly, depending on the declaration of Helsinki, Ethics Committee approval was obtained from This University (E-81477236-604.01.01-65). For participants recruitment, informed consent was obtained by stating they were free to quit replying in case of a discomfort by either the questions or the interviewer. Their confidentiality was also guaranteed by keeping them anonymous and their names were given as "Student A, B, etc." instead. Data collection was conducted after final exams not to give any impressions to the participants that they could take an academic disadvantage because they were not willing to participate in the research or would give answers coherent with the researchers' expectations. The interviewer was one of the other two researchers who were not the lecturing the internal medicine nursing course in order not to cause any impact on the students.

RESULTS

The qualitative analysis resulted in 6 major themes with their subthemes stemming from the depth-interview questions which had been based on Werbach D6 steps as a gamification model. (Table 2, Figure 2).

Table-2. Werbach D6 Model of Gamification Elements for Effective Communication in Internal Medicine Nursing Education

Theme	Subtheme	Participants' Statements
1. Defining Business Goals: To Gain Internal Medicine Nursing skills via effective communication	To gain analysis competency in Internal Medicine systems	S.B: "I was able to understand nursing care as a general. The skills of analyzing, communication and history recording."
	To be able to adapt theoretical knowledge into practice in Internal Medicine systems	S.A: "To transfer what we learned theoretically during classes into practice got more and more simpler."
	To gain effective communication skills in Internal Medicine Nursing	S.G: "By the means of team work activities by gaming we see we had most difficulty in communication. We had the biggest problems because of not listening to each other. And this caused confusion among us."
2. Delineating Target Behaviors: Learning outcomes	Educational attainments through gamification	S.H: "The use of gameful elements in courses have helped theoretical knowledge run deep in my mind. The games utilized in practices have committed theoretical knowledge to my memory because cases were portrayed physically." S.F: "Case games have provided me with practicability and self-confidence in what to do in case of an emergency." S.E: "When we brought solutions to cases of Internal Medicine systems by gamifying techniques, I understood them much better and I got enjoyed."
	Learning Main Internal Medicine Nursing Skills	S.I: "I learned what symptoms and processes I should prioritize depending on the disease." S.J: "Because we had the opportunity to practice on our classmates as if they had been real patients, I think my analysis skill has developed through gamification activities." S.H: " I was able to analyze the patients better and realized the moments I should think quicker."
	Effective communication skills in Internal Medicine Nursing	S.D: "Even though I could not get involved in communication, I realized the difference between proper and improper communication ways S.J: "The moments we completed our sentences and helped each other contribute to the emergencies' getting easy." S.H: "I was able to enhance the attitudes and approaches towards patients and their relatives thanks to the feedback by the lecturer during case simulations in the classroom."
	Time management in Internal Medicine Nursing skills	S.A: "We learned what priorities were urgent in emergency patients' conditions by the means of timing criterion in simulations". S.H: "After the games, I realized I became more practical in the analysis of minor symptoms". S.G: "I tried to cure symptoms according to order of priority. So, I understood the significance of time management better."
3. Describing Players	Nurse	S.D: "To act as a nurse in the games as in-class activities helped me to enhance my theoretical knowledge"
	Patient	S.C: "I acted as a doctor, nurse and a patient in different games. The patient role was the most impressive because it gave the chance to understand their both physical and emotional feelings."
	Patients' relatives	S.B: "To act as a patient's relative indicated the importance of empathy. You could feel terrible when a nurse acted so lazy or showed ignorance to my sick sister."
4. Devising Activity Loops: Various cases, patient profiles and Internal Medicine Systems	Practicing on different patient profiles	S.A: "We performed in different gamification activities which present a broad range of patients who are cooperative or noncooperative, conscious or unconscious, stubborn, withdrawn, prone to anxiety and have some mental disorders, pains.
	Attending each gamification activities	S.C: "I applied what I had learned as theoretical knowledge to the players, who were my classmates in patient roles. Attending each game has brought me the opportunity to understand the mechanics and rules of the games and Internal Medicine Nursing interventions."
	Determining Rewards	Student J: "To enhance game mechanics in each weeks' mission as a team contributed to our marks as well."

Table-2. (Continued)

Theme	Subtheme	Participants' Statements
5. Deploying Tools	Role play & storytelling	S.G: "What I learned from in-class activities involving gamification was to make a physical examination according to the patient's complaints. I think we learned what we should do urgently by the means of role playing activities. The stories narrated in the games persuaded us to focus on internal medicine diseases symptoms. Actually, the gamification method is not easy to perform and make evaluations in classes over 30-60 students. Because we were 10 people it was functional in terms of realizing our communication faults. Even though we were a few people, we had difficulty in managing the cases. In my opinion, it would be harder in bigger size classes. The gamification we performed in the classroom helped us understand cases better. I know I will not forget about cerebrovascular disease anymore."
6. Not Forgetting the Fun	Creating humorous dialogues	S.G: "I think acting as a patient and exhausting the nurse in the simulation was the high point. Furthermore, behaving as if I hadn't known anything as a patient was so funny." S.I: "Every moment we could reflect the reactions by the patient and the patient's relative real-like as much as possible was quite enjoyable."

Theme 1: Defining Business Goals: To Gain Internal Medicine Nursing skills via effective communication

The first step of Werbach D6 model is to define business goals. The business goals were defined within the frame of Internal Medicine Nursing skills via effective communication as it is the main purpose underlying the study. The statements of the participants are given in Table 2.

Subtheme 1: To be able to adapt theoretical knowledge into practice in Internal Medicine systems.

Subtheme 2: To gain effective communication skills in Internal Medicine Nursing.

Theme 2: Delineating Target Behaviors: Learning outcomes

The students in the Nursing class in which the gamification elements were employed stated they have obtained some critical technical and communication skills as the basis of Internal Medicine Nursing. These could be ranged as some educational attainments, learning the technical skills in the course, effective communication skills and time management as a critical criterion in Internal Medicine Nursing. The students who participated in the gamified activities in the course during the term reported crucial details they had undergone change.

Subtheme 1: Educational attainments through gamification

The most outstanding subthemes of educational attainments through gamification were found: reinforcing theoretical knowledge, acceleration in nursing skills, learning motivation through

Subtheme 2: Reinforcing theoretical knowledge

As the cases of Internal Medicine Nursing

Student H: "The games utilized in practices have committed theoretical knowledge to my memory because cases were portrayed physically."

Subtheme 3: Acceleration in nursing skills

The students seem to be aware of the importance of pace during medical interventions as a nurse. Practicability was particularly essential for emergencies.

Student D: "Pace is critical in case practices. Overall I can say to practicing cases in the course has made contribution to our learning. And it has a dramatic impact on acceleration. Roleplay is particularly favorable and beneficial at this point."

Subtheme 4: Learning motivation through fun

To reinforce theoretical knowledge through practice with fun contributed to learning process. The participants could get the opportunity to distinguish 39 target Internal Medicine systems including cardiovascular, urinary, neural, endocrine.

Student J: "To practice in a gaming activity after issuing theoretical background provides us with revision. Because we have fun during those gaming activities based on system knowledge, we understand the course better."

Subtheme 5: Learning Main Internal Medicine Nursing Skills

One of the most critical learning outcomes of gamification in Internal Medicine Nursing is to achieve competency in main skills as a nurse in this major.

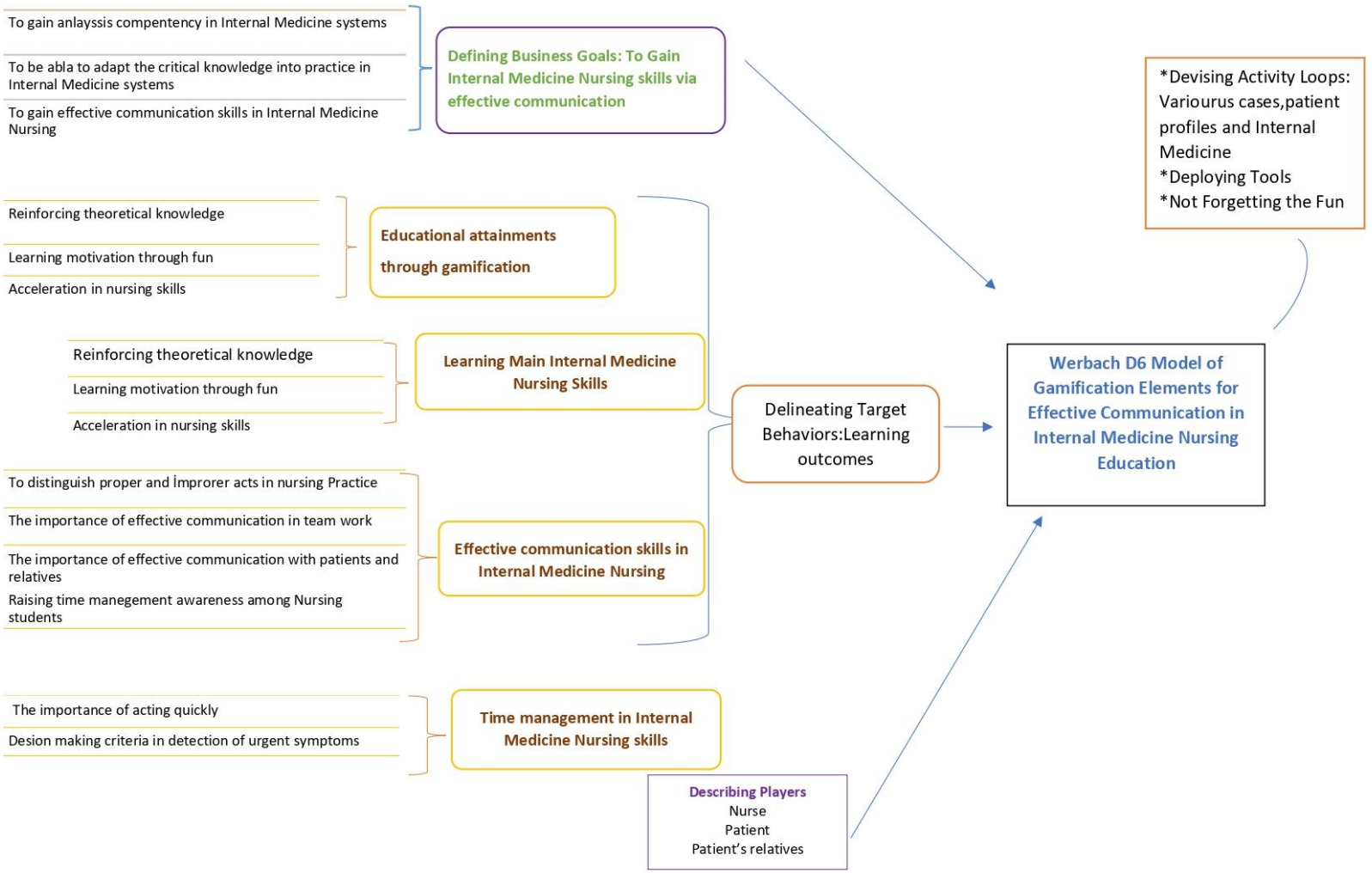


Figure 2. Communication and Nursing Skills in Game-based Werbach D6 Map

To detect urgencies, analyze the patient and perceive and thin quickly were the most frequent outcomes deriving from gamified activities in the course. Some other outcomes could also be remarked such as points to take into account during physical examination, attention, quick perception, nursing care, to record patient's history in a correct way, need for being more inquisitive, to take right decisions competitively.

Subtheme 6: To detect urgencies

What kind or urgencies should be prioritized was the main issue in main skills which the students could develop through gamified course activities. The majority of the participants agreed that they could become competent in detection of focus in Internal Medicine Nursing.

Student A: "We learned well about what to do, what our urgencies should be and what points should be taken into account in physical examination.

Subtheme 7: To analyze the patient

Many participants agreed on the theme of "analysis of the patient".

Student J: "Because we had the opportunity to practice on our classmates as if they had been real patients, I think my analysis skill has developed through gamification activities."

Subtheme 8: Quick perception and thinking

The participants emphasized the reflection of quick perception and thinking on the detection of urgencies and correct information about patients' complaint history, analysis of patients and practicability.

Student F: "The course with gamification elements has developed my ability of quick thinking and decision making. This has also contributed to my ability to prioritize the actions to take and intervene in cases."

Subtheme 9: Effective communication skills in Internal Medicine Nursing

During nursing interventions and actions, to communicate effectively with patients, patients' relatives and other medical personnel was found to be a vital nursing skill in Internal Medicine nursing like other nursing branches as a general. The impact of effective communication skills on nursing was counted by the participants as self-awareness as a nurse, the need for keeping calm, reinforcement in learning, being more active, the opportunity to know different patient profiles, strengthening the team spirit and companionship.

Subtheme 10: To distinguish proper and improper acts in nursing practice

Thanks to gamification in activities such as simulations, role-play and races the students got aware of what kind of communication ways, approaches and behaviors were proper, functional and practical or not.

Student C: "I noticed the role of being a calmer and more knowledgeable nurse and I will encounter every kind of patients."

Subtheme 11: The importance of effective communication in team work and their relatives

Using communication skills particularly including listening skill was the main motivator for the participants in realization of effective communication in Internal nursing Education.

Student E: "Besides the improvement in our learning skills provided by the simulations of communication moments during a team work, another positive result was their contribution to our companionship."

Student H: "I was able to enhance the attitudes and approaches towards patients and their relatives thanks to the feedback by the lecturer during case simulations in the classroom."

Subtheme 12: Time management in Internal Medicine Nursing skills

The simulations and gamified activities taught participants the vitality of timing. Thus, they realized that they had to manage time in decision making, quick acting, emergency, patients' and their relatives' expectations, minor symptoms of upcoming danger.

Student A: "We learned what priorities were urgent in emergency patients' conditions by the means of timing criterion in simulations".

Subtheme 13: The importance of acting quickly

Time management also meant acting quickly during internal medicine interventions. According to the participants, acting more quickly, practical and active in analysis of symptoms and contact to patients and their relatives.

Student H: "After the games, I realized I became more practical in the analysis of minor symptoms".

Subtheme 15: **Decision making criteria in detection of urgent symptoms**

Because any hesitation or wasting time under time-limitation pressure might lead to nurses' false medicine interventions, participants realized they should develop themselves in detecting true symptoms thanks to time management skill.

Student F: "In a time-limited game of internal medicine intervention, we realized it was really hard to decide on what was initially critical in detecting symptoms. And we learned we should firstly check on specific symptoms instead of general ones."

Theme 3: Describing Players

According to Werbach D6 model, players should be defined clearly in order to describe their characteristics, roles and

behavior patterns within the context. In classroom activities involving Internal Medicine nursing simulations with gaming elements, the common players were delivered as patient, nurse, doctor, patient's relatives, chief nurse. The statements of the participants belonging to the sub-themes are given in Table 2.

Subtheme 1: Nurse
As the major role, to act as a nurse was the most frequent one. The participants frequently wanted to take this role in order to practice as a student of this major.
Subtheme 2: Patient
The second common role that was preferred by the students in class was to act as a patient.
Subtheme 3: Patients' relatives

Theme 4: Devising Activity Loops: Various cases, patient profiles and Internal Medicine Systems
To decide on what loops would be included in gamification of a serious activity in a major such as Internal Medicine Nursing was one of the critical themes based on Werbach D6 Model. Since some determinants of activity loops such as starting and ending points, time, any motivators or rewards are not so easy to perceive in only one trial, how often the gaming activity is repeated is quite important to catch the loops. For this reason, various cases and patient profiles were performed by students in the Internal Medicine nursing class gaming activities. The statements of the participants belonging to the sub-themes are given in Table 2.

Subtheme 1: Practicing on different patient profiles
The participants performed 22 different patient profiles in 39 internal medicine systems.
Subtheme 2: Attending each gamification activities
Each gamification activity was seen by the participants as an opportunity to adapt into the game and Internal Medicine Nursing rules.
Subtheme 3: Determining Rewards

Theme 5: Deploying Tools
The common gaming tools which were deployed in the gamification practices of Internal Medicine Nursing class in Spring Term were role-play and storytelling. The statements of the participants belonging to the sub-themes are given in Table 2.
Subtheme 1: Role play & storytelling
The common effect was firstly on cerebrovascular attacks, diabetes cases and endocrine systems while the others could be ranked as neural system, fluid-electrolyte disturbances, cirrhotic patient cases.

Theme 6: Not Forgetting the Fun
To get fun kept the students from the competition greed via gamification. They evaluated as the most enjoyable parts as creating humorous dialogues. The statements of the participants belonging to the sub-themes are given in Table 2.

Subtheme 1: Creating humorous dialogues
The participants found patient-nurse and patient's relative-nurse dialogues funniest.

DISCUSSION

The students stated that with the use of game elements in classes, it became easier for them to remember and apply the theoretical knowledge about internal medicine nursing throughout the semester. They also stated that learning a case by playing a game improved their practical skills since the gamification method they used involves experiencing the events as if they were real. Another study conducted with nursing students included a game in which blood transfusion was performed. In the game, the students engaged in the blood transfusion process in a service in various levels of difficulty. In order to increase the reality of the game, doctor, nurse and student nurse avatars have been added and a step-by-step progress has been made. The findings of the study revealed that the use of games improved learning.[25] Stanley and Latimer[26] reported in their study that making real decisions in a simulated case is effective in learning.[26]

Based on the statements of the nursing students, it was revealed that one of the most critical learning outcomes of gamification in internal medicine nursing is the improvement in the basic skills of being a nurse, which include quick thinking, ordering priorities, developing the ability to analyze, identifying urgencies, evaluating the current situation with physical examination findings, and being more careful and questioning when taking patient history. A video-based game prototype was developed in a study to teach nursing students clinical reasoning and decision-making skills while they were providing care to patients with Chronic Obstructive Pulmonary Disease (COPD). The study revealed that thanks to the game, the students had a better understanding of the care to be given to patients with COPD.[27]

The students further stated that they understood the importance of effective communication, which is a very important nursing skill in internal medicine nursing, as in every stage of health care. Based on the statements of the students, it is understood that establishing active communication with the patient, patient's relatives and other members of the healthcare team while evaluating the patient or planning and providing care; listening as well as speaking; staying calm; self-awareness of individual communication characteristics; and positive

communication with teammates are the essential tools in determining the priorities and needs of patients in internal medicine nursing. In addition, the students participated in each game by taking different roles such as the patient, relatives, the physician, and the nurse, which improved their empathy skills. Ropero-Padilla et al.[28] held nursing classes with mixed method involving both online and face-to-face groups and applied the gamification method in the face-to-face group. They revealed that in the face-to-face group, gamification helped students learn important skills such as team-based communication and responsibility.[28]

In our study, the students emphasized that the case simulations performed through gamification helped them understand the importance of using time effectively in emergency response planning by identifying, interpreting, associating and prioritizing the symptoms of internal diseases. In addition, based on the statements of the students, it can be said that with the acquisition of time management skills, students gained a better insight into two very important criteria for internal medicine nursing, which are critical thinking and critical decision making. Similar to our finding, García-Viola et al.[29] reported that with the gamification method, nursing students in the experimental group were able to make decisions earlier and adapt to situations more quickly compared to the control group.[29]

The students in our study stated that the role-play based gamification method increased their learning motivation as it entertained them, and thus, they analyzed case studies and learned the systems within the case studies better. In addition, it was seen that the students defined the experience of learning the fundamental aspects of internal diseases, which are difficult to learn in theory, with the gamification technique as "fun". Similar to our finding, Stanley and Latimer[26] reported that 93.4% of nursing students found learning through gamification both fun and educational.[26] The study in which Kubin[30] used game elements revealed that all the students found this type of learning fun and would prefer to learn all skills through games.[30] In addition, the teaching of technical and medically significant subjects through gamification created an entertaining learning environment by appealing to the age-specific characteristics of the student group. Ignacio and Chen[31] stated that some people perceive competition as a source of stress in learning environments and therefore their motivation decreases.[31] With the gamified internal medicine curriculum, the students had the opportunity to learn theoretical skills through humorous dialogues with their friends, which helped them stay away from the tension of the feeling of competition. Similarly, many studies reported that playing games makes learning less stressful.[8,32,33]

Limitations of the study

This study was conducted with a limited number of students and only one group. It may be recommended to conduct randomized controlled studies with larger student groups.

As a result, the study revealed that with the use of role-play based gamification, students learn care and communication skills related to internal medicine nursing education in a motivated and more permanent manner. In addition, thanks to the role-playing games, it was seen that they had a fun process away from the stress of the educational environment and learning work. Besides, because having fun is not the mere aim in here, constructing role-playing on a well-based gamification structure is thought to make games more “serious” not because they are lack of fun but full of fun and scientific bases.

Etik Komite Onayı: Etik kurul onayı Ankara Medipol Üniversitesi Yerel Etik Kurulu’ndan (Tarih: 07/01/2022, Sayı: E-81477236-604.01.01-65) alınmıştır.
Bilgilendirilmiş Onam: Çalışmaya katılan hastalardan yazılı onam alınmıştır.
Hakem Değerlendirmesi: Dış bağımsız.
Yazar Katkıları: Fikir- HDK, NBA, UÖY; Tasarım- HDK, NBA, UÖY; Denetleme- HDK, NBA, UÖY; Kaynaklar- HDK, NBA, UÖY; Veri Toplanması ve/veya İşlemesi- HDK, NBA, UÖY; Analiz ve/ veya Yorum- HDK, NBA, UÖY; Literatür Taraması- HDK, NBA, UÖY; Yazıyı Yazan- HDK, NBA, UÖY; Eleştirel İnceleme- HDK, NBA, UÖY.
Çıkar Çatışması: Yazarlar, çıkar çatışması olmadığını beyan etmiştir.
Finansal Destek: Yazarlar, bu çalışma için finansal destek almadığını beyan etmiştir.

Ethics Committee Approval: Ankara Medipol University Health Sciences Non-Invasive Research Ethics Committee, Date: 07/01/2022, No: E-81477236-604.01.01-65.
Informed Consent: Written consent was obtained from participants in this study.
Peer-review: Externally peer-reviewed.
Author Contributions: Concept–HDK, NBA, UÖY; Design- HDK, NBA, UÖY; Supervision-HDK, NBA, UÖY; Resources-HDK, NBA, UÖY; Materials - NBA; Data Collection and/or Processing - HDK, NBA, UÖY; Analysis and/or Interpretation- HDK, NBA, UÖY; Literature Search-HDK, NBA, UÖY; Writing Manuscript-HDK, NBA, UÖY; Critical Review-HDK, NBA, UÖY; Other– HDK, NBA, UÖY.
Conflict of Interest: The authors have no conflicts of interest to declare.
Financial Disclosure: The authors declared that this study has received no financial support.

REFERENCES

1. Xu Y, Lau Y, Cheng LJ, Lau ST. Learning experiences of game-based educational intervention in nursing students: A

systematic mixed-studies review. *Nurse Educ Today*. 2021;107:105139. https://doi.org/10.1016/j.nedt.2021.105139

2. Carey Jeanne. Role-play: A helathcare simulation strategy for teaching problem-solving, communicaiton, & self-awareness. *Healthy Simulation.* Retrieved 10th May, 2022 from https://www.healthysimulation.com/36410/role-play-teaching-strategy/.
3. Ordu Y, Çalışkan N. Hemşirelik eğitiminde oyun temelli öğrenmede yenilikçi bir yaklaşım: Sanal oyun simülasyonu. Journal of Human Sciences. 2021; 18(4):657-664. https://doi.org/10.14687/jhs.v18i4.2021.
4. White M, Shellenbarger T. Gamification of Nursing Education With Digital Badges. *Nurse Educ*. 2018;43(2):78-82. https://doi.org/10.1097/NNE.0000000000000434
5. Blakely G, Skirton H, Cooper S, Allum P, Nelmes P. Educational gaming in the health sciences: systematic review. *J Adv Nurs*. 2009;65(2):259-269. https://doi.org/10.1111/j.1365-2648.2008.04843.x
6. Hanna DR. Using simulations to teach clinical nursing. *Nurse Educ*. 1991;16(2):28-31. https://doi.org/10.1097/00006223-199103000-00012
7. Koivisto JM, Haavisto E, Niemi H, Haho P, Nylund S, Multisilta J. Design principles for simulation games for learning clinical reasoning: A design-based research approach. *Nurse Educ Today*. 2018;60:114-120. https://doi.org/10.1016/j.nedt.2017.10.002
8. Koivisto JM, Niemi H, Multisilta J. *et al.* Nursing students' experiential learning processes using an online 3D simulation game. *Educ Inf Technol*.2017;22: 383–398 https://doi.org/10.1007/s10639-015-9453-x
9. Reed JM. Gaming in Nursing Education: Recent Trends and Future Paths. *J Nurs Educ*. 2020;59(7):375-381. https://doi.org/10.3928/01484834-20200617-04
10. Werbach K, Hunter D. The Gamification Toolkit: Dynamics, Mechanics, and Components for the Win. *Wharton Digital Press*, 2015
11. Donley R. Challenges for nursing in the 21st century. *Nurs Econ*. 2005;23(6):312-279.
12. Lombardi BMM, Oblinger DG. Authentic Learning for the 21st Century : An Overview. *EDUCAUSE Learning Initiative*. 2007; (1): 1-12.
13. Patel JJ, Rice T, Heyland DK. Safety and Outcomes of Early Enteral Nutrition in Circulatory Shock. *JPEN J Parenter Enteral Nutr*. 2020;44(5):779-784. https://doi.org/10.1002/jpen.1793
14. Bayram SB, Caliskan N. Effect of a game-based virtual reality phone application on tracheostomy care education for nursing students: A randomized controlled trial. Nurse Educ Today. 2019;(79):25-31. https://doi.org/10.1016/j.nedt.2019.05.010.
15. Baciu C. From role play to gamification as educational methods. *The European Proceedings of Social&Behavioural Sciences*. 2016. https://doi.org/10.15405/epsbs.2016.12.5
16. Suwanmolee S. Gamified Chaingrai Earthquake lesson learnt for Disaster Education. Disaster Risk Governance Academic Seminar, 2018, South Asia.
17. Nickerson S. Role-play: An Often Misused Active Learning Strategy. Essays of Teaching Excellence. Toward the Best in the Academy. 2008; 19(5). http://podnetwork.org/content/uploads/V19-N5-Nickerson.pdf
18. Boada I, Rodriguez-Benitez A, Garcia-Gonzalez JM, Olivet J, Carreras V, Sbert M. Using a serious game to complement CPR instruction in a nurse faculty. *Comput Methods Programs Biomed*. 2015;122(2):282-291. https://doi.org/10.1016/j.cmpb.2015.08.006
19. Johnsen HM, Fossum M, Vivekananda-Schmidt P, Fruhling A, Slettebø Å. A Serious Game for Teaching Nursing Students Clinical Reasoning and Decision-Making Skills. *Stud Health Technol Inform*. 2016;225:905-906. https://doi.org/10.3233/978-1-61499-658-3-905
20. Del Blanco Á, Torrente J, Fernández-Manjón B, Ruiz P, Giner M. Using a videogame to facilitate nursing and medical students' first visit to the operating theatre. A randomized controlled trial. *Nurse Educ Today*. 2017;55:45-53. https://doi.org/10.1016/j.nedt.2017.04.026
21. Lincoln YS, Lynham S A, Guba E G. *Paradigmatic controversies, contradictionsi and emerging confluences,* revisited. In N. K. Denzin & Y. S. Lincoln (Eds.). The SAGE handbook of qualitative research (4th edition). Thousand Oaks, CA: Sage. 2011
22. O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. *Acad Med*. 2014;89(9):1245-1251. https://doi.org/10.1097/ACM.0000000000000388
23. Creswell JW, Hu CP, Chang YY. Research Design:Qualitative,Quantitative, and Mixed Methods Approaches. J Soc Adm Sci. 2017; 4(2):205-207.
24. Creswell JW and Creswell JD. Research Design Qualitative, Quantitative, and Mixed Methods Approaches. 5th edition. SAGE Publishing, USA.2017
25. Tan AJQ, Lee CCS, Lin PY, et al. Designing and evaluating the effectiveness of a serious game for safe administration of blood transfusion: A randomized controlled trial. *Nurse Educ Today*. 2017;55:38-44. https://doi.org/10.1016/j.nedt.2017.04.027
26. Stanley D, Latimer K. 'The Ward': A simulation game for nursing students. *Nurse Educ Pract*. 2011;11(1):20-25. https://doi.org/10.1016/j.nepr.2010.05.010
27. Johnsen HM, Fossum M, Vivekananda-Schmidt P, Fruhling A, Slettebø Å. Developing a Serious Game for Nurse Education. *J Gerontol Nurs*. 2018;44(1):15-19. https://doi.org/10.3928/00989134-20171213-05
28. Ropero-Padilla C, Rodriguez-Arrastia M, Martinez-Ortigosa A, Salas-Medina P, Folch Ayora A, Roman P. A gameful blended-learning experience in nursing: A qualitative focus group study. *Nurse Educ Today*. 2021;106:105109. https://doi.org/10.1016/j.nedt.2021.105109

29. García-Viola A, Garrido-Molina JM, Márquez-Hernández VV, Granados-Gámez G, Aguilera-Manrique G, Gutiérrez-Puertas L. The Influence of Gamification on Decision Making in Nursing Students. *J Nurs Educ*. 2019;58(12):718-722. https://doi.org/10.3928/01484834-20191120-07

30. Kubin L. Using an Escape Activity in the Classroom to Enhance Nursing Student Learning. *Clinical Simulation in Nursing*. 2020; 47: 52-56. https://doi.org/10.1016/j.ecns.2020.07.007

31. Ignacio J, Chen HC. The use of web-based classroom gaming to facilitate cognitive integration in undergraduate nursing students: A mixed methods study. *Nurse Educ Pract*. 2020; 46:102820. https://doi.org/10.1016/j.nepr.2020.102820

32. Johnsen HM, Briseid HS, Brodtkorb K, Slettebø Å, Fossum M. Nursing students' perceptions of combining hands-on simulation with simulated patients and a serious game in preparing for clinical placement in home healthcare: A qualitative study. *Nurse Educ Today*. 2021;97:104675. https://doi.org/10.1016/j.nedt.2020.104675

33. Verkuyl M, Romaniuk D, Atack L, Mastrilli P. Virtual Gaming Simulation for Nursing Education: An Experiment. 2017, *Clinical Simulation in Nursing*. https://doi.org/10.1016/j.ecns.2017.02.004

ATATÜRK ÜNİVERSİTESİ YAYINLARI
ATATURK UNIVERSITY PUBLICATIONS

Research Article *Araştırma Makalesi* DOI: 10.17049/jnursology.1425828

Psychosocial Services Provided to Cancer Patients and Nurses' Difficulties in Psychosocial Assessment and Intervention: A Nationwide Study

Kanser Hastalarına Sunulan Psikososyal Hizmetler ve Hemşirelerin Psikososyal Değerlendirme ve Müdahalede Yaşadığı Zorluklar: Ülke Çapında Bir Araştırma

Nazmiye YILDIRIM[1]
Perihan GÜNER[2]
Figen İNCİ[3]

[1]Department of Psychiatric and Mental Health Nursing, Faculty of Health Sciences, Bolu Abant İzzet Baysal University, Bolu, Türkiye

[2]Department of Psychiatric Nursing, Faculty of Health Sciences, Istanbul Bilgi University, İstanbul, Türkiye

[3]Department of Psychiatric Nursing, Zübeyde Hanım Faculty of Health Sciences, Niğde Ömer Halisdemir University, Niğde, Türkiye

ABSTRACT

Objective: The study mainly aims to determine the current state of psychosocial services offered to cancer patients and the views of nurses regarding the ways to meet patients' psychosocial needs. Other aims to evaluate barriers to meeting patients' psychosocial needs and measure nurses' difficulty level of psychosocial assessment and intervention practices.

Methods: This multicenter, cross-sectional study was conducted with 1189 nurses providing direct care to adult cancer patients in 32 hospitals in 12 geographical regions of Türkiye. The data were collected by a survey prepared in accordance with the aims of the study.

Results: Three-quarters of the participants reported that their hospital has psychosocial support services while 67.7% stated that this service was provided by psychiatry consultation. Nearly half (49%) stated that all healthcare professionals are responsible for meeting patients' psychosocial needs, especially it is an integral part of their nursing duties. However, organizational conditions (48.2%-30.7%) are the most important barriers to meeting the psychosocial needs of the patients. Participants have difficulty mostly in assessing and intervening in psychosocial needs of patients mostly in "sexual problems" and "rejection of treatment", and least in "patients' reactions to illness". Also, the participants have more difficulty in assessing seven of the 19 psychosocial dimensions and intervening in five ($P<.05$).

Conclusion: This study may be contributed to better structuring of psychosocial services in Türkiye. It can also guide the planning of psychosocial care training. Institutional barriers need to be overcome, especially the nurse-patient ratio, and the psychosocial care capacity of nurses should be improved.

Keywords: Cancer, nursing, psychosocial oncology, survey

ÖZ

Amaç: Bu çalışma temelde kanser hastalarına sunulan psikososyal hizmetlerin mevcut durumunu ve hemşirelerin hastaların psikososyal gereksinimlerini karşılama yollarına ilişkin görüşlerini belirlemeyi amaçlamaktadır. Ayrıca hastaların psikososyal gereksinimlerinin karşılanmasının önündeki engellerin değerlendirilmesini ve hemşirelerin psikososyal tanılama ve müdahale uygulamalarında zorluk düzeylerinin ölçülmesini amaçlanmaktadır.

Yöntemler: Türkiye'nin 12 coğrafi bölgesinden seçilen 32 hastanede, erişkin kanser hastalarına doğrudan bakım veren 1189 hemşirenin yer aldığı çok merkezli, kesitsel bir çalışmadır. Veriler, araştırmanın amacına uygun olarak hazırlanan anket aracılığıyla toplanmıştır.

Geliş Tarihi/Received: 25.01.2024
Revizyon Tarihi/Revised: 12.03.2024
Kabul Tarihi/Accepted: 03.05.2024
Yayın Tarihi/Publication Date: 25.06.2024

Sorumlu Yazar/Corresponding author:
Perihan Güner
E-mail: perihan.guner@bilgi.edu.tr

Cite this article: Yıldırım N, Güner P, İnci F. Psychosocial Services Provided to Cancer Patients and Nurses' Difficulties in Psychosocial Assessment and Intervention: A Nationwide Study Research. *J Nursology*. 2024;27(2):101-110.

Bulgular: Katılımcıların dörtte üçü hastanelerinde psikososyal destek hizmeti sağlandığını ve %67,7'si bu hizmetin psikiyatri konsültasyonu ile verildiğini bildirmiştir. Yaklaşık yarısı (%49) tüm sağlık çalışanlarının hastaların psikososyal gereksinimlerini karşılamakla yükümlü olduğunu, özellikle hemşirelik görevlerinin ayrılmaz bir parçası olduğunu belirtmiştir. Ancak organizasyonel koşulların (%48,2-%30,7), hastaların psikososyal gereksinimlerinin karşılanmasında en önemli engel olduğu bildirilmiştir. Katılımcıların en çok "cinsel sorunlar" ve "tedaviyi reddetme", en az da "hastaların hastalığa tepkileri" konusunda hastaların psikososyal gereksinimlerini değerlendirmede ve müdahale etmede zorluk yaşadığı ortaya çıkmıştır. Ayrıca katılımcıların 19 psikososyal boyuttan yedisini değerlendirmede ve beşine müdahale etmede daha fazla zorluk yaşadıkları belirlenmiştir (*P<,*05).

Sonuç: Bu çalışma Türkiye'de psikososyal hizmetlerin daha iyi yapılandırılmasına katkı sağlayabilir. Aynı zamanda psikososyal bakım eğitiminin planlanmasına da rehberlik edebilir. Hemşire-hasta oranı başta olmak üzere kurumsal engellerin aşılması ve hemşirelerin psikososyal bakım kapasitesinin geliştirilmesi gerekmektedir.

Anahtar Kelimeler: Kanser, hemşirelik, psikososyal onkoloji, anket

INTRODUCTION

With advances in cancer treatments, the course of the disease and the prognosis of cancer have changed, and patients diagnosed with advanced cancer can live relatively longer. However, long cancer experience and anticancer treatments cause patients to suffer from a wide range of problems including physical, psychological, emotional, and practical problems.[1] Systematic review studies reported that the highest unmet needs of patients and their relatives were 1-89% psychosocial, 10%-84% emotional support, and 6-100% information needs.[2] In addition to the negative impact of unmet needs on patients' well-being, evidence of a close correlation between the unmet psychological needs of patients and poor clinical outcomes is increasing.[3] Studies also state that psychosocial care services should be integrated into routine care,[4] but debates regarding appropriate methods and preferred time points continue.[5] Psychosocial services vary from country to country.[6] Grassi et al.[7] suggest that in order to improve psychosocial services, each country should carry out studies to develop a model which may provide the best service in the context of its own circumstances.[7] There is little information about Türkiye's status in this respect.

The question of who should provide psychosocial support in oncology services is also still uncertain. Daem et al.[8] reported that cancer patients seek psychosocial care from primary care teams such as nurses, rather than needing a mental health professional such as a clinical psychologist.[8] Previous studies is stated that nurses are in an ideal position to evaluate the changes in the mood of the patients and to provide psychological support.[9] From the time of diagnosis to terminal care, oncology nurses spend significant amounts of time attending to patients' needs; they also witness various difficulties patients face in the process.[10] Therefore, a better understanding of nurses' standpoint is important in meeting the psychosocial needs of cancer patients and their families. On the other hand, studies indicate that nurses have difficulties in providing mental and emotional support to cancer patients and their families,[11,12] but it is not known which psychosocial problems they have difficulty in assessing and intervening. For this, it is necessary to understand the difficulties of nurses in providing psychosocial care.

AIM

This nationwide study using a Turkish sample has a threefold aim: The first is to determine the current state of psychosocial services offered to cancer patients and the views of nurses on how psychosocial needs should be met. The second is to evaluate barriers to meeting the psychosocial needs of patients. The third is to measure the nurses' difficulty level of psychosocial assessment and intervention practices.

METHODS

Study design

Part of a larger Turkish project titled "Determining the Psychosocial Care-Related Needs of Oncology Nurses", the present study reports the status of available psychosocial services offered to cancer patients in Türkiye, as well as the difficulty level in assessment and intervention of psychosocial needs. This study is a descriptive, cross-sectional, multicenter study.

Sample and Setting

The participants of this study were nurses providing care to cancer patients in hospitals located in 12 geographical regions in Türkiye and these regions were assigned based on the Turkish Statistical Regional Units Classification.[13] The list of university, state, and private hospitals in each region was compiled and 32 hospitals with the highest number of patients and nurses were selected. The study was carried out in 12 universities, 11 state and 9 private hospitals since

there were no private hospitals in three regions and no state hospitals in one region. The total number of nurses working in outpatient and inpatient oncology clinics was 1389 and this information was obtained from the nursing services managers of these hospitals via telephone. All registered nurses providing care to adult cancer inpatients and outpatients irrespective of the duration of employment in these hospitals were eligible to participate in the study. Nurses who were on leave, working with non-cancer patients, and who were not working in direct patient care such as nurse managers and educators were excluded from this study. The study completed with 1189 registered nurses which meant a response rate of 85.6%.

Instruments

The data were collected by means of a questionnaire that included determining the demographic and professional characteristics of the participants, the psychosocial services in the hospital, the barriers to meeting the psychosocial needs of the patients and their families, and the level of difficulty in psychosocial assessment and intervention practices. The literature was used to develop the survey.[14-16] In addition, researchers (NY, PG) had an average of 18 years of psychosocial oncology experience by providing counseling, psychoeducation to cancer patients, and consultancy, and training (courses, certificates, etc.) for nurses working in oncology. In this process, the researchers decided on the final form of the survey by discussing the survey questions, possible answers, readability, and structure of the survey.

The first part of the survey included seven questions concerning demographics (age, gender) and professional characteristics (educational status, duration of working as a nurse, type of hospital, the unit where they worked, duration of working with cancer patients, and shift).

The second part of the survey included six questions and possible answer options about the current state of psychosocial service and barriers. For example, “Is there a unit that provides psychological help/support in the hospital where you work?”, “Who is primarily responsible for meeting the psychosocial needs of the patients and their families?”, “What are the barriers to meeting the psychosocial needs of patients and their families?” etc.

The third part of the survey included 19 items to determine the level of difficulty in psychosocial assessment and intervention practices. Items included patients’ reactions to and perceptions of illness, as well as patients’ feelings of fear, anxiety, anger, guilt, and hopelessness. The survey also included questions concerning patients’ need for information, body image, interpersonal relations, sexual problems, delirium, and the psychological needs of family members. Responses were recorded on a Likert-type scale scored between 1 and 4 (1. I have no difficulty, 2. I have little difficulty, 3. I have significant difficulty, 4. I have great difficulty). Cronbach's Alpha value was 0.945 for the psychosocial assessment difficulty section and 0.958 for the psychosocial intervention difficulty section.

Data Collection

Ethics committee and institutional permissions were obtained before the study was conducted. A nurse (who had research experience and sufficient communication skills, and who could spare time for data collection, etc.) was selected as the interviewer from each hospital that allowed the nurses to take part in the study. The interviewers were trained (inclusion-exclusion criteria of the study, informed consent, questions in the questionnaire, etc.) and they were contacted when necessary. Survey papers were delivered to the participants by cargo, and they sent the collected survey results by cargo. Data collection was carried out between April-August 2017.

Ethical Consideration

The study was initiated after the approval from Koç University’s Ethics Committee (Protocol number: 2016.162 IRB 3.092) and after written permission from participating institutions and informed consent of participants were obtained.

Statistical Analysis

In the analysis of data, SPSS for Windows (version 24 software) (IBM Corp., Armonk, NY, USA) program was used. For descriptive statistics, numbers, percentages, means, standard deviations, or minimum and maximum scores were used according to the data type. The difference between the psychosocial assessment and intervention difficulty level was evaluated with the Wilcoxon Signed-Rank Test. $P<.05$ was interpreted as statistically significant.

RESULTS

A total of 1189 registered nurses completed the questionnaire, the mean of their ages was 32.75 ± 8.53 (18-63) and were largely female (86.6%). More than half (53.7%) of the participants had a baccalaureate degree, 20.9% associate degree, 18% vocational high school degree, and 7.4% were graduates of master/doctorate programs. Approximately half (44.9%) of the participants worked in university, 35% in state, and 20.1% in private hospitals. Most (47%) were working at oncology/hematology inpatient units, 27.1% were outpatient chemotherapy/radiotherapy units, 10.1% were bone marrow transplantation units, 15.8% were general units including oncology patients. The average working time as a nurse is 136.17 ± 104.98 (1-540) months.

Table 1. Characteristics of Psychosocial Services in Hospitals and Participants' Views

Variable	n	%
Status of psychosocial services		
Present	659	71.6
Not present	530	28.4
Manner of offering psychosocial services *		
Psychiatric consultation is requested	805	67.7
Referred to psychologist	396	33.3
Psychological help is recommended for the patient and relatives	324	27.2
Referred to psychiatric nurse	140	11.8
Referred to the department of consultation liaison	61	5.1
Nothing is done on this issue	30	2.5
Status of meeting psychosocial needs		
Not met	208	18.4
Partially met	640	56.7
Sufficiently met	241	21.4
Completely met	39	3.5
Primary responsibility for meeting psychosocial needs of patients lies with*		
All health workers	569	49.0
Attending physician	383	33.0
Attending nurse	246	21.2
Psychologist	165	14.2
Psychiatrist	128	11.0
Psychiatry nurse	93	8.0
Belief that psychosocial care is the duty of the nurse		
I believe	1008	88.0
I do not believe	46	4.0
Undecided	92	8.0

*More than one response was obtained from the participants.

Table 2. Barriers to meeting the psychosocial needs of patients and their families

Barriers*	n	%
Shortage of staff / High number of patients	534	48.2
Workload	489	44.1
No demand by the patients and their families	416	37.5
Time pressure	341	30.7
Perspective and expectation of the institution (not attaching importance to psychosocial care)	227	20.5
Feeling of inadequacy	185	16.7
Perspective and expectation of the team (lack of effort placed on holistic approach to patients)	162	14.6
The belief that psychosocial care is unnecessary because it will negatively impact the patient	64	5.8

* More than one response was obtained from the participants

The mean duration of working with cancer patients of participants was 74.66 ± 68.07 (1-480) months. The ratio of participants working with a shift is 58.3%. Up to 71.6% of the participants reported that psychosocial support services were offered in their hospital. Most of the participants (67.7%) stated that the primary form of psychosocial services was referral for psychiatry consultation. Nevertheless, 56.7% of the participants reported that the psychosocial needs of patients and their families were only partly met by present psychosocial services. Approximately half (49.0%) claimed that the responsibility of dealing with the psychosocial needs of patients belongs to all health workers, and a large majority (88.0%) reported that psychosocial support is an integral part of nursing duties (Table 1).

The most important barriers to meeting the psychosocial needs of patients and their families included: shortage of staff / high number of patients (48.2%), excessive workload (44.1%), and time pressure (30.7%). A significant proportion of participants (37.5%) reported that patients did not request psychological support (Table 2).

The participants had the most difficulty in assessing and intervening in the sexual problems of the patients (48.4% and 40.6%) and the needs of the patients who refused treatment (34.8% and 32.3%). Difficulty in identifying patients' psychological reactions to illness (13.9%) and need for information (15.5%) were reported only by a minority of the participants. Interventions creating the least difficulty for participants included handling patients' psychological reactions to disease (10.5%), addressing their perceptions about cancer (13%), and meeting their need for information (15.5%) (Table 3).

Table 3. Prevalence of Participants Experiencing Great/Significant Difficulty in Psychosocial Assessment and Intervention

Psychosocial aspects	Assessment		Intervention	
	n	%	n	%
Response to the illness	163	13.9	121	10.5
Illness perception	206	17.7	149	13.0
Being unaware of the diagnosis	376	32.5	303	26.7
Anxiety	224	19.7	225	19.8
Fear	249	21.5	228	20.1
Anger	237	20.4	241	21.2
Guilt	306	26.6	271	23.9
Ask the same questions repeatedly	326	28.4	267	23.6
Treatment rejection	401	34.8	368	32.3
Information need	178	15.5	176	15.5
Depression	252	21.7	234	20.6
Hopelessness	237	20.5	248	21.9
Self-esteem problems	272	23.6	252	22.2
Body image problems	222	19.2	268	23.7
Sexual problems	551	48.4	455	40.6
Interpersonal problems	281	24.4	232	20.6
Psychosocial needs of the families	310	26.9	293	25.9
Delirium	301	26.1	335	29.5
Patient needs during terminal period	269	23.6	309	27.2

The results indicated that the participants had more difficulty in assessing the patient's cancer perception, guilt, sexual and interpersonal problems, and needs of patients who do not know their diagnoses, ask the same questions, and refuse treatment (P<.05). The participants had more difficulty in intervening in patients with anger, hopelessness, body image problems and delirium (p<.05). They also experienced more challenges in meeting the needs of patients during the terminal period (p<.0001) (Table 4).

Table 4. Difference Between Level of Difficulty in Psychosocial Assessment and Intervention

Psychosocial aspects	Assessment Mean[a] ± SD	Intervention Mean[a] ± SD	Z[b]	P[b]
Response to the illness	1.74 ± 0.78	1.70±0.72	-1.537	.124
Illness perception	1.88±0.76	1.79±0.73	-4.250	**<.001**
Being unaware of the diagnosis	2.17±0.90	2.05±0.86	-4.587	**<.001**
Anxiety	1.86±0.80	1.91±0.80	-1.892	.059
Fear	1.89±0.83	1.90±0.82	-.331	.740
Anger	1.88±0.80	1.95±0.78	-2.604	**.009**
Guilt	2.01±0.82	1.99±0.83	-3.132	**.002**
Ask the same questions repeatedly	2.05±0.88	1.99±0.84	-2.154	**.031**
Treatment rejection	2.20±0.90	2.14±0.87	-2.304	**.021**
Information need	1.72±0.79	1.74±0.77	-.435	.663
Depression	1.90±0.83	1.93±0.81	-1.373	.170
Hopelessness	1.84±0.83	1.94±0.80	-3.819	**<.001**
Self-esteem problems	1.97±0.79	1.96±0.79	-.756	.450
Body image problems	1.84±0.81	1.98±0.83	-5.649	**<.001**
Sexual problems	2.49±0.96	2.35±0.96	-5.349	**<.001**
Interpersonal problems	2.00±0.81	1.94±0.80	-2.946	**.003**
Psychosocial needs of the families	2.03±0.83	2.01±0.85	-.608	.543
Delirium	1.95±0.90	2.06±0.89	-4.492	**<.001**
Patient needs during terminal period	1.89±0.90	2.00±0.90	-4.505	**<.001**

[a]Min-Max,1-4 (1 I have no difficulty, 2 I have little difficulty, 3 I have significant difficulty, 4 I have great difficulty)
[b]Wilcoxon Sign Rank test

DISCUSSION

According to our results, psychosocial services in oncology services are commonly provided by psychiatry consultation in Türkiye. Nurses accepted their role in meeting the psychosocial needs of patients, but they also stated that there were organizational barriers. Although there are dimensions that they have difficulty in psychosocial assessment and intervention, the results have revealed that the mean score of difficulty is low in general.

This study establishes that Türkiye uses various practices of providing psychosocial support to cancer patients. Over half of the nurses stated that they regularly requested psychiatry consultations for patients, and one-third of nurses referred patients to psychologists. One study investigating psychological care services offered to cancer patients in 29 countries established that primary responsibility is assumed by psychologists (30%) and physicians (28%), including psychiatrists.[6] In Türkiye, psychiatry services in general hospitals are usually conducted via psychiatric consultations.[17] Nurses participating in the present study shared some common beliefs on the subject. One such belief is that psychosocial assistance is the responsibility of the team giving direct care to cancer patients rather than that of psychiatrists and psychologists. Another is the belief in the absolute necessity of nurse participation in psychosocial services. This important finding can guide the structuring of psychosocial services. The role of nurses is different from that of a psychologist or psychiatrist. Nurses should provide basic psychosocial interventions to patients. Additionally, nurses must determine when patients need more specialized or in-depth intervention. If advanced psychosocial interventions are required, they should provide referrals. As a matter of fact, Uitterhoeve et al. [18] reported that both nurses and physicians believe that identifying and assessing patients' emotional needs, as well as providing social support to patients and their relatives, are the primary responsibility of nurses. According to a study conducted with members of the Oncology Nursing Society, the primary responsibility of offering psychosocial health services lies with nurses (35%).[19] According to

Turkish nursing legislations, psychosocial care is among the required duties of nurses; most nurses in this study also believed that this is the case. However, participating nurses reported various obstacles in meeting such needs.

Similar to the results of this study, previous studies have also found that a high number of patients, excessive workloads, and time pressure are among the primary obstacles in meeting patients' psychosocial needs.[19,20] In a systematic review of 25 articles, it is asserted that most reported barriers to the provision of psychosocial services are organizational obstacles and lack of need for psychological services and support.[21] According to Gosselin et al.[19] as well as the present study, one-third of nurses claim that patients and families do not request psychosocial services and that this is one of the main barriers to their provision. It may not be reasonable to expect patients and families in crisis to determine their own needs and demand help. Cancer patients need to be informed about psychosocial care and services.[22] To ensure that cancer patients receive quality care, challenges that negate effective provision of psychosocial support should be urgently addressed.

The ability to provide timely and holistic care to patients requires that their problems and needs be identified and met. The present study shows that nurses experience more difficulty in both identifying and meeting the needs of patients who experience sexual problems or who refuse treatment. Studies have reported that nurses have trouble speaking about sexual concerns with cancer patients.[23,24] One study reported that most nurses felt comfortable speaking about sexual concerns with their patients, but less than one-third of them had discussed such concerns with their patients in the previous year. It also reported that 92% of the nurses expressed a need for additional sexual health consultancy training. Considering these results, as well as the fact that sexuality is altered in 40-100% of cancer patients,[25] priority should be given to developing nursing skills in assessment and intervention. Several studies have investigated sexual problems experienced by cancer patients, but no previous studies to our knowledge have investigated the needs of patients who refuse treatment or repeatedly ask the same questions. The administration of medical treatment to patients is one of the basic roles of nurses and requires both technical and communication skills. Considering the negative impact of treatment refusal on nurses and patients, this phenomenon should be investigated from a multidimensional perspective. Patients' need for information is vital throughout all stages of the cancer process.[26] Patients have the need for and the right to an explanation of their diagnosis, the opportunity to ask questions, and get responses to their questions. The present study has indicated that nurses do not believe they have difficulty in providing information; they do have trouble, however, in identifying the needs of patients who do not know their diagnoses or who constantly ask the same questions. A study has found that nurses have difficulty in caring for patients who are not properly informed about their diagnoses.[27] If the patient is not told of his/her diagnosis, if it is not explained properly, or if the family has prevented the patient from being informed,[28] nurses do not know what to ask and/or how to ask questions that aim to identify patients' needs. As such, patients may display the behavioral pattern of asking constant repetitive questions.

Cancer may influence patients' relationships with family and friends, and studies emphasize the importance of social support[29] and the prevalence of the family's unmet psychosocial needs.[2] However, no previous studies to our knowledge have investigated the difficulties experienced by nurses in identifying and managing patients' interpersonal problems. The findings of the present study suggest that nurses have trouble with this issue and lacked the skills required to address it. To offer psychosocial care, one must first determine how the patient perceives the disease and help him/her to establish connections via their reactions. Although this subject has been extensively examined,[30] no current study has identified the nursing skills required to understand patients' perceptions of cancer. The present study shows that nurses have difficulty in understanding patients' perceptions of cancer; therefore, this subject should also be incorporated into psychosocial care skills training.

The result of this study indicates that nurses experience little difficulty in identifying and managing common patient reactions such as denial, anxiety, fear, and depression. But a study in Japan reported that more than 50% of oncology nurses felt anxious about-facing patients' feelings of fear and depression, and about 20% were extremely anxious about caring for patients experiencing depression and anger. The study also showed that 83.2% of the nurses experienced general feelings of distress.[31] A study of cancer patients hospitalized in the oncology ward revealed that they do not always want to talk to nurses about difficult feelings.[32] In another study, it was found that cancer patients do not expect emotional conversations or counseling from busy nurses.[33] Although the results seem contradictory, this may actually be related to the coping with avoidance of both patients and nurses. For this reason, a result may have emerged in our study that nurses had less difficulty.

This study shows that nurses have difficulty approaching patients who are in the terminal period. Various studies

have consistently shown that oncology nurses have difficulty when communicating with dying patients and their families. In particular, it has been reported that they avoid talking to patients about intense emotional issues such as death and dying.[8,34] The patient's anticipated death contradicts the aim of protecting and maintaining life and speaking about death often causes distress.[35] Because oncology nurses care for dying patients and offer support to the family after the loss of life, the difficulties they experience should be taken into serious consideration and should therefore be incorporated into training both before and after graduation. The nurses have trouble also in managing delirium. Similarly, in another study, 57.3% of nurses were found to have anxiety related to delirium assessment.[31] Many nurses caring for cancer patients encounters cases of delirium, and though it has been extensively studied, there is still room to develop nursing skills in managing such psychosocial interventions.

Limitations

The present study has some limitations. The first is that there is no standard measurement tool to evaluate oncology nursing skills in meeting patients' psychosocial needs. Therefore, although this study's questionnaire was developed by experienced investigators and is based on a comprehensive review of the literature, it is not a scale whose reliability and validity have been verified. This study may be repeated after reliable and valid measurement tools have been developed, which would allow for the findings to be tested. Second, this study's findings are based solely upon the reports of participants. Therefore, they may not reflect observable behavior. Studies using more objective measurement tools may increase the reliability and consistency of the data. Third, this study's data is descriptive. Analytic studies disclosing the areas in which nurses have trouble when meeting psychosocial needs (along with their causes) will help to plan more specific interventions. Finally, although this study used a large sample and resulted in a high response rate (85.60%), there is no information about the skills of nurses who did not respond to the questionnaire.

In light of the fact that present services do not meet patients' psychosocial needs, this study presents important data that may guide the structuring of better psychosocial services. A consideration of oncology nurses' opinions concerning the psychosocial care offered to patients and their families is crucial in such a restructuring. The present study discloses that all healthcare personnel providing direct care to cancer patients (rather than just psychiatry consultants) should be responsible for meeting patients' psychosocial needs. It also reinforces the absolute belief that nurses should participate in the provision of psychosocial services and shows that nurses consider organizational factors to be the main impediment to meeting psychosocial needs.

The results of this study reveal that while nurses experience less difficulty in identifying and managing patients' reactions to their disease and patients' need for information, they have more difficulty meeting the needs of patients who experience sexual problems or refuse treatment. In 12 of 19 psychosocial issues encountered by nurses, a statistically significant difference was found between the identification and management of such needs. The results of the present study may guide future training programs designed to develop and improve nursing psychosocial care skills. Special emphasis should be placed on investigating the needs of patients who refuse treatment, who do not know their diagnoses, and who incessantly ask the same questions.

Etik Komite Onayı: Etik kurul onayı Koç Üniversitesi Yerel Etik Kurulu'ndan (Tarih: 01.07.2016, Sayı: 2016.162 IRB 3.092) alınmıştır.
Bilgilendirilmiş Onam: Çalışmaya katılan hastalardan yazılı onam alınmıştır.
Hakem Değerlendirmesi: Dış bağımsız.
Yazar Katkıları: Fikir – N.Y., P.G, F.İ.; Tasarım – N.Y., P.G, F.İ.; Denetleme – P.G, N.Y., F.İ.; Kaynaklar – P.G, N.Y., F.İ.; Malzemeler – P.G, N.Y., F.İ.; Veri Toplanması ve/veya İşlemesi – P.G.; Analiz ve/veya Yorum – N.Y., P.G.; Literatür Taraması – N.Y., F.İ., P.G.; Yazıyı Yazan – N.Y., P.G; Eleştirel İnceleme – P.G, F.İ., N.Y.
Çıkar Çatışması: Yazarlar, çıkar çatışması olmadığını beyan etmiştir.
Finansal Destek: Yazarlar, bu çalışma için finansal destek almadığını beyan etmiştir.

Ethics Committee Approval: The study was initiated after approval from Koç University's Ethics Committee (Date: 01.07.2016, Protocol number: 2016.162 IRB 3.092) and after written permission from participating institutions and informed consent of participants were obtained.
Informed Consent: Written permission was obtained from the hospitals was the study was conducted.
Peer-review: Externally peer-reviewed.
Author Contributions: Concept – N.Y., P.G, F.İ.; Design – N.Y., P.G, F.İ.; Supervision – P.G, N.Y., F.İ.; Fundings – P.G, N.Y., F.İ.; Materials – P.G, N.Y., F.İ.; Data Collection and/or Processing – P.G.; Analysis and/or Interpretation – N.Y., P.G.; Literature Review – N.Y., F.İ., P.G.; Writing – N.Y., P.G; Critical Review – P.G, F.İ., N.Y.
Conflict of Interest: The authors have no conflicts of interest to declare.
Financial Disclosure: This work was supported by the Vehbi Koç Foundation Nursing Fund, in Istanbul, Turkey [grant number 2016.2-2].

REFERENCES

1. Miller KD, Nogueira L, Devasia T. et al. Cancer treatment and survivorship statistics, 2022. *CA Cancer J Clin.* 2022;72(5):409-436. doi:10.3322/caac.21731

2. Wang T, Molassiotis A, Chung BPM, Tan JY. Unmet care needs of advanced cancer patients and their informal caregivers: a systematic review. *BMC Palliat Care.* 2018;17(1):96. doi:10.1186/s12904-018-0346-9
3. Adler NE, Page AEK. Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs. National Institute of Medicine Committee on Psychosocial Services to Cancer Patients/Families in a Community Setting. Washington, DC: National Academies Press; 2008.
4. Holland J, Watson M, Dunn J. The IPOS new International Standard of Quality Cancer Care: integrating the psychosocial domain into routine care. *Psychooncology.* 2011;20(7):677-680. doi:10.1002/pon.1978
5. Singer S, Kojima E, Deppisch L. et al. What is the best time for psychosocial counselling from the perspective of cancer patients and their relatives? A multi-centre qualitative study. *Couns Psychother Res.* 2022;22:558-568. DOI: 10.1002/capr.12488
6. Grassi L, Fujisawa D, Odyio P. et al. Disparities in psychosocial cancer care: a report from the International Federation of Psycho-oncology Societies. *Psychooncology.* 2016;25(10):1127-1136. doi:10.1002/pon.4228
7. Grassi L, Watson M; IPOS Federation of Psycho-Oncology Societies' co-authors. Psychosocial care in cancer: an overview of psychosocial programmes and national cancer plans of countries within the International Federation of Psycho-Oncology Societies. *Psychooncology.* 2012;21(10):1027-1033. doi:10.1002/pon.3154
8. Daem M, Verbrugghe M, Schrauwen W, Leroux S, Van Hecke A, Grypdonck M. How interdisciplinary teamwork contributes to psychosocial cancer support. *Cancer Nurs.* 2019;42(3):E11-E20. doi:10.1097/NCC.0000000000000588
9. Bultz BD. Cancer care and the role of psychosocial oncology: Where are we and where are we going? *Asia Pac J Oncol Nurs.* 2016;3(2):118-120. doi:10.4103/2347-5625.182929
10. Banerjee SC, Manna R, Coyle N, et al. Oncology nurses' communication challenges with patients and families: A qualitative study. *Nurse Educ Pract.* 2016;16(1):193-201. doi:10.1016/j.nepr.2015.07.007
11. Haavisto E, Soikkeli-Jalonen A, Tonteri M, Hupli M. Nurses' required end-of-life care competence in health centres inpatient ward - a qualitative descriptive study. *Scand J Caring Sci.* 2021;35(2):577-585. doi:10.1111/scs.12874
12. Uwayezu MG, Nikuze B, Maree JE, Buswell L, Fitch MI. Competencies for nurses regarding psychosocial care of patients with cancer in Africa: An imperative for action. *JCO Glob Oncol.* 2022;8:e2100240. doi:10.1200/GO.21.00240
13. Taş B. Adaptation Process to The European Union for Turkey's New Region Concept: The Nomenclature of Territorial Units for Statistics (NUTS). *The Journal of Social Sciences.* 2006; 8(2):186-198.
14. Laffan AJ, Daniels J, Osborn M. Profiling the psychological training and support needs of oncology staff and evaluating the effectiveness of a level 2 psychological support training program workshop. *J Psychosoc Oncol.* 2015;33(6):686-702. doi:10.1080/07347332.2015.1082170
15. National Institute for Health and Clinical Excellence. Improving Supportive and Palliative Care for Adults with Cancer. London: NICE, 2004.
16. National Cancer Action Team, National Cancer Programme. The Manual for Cancer Services: Psychological Support Measures. Version 1.0. London: National Cancer Programme, 2011.
17. Kocaman Yıldırım N, Terakye G. Future and present of psychiatric consultation liaison nursing. *Türkiye Klinikleri J Psychiatr Nurs* (Special Topics). 2017;3(1):1-6.
18. Uitterhoeve R, Duijnhouwer E, Ambaum B, van Achterberg T. Turning toward the psychosocial domain of oncology nursing: A main problem analysis in the Netherlands. *Cancer Nurs.* 2003;26(1):18-27. doi:10.1097/00002820-200302000-00003
19. Gosselin TK, Crane-Okada R, Irwin M, Tringali C, Wenzel J. Measuring oncology nurses' psychosocial care practices and needs: Results of an Oncology Nursing Society psychosocial survey. *Oncol Nurs Forum.* 2011;38(6):729-737. doi:10.1188/11.ONF.729-737
20. Iheanacho PN, Opara HC, Ifezulumba JC, Omotola N, Ingwu JA, Anarado AN. Nurses' perceived challenges in the management of hospitalized cancer patients in a Comprehensive Cancer Center in Southeastern Nigeria. *Asian Pac J Cancer Prev.* 2022;23(10):3587-3593. doi:10.31557/APJCP.2022.23.10.3587
21. Dilworth S, Higgins I, Parker V, Kelly B, Turner J. Patient and health professional's perceived barriers to the delivery of psychosocial care to adults with cancer: A systematic review. *Psychooncology.* 2014;23(6):601-612. doi:10.1002/pon.3474
22. Kenny A, Endacott R, Botti M, Watts R. Emotional toil: Psychosocial care in rural settings for patients with cancer. *J Adv Nurs.* 2007;60(6):663-762. doi:10.1111/j.1365-2648.2007.04453.x
23. Papadopoulou C, Sime C, Rooney K, Kotronoulas G. Sexual health care provision in cancer nursing care: A systematic review on the state of evidence and deriving international competencies chart for cancer nurses. *Int J Nurs Stud.* 2019;100:103405. doi:10.1016/j.ijnurstu.2019.103405
24. Fennell R, Grant B. Discussing sexuality in health care: A systematic review. *J Clin Nurs.* 2019;28(17-18):3065-3076. doi:10.1111/jocn.14900
25. Depke JL, Onitilo AA. Sexual health assessment and counseling: Oncology nurses' perceptions, practices, and perceived barriers. *J Community Support Oncol.* 2015;13(12):442-443. doi:10.12788/jcso.0174
26. Faller H, Koch U, Brähler E, et al. Satisfaction with information and unmet information needs in men and women with cancer. *J Cancer Surviv.* 2016;10(1):62-70. doi:10.1007/s11764-015-0451-1
27. Kendall S. Being asked not to tell: Nurses' experiences of caring for cancer patients not told their diagnosis. *J Clin Nurs.* 2006;15(9):1149-1157. doi:10.1111/j.1365-2702.2006.01460.x
28. Dunniece U, Slevin E. Nurses' experiences of being present with a patient receiving a diagnosis of cancer. *J Adv Nurs.* 2000;32(3):611-8. doi:10.1046/j.1365-2648.2000.01518.x

29. Usta YY. Importance of social support in cancer patients. *Asian Pac J Cancer Prev.* 2012;13(8):3569-3572. doi:10.7314/apjcp.2012.13.8.3569
30. Richardson EM, Schüz N, Sanderson K, Scott JL, Schüz B. Illness representations, coping, and illness outcomes in people with cancer: A systematic review and meta-analysis. *Psychooncology.* 2017;26(6):724-737. doi:10.1002/pon.4213
31. Kaneko M, Ryu S, Nishida H, Tamasato K, Shimodaira Y, Nishimura K, Kume M. Nurses' recognition of the mental state of cancer patients and their own stress management - a study of Japanese cancer-care nurses. *Psychooncology.* 2013;22(7):1624-1629. doi:10.1002/pon.3191
32. Kvåle K. Do cancer patients always want to talk about difficult emotions? A qualitative study of cancer inpatients communication needs. *Eur J Oncol Nurs.* 2007;11(4):320-327. doi:10.1016/j.ejon.2007.01.002
33. Chan EA, Wong F, Cheung MY, Lam W. Patients' perceptions of their experiences with nurse-patient communication in oncology settings: A focused ethnographic study. *PLoS One.* 2018;13(6):e0199183. doi:10.1371/journal.pone.0199183
34. Zheng RS, Guo QH, Dong FQ, Owens RG. Chinese oncology nurses' experience on caring for dying patients who are on their final days: a qualitative study. *Int J Nurs Stud.* 2015;52(1):288-296. doi:10.1016/j.ijnurstu.2014.09.009
35. Boyle DK, Miller PA, Forbes-Thompson SA. Communication and end-of-life care in the intensive care unit: Patient, family, and clinician outcomes. *Crit Care Nurs Q.* 2005;28(4):302-316. doi:10.1097/00002727-200510000-00002

ATATÜRK ÜNİVERSİTESİ YAYINLARI
ATATURK UNIVERSITY PUBLICATIONS

Research Article *Araştırma Makalesi* DOI: 10.17049/jnursology.1428046

Evaluation of Suicide in Nursing Students from The Perspective of Meaning of Life and Hope

Hemşirelik Öğrencilerinde İntiharın Yaşamda Anlam ve Umut Perspektifinde İncelenmesi

Nurdan ÇETİN[1]
Esra USLU[2]
Gülcan KENDİRKIRAN[3]

[1] Air Force Command, Eskişehir, Türkiye
[2] Eskisehir Osmangazi University, Faculty of Health Sciences, Department of Mental Health Nursing, Eskişehir, Türkiye
[3] Halic University, Faculty of Health Sciences, Department of Nursing, İstanbul, Türkiye

ABSTRACT

Objective: This study was conducted to determine the effect of meaning in life and hope on suicide probability in nursing students.

Methods: A descriptive and correlational design was used. The sample of the study consisted of 266 nursing students from April 2020-June 2020. Data collected with "the Suicide Probability Scale", "The Meaning in Life Questionnaire", and "The Hope Scale".

Results: Students' suicide probability score is 73.6±19.5. Low levels of meaning in life (β=-0.216, *P*<.001), low levels of hope (β=-0.273, *P*<.001), inadequate social support (β=0.302, *P*<.001), low level of perceived academic success (β=-0.121, p=0.003) and previous suicidal ideation (β=0.352, *P*<.001), using psychiatric medication (β=0.123, *P*=.011) increased the probability of suicide.

Conclusion: This study revealed that the probability of suicide among nursing students is above the average and that meaning in life, hope and different variables affect the process. The results underline the necessity of evaluating the suicide risk in nursing students with a holistic approach and taking protective measures.

Keywords: Hope, life expectancy, nursing students, suicide, value of life

ÖZ

Amaç: Bu çalışma hemşirelik öğrencilerinde yaşamın anlamı ve umudun, intihar olasılığına etkisini belirlemek amacıyla yapıldı.

Yöntemler: Tanımlayıcı ve ilişkisel bir dizayn kullanıldı. Araştırmanın örneklemini Nisan 2020-Haziran 2020 tarihleri arasında 266 hemşirelik öğrencisi oluşturdu. Veriler İntihar Olasılığı Ölçeği, Yaşamdan Anlam Bulma ve Umut Ölçeği ile toplandı.

Bulgular: Öğrencilerin intihar olasılık puanı 73,6±19,5'tir. Yaşamda anlamının düşük olması (β=-0,216, *P*<,001), umudun düşük olması (β=-0,273, *P*<,001), sosyal desteğin yetersiz olması (β=0,302, *P*<,001), akademik başarı algısının düşük olması (β=-0,121, *P*=,003) ve daha önce intihar düşüncesinin varlığı (β=0,352, *P*<,001), psikiyatrik ilaç kullanımı (β=0,123, *P*=,011) intihar olasılığını artırdı.

Sonuç: Bu çalışma hemşirelik öğrencilerinde intihar olasılığının ortalamanın üzerinde olduğunu, yaşamdaki anlam, umut ve farklı değişkenlerin süreci etkilediğini ortaya koymuştur. Sonuçlar hemşirelik öğrencilerinde intihar riskinin bütünsel bir yaklaşımla değerlendirilmesi ve koruyucu önlemlerin alınması gerekliliğini vurgulamaktadır.

Anahtar Kelimeler: Umut, yaşam beklentisi, hemşirelik öğrencileri, intihar, yaşamın değeri

Geliş Tarihi/Received 30.01.2024
Revizyon Tarihi/Revised 03.05.2024
Kabul Tarihi/Accepted 06.06.2024
Yayın Tarihi/Publication Date 25.06.2024

Sorumlu Yazar/Corresponding author: Nurdan ÇETİN
E-mail: nrdnctn3066@hotmail.com
Cite this article: Çetin N, Uslu E, Kendirkıran G. Evaluation of suicide in nursing students from the perspective of meaning of life and hope. *J Nursology*. 2024;27(2):111-119.

INTRODUCTION

The World Health Organization (WHO) data have shown that more than half of suicides take place before the age of 45, especially between the ages of 15-29 and that suicide is the 2nd leading cause of death among youth.[1] This situation, which threatens especially young adults globally, is an important public health problem.[1-4]

University students, who constitute an important part of the young population, struggle with various problems in many areas of their lives along with the education process. Emotional, academic, and economic problems, adaptation to university life, and anxiety about being unemployed are among the difficulties that university students may encounter.[5] There is a relationship between distress experienced by students and suicidal behavior.[3] According to studies conducted on the subject, the prevalence of suicidal ideation is high among university students[2], 24% of them have suicidal ideation, and 9% of them have committed suicide.[4]

The meaning of life varies from person to person, but having meaning in life is the most basic fact of an individual's survival.[6] According to a study conducted with university students, the perception of meaning in life has a direct determining effect on suicidal attitude and suicidal ideation[7] and plays a protective role on suicidal behavior.[8] Similarly, the protective effect of hope on suicide has been emphasized in another study in university students.[9] While individuals' ability to cope with their problems that they encounter in life and make sense of what they experience is spiritually protective[10], believing that their problem is inevitable and endless may damage the sense of meaning in life, lead to hopelessness, and thus suicide.[11] For this reason, finding meaning in life and hope are important phenomena that need to be studied in terms of suicide. Therefore, evaluating the effect of finding meaning in life and the level of hope on the suicide probability in university students, who are in the risk group for suicide, may play an important role in determining the developmental services to be provided for them.

From this point of view, this study focused on suicide probability in nursing students, and some variables of students (sociodemographic, individual, and familial characteristics and suicide history), as well as the level of meaning in life and hope, which are thought to be related to the suicide phenomenon, were also examined in this context. Due to the limited number of studies directly examining the phenomenon of suicide in nursing students in the literature.[12,13]

AIM

This study was conducted to determine the effect of meaning in life and hope on suicide probability in nursing students.

In this context, the research hypothesis is as follows:
H_1: "Meaning in life and hope" affect suicide probability in nursing students.

METHODS

Study Design

This study was carried out with a descriptive and correlational design. Researchers have adhered to relevant "STROBE" the reporting method.

Study Sample

The study was conducted with nursing students of a university in Istanbul between April 2020 and June 2020. The population of the study consisted of a total of 386 nursing students in the university. The sample size was calculated in line with the study that was conducted by Hisli Şahin and Durak Batıgün[14] to determine the suicide risk in high school and university students. Accordingly, the minimum sample size was determined as 232 individuals based on the standard deviation of the Suicide Probability Scale (σ=12.25), a population size of 386, and a 95% confidence interval (t=1.96; d=1). The study was completed with 266 (n=266) participants. The inclusion criteria were as follows: (i) being aged >18 years; (ii) volunteering to participate in the study.

Data Collection Tools

The data of this study was collected using the online questionnaire. The questionnaire was sent to the e-mail address of the students. The system allowed students to fill out the form only once.

Personal Information Form: This form, which was developed by the researchers, consists of 23 items (sociodemographic, individual, and familial characteristics and suicide history).[11]

The Suicide Probability Scale (SPS): This scale was developed by Cull and Gill[15] to evaluate suicide probability, and Turkish validity study was conducted by Durak Batıgün and Hisli Şahin.[16] The four-point Likert-type scoring structure of the scale was converted into percentiles in the current form. Accordingly, the responses are evaluated as "0% appropriate, 30% appropriate, 70% appropriate, 100% appropriate". The scale has 36 items in total. The highest score that can be obtained from the scale is 144. A high

total score on the scale is interpreted as a high risk of suicide. Cronbach alpha value of the scale was found to be 0.95.

The Meaning in Life Questionnaire (MLQ): This scale was developed by Steger et al.[17] to evaluate meaning in life, and Turkish validity study was conducted by Demirbaş.[18] The MLQ has two independent sub-dimensions, namely "the presence of meaning" and "search for meaning" and consists of a total of 10 items. Scores on each sub dimension range between 5 and 35. High scores on the subscales are interpreted as finding meaning in life and searching for meaning. A high score on the scale is interpreted as a high level of finding meaning in life. The Cronbach's alpha value of the MLQ was found to be 0.88 for the presence of meaning in life subscale and 0 .93 for the search for meaning in life subscale.

The Hope Scale (HS): This scale was developed by Snyder et al.[19] to evaluate hope levels of individuals, and Turkish validity study was conducted by Akman and Korkut.[20] The scale has 12 items scored on a four-point Likert-type structure with options ranging from “strongly disagree to strongly agree”. The scores that can be obtained from the scale range from 8 to 32. An increase in the scale score is interpreted as an increase in the level of hope. In the reliability study conducted with the test-retest method, the reliability values of the scale were found to be 0.85 at 3-week intervals, 0.73 at 8-week intervals and 0.76 at 10-week intervals.

Ethical Considerations

Ethical approval of the “Non-Interventional Clinical Research Ethics Committee” of Haliç University (Date: 20.03.2020 / No: 51), and the permission of the authors of the scales were obtained. In addition, the consent of all students was obtained before the study was initiated.

Data Analysis

Continuous data were presented by “mean ±s tandard deviation (SD)” and “frequency values (n)”, and “percentages (%)” were used for categorical data. The normality assumptions were tested with “the Shapiro-Wilk test”. In the analysis of the data, “The independent t-test”, “One-Way ANOVA” and the “Tukey HSD test” were used. “Pearson” and “Spearman” correlation tests were used to examine the relationship of the suicide probability with other parameters. Multiple linear regression analysis was performed to determine factors associated with participants’ suicide probability. Statistical analysis was conducted on a software package and *P*<.05 was considered statistically significant.

RESULTS

The mean scores of participants were found as 73.6±19.5 on the total SPS, 42.54±10.25 on the total MLQ, and 25.1±4.1 on the total HS (Table 1).

Table 1. The Total Scores of Students on SPS, MLQ, and HS

Scales	$\bar{X}$±SD	Min-Max	Cronbach’s Alpha
Total SPS Score	73.6±19.5	39-128	0.94
Total MLQ Score	42.54±10.25	19-70	0.81
Total HS Score	25.1±4.1	10-32	0.79

$\bar{X}$, Mean; SD, Standard deviation; Min-Max, Minimum-Maximum.

It was found that being male (*P*<.001), living with a friend (*P*=.026), separated parents (*P*=.006) or death of father or mother (*P*=.007), and smoking (*P*=.006) or alcohol use (*P*<.001), inadequate social support systems (*P*<.001), previous suicidal ideation (*P*<.001), committed suicide (*P*=.007), family member or acquaintance committing suicide (*P*<.001) and dying due to suicide (*P*=.01), received psychiatric support (*P*<.001), and a psychiatric diagnosis (*P*=.01) and used psychiatric drug (*P*=.037) increase the probability of suicide compared to other groups (Table 2).

It was found that there was a negative correlation between total SPS score and school year (*P*=.002, r=-0.191), academic achievement (r=-0.406, *P*=.001) and perceived level of coping with stress (*P*<.001, r=-0.258), and a positive correlation with the education level of the mother (*P*=.028, r=0.135) and father (*P*=.001, r=0.201). In addition, a negative correlation was found between the SPS-total score and the MLQ-total score (*P*<.001, r=-0.554) and the total HS score (*P*<.001, r=-0.618) (Table 3).

Factors associated with participants' SPS scores were analyzed with multivariate linear regression analysis. As a result of the analysis, it was found that inadequate social support system (β=0.302, P<.001), poor perceived academic achievement (β=-0.121, P=.003), previous suicidal ideation (β=0.352, P<.001), use of psychiatric drug recommended by an expert (β=0.123, P=.011), low MLQ score (β=-0.216, P<.001), and low HS score (β=-0.273, P<.001) increased the probability of suicide. In this model, related variables explained approximately 75% of the suicide probability (Table 4).

Table 2. The Mean Scores of Students on the Total SPS According to Independent Variables

Variables	SPS Score		
	n (%)	X̄±SD	Test and *P*
Gender			
Male	50 (18.8)	82.44±20.05	t=3.658
Female	216 (81.2)	71.5±18.83	**<0.001**
Marital status			
Single	259 (97.4)	73.31±19.69	t=1.641
Married	7 (2.6)	82.57±6.4	.101
Lives with			
Family	232 (87.2)	72.33±19.08	F=3.685
Friends	16 (6)	82.81±19.05	**.026**
Alone	18 (6.8)	81.11±22.39	
Significant difference		1-2	
Status of parents			
Together	216(81.2)	71.78±19.21	F=5.092
Separated	39 (14.7)	80.26±18.36	**.007**
Mother and/or father died	11 (4.1)	84.55±22.16	
Significant difference		1-2. 1-3	
Tobacco use			
Yes	70 (26.3)	79±18.47	t=-2.756
No	196 (73.7)	71.61±19.54	**.006**
Alcohol use			
Yes	41 (15.4)	86.68±18.26	t=-4.885
No	225 (84.6)	71.16±18.8	**<.001**
Existence of a disorder requiring regular medication			
Yes	22 (8.3)	79.36±24.7	t=-1.462
No	244 (91.7)	73.03±18.94	.145
Social support systems			
Adequate	182 (68.4)	66.04±14.58	t=-11.217
Inadequate	84 (31.6)	89.83±18.95	**<.001**
Having suicidal ideation			
Yes	65 (24.4)	91.02±20.28	t=-8.422
No	201 (75.6)	67.91±15.53	**<.001**
Having attempted suicide			
Yes	19 (7.1)	92.11±28.41	t=-3.019
No	247 (92.9)	72.13±17.95	**.007**
Presence of a family member/ acquaintance who committed suicide			
Yes	69 (25.9)	80.13±15.83	t=-3.720
No	197 (74.1)	71.25±20.17	**<.001**
Presence of a family member/ acquaintance who died due to suicide			
Yes	29 (10.9)	82.28±14.36	t=-2.579
No	237 (89.1)	72.49±19.8	**.010**
Receiving psychiatric support			
Yes	40 (15)	85.95±20.91	t=-4.518
No	226 (85)	71.36±18.44	**<.001**
Presence of a psychiatric diagnosis			
Yes	22 (8.3)	87.77±25.2	t=-2.818
No	244 (91.7)	72.27±18.44	**.010**
Status of psychiatric drug use			
Yes	15 (5.6)	83.73±24.6	t=-2.094
No	251 (94.4)	72.94±19.05	**.037**

F, One-Way ANOVA test; t, Independent t-test

Table 3. Evaluation of the Relationship Between the Total SPS Score and Independent Variables

Variables	Suicide Probability Scale (SPS)	
	r	*P*
Age	0.013	.830[1]
School year	-0.191	**.002[2]**
Family income	-0.102	.097[2]
Education level of mother	0.135	**.028[2]**
Education level of father	0.201	**.001[2]**
Perceived academic achievement	-0.406	**<.001[2]**
Perceived level of coping with stress	-0.258	**<.001[2]**
Meaning in Life Questionnaire (MLQ)	-0.554	**<.001[1]**
Hope Scale (HS)	-0.618	**<.001[1]**

[1]Pearson correlation test, [2]Spearman correlation test

Table 4. Suicide Probability and Factors Influencing It

Model	Suicide probability						95% Confidence Interval	
	B	SE	β	t	Sig.	VIF	Lower	Upper
Constant	126.111	6.638	-	18.997	**<.001**	-	113.034	139.187
Male gender	-1.435	1.976	-0.029	-0.726	.468	1.467	-5.328	2.458
School year	-0.841	0.649	-0.049	-1.296	.196	1.317	-2.118	0.437
Living with a friend	0.799	2.947	0.010	0.271	.786	1.208	-5.006	6.604
Living alone	3.082	2.86	0.040	1.078	.282	1.270	-2.552	8.715
Family income	0.484	1.398	0.013	0.346	.730	1.258	-2.27	3.237
Education level of mother	0.624	0.763	0.033	0.818	.414	1.542	-0.879	2.127
Education level of father	0.269	0.757	0.014	0.356	.722	1.53	-1.222	1.761
Separated parents	-1.529	2.196	-0.028	-0.696	.487	1.484	-5.854	2.796
Death of one or both of parents	3.096	3.445	0.032	0.899	.370	1.158	-3.689	9.882
Tobacco use	-0.453	1.817	-0.010	-0.25	.803	1.575	-4.033	3.126
Alcohol use	1.216	2.278	0.023	0.534	.594	1.665	-3.272	5.705
Inadequate social support system	12.642	1.786	0.302	7.078	**<.001**	1.696	9.123	16.16
Perceived academic success	-4	1.348	-0.121	-2.968	**.003**	1.539	-6.655	-1.345
Perceived level of coping with stress	-1.07	1.106	-0.038	-0.967	.334	1.459	-3.248	1.108
Suicidal ideation	15.949	1.816	0.352	8.780	**<.001**	1.499	12.371	19.527
Committing suicide	2.233	3.241	0.030	0.689	.491	1.714	-4.15	8.616
Presence of a family member committing suicide	-1.004	1.826	-0.023	-0.550	.583	1.576	-4.601	2.592
Presence of a family member who died due to suicide	1.688	2.478	0.027	0.681	.496	1.467	-3.192	6.569
Getting psychiatric support	4.394	2.513	0.081	1.749	.082	1.985	-0.556	9.344
Having a psychiatric diagnosis	3.987	4.063	0.056	0.981	.327	3.081	-4.016	11.989
Using psychiatric drug	10.371	4.041	0.123	2.566	**.011**	2.138	18.331	2.41
Meaning in Life Questionnaire (MLQ)	-0.41	0.076	-0.216	-5.378	**<.001**	1.499	-0.561	-0.26
Hope Scale (HS)	-1.29	0.201	-0.273	-6.412	**<.001**	1.695	-1.687	-0.894

R=0.861, R^2=0.741, *P*<.001

DISCUSSION

This study, which examines the factors affecting the probability of suicide in nursing students; revealed that the level of meaning and hope in life is important in terms of suicide probability. However, due to the limited number of studies directly examining the suicide phenomenon in nursing students when the literature was examined, suicide-focused studies conducted with both nursing students and university students were included in this section.

Recent studies have dramatically shown the risk of suicide among young people.21,22 According to a study conducted with nursing students in Brazil, it was determined that 53.3% of students had a suicide probability, and that 22.67% had committed suicide before.13 It was found that the nursing students participating in this study had a high suicide probability in line with the literature. Similarly, in another study conducted with university students in Sweden, the risk of suicide was found to be high in female nursing students, while the risk of self-harm was found to be high in both male and female nursing students.23 According to a study conducted in Norway, the prevalence of suicide attempts among students was underlined, and it was determined that there was a significant increase in students' suicidal thoughts from 2010 to 2018.24 When evaluated in light of the literature, this result of our study underlines that suicide among all young people, especially nurse students, is a phenomenon that needs to be addressed on a global scale and that necessary measures should be taken. As the WHO stated in its 2019 emergency action plan, the implementation of national policies to prevent suicide, especially school/university-based prevention studies, is not a choice but a necessity.1 It is possible to detect students at risk for suicide in the early period and evaluate and manage the process.

It is stated that the level of meaning in life and hope are predictors of suicide.25 In this study, similar to the literature7-9, it was determined that the probability of suicide increased as the level of meaning in life and hope in students participating in the study decreased and that these variables were also risk factors for the probability of suicide. In a study conducted with university students in China, it was stated that hopelessness was a major risk factor for suicidal behavior, and it was emphasized that students' meaning in life was a very important protective factor in terms of suicide.26 Similarly, as a result of another study conducted with university students, it was stated

that both the search for meaning in life and the existence of meaning were important protective factors against suicidal behavior.[8] In this context, although the results of this study are in parallel with studies on the subject, it is possible to say that the decrease in meaning in life and hope in students participating in the study increases the probability of suicide. In line with these results, it can be said that, based on the idea that problems of students at risk of suicide are not permanent, it is necessary to address negative basic beliefs.[11] At this point, developmental services that can be provided to students about finding meaning in life come to the fore. It is thought that therapeutic interventions such as self-knowledge in finding meaning in life, helping to create a perception of what they want for themselves, setting clear and achievable goals within the scope of hope, developing different solutions, discovering their strengths, supporting their belief in themselves, and strengthening positive emotions will contribute. [11,27]

Within the scope of the study, variables related to sociodemographic, individual, and familial characteristics and suicide history, which are thought to affect the suicide probability of students, were examined. When suicide probability of students participating in the study was examined according to their sociodemographic characteristics, it was determined that the probability of suicide was higher in participants who were male, were in lower classes, and lived with their friends. Although the data in the literature on suicide among students in terms of gender are variable, there are data indicating that the probability of suicide is higher among male students.[28] There are studies showing that the rate of self-harm and suicidal ideation is higher in first-year students[29] and that the risk of suicide is higher in undergraduate students than in graduate students.[11] In parallel with the literature, it was determined that the probability of suicide decreased as the school year of students participating in the study increased. This result points out the importance of screening especially students who are new to university life in terms of suicide probability and supporting them psychosocially. The literature on the relationship between the place where students live and the probability of suicide is limited; however, in line with the results obtained from this study, it is necessary to more closely monitor/follow up male students who have just started university and live with their friends in terms of suicide probability.

When the familial characteristics of students in the study were evaluated in terms of suicide probability, it was found to be higher in students whose family income was lower than their expenses,-whose parents separated or one/both of them died, and whose father or mother was university graduates. While there are studies in the literature showing

that economically challenged students are at risk for suicide[30,31], there is no data that evaluates the separation or death of parents in terms of students' suicide probability. Another remarkable finding of this study was that as the education level of parents increased, students' suicide probability increased, as well. It was observed that the literature generally focused on the effects of parenting attitudes and family environment characteristics on suicide, rather than the relationship between parents' education level and students' suicide probability.[32,33] However, as a result of a study conducted with adolescent students, it was stated that as the education level of parents increased, the stress in the family increased, but that the effect of this on suicidal ideation was not statistically significant.[34] Considering that the majority of the participants lived with their families and the living conditions in the region where the research was conducted were challenging, it can be thought that parents with a high level of education were more exposed to stressors due to intense working conditions and challenging lifestyle and that these conditions had a negative effect on the parent-child relationship and the phenomenon of suicide. In line with these results, considering the multiple etiology of suicide, it is necessary to question the family history of students with suicide probability and to carefully evaluate those with inadequate family support in terms of suicide.

It is important to evaluate the effect of individual characteristics of students, such as substance abuse, and loneliness, along with familial characteristics on the suicide phenomenon. When the suicide probability of students participating in the study was examined according to their individual characteristics, it was found that those who used tobacco or alcohol, perceived the social support system as inadequate, and had a low level of perceived academic success and coping with stress were more likely to commit suicide. At the same time, it was determined that inadequate social support and low perceived academic achievement were important risk factors for suicide. In parallel with the results of this study, it is emphasized in the literature that students who use tobacco, alcohol, or substances[35,36], have inadequate social support[36], think that they have difficulty in academic success[31,36] should be especially evaluated in terms of suicide probability. In addition, it has been reported that other stressors experienced by students in campus life have an effect on suicidal ideation, and feelings of helplessness may increase in those who cannot cope with stress in the face of difficulties, thereby increasing the probability of thinking and attempting suicide.[38] In this context, guiding students in coping with academic or environmental stressors, having them gain effective coping skills instead of ineffective ones such as smoking and alcohol use, activating social support systems, and improving their mood can be considered among effective ways to reduce suicidal thoughts.[11]

One of the most important areas to be considered while studying the phenomenon of suicide is the data on the mental map of individuals. When the data on the suicide history of the students in the study were examined, it was found that the suicide probability was higher in students who had suicidal thoughts, had committed suicide before, had a family member or acquaintances committing suicide and/or died due to suicide, received psychiatric support, had a psychiatric diagnosis, and used psychiatric drugs. It was also found that having suicidal thoughts and using psychiatric drugs were risk factors for suicide. In parallel with our study findings, there are similar research findings indicating that students with a previous suicide history[29,35] and those with a psychiatric diagnosis[38] are at risk for suicide. In this context, it becomes clear that students who are thought to be at risk for suicide should be examined in detail in terms of the history of suicide, their family history of suicide attempts and completion and that students who have a psychiatric diagnosis and use psychiatric drug should be followed more closely.

Considering the multidimensional and complex structure of the suicide phenomenon, the importance of defining the risk factors related to the sociodemographic, individual, familial characteristics and suicide history of the students is clearly seen in this study. In this direction, it is thought that identifying the risk factors for suicide is important for the development of preventive mental health services that can be provided to students.

Limitations of the Study: The first limitation of this study is that a descriptive research design was used. This limits the power of the research to determine causality. Second, the study was conducted in only one university. Therefore, the results cannot be generalized. New studies with large samples and different designs are recommended to be conducted in different regions. For these reasons, the results should be carefully evaluated.

As a result of this study it was determined that the suicide probability of students in the study was above the average and that the decreasing level of meaning and hope in life increased the probability of suicide in students. In addition, the findings of the study showed that students inadequate social support system, low level of perceived academic success, previous suicidal ideation, using psychiatric drug increased the probability of suicide too. In line with the results of the study, the importance of supporting students in finding meaning in life and hope is clearly seen. In this context, developmental services that

can be provided for students about finding meaning in life and hope come to the fore. In addition, it is recommended that the risk factors described above should be evaluated with a holistic approach, preventive services against them should be put into operation, students at risk for suicide should be detected earlier, these individuals should be guided and directed to emergency psychiatric treatment, and that they should be supported comprehensively by contacting their social environment, especially their families.

Etik Komite Onayı: Bu çalışma için Haliç Üniversitesi Etik Kurulu'ndan etik kurul onayı alınmıştır. Tarih: 20 Mart 2020, Karar Numarası: 04
Bilgilendirilmiş Onam: Bu çalışmaya katılan tüm katılımcılardan yazılı bilgilendirilmiş onam alınmıştır
Hakem Değerlendirmesi: Dış bağımsız.
Yazar Katkıları: Fikir- NÇ, EU; Tasarım- NÇ, EU; Denetleme- EU,GK; Kaynaklar-GK; Veri Toplanması ve/veya İşlemesi- GK; Analiz ve/ veya Yorum- NÇ, EU; Literatür Taraması-NÇ; Yazıyı Yazan- NÇ; Eleştirel İnceleme- NÇ, EU.
Teşekkür: Araştırmacılar, araştırmaya katılan ve bu sayede intiharı önlemeye yönelik müdahalelerin planlanmasına katkı sağlayan hemşirelik öğrencilerine teşekkür ediyor.
Çıkar Çatışması: Yazarlar, çıkar çatışması olmadığını beyan etmiştir.
Finansal Destek: Yazarlar bu çalışmanın herhangi bir finansal destek almadığını beyan etmektedir.

Ethics Committee Approval: Ethics committee approval was received for this study from the Ethics Committee of Haliç University. Date: 20 March 2020 Decision, Number: 04
Informed Consent: Written informed consent was obtained from all participants who participated in this study
Peer-review: Externally peer-reviewed.
Author Contributions: Author Contributions: Concept – NÇ, EU; Design – NÇ, EU; Supervision – EU, GK; Resources – GK; Materials – GK; Data Collection and/or Processing – GK; Analysis and/or Interpretation – NÇ, EU, GK; Literature Search – NÇ, EU, GK; Writing Manuscript – NÇ, EU, GK; Critical Review – NÇ, EU, GK.
Acknowledgements: The researchers thank the nursing students who participated in the study and thus contributed to the planning of interventions on suicide prevention.
Conflict of Interest: The authors have no conflicts of interest to declare.

Financial Disclosure: The authors declare that this study had received no financial support.

REFERENCES

1. World Health Organization (WHO). Suicide data, Suicide in the Word Global Health Estimates. 2019. Accessed 17.02.2022 http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/
2. Chow, WS, Schmidtke J, Loerbroks A, Muth T, Angerer P. The relationship between personality traits with depressive symptoms and suicidal ideation among medical students: a cross-sectional study at one medical school in Germany. *Int J Environ Res Public Health.* 2018;15(7):1462. https://doi.org/10.3390/ijerph15071462
3. Tang F, Byrne M, Qin, P. Psychological distress and risk for suicidal behavior among university students in contemporary China. *J Affect Disord.* 2018;228:101-108. https://doi.org/10.1016/j.jad.2017.12.005
4. Liu CH, Stevens C, Wong S, Yasui M, Chen JA. The prevalence and predictors of mental health diagnoses and suicide among U.S. college students: implications for addressing disparities in service use. *Depress Anxiety.* 2019;36(1):8–17. https://doi.org/10.1002/da.22830
5. Friedrich A, Schlarb AA. Let's talk about sleep: a systematic review of psychological interventions to improve sleep in college students. *J Sleep Res.* 2018;27(1):4–22. https://doi.org/10.1111/jsr.12568
6. Frankl V. *Man's Search for Meaning.* 4th ed. Okuyan Us Publishing; 2009.
7. Moscardini EH, Oakey-Frost DN, Robinson A, et al. Entrapment and suicidal ideation: The protective roles of presence of life meaning and reasons for living. *Suicide Life Threat Behav.* 2022;52(1):14-23. https://doi.org/10.1111/sltb.12767
8. Lew B, Chistopolskaya K, Osman A, Huen J, Abu Talib M, Leung A. Meaning in life as a protective factor against suicidal tendencies in Chinese University students. *BMC Psychiatry*. 2020;20(1):73. https://doi.org/10.1186/s12888-020-02485-4
9. Griggs S. Hope and mental health in young adult college students: An integrative review. *J Psychosoc Nurs Ment Health Serv.* 2017;55(2):28-35. https://doi.org/10.3928/02793695-20170210-04
10. Ruth Elder, Katie Evans, Debra Nizette. *Travelbee, Psychiatric Menthal Nursing.* 2nd ed. Elsevier Australia; 2009.
11. Halter MJ. *Varcarolis' manual of psychiatric nursing care planning: An Interprofessional Approach*. 6th ed. United States of America, Suicide: 275-289; 2019.
12. Arslantaş H, Adana F, Harlak H, Eskin M. Suicidal behaviour attitudes among nursing and midwifery students. *Neuropsychiatr Invest.* 2019;57(2):6-12. https://doi.org/10.5455/NYS.20190215102533
13. Moraes SMAB, Barbosa VFB, Alexandre ACS, Santos SCD, Guimarães FJ, Veras JLA. Risk of suicide among nursing students. *Rev Bras Enferm.* 2021;74(6):e20200867. https://doi.org/10.1590/0034-7167-2020-0867
14. Hisli Şahin N, Durak Batıgün A. Testing a model for determining suicide risk in high school and university students. *Turkish Journal of Psychiatry.* 2009;20(1):28-36.
15. Cull JG, Gill WS. *Suicide Probability Scale (SPS) Manual Western Psychological Services*, Los Angeles, California;1988.
16. Durak Batıgün A, Hisli Şahin N. Suicide Probability Scale: Revision, validity and reliability. *KPD.* 2018;2(2):52-64. https://dergipark.org.tr/tr/pub/klinikpsikoloji/issue/76353/1271009
17. Steger MF, Frazier P, Oishi S, Kaler M. The meaning in life questionnaire: Assessing the presence of and search for meaning in life. *Journal of Counseling*

*Psychology.*2006;53(1):80–93. https://doi.org/10.1037/0022-0167.53.1.80
18. Demirbaş N. *Meaning and resilience in life*. Hacettepe University, Master Thesis, Ankara; 2010.
19. Snyder CR, Harris C, Anderson JR, et al. The will and the ways: Development and validation of an individual-differences measure of hope. *J Pers Soc Psychol.* 1991; 60(4):570-585. https://doi.org/10.1037//0022-3514.60.4.570
20. Akman Y, Korkut F. A study on the Hope Scale. *H U Journal of Education.* 1993; 9:193-202. https://dergipark.org.tr/tr/pub/hunefd/issue/7828
21. Nunez-Mulder L. Researcher cautions against initiatives to reduce student suicide that lack evidence. *BMJ.* 2018;362:k3969. https://doi.org/10.1136/bmj.k3969
22. Wang X, Hegde S, Son C, Keller B, Smith A, Sasangohar F. Investigating mental health of US college students during the COVID-19 pandemic: Cross-sectional survey study. *J Med Internet Res.* 2020;22(9):e22817. https://doi.org/10.2196/22817
23. Lageborn CT, Bjureberg J, Song J, et al. Risk of suicide and self-harm in university students entering different university programs–a national register-based cohort study in Sweden. *Soc Psychiatry Psychiatr Epidemiol.* 2023;58(8):1139-1149. https://doi.org/10.1007/s00127-023-02484-2
24. Moscardini EH, Oakey-Frost DN, Robinson A, et al. Entrapment and suicidal ideation: The protective roles of presence of life meaning and reasons for living. *Suicide Life Threat Behav.* 2021;52(1):14-23. https://doi.org/10.1111/sltb.12767
25. Lew B, Huen J, Yu P, et al. Associations between depression, anxiety, stress, hopelessness, subjective well-being, coping styles and suicide in Chinese university students. *PloS one.* 2019;14(7):e0217372. https://doi.org/10.1371/journal.pone.0217372
26. Gunnell D, Caul S, Appleby L, John A, Hawton K. The incidence of suicide in University students in England and Wales 2000/2001–2016/2017: Record linkage study. *J Affect Disord.* 2020; 261:113-120. https://doi.org/10.1016/j.jad.2019.09.079.
27. Kavradım ST, Özer ZC. Hope in patients with Cancer. *Current Approaches in Psychiatry*. 2014;6(2):154-164. https://doi.org/10.5455/cap.20130901084242
28. Wyatt TJ, Oswalt SB, Ochoa Y. Mental health and academic performance of first-year college students. *International Journal of Higher Education.* 2017;6(3):178-187. https://doi.org/10.5430/ijhe.v6n3p178
29. Horgan A, Kelly P, Goodwin J, Behan L. Depressive symptoms and suicidal ideation among Irish undergraduate college students. *Issues Ment Health Nurs.* 2018;39(7):575-584. https://doi.org/10.1080/01612840.2017.1422199
30. McLaughlin JC, Gunnell D. Suicide deaths in university students in a UK city between 2010 and 2018–Case series. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*. 2021;42(3):171-178. https://doi.org/10.1027/0227-5910/a000704
31. Sun L, Zhou C, Xu L, Li S, Kong F, Chu J. Suicidal ideation, plans and attempts among medical college students in china: the effect of their parental characteristics. *Psychiatry Research.* 2017;247:139-143. https://doi.org/10.1016/j.psychres.2016.11.024
32. Gui Z, Ren X, Li X, Zhou C, Sun L. Parents' parenting styles differences are associated with lifetime suicidal ideation: Evidences from the Chinese medical college students. *Journal of Health Psychology*. 2021;27(10):2420-2434. https://doi.org/10.1177/13591053211044532
33. Lee E, Kim KY. The association between secondhand smoke and stress, depression, and suicidal ideation in adolescents. *Healthcare (Basel).* 2021;9(1):39. https://doi.org/10.3390/healthcare9010039
34. Wang M, Kou C, Bai W, et al. Prevalence and correlates of suicidal ideation among college students: a mental health survey in Jilin Province, China. *J Affect Disord.* 2019;246:166-173. https://doi.org/10.1016/j.jad.2018.12.055
35. Gselamu L, Ha K. Attitudes towards suicide and risk factors for suicide attempts among university students in South Korea. *J Affect Disord.* 2020;272:166-169. https://doi.org/10.1016/j.jad.2020.03.135
36. National Confidential Inquiry into Suicide and Homicide (NCISH) by People with MentalIllness,7. Accessed 26.03.2022 https://documents.manchester.ac.uk/display.aspx?DocID=37560
37. Kim G, Cha S. A predictive model of suicidal ideation in Korean college students. *Public Health Nurs.* 2018;35(6):490-498. https://doi.org/10.1111/phn.12541
38. Uchida C, Uchida M. Characteristics and risk factors for suicide and deaths among college students: A 23-year serial prevalence study of data from 8.2 million Japanese college students. *J Clin Psychiatry.* 2017;78(4):e404-e412. https://doi.org/10.4088/JCP.16m10807.

ATATÜRK ÜNİVERSİTESİ YAYINLARI
ATATURK UNIVERSITY PUBLICATIONS

Research Article *Araştırma Makalesi* DOI: 10.17049/jnursology.1431267

Difficulties Experienced by Mothers in Newly Diagnosed Type 1 Diabetes Mellitus: A Phenomenological Study

Yeni Başlangıçlı Tip 1 Diabetes Mellitusta Annelerin Yaşadıkları Güçlükler: Fenomenolojik Bir Çalışma

Melike TAŞDELEN BAŞ[1]
Nebahat BORA GÜNEŞ[2]
Nurdan YILDIRIM[3]
Semra ÇETİNKAYA[4]

[1]Selcuk University Aksehir Kadir Yallagoz Health School, Department of Nursing Konya, Türkiye
[2]Hacettepe University Faculty of Nursing, Department of Child Health and Diseases Nursing, Ankara, Türkiye
[3]Ministry of Health Etlik City Hospital Ankara, Türkiye
[4] University of Health Sciences Dr Sami Ulus Childrens Health and Diseases Health Implementation and Research Center, Ankara, Türkiye

ABSTRACT

Objective: The aim of this study was to explore the experiences of mothers of newly diagnosed Type 1 Diabetes Mellitus (T1DM) children, to identify the difficulties mothers face in diabetes care, and to identify appropriate solutions.

Methods: Mothers of children aged 6-12, who have been newly diagnosed with T1DM, have been included in the workforce due to the adaptation period for school. Online interviews were conducted with the mothers using a phenomenological research design and hermeneutic phenomenological approach.

Results: It was determined that the mothers had concerns about their children diagnosed with T1DM, that the children diagnosed with T1DM had concerns about their siblings, and additionally, they had psychosocial problems. The reasons for these concerns and problems are restrictions or rules, the approaches of the child's friends, and the attitudes of individuals in society. The resources that mothers receive support from in the process are family, friends, health professionals, school administration, school teachers, and a school nurse.

Conclusion: As a result, it was concluded that the school management and teachers, health team, social awareness, psychosocial support groups, and technological developments are or will benefit from them, and that these resources are important in supporting mothers and children to cope with T1DM and increasing positive experiences in follow-up.

Keywords: Type 1 diabetes mellitus, newly diagnosed, mother, psychosocial support

ÖZ

Amaç: Bu çalışmada, yeni Tip 1 diyabetes mellitus (T1DM) tanısı almış çocukların annelerinin deneyimlerini incelemek, annelerin diyabet bakımı sürecindeki zorluklarını belirlemek ve uygun çözüm yollarını belirlemek amaçlanmıştır.

Yöntemler: Yeni T1DM tanısı konulmuş, okula uyum dönemi olduğundan 6-12 yaş aralığındaki çocukların anneleri çalışmaya dahil edildi. Anneler ile fenomenolojik araştırma deseni ve hermenötik fenomenolojik yaklaşım kullanılarak çevrimiçi görüşme yapıldı.

Bulgular: Annelerin T1DM tanısı almış çocuklarına ilişkin kaygıları olduğu, T1DM tanısı almış çocukların kardeşlerine yönelik kaygıları olduğu ve ek olarak psikososyal sorunlar yaşadıkları saptandı. Bu kaygı ve sorunların nedenlerinin; kısıtlamalar/kurallar, bilinmezlik, çocuğun arkadaşlarının yaklaşımları ve toplumdaki bireylerin yaklaşımları olduğu belirlendi. Annelerin süreçte destek aldıkları kaynakların; aile, arkadaşlar, sağlık profesyonelleri, okul yönetimi, okul öğretmenleri, okul hemşiresi olduğu bulundu.

Sonuç: Sonuç olarak, yeni tanı T1DM tanılı çocuğu olan annelerin; okul yönetimi ve öğretmenlerden, sağlık ekibinden, toplumsal bilinçten, psikososyal destek gruplarından ve teknolojik gelişimlerden fayda gördüğü/göreceği, bu kaynakların anne ve çocukların T1DM ile başa çıkmasını desteklemekte ve izlemdeki olumlu deneyimleri arttırmakta önemli olduğu sonucuna varıldı.

Anahtar Kelimeler: Tip 1 Diabetes mellitus, yeni tanı, anne, psikososyal destek

Geliş Tarihi/Received 03.02.2024
Revizyon Tarihi/Revised 23.05.2024
Kabul Tarihi/Accepted 06.06.2024
Yayın Tarihi/Publication Date 25.06.2024

Sorumlu Yazar/Corresponding author:
Melike TAŞDELEN BAŞ
E-mail: meliket@gmail.com

Cite this article: Baş MT, Güneş NB, Difficulties experienced by mothers in newly diagnosed type 1 diabetes mellitus: A phenomenological study. *J Nursology*. 2024;27(2):120-128.

INTRODUCTION

Type 1 diabetes mellitus (T1DM) is a prevalent chronic disease in children, with an incidence of 15 per 100,000 globally.[1,2] Diagnosed typically in childhood and adolescence, managing T1DM involves rigorous blood glucose monitoring and insulin administration to maintain optimal glucose levels, minimize hypoglycemia, and prevent long-term complications.[3] Initially, parents handle all diabetes management tasks until the child turns 8, after which children gradually assume more responsibility. Despite this, parents continue to bear a significant burden throughout adolescence.[4] Understanding parents' perspectives on treatment and daily challenges is crucial for effective management.[5]

The diagnosis of T1DM in childhood is a stressful period for both the child and their parents, emphasizing the continuous nature of diabetes management.[6] Treating children with T1DM requires daily medical decisions and technical procedures that start immediately upon diagnosis and affect every aspect of family life.[7] Mothers often bear the primary responsibility for diabetes care, experiencing feelings of abandonment, loneliness, and uncertainty, while fathers typically take on more household tasks to support them.[8,9] Many studies highlight the significant psychological burden on parents at the time of their child's diagnosis and shortly thereafter.[10-12]

The continuous care required for T1DM poses additional challenges during school hours when children are away from their families.[13] Responsibility shifts from parents to children and teachers, potentially leading to inconsistencies in care. Mothers often need support in explaining T1DM to their peers, collaborating with teachers, engaging in activities, and managing diet and carbohydrate intake.[14] Many school staff members are not adequately trained to handle emergencies and hypoglycemic events, exacerbating family difficulties.[15] International Society for Pediatric and Adolescent Diabetes (ISPAD) guidelines[16] stress the importance of family involvement in managing diabetes, and studies show that effective family support significantly improves diabetes management in children.[17,18]

Managing family processes is crucial when a child is diagnosed with T1DM. Mothers often experience shock, intense anger, and denial, bearing more responsibility than fathers. Understanding mothers' experiences allows healthcare professionals to better support families.

AIM

The objective is to evaluate how mothers of children with T1DM feel at the time of diagnosis.

METHODS

Study Design

This hermeneutic phenomenological study focused on the experiences of mothers with children aged 6-12 newly diagnosed with T1DM. Using purposive sampling, mothers whose children were treated at a pediatric endocrinology outpatient clinic in Ankara, Türkiye, were invited to participate. Inclusion criteria were having a child newly diagnosed with T1DM, aged 6-12, mothers without mental illness, ability to conduct online interviews, and voluntary participation.

Participants

The study was conducted with 13 mothers living in Türkiye with children aged 6 to 12 years who were newly diagnosed with T1DM. Relevant introductory characteristics of the mothers and children are listed in Table 1.

Table 1. Characteristics of the Participants

Participant code	Age of participant	Participant's educational status	Number of children in the family	Child's diagnosis age	Age of child	Gender of the child
P1	45	University	2	5 months	10	Boy
P2	40	University	2	9 months	5	Girl
P3	32	High School	3	5 months	7	Girl
P4	38	High School	2	6 months	9	Girl
P5	51	University	2	7 months	11	Boy
P6	42	Primary School	4	7 months	11	Boy
P7	29	High School	3	8 months	8	Girl
P8	31	Middle School	3	8 months	7	Boy
P9	36	High School	2	7 months	8	Boy
P10	41	University	1	4 months	11	Girl
P11	48	University	1	2 months	10	Boy
P12	37	University	2	6 months	10	Girl
P13	39	High School	1	3 months	11	Boy

Data Collection

The COREQ guide was used for the study's design, data collection, analysis, and reporting. A pediatric nurse practitioner with a doctorate and qualitative research experience collected the data. Participants were randomly selected, completed an introductory questionnaire, and were interviewed via Zoom.

Table 2. Semi-Structured Focus Interview Questions

1. "How did you feel when your child was diagnosed with T1DM?"
2. "What challenged you most when you first learned of the diagnosis?"
3. "What changes have occurred in your life after diagnosis and discharge from the hospital?"
4. "What were the factors that made it more difficult or easier for you to adjust during this process?"
5. "How do you think we can make this process more comfortable for you?

To ensure comfort and privacy, interviews were conducted in a secure, private environment. Three researchers participated: one asked questions, and two took notes. Focus group interviews were recorded online, and participants consented to open-ended questions in a semi-structured format.

After participants provided consent, the researcher utilized a semi-structured focus group interview format, posing open-ended questions as outlined in Table 2.

Study data were collected between June and September 2022. Each interview lasted between 80 and 100 minutes. In total, the study was completed with four interviews and 13 participants, with the data reaching saturation.

Data Analysis

The thematic analysis method was used to analyze the data. Two researchers conducted the analysis jointly, while the other two researchers analyzed the data independently. Researchers reviewed decoded interviews, coded each interview, and identified important statements. Data collection concluded after the fourth focus group meeting, as important statements were reiterated and deemed satisfactory. Analysis was performed manually by researchers without software assistance.

Precision and Reliability of Study Data

The study ensured data accuracy and reliability following principles of credibility, reliability, confirmability, transferability, and transparency. Three researchers held master's or PhD degrees in pediatric nursing, while the fourth was a pediatric endocrinology physician. After each focus group discussion, participants received transcripts to verify accuracy and clarity of their statements before analysis. Thematic analysis was independently conducted by researchers to ensure reliability.

Ethical Considerations

The ethical suitability of the study was reviewed by Hacettepe University Non-interventional Clinical Research Ethics Committee (Date: May 10, 2022, Decision No. 2022/08-20). After approval by the Ethics Committee, the study was announced, and participants who volunteered to participate were informed by the researchers, and their verbal consent was obtained first, followed by their online consent.

RESULTS

The categories, themes, and subthemes that emerged from the thematic analysis of the data after the focus group interview are listed in Table 3.

Negative Experiences / Difficulties

One mother succinctly articulated her fear of stigmatization as follows: "……. *for example, my child heard his friends say "he is sick, he faints, he should not be in our team". Everyone labels the child as sick. When he doesn't have such a thought, he gets the thought that I'm sick, I can't do it."* Another mother, regarding her child's physiological losses and concerns about her future, said, *"When I think about what happens in his body in hypoglycemia and hyperglycemia, I feel like going crazy. Let's see what else he will have to give up in the future. I don't know if he will be able to do the job he wants. Undoubtedly, this situation will affect even the choice of spouse"*

Second, theme is " Worries regarding the sick child". Two mothers stated that other children were deprived of attention and their routines changed as follows. *"I mean, for example, because her sister is older, she can do anything. But my little boy is 3 years old and let's check out mom A's blood glucose. I mean, he says if we can eat it, let's eat this". "So you don't want to be unfair to your other children, but on the other hand, A is more prominent". "For example, her older sister or younger brother eats whatever A eats. So it's such a depressing situation. We don't have any of our old order at home"*

Table 3. Themes and Sub-Themes of Mothers' Difficulties in Newly Diagnosed T1DM

Categories	Themes	Subthemes
Negative Experiences/ difficulties	Worries regarding the sick child	Future
		Physiological losses
		Fear of stigmatization
		Worries about child's death
	Worries for siblings	Disinterestedness
		Change in daily routines
		Fear of having diabetes
	Psychosocial problems of the mother	State of self-blame
		Anxiety
		Overloading
		Feeling of loneliness
		Feeling of helplessness
Factors causing difficulties	Restrictions / Rules	
	Obscurity	
	Peer approach	Stigma
	Other social environment approaches	Lack of empathetic approach
		Ignorance
		Make it dramatic
		Blame
Support resources	Family	The child herself /himself
		Siblings
		Husband
	Friends	Child's friends
		The mother's friends
	Health professionals	
	School administration and teachers	Interest and communication
		Support and arrangement of care
	School nurse and infirmary presence	
	Other children with T1DM	At diagnosis/in hospital
		At school/social environment
Support resources	Technological innovations	Provide instant tracking
		Get reliable results
Expectations and recommendations	School administration and teachers	
	Healthcare team	Extending education and change over a longer period of time
		Empathetic approach
		Professionalism of the healthcare team in diabetes
	Social consciousness	Adult public service announcements
		Placing information in favorite programs
		School education
	Psychosocial support groups	For mothers
		For children
	Technological development	Application
		Virtual social network support
		Treatment

Finally, the psychosocial problems of mothers were discussed under this theme. One mother expressed her feelings of guilt as follows: *"On the one hand, I think I might have done something wrong. We know how it happens, but I can't explain it to myself. I am constantly questioning myself whether I am doing everything right now. I get angry with myself if my child's blood sugar drops or goes up."*

One mother expressed her feelings of helplessness as follows: *"Every time I go, I still ask the doctor, do you ever have a patient who is well? Do you have any patients recovering? Every time I go, I still persistently ask this question. I still haven't accepted it."* A mother explained that her burden was too much with the following words: *".....will I be able to run this process? Can I make insulin at home? Will I make my child's condition worse? You have to think about all of these, so for example, fathers are not as responsible as mothers. Fathers are a little more comfortable, but not so for mothers. It also gets harder when you work."*

Another mother expressed her burden and loneliness as follows*: "Because, as I said, we all have two or three*

children. This also affects other children. In other words, since everyone is affected, the pressure is greater. Especially on the mother. Sometimes you do not even know who to catch up with.""".....this is means my child is on my mind 24 hours a day. I am sure no mother in our old order ever slept uninterrupted. Preparing food, managing the process....."

Factors Causing Difficulties

One mother expressed that restrictions /rules are a difficulty factor as follows: *"In the beginning, we had a hard time because we were going by the clock. We didn't let on that we were struggling, but it was very difficult."* Many mothers indicated that they see the unknown as a source of difficulty in the T1DM diagnostic process. Some mother expressions are as follows: *"...if only the doctor had explained that you would make this much insulin for such and such meals. The dose to make insulin and how much is up to you. It's something you don't know. We have never injected before. It was a very difficult process, of course". "It's a really difficult situation. For example, will my child be able to be discharged from the PICU? We do not know the disease. Believe me, it is very difficult."*

Mothers indicated that peer interaction with their children can also be an important source of difficulty in the new diagnosis process. One mother said, *"...for example, she was picked on a lot. 'You're always sick, A. Are you sick?' they asked. I also told the teacher to inform A's friends so that he doesn't face any difficulties."*

Social environment approaches, such as spouses, friends, relatives, and neighbors, were also found to be a source of difficulty in the process of rediagnosis. The mothers described their experiences in this regard as follows: *"Then explain it to the children like this, but for example, what happens when the adults eat it, so what happens, what will happen when they eat it?", "There is something you are very sad about, A. We are very sorry for you. That was what worried me the most. Those who come to get well quickly with baklava. Some also brought chocolate.", "The people around me ate chips, was it because of these children? Did you eat too much sugar? Has it gotten better? Is it over? It would be better if there were no such questions from our environment..."*

Support Resources

Under the theme of family, the first sub-theme in this category, mothers noted that they can receive support in numerous ways from all family members, including the child themselves, siblings, and spouses:*"...My eldest son was my savior in every way. How can I explain this? I knew from the first moment that you were very upset, but those words... We'll work it out together, Mom, we'll work it out, won't we, Mom? of course there were many questions and concerns, but especially in the beginning. He opened and read something on the Internet. Later, the questions also became less. My husband was very supportive, I can't deny that. But my oldest son stood by me like a lion". "A much more understanding child, intelligent, able to do anything he was told. For example, we started school, talked with our teacher, constantly exchange information. D. is already able to make his own insulin at school. Fortunately, we haven't had any problems with that. We'll have to live with it. I hope that with the help of our teachers, nurses and children, we'll make it to better times."*

On the theme of friends, the second theme in this category, the mothers expressed that they receive support from the child's friends and their friends, saying, *"When we come home, their friends blow up balloons, ornaments, and things like that. They celebrated when they saw that S. was very happy. He was in need of it."*

In the category of support resources, the theme of health professionals was raised. One mother expressed the support she received from health professionals as *"….Mrs. İ., She was our training nurse. She is a very understanding woman. He explained everything to me in detail, she taught me in detail. I consider myself very lucky in this respect."*

The involvement of school management and teachers. One mother expressed the good communication she had with her teacher in these words, *"Actually, it was our teacher who comforted us a little bit. We have a sensor, but in fact, sometimes there may be a problem with the sensor, the blood device is in the him pocket. If there is a problem, she looks at the WhatsApp message Ms. A. (teacher). She takes care of it immediately. She sets up a separate room. Fortunately, we have a teacher in charge. It's very reassuring."* Another mother stated that the school administration supported the care by making the necessary arrangements in the school as follows, *"Our principal organized a refrigerator for me. I put a spare blood meter in the room. I put a Humalog insulin in it. I wrote note everywhere that says, "Do not unplug the refrigerator".*

Another theme in this category was the presence of a nurse and a infirmary in the school. One mother expressed her support for this theme by saying, *".....the school has a nurse's station. And the school is a big school, and they have experience in this regard. There are other diabetic children in the school. That is why A. doesn't have insulin with him. One of his Humalog insulin is in the infirmary. With that in mind, you know, they set up a system like this to make us feel comfortable in the school."*

Presence of neighborhood and school peers with T1DM.

One mother expressed the support she received from another T1DM Patient at the time of diagnosis in these words, *"…….And then there was B., who had T1DM. That was very helpful for A. Because A could not accept the disease at first. I mean, she cried a lot, she never got her first insulin or anything. B was already using a pump. He showed it himself, so I know, I use it too. He helped us a lot."*

Finally, in this category, mothers reported that technological innovations are a source of support because they allow immediate follow-up and provide reliable results. One mother made the following comment about the sensor, *"...the data comes from my sensor to my phone. This way I can continue the process conveniently. Otherwise, it would be very difficult to start working or something."*

Expectations and Recommendations

In this category, they indicated that they expect school administrators and teachers to organize training to recognize and intervene in the symptoms of T1DM, which includes all staff and students, and to make the necessary physical arrangements for teachers, nurses, and school staff to support the care of the child in school to manage the child's diabetes*. "... so now the child is not always with his teacher. What happens if his blood glucose level drops in the bathroom or in the backyard and he passes out? In other words, I am not saying that everyone in front of them should be able to check blood glucose and give a shot, but this child's blood glucose drops, he faints, his sugar comes out, he faints, so those in the know should" "...our children have diabetes and they need help. Teachers can not know everything. So there are a lot of people who say, "I can not do this. I can not take that responsibility. There are a lot of people who say, I am not going to take this on. Imagine your child faints at school, and the teacher says, I can not do that. They called the ambulance, but your child could not be treated until the ambulance arrived. I mean, I do not even want to think about it"*

Another theme in this category was expectations of the healthcare team. One mother expressed her expectation that education and change would take place over a longer period of time, *"The child had a hard time at the beginning. I do not think there is such a thing. It's not right to smother children all at once and deprive them of the things they love. If the child eats something, we are aware of it, but I have gone through this a lot. For example, he had a crisis. He wanted dessert."*

In the category of expectations, the third theme was the acquisition of social awareness. One mother expressed her expectation as follows, *"...sooner both teachers and students can be informed about chronic diseases in this way, at least in schools. For example, English lesson. Now it starts in first grade and continues in second grade. The kids can understand that. I think they can understand that, too. I would request that they be taught that as a little lesson, even if it's superficial."*

In the expectations and recommendations category, the fourth theme identified was psychosocial support groups. The subthemes of psychosocial support for mothers and children among psychosocial support groups were determined with the following statements: *"..... But now that I'm listening to friends like that, I'm looking at that, that's really good for me. I also felt the need to speak. I wish this would have happened sooner."".....though there is no child with type 1 diabetes near me. Something else you don't know the name of seems foreign. Those drug names over there, for example, Novorapid. I had a hard time pronouncing them. I'm going to learn it as I live and practice."*

Under the theme of technological development, subthemes such as various mobile applications for T1DM, the establishment of professionally moderated social networks in the virtual realm, and technological advancements for treatment were identified within the category of expectations and recommendations. One mother succinctly expressed this expectation with the following words: "*It makes our lives easier. When the child is outside eating a hamburger, I say, stop now, let's get her and go home. Let's go home and weigh some sandwiches. At least I'm not torturing the kid by saying, let's separate this from the meatballs, let's look at the potatoes or something."*

DISCUSSION

In this study, four main categories were identified: "negative experiences/difficulties," "factors causing difficulties," "support resources," and "expectations and recommendations." Initially, the category "negative experiences/difficulties" emerged due to the anxiety mothers felt after their children's T1DM diagnosis and the fear of potential stigmatization. Similar findings were reported by Khandan et al. (2018), who observed that mothers of diabetic children experience high levels of anxiety and face challenging circumstances. Additionally, our study revealed that mothers of children with T1DM experience significant anxiety, consistent with the findings of previous research.[20] Another study indicated that mothers also experience general stress and parenting stress related to the disease. [21] Similarly, Rossiter et al. (2019) found that parents experience anxiety and fear

regarding potential stigmatization of their children.[22] The "negative experiences/difficulties" category encompasses concerns about the future, physiological losses, stigmatization, and fear of losing the child. These challenges faced by mothers may stem from inadequate support systems during the diagnostic process. Many parents undergo significant stress following their child's initial diagnosis, with depressive symptoms often worsening over time.[24] Offering emotional support, education, practical resources, and financial assistance can enhance the well-being of both parents and children, resulting in improved diabetes management and overall quality of life. Lack of support networks for parents to share their difficulties and negative thoughts can exacerbate these challenges further.

The second category, "factors causing difficulties," was identified. Within this category, themes such as restrictions and exceeding rules due to the disease, ambiguity, peer and societal attitudes towards the children, emerged. Managing T1DM involves adherence to numerous rules and regulations.[25] Parents often find meal preparation for their children particularly challenging. Key aspects of diabetes management include adjusting insulin doses, modifying diet, following exercise recommendations, monitoring blood glucose levels day and night, and providing constant supervision.[4] These requirements can intensify the caregiving burden and create challenges in disease management. Conversely, in a study involving 11-year-old children with T1DM, parents noted concerns about situations like sleepovers, despite wanting their children to feel capable and independent.[26] Mothers also express concern that their children may believe their diabetes will impact their future opportunities.[22] Moreover, they worry about society's inappropriate attitudes towards their children's condition. Studies have shown that many parents fret over how diabetes will influence their children's future prospects.[19,27,28] The diagnosis of T1DM in a child can be emotionally overwhelming for mothers, leading to feelings of shock, guilt, anxiety, and stress. Additionally, mothers may struggle to acquire the necessary knowledge and skills to effectively manage their child's diabetes. Comprehensive education, emotional support, practical tools, and resources from healthcare professionals can empower mothers to navigate the complexities of their child's T1DM condition successfully.

The third category, "support resources," was identified. Based on interview data, sources of support included family, friends, healthcare professionals, school administrators and teachers, school nurses, other children with T1DM, and technological innovations. Lindström et al. (2017) discovered that parents received support from relatives who lacked knowledge of the disease.[28] While one study highlighted ample support from Facebook groups, others noted difficulties in accessing professional diabetes teams.[19,30] Parents also reported insufficient education about diabetes after their child's diagnosis, receiving conflicting messages from different medical professionals, which exacerbated their psychological and emotional distress.[31] Rankin et al. (2016) found that parents felt overwhelmed post-diagnosis and required more emotional support before receiving specific guidance on training and nutrition for managing their child's diabetes.[32] A study in Saudi Arabia underscored the need for tailored support methods addressing the psychosocial and cultural needs of newly diagnosed children and their mothers.[33] Mothers of children with T1DM play a pivotal role in helping their children cope with challenging responsibilities, emphasizing the importance of recognizing and addressing their support needs.

The fourth category, "expectations and recommendations," was identified. Within this category, mothers expressed expectations of the school administration, healthcare team, society, support groups, and advancements in technology. Mothers emphasized the importance of effective communication and receiving information from staff at their children's school or daycare regarding physical activity and nutrition.[14] However, many school staff lacked training in diabetes management, as highlighted in several studies.[15] Parents stressed the significance of schools in successfully managing their child's diabetes, noting that better-trained school staff and teachers resulted in improved monitoring and control of their children's blood glucose levels, providing parents with peace of mind. Additionally, positive relationships with the healthcare team motivated parents to adhere to diabetes care protocols.[34] Some parents experienced increased anxiety due to the desire to constantly monitor their child's blood glucose levels, leading to greater use of diabetes technology and associated expectations.[35] Moving forward, it is crucial to assess and implement the recommended actions to effectively meet these mothers' expectations and create an environment supportive of their children's well-being and success. By actively evaluating and integrating these recommendations, improvements can be made to the overall support system, enhancing the quality of life for both mothers and children living with T1DM.

Strenghts and Limitations of the Study

The study's strength lies in the researchers not being primary care providers, ensuring unbiased interviews. Participants were not pre-interviewed, and contacts were made and interviews completed on the same day by telephone, conducted sensitively and nonjudgmentally.

This facilitated participants' ease of expression. However, the results may not generalize to populations with different sociodemographic characteristics, necessitating further studies for confirmation.

Etik Komite Onayı: Bu çalışma için Hacettepe Üniversitesi etik kurulundan etik kurul onayı alınmıştır (Tarih: 10 Mayıs 2022, Karar No: 2022/08-20).
Bilgilendirilmiş Onam: Araştırmaya katılan annelerden online onay alındı.
Hakem Değerlendirmesi: Dış bağımsız.
Yazar Katkıları: Fikir- MTB, NBG; Tasarım- MTB, NBG, NY, SÇ; Denetleme- MTB, NBG, NY; Kaynaklar- MTB, NBG, NY, SÇ; Veri Toplanması ve/veya İşlemesi MTB, NBG, NY, SÇ; Analiz ve/ veya Yorum- MTB, NBG, NY, SÇ; Literatür Taraması- MTB, NBG, SÇ; Yazıyı Yazan- MTB, NBG, NY, SÇ; Eleştirel İnceleme- MTB, NBG, NY, SÇ.
Çıkar Çatışması: Yazarlar, çıkar çatışması olmadığını beyan etmiştir.
Finansal Destek: Yazarlar bu çalışma için finansal destek almadıklarını beyan etmişlerdir.

Ethics Committee Approval: Ethics committee approval was received for this study from the ethics committee of Hacettepe University (Date: May 10, 2022, Decision No. 2022/08-20).
Informed Consent: Online consent was obtained from the mothers participating in the study.
Peer-review: Externally peer-reviewed.
Author Contributions: Concept- MTB, NBG; Design- MTB, NBG, NY, SÇ; Supervision- MTB, NBG, NY; Resources- MTB, NBG, NY, SÇ; Data Collection and/or Processing- MTB, NBG, NY, SÇ; Analysis and/or Interpretation- MTB, NBG, NY, SÇ; Search- MTB, NBG, SÇ; Writing Manuscript- MTB, NBG, NY, SÇ; Critical Review- MTB, NBG, NY, SÇ.
Conflict of Interest: The authors have no conflicts of interest to declare.
Financial Disclosure: The authors declared that this study has received no financial support.

REFERENCES

1. Insel RA, Dunne JL, Atkinson MA, et al. Staging presymptomatic type 1 diabetes: a scientific statement of JDRF, the Endocrine Society, and the American Diabetes Association. *Diabetes Care*. 2015;38(10):1964-1974. https://doi.org/10.2337/dc15-1419
2. Mobasseri M, Shirmohammadi M, Amiri T, Vahed N, Fard HH, Ghojazadeh M. Prevalence and incidence of type 1 diabetes in the world: a systematic review and meta-analysis. *Health Promot Perspect.* 2020;10(2):98-115. https://doi.org/10.34172/hpp.2020.18
3. Association AD. Standards of medical care in diabetes-2021 abridged for primary care providers. *Clin Diabetes*. 2021;39(1):14-43. https://doi.org/10.2337%2Fcd21-as01
4. Streisand R, Monaghan M. Young children with type 1 diabetes: Challenges, research, and future directions. *Curr Diab Rep.* 2014;14:520. https://doi.org/10.1007%2Fs11892-014-0520-2
5. Patterson CC, Dahlquist GG, Gyürüs E, Green A, Soltész G. Incidence trends for childhood type 1 diabetes in Europe during 1989–2003 and predicted new cases 2005–20: a multicentre prospective registration study. *Lancet*. 2009;373(9680):2027-2033. https://doi.org/10.1016/s0140-6736(09)60568-7
6. Rifshana F, Breheny M, Taylor JE, Ross K. The parental experience of caring for a child with type 1 diabetes. *J Child Fam Stud.* 2017;26(11):3226-3236. https://doi.org/10.1007/s10826-017-0806-5
7. Sullivan-Bolyai S, Deatrick J, Gruppuso P, Tamborlane W, Grey M. Constant vigilance: Mothers' work parenting young children with type 1 diabetes. *J Pediatr Nurs*. 2003;18(1):21-29. https://doi.org/10.1053/jpdn.2003.4
8. Sullivan-Bolyai S, Deatrick J, Gruppuso P, Tamborlane W, Grey M. Mothers' experiences raising young children with type 1 diabetes. *J Spec Pediatr Nurs*. 2002;7(3):93-103. https://doi.org/10.1111/j.1744-6155.2002.tb00158.x
9. Sparud-Lundin C, Hallström I, Erlandsson L-K. Challenges, strategies, and gender relations among parents of children recently diagnosed with type 1 diabetes. *J Fam Nurs.* 2013;19(2):249-273. https://doi.org/10.1177/1074840713484386
10. Bassi G, Mancinelli E, Di Riso D, Salcuni S. Parental stress, anxiety and depression symptoms associated with self-efficacy in paediatric type 1 diabetes: a literature review. *Int J Environ Res Public Health.* 2021;18(1):152. https://doi.org/10.3390/ijerph18010152
11. Fornasini S, Miele F, Piras EM. The consequences of type 1 diabetes onset on family life. An integrative review. *Journal of Child and Family Studies*. 2020;29:1467-1483. https://doi.org/10.1007/s10826-019-01544-z
12. Gallegos E, Harmon KB, Lee G, Qi Y, Jewell VD. A descriptive study of the quality of life and burden of mothers of children and adolescents with type 1 diabetes. *Occup Ther Health Care.* 2022:1-17. https://doi.org/10.1080/07380577.2022.2038401
13. Markowitz JT, C Garvey K, MB Laffel L. Developmental changes in the roles of patients and families in type 1 diabetes management. *Curr Diabetes Rev.* 2015;11(4):231-238. http://dx.doi.org/10.2174/1573399811666150421114146
14. Herbert LJ, Clary L, Owen V, Monaghan M, Alvarez V, Streisand R. Relations among school/daycare functioning, fear of hypoglycaemia and quality of life in parents of young children with type 1 diabetes. *J Clin Nurs.* 2015;24(9-10):1199-1209. https://doi.org/10.1111/jocn.12658
15. Silistre ES, Hatipoğlu HU. İstanbul'daki Okullarda Çalişan Öğretmenlerin Tip 1 Diyabet Hakkindaki Genel Bilgi Durumlarinin Değerlendirilmesi: Dört Yillik Diyabet Eğitim Programinin Etkileri. Kesitsel Bir Çalişma. *IAAOJ*. 2019;5(2):128-136. https://dergipark.org.tr/tr/pub/iaaojh/issue/43801/509032
16. Shah AS, Zeitler PS, Wong J, et al. ISPAD Clinical Practice Consensus Guidelines 2022: Type 2 diabetes in children and adolescents. *Pediatr Diabetes*. 2022;23(7):872-902. https://doi.org/10.1111/pedi.13409

17. Gruhn MA, Lord JH, Jaser SS. Collaborative and Overinvolved Parenting Differentially Predict Outcomes in Adolescents With Type 1 Diabetes. *Health Psychol.* Mar 21 2016; https://doi.org/10.1037/hea0000349
18. Wu YP, Hilliard ME, Rausch J, Dolan LM, Hood KK. Family involvement with the diabetes regimen in young people: the role of adolescent depressive symptoms. *Diabet Med.* 2013;30(5):596-602. https://doi.org/10.1111/dme.12117
19. Khandan M, Abazari F, Tirgari B, Cheraghi MA. Lived experiences of mothers with diabetic children from the transfer of caring role. *Int J Community Based Nurs Midwifery*. 2018;6(1):76.
20. Duru N, Civilibal M, Elevli M. Quality of life and psychological screening in children with type 1 diabetes and their mothers. *Exp Clin Endocrinol Diabetes.* 2015:105-110. https://doi.org/10.1055/s-0035-1555938
21. Van Gampelaere C, Vervoort T, Luyckx K, De Paepe A, Van Aken S, Goubert L. Maternal distress in the context of their child's type 1 diabetes: Exploring the role of adaptive maternal emotion regulation on child outcomes. *Psychol Health Med.* 2018;23(3):337-346. https://doi.org/10.1080/13548506.2017.1394475
22. Rossiter RC, Cooper JL, Marjei SI, Brownie S. Case-based insights: Arab Muslim mothers' experiences of managing a child newly diagnosed with type 1 diabetes mellitus. *SAGE Open Nurs.* 2019;5:2377960819870979. https://doi.org/10.1177/2377960819870979
23. Costa-Cordella S, Luyten P, Cohen D, Mena F, Fonagy P. Mentalizing in mothers and children with type 1 diabetes. *Dev Psychopathol.* 2021;33(1):216-225. https://doi.org/10.1017/s0954579419001706
24. Noser AE, Dai H, Marker AM, et al. Parental depression and diabetes-specific distress after the onset of type 1 diabetes in children. *Health Psychol.* 2019;38(2):103. https://doi.org/10.1037/hea0000699
25. Tong H-J, Qiu F, Fan L. Parents' experience of caring for children with type 1 diabetes in mainland China: A qualitative study. *World J Clin Cases.* 2021;9(11):2478. https://doi.org/10.12998%2Fwjcc.v9.i11.2478
26. Smaldone A, Ritholz MD. Perceptions of parenting children with type 1 diabetes diagnosed in early childhood. *J Pediatr Health Care.* 2011;25(2):87-95. https://doi.org/10.1016/j.pedhc.2009.09.003
27. Elissa K, Bratt E-L, Axelsson ÅB, Khatib S, Sparud-Lundin C. Societal norms and conditions and their influence on daily life in children with type 1 diabetes in the West Bank in Palestine. *J Pediatr Nurs.* 2017;33:16-22. https://doi.org/10.1016/j.pedn.2016.12.005
28. Perez L, Romo LK, Bell T. Communicatively exploring uncertainty management of parents of children with type 1 diabetes. *Health Commun.* 2019;34(9):949-957. https://doi.org/10.1080/10410236.2018.1446249
29. Lindström C, Åman J, Norberg AL, Forssberg M, Anderzén-Carlsson A. "Mission Impossible"; the mothering of a child with type 1 diabetes–From the perspective of mothers experiencing burnout. *Journal of Pediatric Nursing*. 2017;36:149-156. https://doi.org/10.1016/j.pedn.2017.06.002
30. Boman Å, Povlsen L, Dahlborg-Lyckhage E, Hanas R, Borup I. Fathers' encounter of support from paediatric diabetes teams; the tension between general recommendations and personal experience. *Health Soc Care Community.* 2013;21(3):263-270. https://doi.org/10.1111/hsc.12013
31. Kimbell B, Lawton J, Boughton C, Hovorka R, Rankin D. Parents' experiences of caring for a young child with type 1 diabetes: a systematic review and synthesis of qualitative evidence. *BMC Pediatrics.* 2021;21(1):1-13. https://doi.org/10.1186/s12887-021-02569-4
32. Rankin D, Harden J, Jepson R, Lawton J. Children's experiences of managing Type 1 diabetes in everyday life: a thematic synthesis of qualitative studies. *Diabeti Med.* 2017;34(8):1050-1060. https://doi.org/10.1111/dme.13362
33. Asaad M, Forde R, AlFares A, Bin Abbas B, Sturt J. Experiences and needs of Saudi mothers when a child or adolescent is diagnosed with type 1 diabetes mellitus: a qualitative study. *Int J Qual Stud Health Well-being*. Dec 2022;17(1):2107151. https://doi.org/10.1080/17482631.2022.2107151
34. Bekker CI, Deacon E, Segal D. Meaning in life experienced by parents of children living with diabetes. *Health Psychol Open.* 2019;6(1):2055102919832221. https://doi.org/10.1177/2055102919832221
35. Edge J, Acerini C, Campbell F, et al. An alternative sensor-based method for glucose monitoring in children and young people with diabetes. *Arch Dis Child.* 2017;102(6):543-549. https://doi.org/10.1136/archdischild-2016-311530

ATATÜRK ÜNİVERSİTESİ YAYINLARI
ATATURK UNIVERSITY PUBLICATIONS

Araştırma Makalesi *Research Article* DOI: 10.17049/jnursology.1415548

Hemşirelik Öğrencileri için Klinik Muhakeme Ölçeğinin Türkçe Geçerliği ve Güvenirliği: Bir Metodolojik Çalışma

The Turkish Validity and Reliability of Clinical Reasoning Scale for Nursing Students: A Methodological Study

Betül BAL[1]
Nagihan KÖROĞLU KABA[2]
Havva ÖZTÜRK[3]

[1] Karadeniz Teknik Üniversitesi Sağlık Bilimleri Enstitüsü Hemşirelik Doktora Programı, Trabzon, Türkiye
[2] Bayburt Üniversitesi Sağlık Hizmetleri Meslek Yüksekokulu, Yönetim ve Organizasyon, Bayburt, Türkiye
[3] Karadeniz Teknik Üniversitesi Sağlık Bilimleri Fakültesi Hemşirelik Esasları ve Yönetim Anabilim Dalı, Trabzon, Türkiye

ÖZ

Amaç: Araştırmada Klinik Muhakeme Ölçeğinin Türkçeye uyarlanarak hemşirelik öğrencilerinde geçerlik ve güvenirliğinin değerlendirilmesi amaçlanmıştır.

Yöntemler: Metodolojik bir araştırma olan çalışma, İç Anadolu Bölgesinde bulunan bir üniversitedeki 271 hemşirelik öğrencisi ile yürütülmüştür. Veriler, Kişisel Bilgi Formu ve taslak halindeki 'Klinik Muhakeme Ölçeği' ile toplanmıştır. Ölçeğin dil ve kapsam geçerliği yapıldıktan sonra yapı geçerliği doğrulayıcı faktör analizi ile sağlanmıştır. Ölçeğin güvenirliği için Cronbach Alpha, madde-toplam korelasyonları, ayırt edicilik ve test-tekrar test yöntemleri kullanılmıştır.

Bulgular: Klinik Muhakeme Ölçeğinin klinik ipuçlarının farkındalığı, klinik sorunların doğrulanması, eylemlerin belirlenmesi ve uygulanması, değerlendirme ve yansıtma olmak üzere 4 alt boyutu ve toplam 16 maddelik yapısına ilişkin uyum indeksleri 0,90'ın üzerindedir ve bu sonuçlara göre ölçeğin yapısı geçerli kabul edilmiştir. Alt boyutların ortalama açıklanan varyansı 0,476-0,579, bileşik güvenirlik ise 0,778-0,854 arasındadır. Ölçeğin toplamda Cronbach Alpha'sı 0,92'dir. Ölçeğinin Alt %27 ile Üst %27 grupları arasında anlamlı farklılık bulunmaktadır ve test-tekrar test korelasyon katsayısı 0,902 olarak hesaplanmıştır.

Sonuç: Klinik Muhakeme Ölçeğinin 16 madde ve 4 alt boyut ile hemşirelik öğrencilerinde klinik muhakeme düzeyinin belirlenmesinde kullanılabilecek geçerli ve güvenilir bir ölçek olduğu belirlenmiştir.

Anahtar Kelimeler: Hemşirelik eğitimi, hemşirelik öğrencileri, klinik muhakeme, ölçek uyarlaması

ABSTRACT

Objective: The aim of the study was to adapt the Clinical Reasoning Scale into Turkish and to evaluate its validity and reliability in nursing students.

Methods: The study, which is methodological research, was conducted with 271 nursing students at a university in the Central Anatolia Region. The data were collected with the Personal Information Form and the 'Clinical Reasoning Scale' in its draft form. After the language and content validity of the scale, its construct validity was ensured by confirmatory factor analysis. Cronbach Alpha, item-total correlations, divergent and test-retest methods were used for the reliability of the scale.

Results: The fit indices of the Clinical Reasoning Scale for its 4 sub-dimensions, namely awareness of clinical clues, verification of clinical problems, identification and implementation of actions, evaluation and reflection, and a total of 16 items, are above 0.90, and according to these results, the structure of the scale is accepted as valid. The average explained variance of the sub-dimensions is between 0.476-0.579, and the composite reliability is between 0.778-0.854. The total Cronbach Alpha of the scale is 0.92. There is a significant difference between the top 27% and the bottom 27% groups of the scale and the test-retest correlation coefficient is 0.902.

Geliş Tarihi/Received: 05.01.2024
Revizyon Tarihi/Revised 23.05.2024
Kabul Tarihi/Accepted: 24.05.2024
Yayın Tarihi/Publication Date: 25.06.2024

Sorumlu Yazar/Corresponding author:
Betül BAL
E-mail:b3tul.bal@gmail.com

Cite this article: Bal B, Köroğlu Kaba N, Öztürk H. Hemşirelik Öğrencileri için Klinik Muhakeme Ölçeğinin Türkçe Geçerliği ve Güvenirliği: Bir Metodolojik Çalışma. *J Nursology*. 2024;27(2):129-135.

Conclusion: It has been determined that the Clinical Reasoning Scale is a valid and reliable scale that can be used to determine the level of clinical reasoning in nursing students with 16 items and 4 sub-dimensions.

Keywords: Nursing education, nursing students, clinical reasoning, scale adaptation

GİRİŞ

Klinik muhakeme, hasta bilgilerini toplamak, analiz etmek ve hemşirelik girişimlerini belirlemek için kullanılan bilişsel bir süreçtir.[1] Klinik muhakeme, hemşireleri diğer sağlık meslek gruplarından ayıran hayati bir özelliktir.[2] Mesleki ve etik gereklilikleri karşılamak için hemşirelerin uygulama ortamlarına girmeden önce sahip olması gereken temel hemşirelik becerisi olarak da ifade edilebilir.[2]

Hemşirelik öğrencilerinin kişisel ve mesleki gelişimini kolaylaştıran klinik muhakeme[3], ayrıca kaliteli hemşirelik bakımı, hasta refahı ve olumlu hasta sonuçları ile ilişkilendirilmesinden[4-6] dolayı hemşirelik eğitiminde gereklidir.[7] Hemşirelik akreditasyon kuruluşları[2] tarafından hemşirelik eğitiminde klinik muhakemenin gerekliliği ve öneminin vurgulanmasına rağmen, hemşirelik öğrencisi ve birçok yeni mezun hemşire hala klinik muhakemeyi klinik ortamlarda uygulamada yetersizdir.[8,9] Yapılan bir nitel araştırmada, hemşirelik öğrencilerinin, uygulama ortamlarında kötüleşen hastaların klinik bulgularını yönetme becerilerinde önemli eksiklikler olduğu bildirilmiştir.[10] Ayrıca 5.000 yeni mezun hemşireyle yapılan bir çalışmada, hemşirelerin %23'ünün çoğu zaman hastanın durumundaki bir değişikliği belirleyemediği ve önceliklendirmeyi yapamadığı; %54'ünün ise hastanın sağlık sorunlarını yönetemediği tespit edilmiştir.[8] Bu bağlamda hemşirelik öğrencilerinde uygulamaya başlamadan önce klinik muhakemenin hazırlığı önemlidir.[8,10]

Ulusal literatür incelendiğinde hemşirelik öğrencilerinin klinik muhakeme becerilerini değerlendiren bir ölçme aracına rastlanmamıştır. Bu bilgiler doğrultusunda, hemşirelik öğrencilerinin klinik muhakeme becerisini değerlendirmek, klinik muhakemeye ilişkin öğrenme ihtiyaçlarını doğru bir şekilde belirlemek, öğrencilerin klinik muhakeme becerilerini güçlendirmeye yönelik eylemlerin etkilerini incelemek için geçerli ve güvenilir araçlara ihtiyaç duyulmaktadır.[11]

AMAÇ

Bu çalışmada, Klinik Muhakeme Ölçeğinin (KMÖ) geçerlik-güvenirliğini test edilmesi ve literatüre hemşirelik öğrencilerinin klinik muhakeme becerilerini değerlendirmelerini sağlayan spesifik bir ölçüm aracı kazandırılması amaçlanmıştır.

YÖNTEMLER

Araştırmanın Türü ve Amacı

Metodolojik olarak yürütülen bu araştırmada, Klinik Muhakeme Ölçeğinin (Clinical Reasoning Scale) Türkçeye uyarlanarak geçerlik ve güvenirliğinin belirlenmesi amaçlanmıştır.

Araştırma Soruları

Çalışmada aşağıdaki sorulara yanıt aranmıştır.

- Hemşirelik öğrencilerinin klinik muhakeme düzeyini değerlendirmek için kullanılacak olan "Klinik Muhakeme Ölçeği" geçerli bir ölçüm aracı mıdır?
- Hemşirelik öğrencilerinin klinik muhakeme düzeyini değerlendirmek için kullanılacak olan "Klinik Muhakeme Ölçeği" güvenilir bir ölçüm aracı mıdır?

Evren ve Örneklem

Araştırmanın evrenini, İç Anadolu Bölgesinde bulunan bir üniversitenin hemşirelik bölümünde öğrenim gören ve klinik uygulamaya çıkan hemşirelik öğrencileri oluşturmaktadır (N=327). Ölçek çalışmalarında her bir ölçek maddesinin 5-10 katı örnekleme alınması önerilmektedir.[12] Ölçeğin 16 maddeden oluşması nedeniyle örneklem büyüklüğü minimum 80 kişi olarak belirlenmiştir ve çalışma 271 hemşirelik öğrencisi ile yürütülmüştür. Çalışmanın dahil edilme kriterleri; hemşirelik öğrencisi olmak, 18 yaşından büyük olmak, Türkçe konuşuyor olmak ve çalışmaya katılmaya gönüllü olmaktır. Çalışmanın dışlama kriterleri ise klinik uygulamaya çıkmamış ve ilk defa çıkmış olmaktır.

Veri Toplama Araçları

Veri toplama formları olarak "Öğrenci Bilgi Formu" ve Clinical Reasoning Scale ölçme aracının Türkçe formu olan "Klinik Muhakeme Ölçeği" kullanılmıştır.

Öğrenci Bilgi Formu: Araştırmacılar tarafından hazırlanan bu formda, öğrencilerin yaşı, cinsiyeti ve kaçıncı sınıf olduğunu öğrenmeye yönelik üç soru yer almaktadır.

Klinik Muhakeme Ölçeği (KMÖ): Huang ve arkadaşlarının (2023) geliştirmiş olduğu bu ölçek, hemşirelik öğrencilerinin klinik muhakeme becerilerini değerlendirmektedir. Beşli likert (1=kesinlikle katılmıyorum, 2=katılmıyorum, 3=kararsızım, 4=katılıyorum ve 5=kesinlikle katılıyorum) tarzında ölçek dört alt boyuttan ve pozitif yönde olan 16 maddeden

oluşmaktadır. Alt boyutlar; klinik ipuçlarının farkındalığı (1-4. maddeler), klinik sorunların doğrulanması (5-8. maddeler), eylemlerin belirlenmesi ve uygulanması (9-12. maddeler) ve değerlendirme ve yansıtma (13-16. maddeler)'dır. Ölçek için toplam puan 16 ile 80 arasında değişmektedir ve ölçek puanı arttıkça katılımcıların klinik muhakeme düzeyi artmaktadır. Ölçeğin Cronbach Alpha değeri 0,894'tür.[13] Bu çalışmada ise Cronbach alfa katsayısı 0,927 bulunmuştur.

Verilerin Toplanması

Araştırmaya başlamadan önce gerekli izinler alınmış ve hemşirelik öğrencilerine çalışma hakkında bilgi verilmiştir. Daha sonra ölçeğin sırasıyla dil, kapsam ve yapı geçerliği ve güvenirlik analizleri yapılmış ve araştırma 20 Eylül-10 Kasım 2023 tarihleri arasında tamamlanmıştır.

Verilerin Analizi

Elde edilen verilerin analizinde Statistical Package for Social Sciences (SPSS) for Windows 25.0, Analysis of Moment Structures (AMOS) V22 kullanılmıştır. Öğrencilerin demografik özellikleri sayı, yüzde, ortalama ile tanımlanmıştır. Daha sonra örneklem sayısının yeterliliğini ve verilerin faktör analizine uygun olup olmadığını kontrol etmek amacıyla Kaiser-Meyer-Olkin (KMO), Bartlett küresellik testi kullanılmıştır. Doğrulayıcı faktör analizi testleri (DFA), yakınsak geçerlik testleri ile ölçeğin geçerliği sınanmıştır. Güvenirlik için Cronbach Alpha katsayısı, madde-toplam madde korelasyonları, ayırt edicilik ve test-tekrar test analizleri yapılmıştır. İstatistiksel anlamlılık düzeyi $p<0,05$ olarak kabul edilmiştir.

Araştırmanın Etik Yönü

Araştırma, Helsinki Deklarasyonu prensiplerine uygun yapılmıştır. Orijinal Klinik Muhakeme Ölçeğinin (Clinical Reasoning Scale) Türkçeye uyarlanabilmesi için Hui-Mane-Huang'dan posta yolu ile yazılı izin alınmıştır. Ayrıca araştırmanın uygulanabilmesi için çalışmanın yürütüldüğü üniversiteden kurum izinleri alınmıştır. Daha sonra araştırmanın yapılacağı üniversitenin etik kurulundan (tarih: 20 Eylül 2023, no: 06/40) onay alınmıştır.

BULGULAR

Katılımcıların Genel Özellikleri

Araştırmaya katılan hemşirelik öğrencilerinin yaş ortalaması 21,77±5,55 olup %54'ü ikinci sınıf (n=146) ve %67'si (n=182) kadındır.

Dil Geçerliği

KMÖ'nün Türkçeye uyarlamasında çeviri-geri çeviri yöntemi kullanılarak dil geçerliği yapılmıştır. Ölçek ilk olarak iki dil uzmanı tarafından Türkçeye çevrilmiştir. Sonra araştırmacılar çevrilen ölçeği incelemiş ve Türkçe maddeler üzerinde uzlaşma sağladıktan sonra ölçek Türkçe ve İngilizceyi ana dil düzeyinde bilen farklı iki uzman tarafından yeniden İngilizceye çevrilmiştir. Araştırmacılar ölçeğin ilk ve son İngilizce çeviri halini karşılaştırmış ve daha sonra bir Türk dili uzmanı metni dilsel uygunluk ve anlaşılırlık açısından değerlendirmiştir. Böylece ölçeğin dil geçerliği sağlanmıştır.

Kapsam Geçerliği

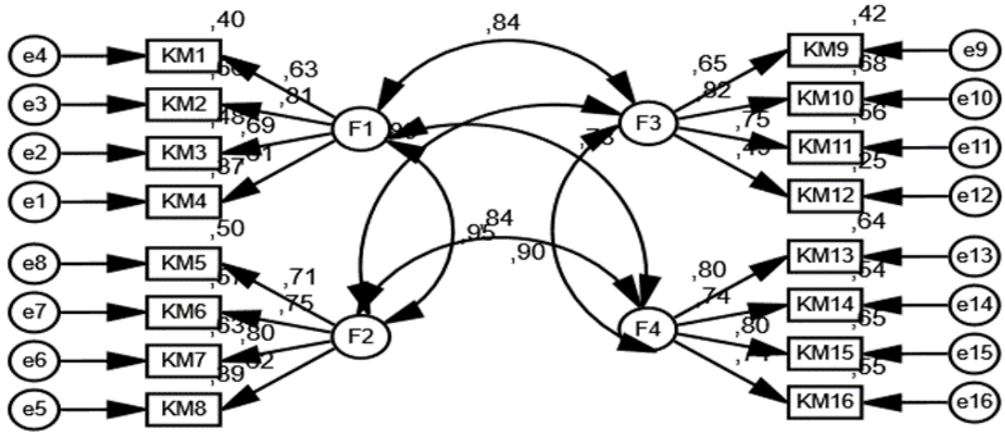
Ölçek, dil geçerliği sağlandıktan sonra kapsam geçerliğinin incelenmesi için dokuz uzmanın görüşüne sunulmuştur. Uzmanlardan her maddeyi (a) 'madde uygun", (b) 'madde hafifçe gözden geçirilmeli', (c) 'madde ciddi olarak gözden geçirilmeli' ve (d) 'madde uygun değil' şeklinde Davis tekniği kullanılarak incelenmesi istenmiştir (Davis, 1992). Uzmanlardan elde edilen veriler sonucunda KMÖ'nün kapsam geçerlik oranlarının 0,88 ile 1.00 arasında değiştiği görülmüş ve Kapsam Geçerlik İndeksi (KGİ) 0,97 olarak hesaplanmıştır. Ölçek maddelerinin anlaşılırlığını değerlendirmek ve ölçeğin yanıtlama süresini belirlemek amacıyla örnekleme benzer özellikleri taşıyan 30 hemşirelik öğrencisine pilot uygulama yapılmıştır. Hemşirelik öğrencilerinin görüşleri doğrultusunda taslak ölçek maddelerinde anlam değişikliği yapılmamıştır ve ölçeğin yanıtlama süresinin yaklaşık 5-10 dakika arasında olduğu belirlenmiştir.

Yapı Geçerliği

Yapı geçerliği öncesi öncelikle örneklem sayısının yeterliliğini ve verilerin faktör analizi açısından uygunluğu belirlenmiştir. Bu kapsamda KMÖ'nün Kaiser-Meyer-Olkin değeri 0,94 ve Bartlett test ki-kare değeri X^2 = 2270,982; df=120; *P*<,001 olarak saptanmıştır. Daha sonra 16 maddeden oluşan KMÖ'nün DFA sonuçlarına göre X^2/sd değeri 2,13, RMSEA (Root Mean Square error of Approximation - Yaklaşık Hataların Ortalama Karekökü) 0,07, GFI -Goodness of Fit Index - İyilik Uyum İndeksi) 0,91, AGFI (Adjustment Goodness Of Fit İndex - Düzeltilmiş Iyilik Uyum Indeksi) 0,90, CFI (Comparative Fit Index - Karşılaştırmalı Uyum Indeksi) 0,95 ve RMR (Root Mean Square Residuals - Hata Kareler Ortalamasının Karekökü) 0,03 olarak hesaplanmıştır ve faktör yapısı ile kabul edilebilir düzeyde uyumlu olduğu saptanmıştır. DFA'ya ilişkin path diyagramı Şekil 1'de verilmiştir.

Ölçeğin yakınsak geçerliği için bileşik güvenirlik (Composite reliability-CR) değerleri ve Ortalama Açıklanan Varyans (Average variance extracted - AVE) değerleri hesaplanmış ve klinik ipuçlarının farkındalığı alt boyutu için CR=0,783, AVE=0,478, klinik sorunların doğrulanması alt boyutu için CR=0,812, AVE=0,521, eylemlerin belirlenmesi ve uygulanması alt boyutu için CR=0,778, AVE=0,476, değerlendirme ve yansıtma alt boyutu için CR=0,854, AVE=0,594 olarak hesaplanmıştır. KMÖ'nün faktör yükleri

0,495- 0.809 değer aralığındadır. KMÖ toplamında Cronbach Alpha değeri 0,92, alt boyutlar için 0,73- 0,85 arasındadır. Doğrulanmış madde-toplam madde korelasyon değerleri ise r=0,459-0,740 olarak saptanmıştır (Tablo 1).



Şekil 1. DFA Sonucu Klinik Muhakeme Ölçeğine İlişkin Path Diyagramı

Tablo 1. Ölçek Maddelerinin Doğrulanmış Faktör Yükleri, Madde Toplam Puan Korelasyonları ve Cronbach Alpha Değerleri

Ölçek maddeleri	Faktör yükleri	Doğrulanmış madde toplam korelasyonları	Cronbach Alpha değerleri
Klinik ipuçlarının farkındalığı			0,776
Hastayla iletişime geçtiğimde hastanın ihtiyaçlarını fark edebilirim.	0,635	0,594	0,924
Gözlemlediğim klinik ipuçlarına dayanarak hastanın olası sorunlarını fark edebilirim.	0,809	0,705	0,921
Sorunla ilgili ipuçları toplamak için tıbbi öykü, fiziksel değerlendirme gibi çeşitli yöntemleri kullanabilirim.	0,694	0,637	0,923
Klinik uygulama deneyimim, hastanın sorunlarını tespit etmeme yardımcı olabilir.	0,610	0,526	0,927
Klinik sorunların doğrulanması			0,807
Bir hastanın sağlık sorununa karar vermeden önce, hastadaki anormallikle ilgili tüm verileri toplayabilirim.	0,706	0,654	0,922
Farklı ipuçları ile hasta sorunları arasındaki bağlantıyı açıklayabilirim	0,752	0,687	0,921
Toplanan verileri analiz ederek bir hastanın sorunlarını belirleyebilirim.	0,796	0,740	0,920
Hastanın sorunlarını belirlemek ve klinik bulguların ipuçlarını açıklamak için hemşirelik bilgisini kullanabilirim.	0,622	0,611	0,924
Eylemlerin belirlenmesi ve uygulanması			0,737
Hasta sorunlarını çözmeden önce problem çözme basamaklarını düşünebilirim.	0,648	0,592	0,924
Hastanın durumuna göre problem çözme hedefini belirleyebilirim.	0,822	0,737	0,921
Hastanın durumuna göre en uygun çözümü bulabilirim.	0,746	0,681	0,922
Hemşirelik girişimleri teori ve kanıta dayalıdır.	0,495	0,459	0,928
Değerlendirme ve yansıtma			0,851
Hastanın sorunlarının çözülüp çözülmediğini değerlendirebilirim.	0,801	0,693	0,921
Problem çözmenin etkinliğini farklı açılardan değerlendirebilirim.	0,736	0,654	0,922
Sorun çözülmezse, hastanın ihtiyaçlarını yeniden düşünebilirim.	0,804	0,692	0,922
Problem çözülse de çözülmese de iyileştirme için problem çözme adımları üzerinde düşünebilirim ve geliştirebilirim.	0,739	0,696	0,921
Toplam			0,927

Tablo 2. Ölçek Puanlarının Alt-üst %27 Gruplarına Göre Farklılaşma Durumu

Gruplar	Alt %27 (n=74)		Üst %27 (n=74)		t*	sd
	Ort	**SS**	**Ort**	**SS**		
Ölçek Toplam	54,23	8,43	72,59	4,27	-16,707	146
Klinik ipuçlarının farkındalığı	13,70	2,81	18,36	1,32	-12,891	146
Klinik sorunların doğrulanması	12,66	2,33	17,77	1,63	-15,435	146
Eylemlerin belirlenmesi ve uygulanması	13,97	2,51	17,86	1,52	-11,391	146
Değerlendirme ve yansıtma	13,89	2,41	18,59	1,39	-14,516	146

*P<.001; sd, standart sapma; SS: standart sapma; Ort, aritmetik ortalama; t, t testi.

Ayrıca ölçeğin %27'lik alt ve üst çeyreklik gruplarına göre ayırt ediciliği değerlendirilmiştir, toplamda KMÖ için t=-16,707; *P* <,001, alt boyutlar için de anlamlılık saptanmıştır (*P<,*001) (Tablo 2).

Ölçeğin zaman göre değişmezliğini saptamak için iki hafta ara ile yapılan test-tekrar test analizine göre korelasyon değerleri toplam ölçek için r= 0,902, *P<*,001 iken, t= 1,403 ve *P=*,168 olarak bulunmuştur. Klinik ipuçlarının farkındalığı alt boyutu için için r= 0,899, *P<*,001 iken, t= -1,433 ve *P=*,160, klinik sorunların doğrulanması alt boyutu için için r=0,886, *P<*,001 iken, t= -1,356 ve *P=*,183, eylemlerin belirlenmesi ve uygulanması alt boyutu için için r= 0,906, *P<*,001 iken, t= -1,418 ve *P=*,164, değerlendirme ve yansıtma alt boyutu için için r= 0,884, *P<*,001 iken, t= -1,423 ve *P=*,163 olarak saptanmıştır.

TARTIŞMA

Bu çalışmada "Klinik Muhakeme Ölçeğinin Türk toplumuna uyarlanması amaçlanmıştır. Ölçeğin başka toplumlar için uyarlandığı çalışmalara rastlanmamış, fakat ölçeğe atıfta bulunan yarı deneysel bir çalışmaya rastlanmıştır.[14]

Sırasıyla dil, kapsam, yapı geçerliği sınanan Klinik Muhakeme Ölçeğinin İngilizceden Türkçeye dil geçerliliği Çapık ve ark.[15] çalışmasında belirtilmiş olduğu gibi 4 dil uzmanı ve araştırmacıların ortak değerlendirmeleri sonucunda sağlanmıştır.[15]

Dil geçerliği sonrası ölçek maddelerinin ölçülecek alanı yansıtıp yansıtmadığını yani amaca uygunluğunu değerlendirmek amacıyla yapılan kapsam geçerliliği uzmanın görüşü ile değerlendirilmiştir.[15] Uzman görüşü tekniği; ölçeğin ölçülmesi arzu edilen özelliğe uygun ve yeterli olup olmadığının konunun uzmanları tarafından değerlendirilmesidir.[16] Davis tekniği ile değerlendirilen uzmanların görüşlerinin değerlendirmesine göre ölçek maddelerin kapsam geçerlilik oranlarının 0,88 ve KGİ'nin 0,80 üzerinde olduğu belirlenmiş, ölçeğin kapsam geçerliği açısından ölçütleri karşıladığı tespit edilmiştir.[17] Çünkü kapsam geçerlilik indeksinin 0,78 veya daha yüksek olması maddelerin iyi bir içerik geçerliliğinin kanıtı olarak değerlendirilmektedir.[18] Bu kapsamda 16 maddelik ölçekten hiçbir madde çıkarılmamış ve maddelerin ölçekte kalmasına karar verilmiştir.

Daha sonra ölçeğin yapı geçerliliğinin sağlanmasında faktör analizinin yapılabilmesi için Kaiser-Meyer-Olkin ve Bartlett testi değerlerine bakılmıştır. Klinik Muhakeme Ölçeğinin Kaiser-Meyer-Olkin değerinin 0,94 olması araştırmanın örneklem büyüklüğünün yeterli düzeyde olduğunu göstermiştir. Değişkenler arasındaki ilişkiyi belirleyen Bartlett testinin[19] anlamlı olması ise verilerin çok değişkenli normal dağılımdan geldiğini göstermiştir.

Belirlenen yapının doğruluğunu test etmek için DFA yapılmıştır. Taslak ölçeğin yapısı X^2/sd, GFI, AGFI, CFI, RMSEA ve RMR uyum iyiliği testleri ile incelenmiştir. Ölçeğin uyum indeks değerlerinin iyi ve kabul edilebilir düzeyde olduğu görülmüş ve dört alt boyuttan oluşan ölçeğin daha önce belirlenen bu yapısının toplanan verilerle genel olarak uyumlu olduğuna karar verilmiştir. Çünkü iyi uyuma işaret eden X^2/sd değeri üçten küçük, RMSEA 0.08'den küçük, GFI, AGFI, CFI değerleri 0.90'ın üzerindedir.[20]

Bununla birlikte yapı geçerliliğini test edebilmek için yapı güvenilirliği CR ve AVE değerleri incelenmiştir. AVE standardize edilmiş faktör yüklerinin karelerinin toplamının madde sayısına bölünmesiyle bulunmaktadır. Bu koşul sağlanmışsa yakınsak geçerliliği sağlanmış demektir.[21] CR değerinin 0,7'den yüksek olması yakınsak geçerliliğin diğer bir göstergesidir.[22] Yakınsak geçerlilik için ölçeğin CR değerlerinin AVE değerlerinden büyük ve AVE değerinin ise 0,5'ten büyük olması beklenmektedir. AVE değerinin 0,5'e yakın bir değer olması ölçeğin yakınsak geçerliğinin sağlandığını göstermektedir.[21, 23] Bu çalışmada alt boyutların AVE'si>0,476 ve CR'si>0,778'dir. CR değerleri AVE değerlerinden büyük ve iki alt boyutun AVE değerleri 0,5 yakındır. Bu kapsamda ölçeğe ilişkin yakınsak geçerliğin sağlandığı kabul edilmektedir.

Klinik Muhakeme Ölçeğinin geçerliliği sağlandıktan sonra güvenirlik analizleri incelenmiştir. Güvenirlik, ölçme aracının ölçtüğü değişkeni ne tutarlılıkta ölçtüğü ne derece

doğru ölçtüğü veya ölçme çıktılarının hatalardan arınmış olma derecesi olarak açıklanabilir.[12] Ölçeğin güvenirlilik analizleri Cronbach Alpha, toplam-madde korelasyonları, ayırt edicilik ve test-tekrar test teknikleri kullanılarak yapılmıştır. Ölçeğin Cronbach Alpha değerinin toplamda ve alt boyutlar düzeyinde 0.70'in üzerinde olduğu belirlenmiştir. Bu durum, 16 madde arasında iç korelasyon veya iyi bir homojenlik olduğunu göstermektedir. Bununla birlikte ölçeğin madde-toplam korelasyonlarının eşik değer olan 0,25'in üzerinde olması[24] katılımcıların ifadeleri doğru anlayıp objektif yanıtlar verdiklerini göstermektedir.[12] Ölçeğin aşırı uçtaki iki grubu (alt ve üst %27'lik gruplar) birbirinden açıkça ayırt etmesi beklenir.[25] İki grup arasında fark olması ayırt ediciliğin göstergesidir. Ölçeğinin alt %27 ile üst %27 grupları arasında anlamlı farklılık gösterdiği saptanmıştır (p<0,05). Bu sonuçlara göre ölçeğin ayırt edecek hassas ölçüm yaptığı belirlenmiştir. Klinik Muhakeme Ölçeğinin güvenirliği, ölçeğin/testin aradan geçen zaman içinde ne kadar kararlı şekilde ölçme yaptığını ya da benzer cevaplara ulaşıldığını gösteren test-tekrar test yöntemiyle de değerlendirilmiştir. Çalışmada ölçeğin test-tekrar test sonuçlarına göre iki ölçüm arasındaki korelasyon katsayısının alt boyutlarda ve toplamda 0,88 üzerinde olması ve anlamlı olması, Klinik Muhakeme Ölçeğinin kararlı bir ölçme yaptığını veya zamana göre ölçüm sonuçlarının değişmediğini göstermektedir.[26] Genel olarak Klinik Muhakeme Ölçeğinin Türkçe versiyonu hemşirelik öğrencileri arasında oldukça güvenilirdir.

Araştırmanın Sınırlılığı

Araştırma, İç Anadolu Bölgesi'ndeki bir üniversitenin hemşirelik bölümünde öğrenim gören öğrencilerin görüşleri ile sınırlıdır. Bununla birlikte benzer ölçek geçerliliğinin sağlanamaması diğer sınırlılığıdır.

Sonuç olarak hemşirelik öğrencilerinin, klinik muhakeme düzeylerini ölçmek amacıyla Huang ve ark. tarafından geliştirilmiş olan KMÖ'nün Türkçe formunun geçerli ve güvenilir bir araç olduğu saptanmıştır. Bu doğrultuda ölçeğin hemşirelik öğrencilerinin klinik muhakeme düzeylerini değerlendirmede kullanılabileceği söylenebilir.

Etik Komite Onayı: Etik kurul onayı Yozgat Bozok Üniversitesi Yerel Etik Kurulu'ndan (Tarih: 20.09.2023, Sayı: 06/40) alınmıştır.
Bilgilendirilmiş Onam: Çalışmaya katılan öğrencilerden yazılı onam alınmıştır.
Hakem Değerlendirmesi: Dış bağımsız.
Yazar Katkıları: Fikir- BB, NKK, HÖ; Tasarım- BB, NKK; Denetleme- HÖ; Malzemeler- BB, NKK, HÖ; Veri Toplama ve/veya İşleme- BB, NKK; Analiz ve/veya Yorum- BB, NKK, HÖ; Literatür- BB, NKK; Yazıyı yazan- BB, NKK; Eleştirel İnceleme: HÖ
Çıkar Çatışması: Yazarlar, çıkar çatışması olmadığını beyan etmiştir.
Finansal Destek: Yazarlar, bu çalışma için finansal destek almadığını beyan etmiştir.

Ethics Committee Approval: Ethics committee approval was obtained from Yozgat Bozok University Local Ethics Committee (Date: 20.09.2023, Number: 06/40)
Informed Consent: Written consent was obtained from participants in this study.
Peer-review: Externally peer-reviewed.
Author Contributions: Conceptualization – BB, NKK, HÖ; Design – BB, NKK; Supervision – HÖ; Sources – GS, AÜ; Materials – G., AÜ, GDB; Data Collection and/or Processing – BB, NKK; Analysis and/or Interpretation – BB, NKK, HÖ; Literature Review – BB, NKK; Written by – BB, NKK; Critical Review – HÖ.
Conflict of Interest: The authors have no conflicts of interest to declare.
Financial Disclosure: The authors declared that this study has received no financial support.

KAYNAKLAR

1. Simmons B. Clinical reasoning: Concept analysis. *J Adv Nurs* 2010;66(5): 1151–1158. https://doi.org/10.1111/j.1365-2648.2010.05262.x
2. American Association of Colleges of Nursing. The essentials: Core competencies for professional nursing education. [Erişim adresi: https://www.aacnnursing.org/Portals/42/AcademicNursing/pdf/Essentials-2021.pdf]. 2021.
3. Alfayoumi I. The impact of combining concept-based learning and concept-mapping pedagogies on nursing students' clinical reasoning abilities. *Nurse Educ Today*. 2019;*72*: 40-46. https://doi.org/10.1016/j.nedt.2018.10.009
4. Kao CC, Chao HL, Liu YH, Pan IJ, Yang LH, Chen WI. Psychometric testing of the newly developed competence scale for clinical nurses. *J Nurs Res* 2022;30(2):198. https://doi.org/10.1097/jnr.0000000000000472
5. Jang A, Song M, Kim S. Development and effects of leukemia nursing simulation based on clinical reasoning. *Int J Environ Res Public Health* 2021;18(8):4190. https://doi.org/10.3390%2Fijerph18084190
6. Manetti W. Sound clinical judgment in nursing: A concept analysis. *Nurs Forum* 2018;54(1):102–110. https://doi.org/10.1111/nuf.12303
7. Benner, P, Sutphen, M, Leonard, V, Day, L. *Educating nurses: A call for radical transformation.* 2009;(15). John Wiley & Sons.p.211.
8. Kavanagh JM, Szweda C. A crisis in competency: The strategic and ethical imperative to assessing new graduate nurses' clinical reasoning. *Nurs Educ Perspect* 2017;8(2): 57–62. https://doi.org/10.1097/01.nep.0000000000000112
9. Killam LA, Luhanga F, Bakker D. Characteristics of unsafe undergraduate nursing students in clinical practice: An integrative literature review. *J Nurs Educ* 2011;50(8): 434–446. https://doi.org/10.3928/01484834-20110517-05
10. Jarvelainen M, Cooper S, Jones J. Nursing students' educational experience in regional Australia: Reflections on acute events. A qualitative review of clinical incidents. *Nurse Educ Pract* 2018;12(31):188–193. https://doi.org/10.1016/j.nepr.2018.06.007

11. Menezes SS, Corrêa CG, Silva Rde CG, Cruz Dde A. Clinical reasoning in undergraduate nursing education: A scoping review. *Rev Esc Enferm USP.* 2015;49(6):1037–1044. https://doi.org/10.1590/s0080-623420150000600021
12. Büyüköztürk Ş. Sosyal Bilimler için Veri Analizi El Kitabı İstatistik Araştırma Deseni SPSS Uygulamaları ve Yorum. Pegem Akademi. 29. Baskı. Ankara; 2021.
13. Huang HM, Huang CY, Kuan-Chia LIN, Chia-Hui YU, Cheng SF. Development and Psychometric Testing of the Clinical Reasoning Scale Among Nursing Students Enrolled in Three Types of Programs in Taiwan. *J Nurs Res* 2023;31(2):263. https://doi.org/10.1097/jnr.0000000000000547
14. Yeh CH, Huang HM, Kuo CL, Huang CY, Cheng SF. Effectiveness of e-STORY App in clinical reasoning competency and self-directed learning among students in associate nursing program: A quasi experimental study. *Nurse Educ Pract* 2022; 64:103456. https://doi.org/10.1016/j.nepr.2022.103456
15. Çapık C, Gözüm S, Aksayan S. Kültürlerarası ölçek uyarlama aşamaları, dil ve kültür uyarlaması: Güncellenmiş rehber. *FNJN* 2018;26(3):199-210. https://doi.org/10.26650/FNJN397481
16. Çarkçı J. Sosyal Bilimlerde Ölçek Geliştirme Kılavuzu. Çizgi Kitapevi, Konya: 2020.
17. Davis LL. Instrument review: Getting the most from a panel of experts. *Appl Nurs Res* 1992;5(4):194-197. https://doi.org/10.1016/S0897-1897(05)80008-4
18. Polit DF, Beck CT, Owen SV. Is the CVI an acceptable indicator of content validity? Appraisal and recommendations. *Res Nurs Health* 2007;30(4): 459-467. https://doi.org/10.1002/nur.20199
19. Arifin WN. Exploratory factor analysis and Cronbach's alpha. dim (data1). 2017;1(150):12.
20. Çokluk Ö, Şekercioğlu G, Büyüköztürk Ş. Sosyal bilimler için çok değişkenli istatistik SPSS ve LISREL uygulamaları. Ankara, Türkiye: Pegem Akademi. 2018.
21. Fornell C, Larcker DF. Structural Equation Models with Unobservable Variables and Measurement Errors. *Journal of Marketing Research.* 1981;18(1): 39–50. https://doi.org/10.1177/002224378101800104
22. Hair JF, Black WC, Babin BJ, Anderson RE. Multivariate data analysis: A global perspective (7th ed.). Upper Saddle River, NJ: Pearson. 2014.
23. Temel V. Sporda Kendi Kendine Konuşma Ölçeği'nin Türkçe Uyarlaması: Geçerlik ve Güvenirlik Çalışması. *J Int Anatolia Sport Sci* 2022;7(1): 11-24. https://dx.doi.org/10.5505/jiasscience.2022.63835
24. Alpar R. Spor, Sağlık ve Eğitim Bilimlerinden Örneklerle Uygulamalı İstatistik ve Geçerlik-Güvenirlik. Detay Yayıncılık. 7. baskı. Ankara; 2022.
25. Tezbaşaran AA. Likert tipi ölçek hazırlama kılavuzu (e-kitap). [erişim adresi: http:// www.academia.edu/1288035/LikertTipiÖlçekHazırlamaKılavuzu]. 2008.
26. Tavşancıl E. Tutumların Ölçülmesi ve SPSS ile Veri Analizi. Nobel Akademik Yayıncılık Eğitim Danışmanlık Tic. Ltd. Şti. 6. Basım. Ankara; 2010.

ATATÜRK ÜNİVERSİTESİ YAYINLARI
ATATURK UNIVERSITY PUBLICATIONS

Research Article *Araştırma Makalesi* DOI: 10.17049/jnursology.1439703

Women's Experiences of Decisions-Making on Embryo Cryopreservation and Conceptualization of Their Frozen Embryo

Kadınların Embriyo Kriyoprezervasyona Karar Verme Deneyimleri ve Dondurulmuş Embriyolarının Kavramsallaştırılması

Esra ŞAHİNER[1]
Elif ÖZÇETİN[2]
İlkay BOZ[3]

[1]Akdeniz University, Nursing Faculty, Obstetrics and Gynecology Nursing Department Antalya, Turkey
[2]Akdeniz University Faculty of Medicine IVF Center Antalya, Turkey
[3]Akdeniz University, Nursing Faculty, Obstetrics and Gynecology Nursing Department Antalya, Turkey

ABSTRACT

Objective: The aim of this research is to clarify the experiences of women in deciding on the Embryo Cryopreservation (EC) procedure and the meanings they attribute to their frozen embryos.

Methods: This study employed a descriptive phenomenological design and a thematic analysis approach rooted in Husserl's philosophical perspective. Random sampling techniques and maximum diversity sampling methods were both utilized, with data collected between April and October 2021 via semi-structured, in-depth interviews.

Results: Following the analysis of the interviews, five themes and 10 sub-themes emerged. The themes were the following: ''Decision-making pathways in embryo cryopreservation'', ''Motivators in the embryo cryopreservation process'', ''Reflections on embryo cryopreservation'', ''Conceptualization of the frozen embryo'', and ''Expectations from the healthcare system''.

Conclusion: In this investigation, it was discovered that women expressed discomfort with embryo cryopreservation when decisions were solely made by doctors without adequate information about the process. Furthermore, it was found that women tend to hold a more positive perception of embryos as the quality of frozen embryos improves.

Keywords: Decision-Making, embryo cryopreservation, embryo transfer, conceptualization of embryo, phenomenological qualitative study

ÖZ

Amaç: Bu araştırmanın amacı, kadınların Embriyo Kriyoprezervasyon (EK) işlemine karar verme deneyimlerini ve dondurulan embriyolarına yükledikleri anlamları açıklamaktır.

Yöntemler: Bu çalışmada, Husserl'in felsefi bakış açısına dayanan betimleyici bir fenomenolojik tasarım ve tematik analiz yaklaşımı kullanılmıştır. Yarı yapılandırılmış, derinlemesine görüşmeler yoluyla Nisan ve Ekim 2021 arasında toplanan verilerde hem rastgele örnekleme teknikleri hem de maksimum çeşitlilik örnekleme yöntemleri kullanıldı.

Bulgular: Görüşmelerin analizi sonucunda beş tema ve 10 alt tema ortaya çıkmıştır. Temalar şu şekildeydi: ''Embriyo kriyoprezervasyonunda karar verme yolları'', ''Embriyo kriyoprezervasyonu sürecinde motive edici faktörler'', ''Embriyo kriyoprezervasyonuna ilişkin düşünceler'', ''Dondurulmuş embriyonun kavramsallaştırılması'' ve ''Sağlık sisteminden beklentiler''.

Sonuç: Bu araştırmada, kadınların embriyo kriyoprezervasyonu konusunda yeterli bilgiye sahip olmadan embriyo kriyoprezervasyon işlemine sadece doktorlar tarafından karar verilmesinden rahatsızlık duydukları ortaya çıktı.Ayrıca, dondurulan embriyoların kalitesi

Geliş Tarihi/Received: 27.02.2024
Revizyon Tarihi/Revised 23.05.2024
Kabul Tarihi/Accepted: 14.06.2024
Yayın Tarihi/Publication Date: 25.06.2024

Sorumlu Yazar/Corresponding author: İlkay BOZ
E-mail: ilkayarslan@akdeniz.edu.tr

Cite this article: Şahiner E, Özçetin E, Boz İ. Women's Experiences of Decisions-Making on Embryo Cryopreservation and Conceptualization of Their Frozen Embryo. *J Nursology*. 2024;27(2):136-145.

arttıkça kadınların embriyolara ilişkin daha olumlu bir algıya sahip olma eğiliminde oldukları da ortaya çıktı.

Anahtar Kelimeler: Embriyonun kavramsallaştırılması, embriyo kriyoprezervasyon, embriyo transferi, fenomenolojik nitel çalışma, karar verme

INTRODUCTION

For couples, Embryo Cryopreservation (EC) is an option that is known to reduce ovarian hyperstimulation syndrome risk and increase the possibility of pregnancy.[1,2] Katz et al.[3] describe the purposes of cryopreservation as the preservation of fertility in the face of death and aging, and the commodification and financialization of protection. The relationship between cryopreservation and reproductive autonomy is still questioned.[3] Bach and Krolokke[4] describe how cryopreservation technologies interfere with reproductive aging aside from disease and death and propose a new term: cryomedicalization.[4]

Currently, couples have to decide whether to go through the EC procedure before the treatment results are known. Couples are making the decision between freezing their embryos for later cycles or donating them to stem cell research or other infertile couples.[5] This is a complex time for couples where they feel stressed, under pressure, worried, and may experience ethical dilemmas.[6] The majority of studies in the literature discuss how the fate of the frozen embryo is decided, ethical and legal considerations, and embryo donation and/or destruction.[5,7-9] However, only one study has been conducted regarding how EC was decided upon at the initial stages and the subsequent of the frozen embryos. In this study conducted in England, certain women expressed concerns regarding the ethical implications of the EC process and expressed apprehension about the future well-being of their frozen embryos in the event of EC being undertaken. It has been observed that couples approach EC from a scientific perspective, i.e., conceptualizing the embryo as "medical," and try to overcome their feelings of guilt and ethical dilemmas related to the "freezing life" point of view.[6] The literature is limited regarding how women decide on EC, the effect of this procedure on their lives, what they experience after the procedure, and the meaning of the frozen embryo, indicating the necessity for additional qualitative investigations.

In Turkey, frozen embryos are not used for donation or research purposes, and the options for embryo transfer (ET) are freezing and destruction. Studies on women's decision-making processes regarding EC in our country, the effects of these processes on their lives, and the conceptualizations of their frozen embryos have not yet been found. Identifying the emotions women experienced during the EK process will help us understand their current stress levels and how much psychological support they require.[10] In the EC process, revealing women's expectations to health professionals and filling in the missing services in healthcare will provide women with a better overall experience.[11-13]

AIM

The purpose of this study is to explore the experiences of women deciding on the EC procedure and the meanings they attribute to frozen embryos.

Research Questions

In this study, we seek to answer the following questions:

1. Is EC presented as a choice or a necessity in a healthcare system where cryomedicalization has become widespread?
2. How are people included in the decision-making process, and are the preferences of the main decision-maker taken into account?
3. What are the meanings that women who undergo EC attach to their embryos?

METHODS

This study employed a descriptive phenomenological design and thematic analysis approach rooted in Husserl's philosophical perspective. This study was conducted to examine women's experiences of deciding on the EC procedure in depth.[14,15] The Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines were used in the reporting of this research.[16]

Setting and Participants

A study was conducted at the In Vitro Fertilization (IVF) Center of Akdeniz University on 17 women undergoing EC treatment. As stated in the sources in the literature, the random sample type was used to reduce bias and increase credibility and reliability, and the maximum diversity sample type was used to determine differences differences.[17,18] Criteria for inclusion in the sampling include agreeing to participate in the research, being able to speak Turkish, receiving infertility treatment, having undergone EC, and not being diagnosed with any psychiatric disease. The exclusion criteria from the sample were having psychological problems and a time lapse of more than three months after the EC process (forgetting

the effect of the experience). Each participant underwent a single interview session. A total of 50 women were interviewed in this study, and 36 women refused to participate in the study due to the workload and the negative results of ET. When similar examples are seen repeatedly, the researcher empirically ensures that the categories are saturated.[19] When the data reached a saturation point, no new information emerged and started to repeat, and the data collection process was terminated with the participation of 17 women.

Data Collection

Data was collected using the interview method between April 2021 and October 2021. The COVID-19 pandemic caused interviews to be conducted over the phone. Personal information form and semi-structured interview form were used to collect data. During the interviews with the women, a personal information form was first filled out, and then the interview was conducted with a semi-structured interview form. Based on the literature, the personal information form contains eight questions pertaining to women's sociodemographics and infertility.[6,20] The semi-structured interview form comprises seven questions crafted following a literature review aimed at elucidating women's decision-making experiences concerning EC and their perceptions of their frozen embryos[6,8,20] (Table 1). There was an average duration of 30 minutes for the interviews.

Rigor

Rigor in this study was ensured through adherence to four key criteria: credibility, transferability, dependability, and confirmability.[24] Developing a conceptual framework from the literature review informed the construction of the interview protocol in order to enhance the credibility of the research. Subsequently, researchers maintained objectivity during data analysis by focusing on participants' statements rather than injecting their own commentary. In order to minimize researcher biases during the analysis phase, detailed literature reviews were avoided, with interviews guided solely by the research questions.

To enhance transferability, all findings were presented without additional commentary. Researchers individually coded the data obtained from interviews. After debate between the two coders, a consensus was reached on the codes to assess the degree of agreement and dependability between them. Ensuring the validity of the research involved seeking input from an external expert regarding data collection tools, raw data, coding, and observation notes. Additionally, researchers underwent qualitative research training, and the principal investigator possessed expertise in qualitative research methodologies.

Data Analysis

The researcher transcribed the audio recordings of the interviews into written form, resulting in an 84-page text derived from the interviews. The analysis of the data followed an inductive approach, adhering to the six-stage thematic analysis framework outlined by Braun and Clarke[21]. The process involved several steps: 1) acquainting oneself with the data; 2) creating initial codes; 3) pinpointing potential themes; 4) revisiting and enhancing themes; 5) delineating and labeling themes; and 6) presenting the findings.[22,23]

In the first stage, transcripts were read several times by all researchers. In the second stage, the codes were defined and a table was created indicating the limits of the codes. In the third stage, the table with the codes was reviewed many times to identify the themes. The fourth stage is described as a two-level analytical process. At the first level of analysis, the codes embedded in each theme were reviewed by the researchers. Whether there was sufficient supporting data for each theme and the relationships between the data and the level of consistency were checked. At this stage, the themes were changed and combined; in this first level, the themes to be included in the analysis were decided and in the second level, the compatibility of the changed themes was reviewed and the thematic table was revised. In the fifth stage, the definition and explanation of each theme and its importance to the research question was determined. In the sixth stage, the final analysis and explanation of the findings were recorded.[21,22]

Ethical Considerations

A clinical research ethics committee at Akdeniz University granted ethical approval for the study (Date:13.01.2021, No: 70904504/39). Participants were notified that their involvement was voluntary, they retained the right to withdraw at any point, their provided data would remain confidential, and measures would be taken to ensure data security. The excerpts from the interviews were coded instead of named (Participant 1= P-1).

RESULTS

Study participants had an average age of 33.17±5.50 (min: 25, max: 44; see Table 2). Analysis of the data identified 115 codes, five main themes, and ten subthemes (see Table 3).

Theme 1. Decision-making pathways in embryo cryopreservation

According to the study, the majority of the women were unfamiliar with the EC process, but they trusted their doctors and would do whatever their doctor told them to in order to have a child.

Table 1 Semi-structured interview questions
General opening question: Could you introduce yourself?
How did you decide on the embryo freezing process?
What did you feel and what did you think during the embryo freezing process?
How has the embryo freezing process affected you?
Has the embryo freezing process affected your social life and relationships? What were the difficulties he faced?
Who did you get support from when deciding on embryo freezing?
What are your expectations from healthcare professionals in the embryo freezing process?
What do you think about your frozen embryo(s)? (What does it mean?)
Closing
My questions are over, is there anything you want to tell me?

Doctor's decision: a paternalistic way

Since most of the women assumed their doctor would not do anything unethical, they stated that they would do whatever their doctor said, e.g., *''The doctor decided, he did not want the embryo to be wasted, we trust the doctor, he will never does anything wrong'' [P-2].* The doctor gave no further information and made a decision regarding the EC procedure on his own without giving more information to some women. They requested information about why EC was performed, what they would experience during this process, and the benefits of this procedure, e.g., *''I mean, I wanted the doctor to talk to us before the treatment, we are going through such a process, you will experience these, these should happen, for example, the embryo is frozen, but I don't know why it is frozen" [P-12].*

In partnership with the doctor: a shared decision-making way

According to some women, their doctors informed them about EC before the procedure, and they decided on EC together, e.g., *''We decided on the embryo cryopreservation process, together with the doctor, the doctor informed us about embryo cryopreservation'' [P-8]***.** After receiving information from healthcare professionals, some women reported a reduction in their hesitations regarding EC, e.g., *''Our doctor informed us, when we train nurses, we have hesitations as a mother, but our hesitations have decreased, we trusted our doctor'' [P-11].*

Theme 2. Motivators in the embryo cryopreservation process

Hope for higher success

Most women who underwent the EC procedure cited their doctor's assurance of increased pregnancy rates as a motivating factor, e.g., *''So that we can achieve higher success with embryo cryopreservation'' [P-6].*

A small number of women, on the other hand, stated that being informed by their doctor that the body will rest and the embryo will hold better with the EC process was a motivating factor, e.g.,*''We decided together, our doctor said that my body should rest, he decided that the embryo would hold better, the doctor asked me, we approved'' [P-17].*

Belief and trust in the healthcare professional

Several women expressed that having healthcare professionals who provided sincere and comforting communication regarding their concerns about the EC process played a significant role in their decision to undergo the procedure, e.g., *''Our doctor's speaking style and sincerity made us very comfortable, we trusted our doctor, we found ourselves in the treatment'' (P-8).* Although some of the women did not know about the EC procedure, they stated that their trust in healthcare professionals was a motivating factor in deciding to have the EC procedure, e.g., *''It was said by the health professionals that the embryo would be frozen, I could not convey it to you because I did not receive any information'' [P-16].*

Supportive environment

The majority of women reported receiving support from their families, spouses, and friends while making the decision about the EC procedure. It has been determined that this supportive environment had a positive effect on their decision to have EC, e.g., *''We received financial and moral support from my wife's family and my family'' [P-12].* Some women also mentioned that they received support from healthcare professionals while making their decision about the EC procedure, e.g., *''Everyone at the IVF center was very helpful'' [P-4].*

Table 2. Participants characteristics

Participant No	Age	Education Status	Working Status	Marriage Duration (years)	Cause of infertility	Infertility Diagnosis Duration (years)	Infertility Treatment Duration (years)	Number of EC*
P-1	30	University	Working	7	Unexplained infertility	4	4	1
P-2	28	High school	Not Working	7	Unexplained infertility	4	4	1
P-3	26	High school	Not Working	7	Unexplained infertility	6	6	1
P-4	30	University	Not Working	4	Unexplained infertility	3	3	1
P-5	35	University	Working	5	Male-induced infertility	2	2	1
P-6	33	High school	Not Working	13	Unexplained infertility	6	6	3
P-7	33	Primary school	Working	8	Female-induced infertility	2	2	3
P-8	30	University	Not Working	1	Female-induced infertility	1	1	1
P-9	37	University	Working	4	Unexplained infertility	3	3	1
P-10	34	University	Working	8	Female-induced infertility	1	1	1
P-11	44	High school	Working	7	Unexplained infertility	1	1	1
P-12	39	University	Working	3	Unexplained infertility	1	1	1
P-13	30	Universiy	Not Working	5	Female-induced infertility	4	4	1
P-14	29	High school	Not Working	6	Female-induced infertility	5	5	1
P-15	25	Primary school	Not working	7	Female-induced infertility	1	1	1
P-16	39	University	Working	6	Female-induced infertility	2	2	2
P-17	42	High school	Working	2	Female-induced infertility	1	1	1

***EC: Embryo cryopreservation**

Theme 3. Reflections of embryo cryopreservation

Troubling

The majority of women indicated unfamiliarity with the EC process and they were nervous because they were doing it for the first time, e.g., *''I was a little nervous because I didn't know what cryopreservation was because I had never experienced anything like this'' [P-2].* A few women expressed unease due to uncertainty about the survival of frozen embryos until the EC process, e.g., *''We are left with a question mark whether it will happen or not, whether we can get over it because we are older'' [P-17].*

The feeling of leaving a piece behind

A portion of the women stated that they were constantly thinking about their embryos after the EC procedure, e.g., *''My mind was always there [in the IVF center], I even wanted to go and see the frozen embryo'' [P-14].* Some women, on the other hand, stated that they felt the feeling of leaving a piece of themselves behind, e.g., *''After all, it was a little strange to leave a part of ourselves or her/him (embryo) to come'' [P-10].*

Table 3. Example of the thematic analysis: from codes to themes

Codes	Sub-themes	Themes
Doctor decided completely by himself (P-12) It was said that it would be frozen, I cannot tell you because I did not receive any information, because I trust the health professionals, I said that they know something (P-16)	Doctor's decision: a paternalistic way	Decision-making pathways in embryo cryopreservation
I researched the freezing process a lot, I had no knowledge about the process, our doctor was very helpful, informed about the process, we proceeded in this way (P-7) We decided together, my body decided that if it rested, the embryo would hold better in the womb, the doctor asked me, we approved (P-17)	In partnership with the doctor: a shared decision-making way	
So that we can achieve higher success with EC (P-6) We decided together, our doctor said that my body should rest, he decided that the embryo would hold better, the doctor asked me, we approved (P-17)	Hope for higher success	Motivators in the embryo cryopreservation process
Our doctor's speaking style and sincerity made us very comfortable, we trusted our doctor, we found ourselves in the treatment (P-8) Our doctor informed us, the nurses gave counseling about the procedure, as a mother, we have hesitations, but we trust our doctor (P-11)	Belief and trust in the healthcare professional	
My biggest supporter was my wife (P-7) Spiritually, my wife is a great supporter, and so were our mothers and friends (P-10)	Supportive environment	
It is a pending process, you become uneasy, you make something you never knew before (P-4) I was a little nervous because I didn't know what cryopreservation was because I had never experienced anything like this'' (P-2)	Troubling	Reflections on embryo cryopreservation
I wanted the cryopreservation process to be done immediately, people are both excited and stressed, their mind is always there (P-3) After all, it was a little strange to leave a part of ourselves or leave him (P-10)	The feeling of leaving a piece behind	
I haven't been out much, there is sickness (covid) (P-4) I tried not to even contact my family so as not to be covid (P-8)	Survival out of fear of Covid-19	
My frozen embryo has no meaning for me, I don't plan to use it anyway (P-1) We have babies, we have healthy embryos (P-7)	-	Conceptualization of the frozen embryo
Maybe something can happen to inform those who come to treatment for the first time, a person can be assigned (P-12) Regarding providing information, we expect that they will call and they will explain, so there was no return on that issue (P-6)	Informative and insightful care -	Expectations from the healthcare system
Health professionals should answer all of our questions, and most importantly, be people who understand our psychology (P-17) When you enter the environment of the IVF center, everyone understands each other, we have very understanding nurses (P-13)	Healthcare professional who understands psychology	

Survival out of fear of Covid-19

The majority of women reported that their lives remained unaffected following the EC procedure, except for concerns about contracting Covid-19, e.g., *''I was very nervous about Covid, I had panic attacks all the time, in case I got Covid-19'' [P-8].*

Women stated that they distanced themselves from their families and social environment until the frozen embryos were transferred in order to manage their fear of getting Covid-19, e.g., *''I couldn't even tried to contact my family because of Covid'' [P-8].*

Theme 4. Conceptualization of the frozen embryo

When the quality of the frozen embryo was high, women explained the meaning of the embryo as *"son/child"* or a *"miracle,"* e.g., *''I feel like my children, they [embryos] are a part of us'' [P-17]. ''A miracle of Allah, the frozen embryo stays outside, then it is with you'' [P-15].* When the quality of the frozen embryo is low, the meaning of the embryo for women is expressed as *"one cell"* or *"meaninglessness,"* e.g., *''Frozen embryo has no meaning for me, I don't plan to use it anyway'' [P-1]. ''So it was like a living cell'' [P-3].*

Theme 5. Expectations from the healthcare system

Informative and insightful care

The majority of the women mentioned that they needed to be informed by health professionals and answered individual questions during the EC process, e.g., *''Regarding giving information, we expect that they will call and they will explain, so there has not been much feedback on that issue'' [P-6]. ''I have a complaint about the embryologist. I am angry with the embryologist; he told us that our embryos were of good quality; why didn't he tell us if the quality was not good? We had embryo cryopreservation done for no reason; we paid for nothing'' [P-1].* In addition, women stated that they expect healthcare professionals to establish an understanding form of communication during the information process, e.g., *''When I ask something or want to learn because I have entered a subject that I do not know, at least I would like not to be scolded'' [P-7].*

Healthcare professional who understands psychology

Most of the women expressed their expectations from healthcare professionals to understand the psychology of infertile individuals, e.g., *''When you enter the environment, everyone understands each other, we have very understanding nurses''[P-13],* and *"…the most important thing is that there are people who understand our psychology'' [P-17].* They stated that they are sensitive during the treatment process, and that healthcare professionals should treat them with understanding and provide moral support, e.g., *''We felt morally and emotionally safe; we could explain our problems whenever we went or called'' [P-2].*

DISCUSSION

This study examined the experiences of women undergoing infertility treatment in their decision-making regarding EC, as well as their conceptualizations of their frozen embryos. As seen in the theme of "Decision-making pathways in EC," it is understood that women generally start the EC process with the doctor's decision, and they think that the doctor will do what is best for them. However, some women want their doctors to provide explanatory information before the EC procedure and want that decision to be made not only by the doctor, but by themselves as well. It was stated that after IVF treatment, 92% of women wanted to continue their treatment with the doctor.[25] There are paternalistic decision-making, informed decision-making, and shared decision-making models regarding diagnosis, treatment, and care processes in the healthcare system. A paternalistic model describes a clinician's decision on behalf of the patient, independent of the patient's preferences, based on a professional assessment of the patient's benefit.[26] Patient-centered, informed decision-making involves healthcare professionals informing the patient and leaving the patient alone to make the decision.[27] In shared decision-making, healthcare professionals and patients collaborate to make decisions. This model encourages patient participation and will contribute positively to patient communication with healthcare professionals.[28-30] According to report, individuals who participate in their treatment process with a shared decision-making model will have better healthcare experiences and outcomes.[13] In this study, most of the women experienced the paternalistic decision-making model in deciding whether to undergo the EC procedure. A small number of women stated that they do not want the paternalistic decision-making model and that they want to make a joint decision with healthcare professionals. In a systematic review on interventions to increase participation in healthcare decisions in non-western countries, it is stated that healthcare professionals should receive training on this issue in order for the shared decision-making model to be applied effectively.[31] It is recommended that healthcare professionals learn about women's decision-making preferences regarding the treatment process and provide necessary information and include women in the planning phase of this process.

This study demonstrates that the primary motivators influencing the decision-making process for the EC procedure are largely associated with healthcare professionals. Research has shown that when healthcare professionals inform women that an EC procedure will enhance pregnancy rates, it positively impacts their motivation to opt for the freezing process. In a study examining the attitudes and preferences of infertile individuals towards the EC process, approximately 50% of the women stated that they would prefer to undergo the procedure with the knowledge that the probability of getting pregnant would increase.[32] Despite limited knowledge about the EC process among some women, research indicates that they tend to place trust in

healthcare professionals who convey information in a positive manner. This positive communication has been observed to influence their decision to undergo the freezing process. Qualitative studies highlight that trust in healthcare professionals is paramount in infertility care.[33,34]

In frozen embryos, when the quality of the embryo is high, women's embryos are considered "son/child" or "miracle;" when it is low, women attribute meanings such as "a cell" or "meaningless." Upon a literature review, it becomes apparent that individuals frequently characterize their embryos using terms like "baby," "child," "living being," or "tissue".[6,31] In the fresh embryo, it is seen that they attribute meanings such as "baby," "child," "healthy child," "cell," or "alive".[20] In this study, it was understood that the meanings women assign to their frozen embryos and the processes of conceptualizing their embryos are related to the quality of the embryos. If the quality of the frozen embryo was high, women were emotionally attached to their embryos, attached positive meanings to them, and talked about their embryos in an possessive manner, while if the quality was low, women did not attribute emotional meanings to their embryos and objectified their frozen embryos with medical terms.

In our study, several women stated that they did not understand why embryos of poor quality were frozen, complained about the incomplete information provided by healthcare professionals regarding embryo quality, and were angry with healthcare professionals for this reason. In a recent mixed-methods study aimed at supporting professionals in the field of infertility, training needs were assessed among healthcare practitioners, it is stated that 34% of healthcare professionals are lacking knowledge about environmental factors affecting embryo culture, and there is no consensus on the time of embryo freezing and the quality of that embryo.[36] Knowing the meanings women attribute to their frozen embryos, healthcare professionals should inform women accurately about the EC process and embryo quality and include them in their decision-making processes. This way, women will consciously take part in the treatment process and their communication with healthcare professionals will not be adversely affected.

In the theme of ''Expectations from the healthcare system'', it is understood that women want to work with healthcare professionals who understand the complex emotions and psychology they experience during the treatment. Pedro et al.[37] found that as a result of healthcare professionals not being empathetic enough towards individuals diagnosed with infertility, and not paying attention to the psychological aspects of the treatment, patients terminated the treatment[37]. According to the European Society of Human Reproduction and Embryology (ESHRE) guidelines, health professionals should be able to understand and pay attention to the emotional impact of infertility in the psychosocial care of women.[10] From the findings of the study, it is understood that women need individual-centered care. Person-centered care is to respect the individual's preferences, needs, dignity, and to ensure that their values guide all clinical decisions.[38,39] Among the social factors affecting individual-centered care are the positive attitude of the professional, good relations with the individual, patient participation in the decision-making process, and emotional support.[11] In clinical work, practices beneficial to individual-centered care can be determined and awareness of health professionals can be increased and strengthened.

This study has limitations, including the inability to interview men who play a role in EC decision-making, the lack of follow-up interviews to assess long-term effects, and constraints on closely observing participants due to the COVID-19 pandemic preventing face-to-face interviews.

In this study, answers were sought to three questions in the introduction section. Firstly, it is understood that EC is not offered as an option to most couples receiving infertility treatment, and the doctor decides on behalf of the couples and performs the EC process. Secondly, it is understood that most couples receiving infertility treatment are not included in the decision-making process for the EC procedure, their preferences are not asked, and there is a lack of information about the EC procedure. This study demonstrated that most women were disturbed by the decisions of their doctor regarding the EC procedure, and some of them were uncomfortable with the lack of detailed information they were provided about EC. It was determined that women were uneasy due to their lack of knowledge about the EC process and their uncertainties regarding the fate of their frozen embryos. It is thought that with an increase in the level of women's knowledge about the EC process and the post-procedure process, their anxiety may decrease following the procedure. It is recommended to examine the effects of decision-making models in the EC process with more qualitative data and to plan trainings to raise awareness among health professionals on this issue. Finally, it is understood that the meanings that women who have EC give to their embryos vary depending on the quality of the embryo. It is understood that women conceptualize their

frozen embryo positively and establish stronger emotional bonds if the quality of the frozen embryo is high. It can be suggested to investigate the long-term effects of this attachment in a multidimensional manner.

Etik Komite Onayı: Etik kurul onayı Akdeniz Üniversitesi Klinik Araştırmalar Etik Kurulu'ndan (Tarih: 29.01.2021, Sayı: 70904504/39) alınmıştır.
Bilgilendirilmiş Onam: Çalışmaya katılan kadınlardan Google form ile online onam alınmıştır.
Hakem Değerlendirmesi: Dış bağımsız.
Yazar Katkıları: Fikir-İB, EŞ, EÖ; Tasarım-EŞ, İB; Denetleme-EŞ, İB; Kaynaklar-EŞ, İB; Veri Toplanması ve/veya İşlenmesi: EŞ; Analiz ve /veya Yorum: EŞ, İB; Literatür Taraması-EŞ, İB; Yazıyı Yazan-EŞ, İB; Eleştirel İnceleme-İB, EŞ.
Çıkar Çatışması: Yazarlar, çıkar çatışması olmadığını beyan etmiştir.
Finansal Destek: Yazarlar, bu çalışma için finansal destek almadığını beyan etmiştir.

Ethics Committee Approval: Ethics committee approval was received from Akdeniz University Clinical Research Ethics Committee (Date: 29.01.2021, Number: 70904504/39).
Informed Consent: Online consent was obtained from the women participating in the study via Google form.
Peer-review: Externally peer-reviewed.
Author Contributions: Conceptualization-İB, EŞ, EÖ; Design-EŞ, İB; Supervision-ES, İB; Sources-EŞ, İB; Data Collection and/or Processing-EŞ; Analysis and/or Interpretation: EŞ, İB; Literature Review-EŞ, İB; Written by-EŞ, İB; Critical Review-İB, EÖ.
Conflict of Interest: The authors have no conflicts of interest to declare.
Financial Disclosure: The authors declared that this study has received no financial support.

REFERENCES

1. Roque M, Haahr T, Geber S, Esteves SC, Humaidan P. Fresh versus elective frozen embryo transfer in IVF/ICSI cycles: a systematic review and meta-analysis of reproductive outcomes. Hum Reprod Update. 2019;25(1):2-14. https://doi.org/10.1093/humupd/dmy033
2. Zaat T, Zagers M, Mol F, Goddijn M, van Wely M, Mastenbroek S. Fresh versus frozen embryo transfers in assisted reproduction. Cochrane Db Syst Rev. 2021;2(2):CD011184. https://doi.org/10.1002/14651858.cd011184.pub3
3. Katz O, Hashiloni-Dolev Y, Kroløkke C, Raz A. Frozen: social and bioethical aspects of cryopreservation. New Genet Soc. 2020;39(3):243-9. http://dx.doi.org/10.1080/14636778.2020.1802823
4. Bach AS, Kroløkke C. Hope and happy futurity in the cryotank: Biomedical imaginaries of ovarian tissue freezing. Sci Cult-Uk. 2020;29(3):425-49. http://dx.doi.org/10.1080/09505431.2019.1681953
5. Fitzgerald RP, Legge M, Rewi P, Robinson RJ. Excluding indigenous bioethical concerns when regulating frozen embryo storage: An Aotearoa New Zealand case study. Reprod Biomed Soc Online. 2019;8:10–22. https://doi.org/10.1016/j.rbms.2019.01.001
6. Goswawi M, Murdoch AP, Haimes E. To freeze or not to freeze embryos: clarity, confusion, and conflict. Hum Fertil. 2015;18(2):113-20. https://doi.org/10.3109/14647273.2014.998726
7. Bruno C, Dudkiewicz-Sibony C, Berthaut I, Weil E, Brunet L, Fortier C, et al. Survey of 243 ART patients having made a final disposition decision about their surplus cryopreserved embryos: the crucial role of symbolic embryo representation. Hum Reprod. 2016;31:1508–14. https://doi.org/10.1093/humrep/dew104
8. Machado CS. The fate of surplus embryos: ethical and emotional impacts on assisted reproduction. JBRA Assist Reprod. 2020;24(3):310–5. https://doi.org/10.5935%2F1518-0557.20200015
9. Raz A, Amer-Alshiek J, Goren-Margalit M, Jacobi G, Hochberg A, Amit A, et al. Donation of surplus frozen pre-embryos to research in Israel: underlying motivations. Isr J Health Policy Res. 2016;5:25. https://doi.org/10.1186/s13584-016-0085-4
10. Gameiro S, Boivin J, Dancet E, de Klerk C, Emery M, Lewis-Jones C, et al. ESHRE guideline: routine psychosocial care in infertility and medically assisted reproduction-a guide for fertility staff. Hum Reprod. 2015;30(11):2476-85. https://doi.org/10.1093/humrep/dev177
11. Jafarzadeh-Kenarsari F, Ghahiri A, Zargham-Boroujeni A, Habibi M, Hashemi M. Patient-centered fertility care: from theory to practice. JMRH. 2016;4(3):712-9. https://doi.org/10.22038/jmrh.2016.7186
12. Shandley LM, Hipp HS, Anderson-Bialis J, Anderson-Bialis D, Boulet SL, McKenzie LJ, et al. Patient-centered care: factors associated with reporting a positive experience at United States fertility clinics. Fertil Steril. 2020;113(4):797-810. https://doi.org/10.1016/j.fertnstert.2019.12.040
13. Veillard J, Fekri O, Dhalla I, Klazinga N. Measuring outcomes in the Canadian health sector: driving better value from healthcare. Toronto: C.D. Howe Institute Commentary. 438. 2015.
14. Neubauer BE, Witkop CT, Varpio L. How phenomenology can help us learn from the experiences of others. Perspect Med Educ. 2019;8(2):90-7. https://doi.org/10.1007%2Fs40037-019-0509-2
15. Sundler AJ, Lindberg E, Nilsson C, Palmer L. Qualitative thematic analysis based on descriptive phenomenology. Nurs Open. 2019;6(3):733-9. https://doi.org/10.1002/nop2.275
16. Booth A, Hannes K, Harden A, et al. COREQ. Guidelines for reporting health research: a user's manual. Int J Qual Methods. 2014;1-16. https://doi.org/10.1002/9781118715598.ch21
17. Baltacı A. Nitel araştırmalarda örnekleme yöntemleri ve örnek hacmi sorunsalı üzerine kavramsal bir inceleme. BEÜ SBD. 2018;7(1):231-274. https://dergipark.org.tr/tr/pub/bitlissos/issue/38061/399955
18. Moser A, Korstjens I. Series: Practical guidance to qualitative research. Part 3: Sampling, data collection and

analysis. Eur J Gen Pract. 2018;24(1):9-18. https://doi.org/10.1080/13814788.2017.1375091
19. Glaser BG, Strauss AL. Discovery of Grounded Theory: Strategies for Qualitative Research. New York: Routledge, 2017.
20. Şahiner E, Boz İ. Experiences of women undergoing infertility treatment from embryo transfer until pregnancy test and their conceptualization of their embryo. J Psychosom Obstet Gynecol. 2021;42:1-10. https://doi.org/10.1080/0167482x.2020.1865909
21. Braun V., Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006; 3(2): 77–101. http://dx.doi.org/10.1191/1478088706qp063oa
22. Maguire M, Delahunt B. Doing a thematic analysis: A practical, step-by-step guide for learning and teaching scholars. AISHE-J. 2017;9(3).
23. Kiger ME, Varpio L. Thematic analysis of qualitative data: AMEE Guide No. 131. Med Teach. 2020;42(8):846-54. https://doi.org/10.1080/0142159x.2020.1755030
24. Cypress BS. Rigor or Reliability and Validity in Qualitative Research: Perspectives, Strategies, Reconceptualization, and Recommendations. Dimens Crit Care Nurs. 2017;36(4):253-63. https://doi.org/10.1097/dcc.0000000000000253
25. Chan CHY, Lau BHP, Tam MYJ, Ng EHY. Preferred problem solving and decision-making role in fertility treatment among women following an unsuccessful in vitro fertilization cycle. BMC Women's Health. 2019;19(1):1-11. https://doi.org/10.1186/s12905-019-0856-5
26. Driever EM, Tolhuizen IM, Duvivier RJ. et al. Why do medical residents prefer paternalistic decision making? An interview study. BMC Med Educ. 2022;22:155. https://doi.org/10.1186/s12909-022-03203-2
27. Friesen-Storms JH, Bours GJ, van der Weijden T, Beurskens AJ. Shared decision making in chronic care in the context of evidence based practice in nursing. Int J Nurs Stud. 2015;52(1):393-402. https://doi.org/10.1016/j.ijnurstu.2014.06.012
28. Blair L, Legare F. Is shared decisions making a utopian dream or achievable goal? Patient. 2015;8:471-76. https://doi.org/10.1007/s40271-015-0117-0
29. Harter M. It's time for shared decision making and person-centred care. Patient. 2020;13;643-44. https://doi.org/10.1007%2Fs40271-020-00471-2
30. Tonelli MR, Sullivan MD. Person-centred shared decision making. J Eval Clin Pract. 2019;25(6):1057-62. https://doi.org/10.1111/jep.13260
31. Dolan H, Li M, Trevena L. Interventions to improve participation in health-care decisions in non-Western countries: A systematic review and narrative synthesis. Health Expect. 2019;22(5):894-906. https://doi.org/10.1111/hex.12933
32. Stormlund S, Schmidt L, Bogstad J, Løssl K, Prætorius L, Zedeler A, et al. Patients' attitudes and preferences towards a freeze-all strategy in ART treatment. Hum Reprod. 2019;34(4):679-88. https://doi.org/10.1093/humrep/dez006
33. Harzif AK, Shafira N, Mariana A, Lovita BT, Mutia HD, Maidarti M, et al. Communication and respect for patient value as significant factors in patient-centered ınfertility care: a survey of patients' experiences in two ınfertility centers. J Hum Reprod Sci. 2020;13(1):22-5. https://doi.org/10.4103%2Fjhrs.JHRS_62_19
34. Streisfield A, Chowdhury N, Cherniak R, Shapiro H. Patient centered infertility care: the health care provider's perspective. PXJ. 2015;2(1):93-7. http://dx.doi.org/10.35680/2372-0247.1062
35. Kayssan M, Dolatian M, Omani Samani R, Maroufizadeh S. Attitudes of ınfertile couples, fertility clinic staff and researchers toward personhood of the human embryo in Iran. Cell J. 2017;19(2):314–23. https://doi.org/10.22074/cellj.2016.4989
36. Peloquin S, Garcia-Velasco JA, Blockeel C, Rienzi L, de Mesmaeker G, Lazure P, et al. Educational needs of fertility healthcare professionals using ART: a multi-country mixed-methods study. Reprod Biomed Online. 2021;43(3):434-45. https://doi.org/10.1016/j.rbmo.2021.06.020
37. Pedro J, Canavarro MC, Boivin J, Gameiro S. Positive experiences of patient-centred care are associated with intentions to comply with fertility treatment: findings from the validation of the Portuguese version of the PCQ-Infertility tool. Hum Reprod. 2013; 28(9):2462-72. https://doi.org/10.1093/humrep/det259
38. Akgün M, Boz İ. Person centered care approach in infertility. JERN. 2019;16(2):170-75. https://doi.org/10.5222/HEAD.2019.170
39. Gülpınar N, Başkaya SS, Yeşilbudak Z, Boz İ. Determination of the caring behaviors and affecting factors women perceived during infertility treatment. JERN. 2019;16(1):21-6. http://dx.doi.org/10.5222/HEAD.2019.021

ATATÜRK ÜNİVERSİTESİ YAYINLARI
ATATURK UNIVERSITY PUBLICATIONS

Research Article *Araştırma Makalesi* DOI: 10.17049/jnursology.1443264

Nursing Care from the Perspective of Cancer Patients

Kanser Hastalarının Bakış Açısından Hemşirelik Bakımı

Hilal PEKMEZCI[1]
Burcu GENÇ KÖSE[2]
Yağmur AKBAL[2]

[1]Recep Tayyip Erdogan University Vocational School of Health Services, Rize, Türkiye

[2]Recep Tayyip Erdogan University Faculty of Health Sciences, Department of Nursing, Rize, Türkiye

ABSTRACT

Objective: This study aimed to determine the experiences and thoughts of cancer patients receiving outpatient chemotherapy about nursing care.

Methods: This study, completed using a phenomenological qualitative research method, included 13 patients receiving treatment in an outpatient chemotherapy unit. Data were collected between September and November 2023 using a semi-structured interview form and audio recording. The descriptive analysis method was used to evaluate the data. Written informed consent was obtained from the participants based on volunteerism.

Results: 53.8% had third-stage cancer and received chemotherapy treatment for an average of 36 months. Patients receiving chemotherapy treatment stated that the nurses were interested in them. They evaluated the care provided by the nurses as good. Their most significant expectations from nurses were patience, understanding, and a smiling face. They stated that they did not have any problems in their communication with nurses during treatment. However, they often experienced communication problems due to inappropriate physical conditions, patient density, insufficient number of nurses, and the noise of the devices used in treatment.

Conclusion: As a result, we recommend that the physical conditions of chemotherapy units be improved, and the number of nurses brought to an adequate level to increase the quality of nursing care.

Keywords: Chemotherapy, Nursing, Nursing care, Perception of care

ÖZ

Amaç: Bu araştırmanın amacı ayaktan kemoterapi tedavisi alan kanser hastalarının hemşirelik bakımı ile ilgili deneyim ve düşüncelerini belirlemektir.

Yöntemler: Fenomenolojik tipte nitel araştırma yöntemi kullanılarak tamamlanan bu araştırmada ayaktan kemoterapi ünitesinde tedavi alan 13 hasta yer aldı. Veriler Eylül-Kasım 2023 tarihleri arasında yarı yapılandırılmış görüşme formu ve ses kaydı yapılarak toplandı. Verilerin değerlendirilmesinde betimsel analiz yöntemi kullanıldı. Araştırmada gönüllülük esas alınarak katılımcılardan yazılı onam alındı.

Bulgular: Çalışmadaki hastaların %61,5'i kadın, ilkokul mezunu ve şehir merkezinde yaşamaktadır. %53,8'i üçüncü evre kanser hastası ve ortalama 36 aydır kemoterapi tedavisi almaktadır. Kemoterapi tedavisi alan hastalar; hemşirelerin kendilerine karşı ilgili olduklarını belirttiler. Hemşirelerin uyguladıkları bakımı iyi olarak değerlendirdiler. Hemşirelerden en büyük beklentilerinin sabır, anlayış ve güler yüz olduğunu ifade ettiler. Tedavi süresince hemşirelerle iletişimlerinde sorun yaşamadıklarını ancak fiziki şartların uygunsuzluğu, hasta yoğunluğu, hemşire sayısının yetersiz olması ve tedavide kullanılan cihazların seslerinden ötürü çoğu zaman iletişim problemleri yaşayabildiklerini dile getirdiler (P<,05).

Geliş Tarihi/Received 26.02.2024
Revizyon Tarihi/Revised 06.06.2024
Kabul Tarihi/Accepted 24.06.2024
Yayın Tarihi/Publication Date 25.06.2024

Sorumlu Yazar/Corresponding author: Hilal PEKMEZCI
E-mail: hilal.pekmezci@erdogan.edu.tr

Cite this article: Pekmezci H, Köse BG, Akbal Y. Nursing care from the perspective of cancer patients . *J Nursology*. 2024;27(2):146-152.

Sonuç: Sonuç olarak, hemşirelik bakımının kalitesinin artması için kemoterapi ünitelerinin fiziki şartlarının iyileştirilmesi ve hemşire sayısının yeterli düzeye getirilmesini öneririz.

Anahtar Kelimeler: Kemoterapi, Hemşirelik, Hemşirelik bakımı, Bakım algısı

INTRODUCTION

The World Health Organization (WHO) defines cancer as a disease in which abnormal cells, starting from tissues or organs, spread uncontrollably to other tissues and organs. [1] Cancer is one of the most critical health problems in the world. Cancer ranks second after cardiovascular diseases among the causes of death in our country and the world. Cancer is the cause of one out of every six deaths globally and one out of every five deaths in Turkey. It is predicted that cancer will rise to the first place in the world in 2040, and approximately 29.5 million new cancer cases will occur. [1- 4]

Traditional cancer therapies include chemotherapy, radiation therapy and surgery. The most commonly used method is chemotherapy.[5, 6] However, while chemotherapy treatment treats the disease, it can also cause many physical and psychological symptoms.[7, 8]

Nursing care in cancer starts with the diagnosis of cancer and continues with selecting appropriate treatment options for the person during treatment, supportive treatment, and care for the symptoms that occur due to treatment.[9] According to a literature review, clinical nurse specialists are a valuable member of the team in improving cancer care services.[10] Quality care in cancer treatment is medical care and meeting and completing all patient care needs.[11] Nursing care, which is of great importance in the mental and physical support of cancer patients, is defined as the actions applied for all care needs of patients.[12] Patients receiving cancer treatment describe the nurse as someone who supports, strengthens coping, makes an essential and valuable contribution and increases satisfaction while reducing anxiety.[9] In the literature, it is reported that the presence of the nurse is vital in the cognitive and physical recovery of cancer patients and coping with.[13]

Evaluation of nursing care from the patient's perspective reveals the importance of patients' experiences. Patients' opinions and experiences can be used in planning, implementing, and evaluating health services. Patient satisfaction positively affects the quality of health care.[14] Patients' experiences are essential data revealing critical healthcare delivery processes.[15] The term "patient's experience" is a complex concept mainly related to the communication between the patient and the nurse.[16] A systematic review found that communicating with healthcare professionals is a key need of cancer patients.[17]

The most crucial output that evaluates health care delivery and reveals care performance is the measurement of patient satisfaction. The data obtained with this indicator contribute to the organization of the total quality management system.[18] In line with this information, this study aimed to determine the experiences and thoughts of cancer patients about nursing care in the unit where they receive health care.

METHODS

Study Design

The study is with outpatient chemotherapy cancer patients receiving treatment in a province of Türkiye. It is a phenomenological qualitative study. In phenomenological studies, the descriptive phenomenological method that reveals lived experiences was used. The outpatient chemotherapy unit where the research was conducted has a capacity of 44 patients, and seven nurses are working.

Participants

The study population consisted of 828 patients who applied to an outpatient chemotherapy unit in a province in Turkey to receive chemotherapy between September and November 2023. The research was conducted with patients who volunteered to answer the research questions and allowed audio recording. Qualitative research does not have a set rule in sample calculation, and the sample size can be decided by the purpose of the research.[19] In accordance with the nature of qualitative research, sampling continued until saturation was achieved in forming the main themes. In this study, snowball sampling method, which is a purposeful sampling method, was used.

Inclusion criteria

The study included patients who agreed to participate, knew their cancer diagnosis, were older than 18, and had received treatment and care from nurses for at least one year.

Data Collection Tools

Data were collected using a "Patient information form" and "Semi-structured interview form."

Patient information form

It consists of nine questions, including six questions about the socio-demographic characteristics of the participants and three questions about the treatment process. The questions were age, gender, education level, marital status, place of residence, employment status, cancer stage, duration of diagnosis and number of years of treatment.

Semi-structured interview form

It consists of questions that enable patients to express their experiences regarding nursing care.

1. How would you comment the nurses who treat and care for you?
2. How would you like nurses to approach you?
3. What should nurses who provide care for you be like? What should they care about?
4. What do you think needs to change in nursing care?
5. What should be the most essential feature of the nurses who care for you during your treatment?

Implementation of Data Collection Tools

Data were collected by visiting the outpatient chemotherapy unit on different days between September and November 2023. After the meeting with the first participant, the other participant recommended by the participant was approached. Face-to-face interviews were conducted with the participants and the interviews were audio recorded. In-depth interview method was used while collecting data. Starting from the first question, all questions were directed to the participant. In the 10th patient, the data started to be repeated. However, the data collection process was completed by interviewing three more patients.

Ethical Considerations

Written informed consent was obtained from the patients immediately before data collection. It was stated that all data obtained during the research would be kept confidential and not used anywhere except for the study. Permission numbered 2023/233 was obtained from the relevant Recep Tayyip Erdoğan University's social and humanities ethics committee on 25.08.2023, and institutional permission numbered 221384599 was obtained from the Provincial Directorate of Health on 03.08.2023.

Statistical Analysis

The process was carried out sequentially in the analysis of qualitative data using the descriptive analysis method. Audio recordings were listened to and converted into written form. Written statements were read at least three times by the researchers and categories were created. Similar/standard categories were combined to reach the main themes. Patients' statements were added as raw data in the reporting process of each central theme. All researchers exhibited consistent behavior during the analysis process. They were impartial in listening and coding all data.

RESULTS

The sociodemographic characteristics of the patients are given in Table 1. The mean age of the patients who participated in the study was 59.30±13.45 years, the duration of diagnosis was 44.31±32.26 months.

Table 1. Sociodemographic Variables of the Patients (n=13)

	n	%
Gender		
Woman	8	61.5
Male	5	38.5
Education Status		
Primary education	8	61.5
High school	4	7.7
University	1	30.8
Marital Status		
Married	13	100
Place of Residence		
Village	1	7.7
District	4	30.8
Province center	8	61.5
Employment Status		
Working	2	15.4
Not working	11	84.6
Cancer Stage		
Phase 1	1	7.7
Phase 2	3	23.1
Phase 3	7	53.8
Phase 4	2	15.4
		Mean±SD (Min-Max)
Age		59.30±13.45 (30-84)
Time to Diagnosis (months)		44.31±32.26 (12-135)
Duration of Treatment (months)		36.00±17.66 (12-72)

Qualitative Results

The study reached three main themes and six sub-themes per the patients' statements (Table 2).

Table 2. Theme Classes (n=13)	n
Positive Perception of Nursing Care	
Nursing care is good and the nurses are attentive	9
Nurses are knowledgeable	7
The Nurse Has A Positive Approach	
Being friendly	7
Patience and understanding	6
External Factors Have Negative Effects	
Inappropriate physical conditions	5
Insufficient number of nurses	5

These three main themes run through descriptive analysis are as follows;

Main theme 1: Positive perception of nursing care
- Nursing care is good and the nurses are attentive
- Nurses are knowledgeable

Main theme 2: The nurse has a positive approach
- Being friendly
- Patience and understanding

Main theme 3: External factors have negative effects
- Inappropriate physical conditions
- Insufficient number of nurses

Main theme 1: Positive Perception of Nursing Care
It was determined that patients receiving chemotherapy treatment perceived nursing care positively during the treatment period. While evaluating the nurses they received care from, they stated that the nursing care was excellent, they were satisfied with the process, they could get enough information, and they were caring.

- Nursing care is good, and the nurses are attentive

Nursing care, which is a dynamic process, is an action that consists of science and art and focuses on individual assistance. Individualized care positively affects the patient's quality of life and satisfaction.[20] In another study conducted with a large sample in Turkey, we see that patients' perceptions of nursing care are in good condition.[21]

God bless them. They take good care and behave well. (P(Patient)-3)

They take good care of me. They come immediately when I call them. They treat people well. (P-4)

I am very satisfied. They are very good at their job. What more can happen? (P-6)

I am happy with all of them. They come when I need them. What more can I ask for. (P-7)

- Nurses are knowledgeable

Although nursing education is based on knowledge and skills, it is obliged to provide care to society and the sick individual by presenting this knowledge gained. While defining the care they provide, nurses used the expressions of respecting the individual, givingthemselves to work, and meeting the needs and expertise.[22]

When I ask, they give information without withholding. They explain everything very well. We can ask anything. (P-2)

We get information on everything. (P-4)

He knows his job very well. I can get information on everything. (P-5)

They can answer everything. (P-7)

Main theme 2: The nurse has a positive approach
When the research data on the expectations of cancer patients in the nursing care process wereevaluated, it was determined that they focused on personal characteristics. It was seen that theyexpected smiling faces and a patient approach from nurses the most.

- Being friendly

The literature shows that patients expect to be valued and respected, have a humanistic approach, and tolerate and be friendly in the nursing care process.[23]

Nurses do their best. There is much intensity, but the nurse should be friendly. (P-1)

They are already exhausted. They could be more friendly. (P-2)

A nurse should be friendly. (P-7)

We, patients, are already bitter. The nurse should be smiling. Smiling and sweet languageis the best medicine. (P-10)

- Patience and understanding

Patience is a concept that increases the employee's ability to empathize and supports an understanding approach to all problems encountered in nursing care.[24]

They can be stressed because of the intensity. I would like them to be more patient. I think themost important thing is to be compassionate. (P-8)

They should be compassionate. I want them to be patient. (P-9)

I have been coming and going for one year. The nurse should be understanding. (P-10)

I want him to be friendly, tolerant, and pleasant. (P-11)

Main theme 3: External factors have negative effects

Patients who evaluated nursing care stated that external factors affected their perception of care. It was stated that the number and density of patients were high, and the physical conditions were unfavorable.

- Inappropriate physical conditions

The suitability of the working environment in the health field is essential in providing effective and quality healthcare services. In nursing care, it is known that when theappropriate workspace is provided, the quality of care increases, and the satisfaction of patients increases.[25]

The environment is noisy. The devices are very loud. (P-1)

The density is too high. (P-4)

For there to be change, the physical conditions must change first. (P-12)

- Insufficient number of nurses

Another critical issue in health care service delivery is the effectiveness and efficiency of staffing and appropriate management of human resources. Inadequate human resources increase negativities such as workload and turnover in terms of employees, and negativities such as medical errors and a decrease in patient safety in terms of patients.[26]

There are many patients. They are already exhausted. (P-2)

Our problem is with the queue because of the density. I have been receiving treatment for two years. They change staff very often. I guess they cannot stand it too much. (P-4)

Attention should be paid to queue priority. There are problems due to lack of personnel. (P-9)

When there is a crowd, I guess they cannot keep up. They try to do the treatments, but they are insufficient in number. (P-13)

DISCUSSION

Our study determined that cancer patients receiving chemotherapy perceived nursing care positively with themes such as "*nursing care is good, and nurses are interested" and "nurses are knowledgeable."* Tolasa (2022) reported in their study with cancer patients thatalmost all patients stated that the cancer treatment process took a long time, that nursing practices helped reduce the symptoms they encountered, and that they trusted nurses' knowledge.[11] Similar to our study findings, oncology patients stated in another study that nurses were reliable, empathetic, and helpful. They also stated that they felt peaceful and robust in individual care processes with the support and guidance of nurses.[27] A study examining nurses' thoughts about the roles and responsibilities of oncology nursing determined that nursing is a profession that needs to continuously develop professional knowledge and skills.[28] When our study results and other studies are examined, the importance of knowledge in nursing care emerges.

In our study, it was determined that patients expected a *"smiling face"*, "patience" and "*understanding*" from nurses during the care process. Cancer diagnosis directly affects both theindividual and his/her family. Cancer can negatively affect the family process by creating stressand imbalance in the family system. During treatment, patients and their relatives experience affective, cognitive, social, and physical symptoms.[29] Sharingthese symptoms with nurses and receiving support from nurses are the most critical steps in thenursing care process.[30] In studies conducted with cancer patients, it has been emphasized that some patients have problems communicating with nurses,[31] their expectations from nurses include understanding, respect, better communication, and good nursing care,[30] and they expect compassion, support, and hope from nurses and reliable, professional knowledge.[12] The fact that patients can hardly cope with the problems that may be experienced during the cancer treatment process suggests that the expectations of smiling face, patience, and understanding come to the fore in the nursing care process.

In this study, it was observed that cancer patients receiving outpatient chemotherapy wanted the institution's physical conditions and the nurses' working conditions to be improved in addition to their expectations for nursing care. In this context, they stated that "*unfavorable physical conditions*" and "insufficient *number of nurses*" caused confusion, and patients had to wait unnecessarily. The physical areas where chemotherapy treatment is administered, and staff resources affect patients' comfort during treatment. Thedensity in outpatient chemotherapy areas causes dissatisfaction in patients.[32] The literature states that the intensity in this area is caused by long infusion times, insufficient nurses, limited working hours in the outpatient chemotherapy unit, and insufficient treatment chairs.[33] Another study conducted with oncology patients revealed that the intense workload of nurses, shortage of nurses, a high number of nursing routines, and being busy with paperwork prevented nurse-patient communication.[34] Similar to our results, in another study, 98.6% of oncology nurses stated that they worked with

insufficient nurses.[35] Patients expect information, counseling, and support from nurses in intensive treatment units such as outpatient chemotherapy. Inadequate physical conditions and an insufficient number of nurses may negatively affect care. Patients' interpretation of the unit where they receive treatment as physical conditions and insufficient number of nurses may cause them to perceive the nursing care process negatively and experience anxiety.

This study was completed with cancer patients receiving outpatient chemotherapy, the majority of whom were stage 3 cancer patients. Patients evaluated the nursing care provided to them positively. They stated that the nurses were concerned and had sufficient knowledge. Patients stated they needed a smiling face, patience, and understanding. They also experienced problems in care due to inappropriate physical conditions and an insufficient number of nurses in the treatment environment. They stated that they had to wait in long queues, were confused while waiting in line, and were exposed to too many machines. They also stated that there was no problem communicating with nurses during the nursing care process. However, nurses were sometimes insufficient to allocate individual time and answer the questions they asked because they worked very intensively. Cancer is a process that leaves the patient worried and threatened about the future. Therefore, it is essential to support patients with a multidisciplinary team at every stage of the treatment process, especially with nurses within this team. Effective patient-nurse interaction during chemotherapy positively affects the treatment process. Therefore, we recommend that the physical conditions and the number of nurses should be considered, especially in outpatient chemotherapy units, and that institutions should consider this in managing human and material resources.

Limitations of the Study: The study is limited to the feelings and opinions of patients receiving treatment in the outpatient chemotherapy unit of a hospital.

Etik Komite Onayı: Etik kurul onayı Recep Tayyip Erdoğan Üniversitesi Sosyal ve Beşeri Bilimler Etik Kurulu'ndan (Tarih: 28.08.2023, Sayı:2023/233) alınmıştır.
Bilgilendirilmiş Onam: Hastalardan bilgilendirilmiş onam alınmıştır.
Hakem Değerlendirmesi: Dış bağımsız.
Yazar Katkıları: Fikir- HP; Tasarım- HP; Denetleme-HP; Kaynaklar-HP, BGK, YA; Veri Toplanması ve/veya İşlemesi HP, BGK; Analiz ve/ veya Yorum- HP, BGK, YA; Literatür tarama-HP, BGK, YA; Yazıyı Yazan- HP, BGK, YA; Eleştirel İnceleme-HP, BGK, YA.
Çıkar Çatışması: Yazarlar, çıkar çatışması olmadığını beyan etmiştir.
Finansal Destek: Bu araştırma kamu, ticari veya kar amacı gütmeyen sektörlerdeki finansman kuruluşlarından herhangi bir özel finansal destek almamıştır.

Ethics Committee Approval: Ethics committee approval was obtained from Recep Tayyip Erdoğan University Social And Humanities Ethics Committee (Date: 28.08.2023, Number: 2023/233)
Informed Consent: Informed consent was obtained from the patients
Peer-review: Externally peer-reviewed.
Author Contributions: Concept - HP; Design- HP; Supervision- HP; Resources- HP, BGK, YA; Data Collection and/or Processing- HP, BGK; Analysis and/or Interpretation- HP, BGK, YA; Literature Search- HP, BGK, YA; Writing Manuscript- HP, BGK, YA; Critical Review- HP, BGK, YA.
Conflict of Interest: The authors have no conflicts of interest to declare.
Financial Disclosure: This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

REFERENCES

1. World Health Organization. Cancer 2022. www.who.int/europe. Accessed November 16, 2023 https://www.who.int/health-topics/cancer#tab=tab_1
2. International Agency for Research on Cancer. © IARC 1965-2020. Cancer tomorrow. Accessed January 23, 2023. https://gco.iarc.fr/tomorrow/en
3. Barajas Galindo DE, Vidal-Casariego A, Calleja-Fernández A, et al. Appetite disorders in cancer patients: Impact on nutritional status and quality of life. Appetite. 2017;1(114): 23-27. http://dx.doi.org/10.1016/j.appet.2017.03.020.
4. The Ministry of Health of Turkey Health Statistics Yearbook 2019. Accessed January 23, 2023. https://sbsgm.saglik.gov.tr/Eklenti/40566/0/health-statistics-yearbook-2019pdf.pdf
5. Baykara O. Current modalities in treatment of cancer. BAUN Health Sci J. 2016;5(3):154-165. http://dx.doi.org/10.5505/bsbd.2016.93823
6. Cheevers K, Armes J, Harris J, Rafferty AM. Adaptation and preliminary testing of the registered nursing forecasting (RN4CAST) nurse survey for use in the ambulatory chemotherapy setting. Eur J Oncol Nurs. 2020;47:101794. http://dx.doi.org/10.1016/j.ejon.2020.101794.
7. Bahar A, Ovayolu Ö, Ovayolu N. Common symptoms of oncology patients and nursing management. Erciyes University Faculty of Health Sciences Journal. 2019; 6(1):42-58. https://dergipark.org.tr/en/pub/erusaglik/issue/47133/593190
8. Tuna Hİ, Ünver G, Molu B. Symptom clustering and nursing in end-stage cancer patients with palliative care. Ankara Journal of Health Sciences. 2018;(2):64-69. doi:10.1501/Asbd_0000000087
9. Doğan P, Tarhan M, Kürklü A. Patient-nurse collaboration: the relationship between the perception of nursing presence levels and self-care activity levels of ındividuals with cancer diagnosis. Journal of Inonu University Health Services Vocational School. 2023;11(2):1591-1602. http://dx.doi.org/10.33715/inonusaglik.1060701.
10. Kerr H, Donovan M, McSorley O. Evaluation of the role of the clinical Nurse Specialist in cancer care: an integrative literature review. Eur J Cancer Care. 2021;30:1-13. https://doi.org/10.1111/ecc.13415.
11. Güngör Tolasa A, Tokem Y. Investigation of the effectiveness

of nursing practices in meeting the care needs of cancer patients. İKÇÜSBFD. 2022;7(2):215-221. https://dergipark.org.tr/tr/pub/ikcusbfd/issue/70141/1027827

12. Tuominen L, Leino-Kilpi H, Meretoja R. Expectations of patients with colorectal cancer towards nursing care- a thematic analysis. Eur J Oncol Nurs. 2020;(44):101699. http://dx.doi.org/10.1016/j.ejon.2019.101699.
13. Tuominen L, Stolt M, Meretoja R, Leino-Kilpi H. Effectiveness of nursing interventions among patients with cancer: An overview of systematic reviews. J Clin Nurs. 2019;28:2401–2419. http://dx.doi.org/10.1111/jocn.14762.
14. Kim-Soon N, Abdulmaged AI, Mostafa SA. A framework for analyzing the relationships between cancer patient satisfaction, nurse care, patient attitude, and nurse attitude in healthcare systems. J Ambient Intell Humaniz Comput. 2022;13(3):87–104. http://dx.doi.org/10.1007/s12652-020-02888-x.
15. Alsaqri S. Patient satisfaction with quality of nursing care at governmental hospitals, Ha'il city, Saudi Arabia. Journal of Biology, Agriculture and Healthcare. 2016;10(6):128-142. https://core.ac.uk/download/pdf/234662014.pdf
16. Zarzycka D, Bartoń E, Mazur A, Turowski K. Socio-Demographic and medical factors associated with patients' satisfaction with nursing care and their perception of pain. Ann Agric Environ Med. 2019; 26(2):298–303. http://dx.doi.org/10.26444/aaem/90385.
17. Webb ME, Murray E, Younger ZW, Goodfellow H, Ross J. The Supportive Care Needs of Cancer Patients: a Systematic Review. Journal of Cancer Education. 2021;36:899–908. https://doi.org/10.1007/s13187-020-01941-9.
18. Karaca A, Durna Z. Patient satisfaction with the quality of nursing care. Nurs Open. 2019;6:535–55. 10.1002/nop2.237.
19. Koçan S, Demirci NG, Demir A, Üstün Ç. Immigrant problem from a group of health professionals' point of view: a qualitative study. Turkish Studies. 2017;12(3);361-378. http://dx.doi.org/10.7827/TurkishStudies.
20. Özakgül AA, Acaroğlu R, Şendir M, Atar YN, Eskimez Z. Evaluating the Individualized Care Perceptions of Patients and Nurses. JAREN. 2022;8(1):20-28. https://doi.org/10.55646/jaren.2022.55376.
21. Kol E, Geçkil E, Arıkan C, et al. Examination of nursing care perception in Turkey ACU Sağlık Bil Derg. 2017;(3):163-172. http://journal.acibadem.edu.tr/tr/pub/issue/61317/914508
22. Toru F. Key point of nursing practices: individualized care. Adnan Menderes University Faculty of Health Sciences Journal. 2020;4(1):46-59. https://dergipark.org.tr/tr/pub/amusbfd/issue/52200/505152
23. Edis EK. Determination of care-oriented nurse patient interaction levels and affecting factors of women who had cesarean introduction. Journal of Nursing Science 2023;6(2):78–87. https://doi.org/10.54189/hbd.1214961.
24. Süzen H, Çevik K. Relationship between nurses' professional values and compassion and patience levels. Turkiye Klinikleri J Nurs Sci. 2020;12(4):528-35. https://doi.org/10.5336/nurses.2020-74896.
25. Yapici D, Yürümezoğlu HA. Evaluation of working environment by clinical nurses according to healthy working environment standards. DEUHFED. 2021;14(3): 240-252. https://doi.org/10.46483/deuhfed.809757.
26. Özkan Ş, Uydacı M. Determining nurse workforce requirement based on workload in the public hospitals. Health and Nursing Management Journal. 2020;7(3):339-351. https://doi.org/10.5222/SHYD.2020.52244.
27. Van Dusseldorp L, Groot M, Adriaansen M, Van Vught A, Vissers K, Peters J. What does the nurse practitioner mean to you? A patient-oriented qualitative study in oncological/palliative care. J Clin Nurs. 2019;(3-4):589-602. https://doi.org/10.1111/jocn.14653.
28. Lemonde M, Payman N. Perceived roles of oncology nursing. Canadian Oncology Nursing Journal. 2015;25(4):422-431. https://doi.org/10.5737/23688076254422431.
29. Costa DS, Mercieca-Bebber R, Rutherford C, Gabb L, King MT. The impact of cancer on psychological and social outcomes. Australian Psychologist. 2016;51(2):89-99. https://doi.org/10.1111/ap.12165.
30. Başkale HA, Serçekuş P, Günüşen NP. Investigation of cancer patients' information sources, information needs and expectations of health professionals. J Psychiatr Nurs. 2015;6(2):65-70. https://doi.org/10.5505/phd.2015.49091.
31. Alshammari M, Duff J, Guilhermino M. Adult patient communication experiences with nurses in cancer care settings: a qualitative study. BMC Nurs. 2022;21(1):201. https://doi.org/10.1186/s12912-022-00981-4.
32. Lamé G, Jouini O, Stal-Le Cardinal J. Outpatient chemotherapy planning: A literature review with insights from a case study. IIE Trans Healthc Syst Eng. 2016; 6(3):127-139. https://doi.org/10.1080/19488300.2016.1189469.
33. Huang YL, Bryce AH, Culbertson T, et al. Alternative outpatient chemotherapy scheduling method to improve patient service quality and nurse satisfaction. J Oncol Pract. 2018;14(2):82-91. https://doi.org/10.1200/JOP.2017.025510.
34. Banerjee SC, Manna R, Coyle N, et al. Oncology nurses' communication challenges with patients and families: a qualitative study. Nurse Educ Pract. 2016;16(1):193-201. https://doi.org/10.1016/j.nepr.2015.07.007.
35. Tuna R, Baykal U. The job stress of the oncology nurses and infl uential factors. Florence Nightingale J Nurs. 2013;21(2):92-10

ATATÜRK ÜNİVERSİTESİ YAYINLARI
ATATURK UNIVERSITY PUBLICATIONS

Derleme *Review* DOI: 10.17049/jnursology.1507498

Bakımda Anlama Sanatı: Empati ve Refleksiyon İlişkisi

The Art of Understanding in Care: The Relationship of Empathy and Reflection

Beyhan BAĞ[1]

Waldeck weg 9, 68309 Mannheim, Almanya

ÖZ

Çok yönlü bir kavram olan anlamayı farklı bağlamlarda değerlendirmek mümkündür. Psikiyatrik bakımda hemşirenin bir eylemi olarak anlamadan kastedilen ötekinin ne söylediğini, neyi nasıl ifade ettiğini, bir şeyin ne olduğunu veya ne anlatılmak istediği betimlenir. Bir anlama aracı olarak ise ötekinin duygularını anlamada çoğunlukla empatiden yararlanılır. Öte yandan bu empatik süreç; duyguların otomatik, bilinçsiz, duygusal aktarımının ve perspektifinin bilişsel varsayımının gerçekleştiği karmaşık ve anlaşılması zor süreçleri içerir. Bu nedenle profesyonel anlamda empatik bir sürecin gerçekleşmesi için empatik eylemin reflekte edilmesine gereksinim duyulur. Reflekte edilmiş empatik eylem psikiyatri hemşiresinin bilinçli bir eylemde bulunmasına yardımcı olarak hizmet kalitesinin yükseltmesine katkı sağlayacaktır.

Anahtar Kelimeler: Psikiyatrik bakım, empati, refleksiyon, anlama

ABSTRACT

It is possible to evaluate understanding, which is a versatile concept, in different contexts. In psychiatric care, what is meant by the nurse as an action is described, what the other says, how he expresses or cannot, what something is or what he wants to be told. As a means of understanding, empathy is often used to understand the feelings of the other. On the other hand, this empathetic process; It involves complex and elusive processes in which the automatic, unconscious, emotional transmission of emotions and the cognitive assumption of perspective take place. For this reason, empathic action needs to be reflected in order for an empathic process to take place in a professional sense. Reflected empathetic action will contribute to the improvement of service quality by helping the psychiatric nurse to take a conscious action.

Keywords: Psychiatric care, empathy, reflection, understanding

Geliş Tarihi/Received 18.03.2023
Revizyon Tarihi/Revised 29.11.2023
Kabul Tarihi/Accepted 19.02.2024
Yayın Tarihi/Publication Date 25.06.2024

Sorumlu Yazar/Corresponding author: Beyhan BAG
E-mail: beyhanbag@hotmail.com
Cite this article: Bag B. The Art of Understanding in Care: The Relationship of Empathy and Reflection. *J Nursology*. 2024;27(2):153-162.

GİRİŞ

Ruh sağlığı ve psikiyatri hemşirelerinin sundukları bakım hizmetleri genel bir ifadeyle anlatı ve gözlem üzerine kuruludur. Psikiyatri hemşireleri anlatılan ve kendi gözlemleri yoluyla elde ettikleri bilgileri sistematize yapı ve kompozisyonlarla analiz ederler. Daha sonra hemşirelik tanılarıyla ayrıntıları eleyerek hastaların iyileşme süreçlerine katkı sağlar. Başka bir ifadeyle, anlama amacıyla merkez noktaya taşınan bireyin, elde edilen ve tekrarlanan özellikleri tespit edildiğinde, niyet ve eylemleri arasında anlamlandırma aracılığıyla bağlantı kurulabilir.[1] Valdes-Stauber[2] insan davranışlarının ve kararlarının dış dünyada gerçekleşen tüm süreçlerin anlaşılması sayesinde gerçekleşeceğinden bahseder. Ona göre yapılması gereken, konuyla ilgili (ör. evrensel yorum bilgisi, motivasyonel psikoloji, kişilik tipolojileri vb.) sistematize

edilmiş modeli izlemektir. Profesyonel meslek olarak ruh sağlığı ve psikiyatri hemşirelerinin hasta bireylere sundukları bakım yalnızca bilimsel bilgi ve uzmanlıkla değil aynı zamanda profesyonel hemşirelerin sundukları hizmetlerle ilgili neyin nasıl yapılmasıyla ilgili soruların yanıtlarını düşünmekle yani reflekte etmekle ilgilidir.[3] Böylece refleksiyon anlamanın kavranması bu süreçte önemli hale gelir. Refleksiyon yapan birey konunun ne olduğunu, konu hakkında ne düşündüklerini veya hissettiklerini, kimin, neden ve ne zaman dahil olduğunu ve diğerinin bu konuda ne deneyimlemiş ve hatta ne düşünmüş veya hissetmiş olabileceğini anlamaya çalışır.[4] Burada anlamayla hastaya sunulan iyileşme yaklaşımlı psikiyatrik bakım hizmetleriyle; bireyin kendi kişisel iyileşmesiyle ilgili sübjektif bilginin doğasını, bireysel kaynakların toplanıp yorumlanması, psikiyatrik bakımla oluşturulan hemşirelik tanılarıyla ilgili hedeflerin konulup nedenlendirilmesi başka bir ifadeyle hastanın anlaşılmasının yeterlilik ön koşullarının oluşturulma süreci anlatılmak istenir.

Oldukça eski ve merkezi bir kavram olan anlama psikiyatrik bakımda, bir öznenin bireysel özelliği bir yandan göreceli olan alışılmış davranış, temel inançların veya duyguların bağlamında gözlemlenen koşullara bağlı, kırılgan, değişken özelliklerin karmaşık yapısıdır.[5] Çünkü insanların sağlık sorunları duygu, düşünce ve davranış anlamalarını içeren bireysel ve zaman zamanda yoğun stresli olarak tanımlanabilecek değişiklikler eşlik eder. Burada hastaya sunulacak olan hemşirelik bakımının yeterlilik göstergesi; hasta ifadelerini, davranışlarını veya duygularını kendi iç değerlendirme çerçevesinde tanımlamaya ve anlamaya çalıştığı süreç olan empatidir.[6]

Empati, yardım edenle yardım isteyen arasındaki ilişkiyi odak noktasına taşıdığı için bakım hizmetlerinde en önemli ve en çok bahsi geçen kavramlardan birisidir. Bunun yanı sıra, empati, ahlaki eylemin temeli olarak kabul edilse de bireyin kendini diğer insanların yerine koyma yeteneğinin ötekini manipüle etme, aşağılama veya işkence etme içinde çoğunlukla ön koşuldur. Dolayısıyla ötekine şefkat ve ilgi göstermenin bile sayısız istenmeyen sonuçları vardır.[7] Örneğin psikiyatrik bakım hizmetlerinin sunulduğu alanlarda empati ile tükenmişlik ve merhamet yorgunluğu duygularıyla yakından ilişkili olduğuna dair hemşirelik literatürü mevcuttur.[8] Ançel'de[9] hemşirelerde psikodramayı kullanarak empati yapma eğilimlerinin ölçümü ve empatik yaklaşımlarını artırmak için yeni bir yöntem geliştirmeyle ilgili olan çalışmasında empati iletişimin reflektif bir değerlendirmeye gereksinimi olduğundan bahseder. Ayrıca hemşirelik teorisinin uygulamayla birleştirilerek empatik eylemin reflekte edilmesi bir nevi terapötik empatiye dönüşeceğinden, hastayı anlamada daha etkili olacağını vurgular. Bu noktada refleksiyon uygulaması bireyin deneyimleri gözden geçirerek farklı bakış açısı geliştirerek öğrenilmesi anlamına gelir.[10] Başka bir ifadeyle refleksiyon diğerleriyle doğrudan ilişkili sosyal bağlamlarda profesyonel eylemlerin geliştirilmesi ve iyileştirilmesini amaç edinir. Bir nevi psikiyatrik bakımda performans ve yeterlilik ölçütü olan empati de refleksiyon gibi hastayı anlama ve ona göre bakım hizmetleri geliştirmede önemli unsurlardandır. Bu makalede empati ve refleksiyon kavramlarının birbirleriyle olan ilişkisi ve psikiyatrik bakımda taşıdıkları anlam ve üstlendikleri roller tartışılacaktır.

Empati ve Refleksiyon

Sosyal mesleklerde empati genellikle yapılan iş kadar önem arz eder çünkü hastalara sunulan hizmetlerde başarı hedefleniyorsa, empatik yaklaşımı hesaba katmadan olmaz. Empatik davranım genel sağlık uygulamalarında ve hemşirelik bakım hizmetlerinin sunumunda bakımla ilgili kurulan terapötik bakımın ilk basamağını oluşturur.[11] Burada söz konusu olan terapötik davranım hemşirenin kişisel alanı olarak görebileceğimiz özerk uygulamalarıdır. Uygulama ortamlarında gerekçelendirme olmasa bile kararlar her zaman alınmalıdır. Genellikle ne yapılmalı sorusuna yanıt aramak için zaman olmadığından hızlı eyleme geçilir. Burada verilen karar ve sonrasında reflekte etme yoluyla gerekçelendirme veya gelecekte benzer bir durumla karşılaşması olasılığına karşı karar verme sorumluluğu yerine getirilmiş olur.[12] Başka bir ifadeyle profesyonelleştirilmiş terapötik uygulamalarda psikiyatri hemşiresi bu iki kavram arasındaki ilişkiyi anlamaya gereksinim duyar.

Empati

Empati toplumsallığı destekleyen yapısı nedeniyle olumlu çağrışımlara sahip bir kavram olarak yaklaşık yüzyılı aşkın bir zamandır çeşitli disiplinlerde kullanım bulan bir kavramdır. [13] Türk Dil Kurumu sözlüğüne göre empati, duygudaşlık yanı bireyin ötekiyle aynı duyguları paylaşması ve kendini duygu ve düşüncede bir başkasının yerine koyabilme anlamında tanımlanır.[14] Dökmen[13] empatiyi; "bir insanın kendisini karşısındaki insanın yerine koyarak onun duygularını ve düşüncelerini doğru olarak anlaması" şeklinde tanımlamıştır. Bischöf-Köhler[15] da empatinin bir gözlemcinin başka bir bireyin hislerine veya niyetine katıldığı ve böylece diğerinin ne hissettiğini anladığı süreç olarak tanımlar. Ona göre kişi hisseder veya niyet eder. Empati öncelikle diğerinin niyetinin veya duygusunun anlaşılmaya çalışıldığı duygusal bir süreçtir.

Eklund ve Summer Meranius[16] yapmış oldukları bir

literatür incelemesinde empati kavramıyla ilgili anlama, duygu, paylaşma ve ben-öteki farklılaşması dört boyut ortaya koymuşlardır.

Anlama: Diğerinin duygusal durumu hakkında bilgi gerektiren bir bilişsel alt alan olan algılama, bakış açısı edinme ve bilgi anlama içerisinde yer alır. Diğer bireyin duygusal durumu tanımlanıp anlamlandırıldığında daha uygun eylemde bulunacağı varsayılır.

Duygu: Bu boyut diğer kişinin duygusal durumuna verilen/verilecek duygusal tepkiyle ilgilenir. Birey diğer kişinin durumuna kendisini koyması nedeniyle duygusal tepki verir.

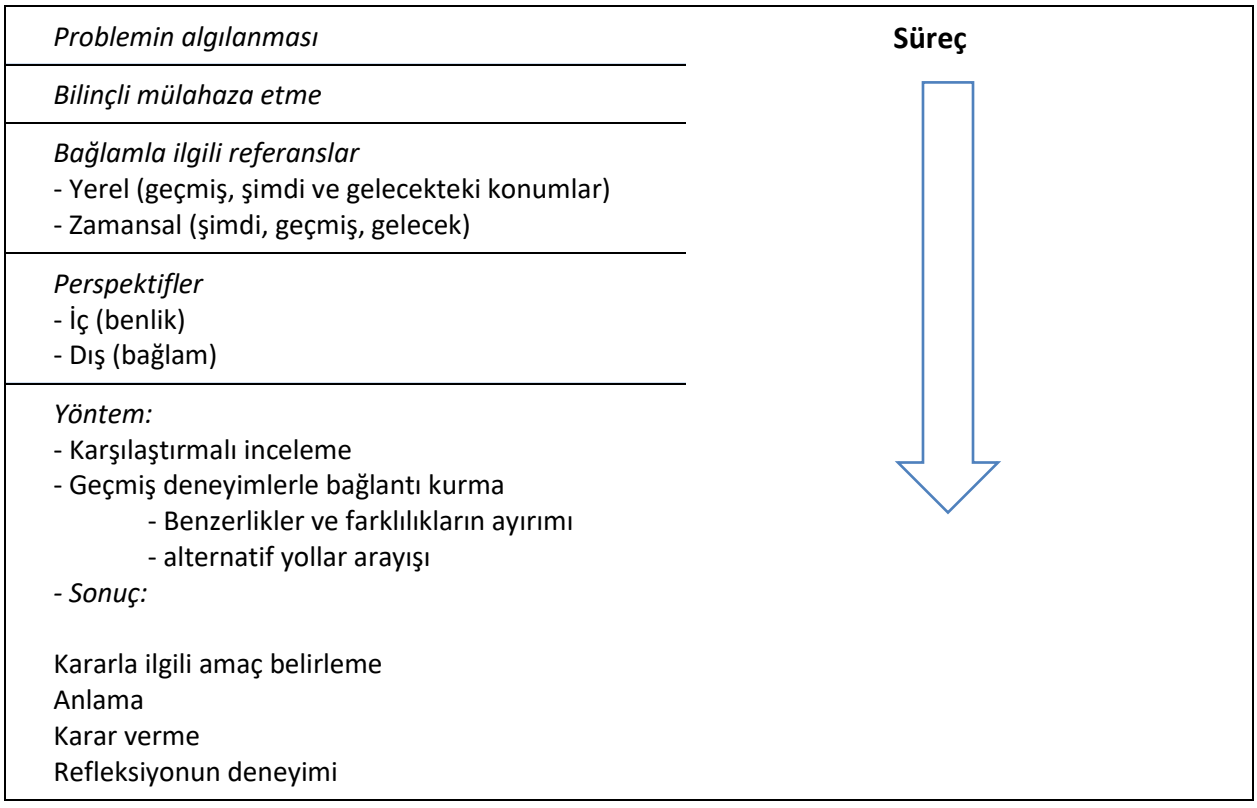
Paylaşma: Diğer kişiyle benzer duyguları duyuşsal manada yaşamak olarak ifade edilebilir. Paylaşmada deneyimler ve duygular ile bunları ifade etme yolları empati kuran ile empatik alıcı arasında oluşan iletişime karşılık gelir.

Tablo 1. Duygusal ve Bilişsel Empatinin Kategorileri ve Özellikleri[17]

Duygusal empati	Bilişsel empati
▪ Empati bir sosyal biliş mekanizmasıdır.	▪ Empati bir sosyal biliş mekanizmasıdır.
▪ Empati, iki (veya daha fazla) kişi arasındaki ilişkide gerçekleşir.	▪ Empati, iki (veya daha fazla) kişi arasındaki ilişkide gerçekleşir.
▪ Empati tarafsız bir deneyimdir, yani diğerinin herhangi bir içsel duygusal durumu deneyimlenir.	▪ Empati tarafsız bir deneyimdir, yani diğerinin herhangi bir içsel duygusal durumu deneyimlenir.
▪ Empati nesneldir, yani başka bir kişiyi yargılayıcı olmayan ve ön değerlendirici olmayan bir şekilde anlamaya çalışmaktır.	▪ Empati nesneldir, yani başka bir kişiyi yargılayıcı olmayan ve ön değerlendirici olmayan bir şekilde anlamaya çalışmaktır.
▪ Kişinin kendi deneyimi ile başkalarınınki arasında bir ayrım olmalıdır.	▪ Kişinin kendi deneyimi ile başkalarınınki arasında bir ayrım olmalıdır.
▪ Dikkat diğer kişiye yöneltilmiştir.	▪ Dikkat diğer kişiye yöneltilmiştir.
▪ Geçici kimlik, geçici özveri	▪ Kendi bencil bakış açısını geçici olarak terk etmek
▪ Duyguların bölünmesine yol açan temsili, anlık, paralel duygusal deneyim	▪ Duyguları paylaşmadan diğerinin içsel durumunu dolaylı olarak tanıma/anlama
▪ Basit bilişsel işleme süreçleri	▪ Karmaşık bilişsel işlem süreçleri
▪ Büyük ölçüde bilinçsiz, kendiliğinden tepki, az bilişsel kontrol	▪ Bilinçli eylem, niyet, bilişsel kontrol altında
▪ Duygusal Uyarılma Yeteneği	▪ Hayal Gücü – Hayal gücünde gerçekliğin simülasyonu
	▪ Birden fazla bakış açısını dikkate alma yeteneği
	▪ İletişim

Ben-öteki-farklılaşması: Empati deneyimleyenler duygunun kaynağının başka bir kişiden geldiğinin ve kendilerini farklılaştırabileceğinin farkındadırlar. Bir empatik iletişim durumunda baskın olan duyguların kaynağının empati yapanda olamamasına yardımcı olur. Bireyin kendisinin ve diğerinin duygularının ayrışmasının önemi vurgulanır. Ben ve öteki ayrıştırmasıyla empati kuranın nesnelliği de sağlanmalıdır.[16] Ruh sağlığı ve psikiyatri hemşireliğinin profilindeki hızlı değişimler ve hızlı geçiş süreçleriyle ilgili kendi mesleki kimliğini ararken temel bakım tutumları yeniden tartışılmaya başlanmıştır. Buna karşılık bu tutumları tanımlayan soyut kavramlar yetersiz tanım ve genellikle farklı bağlamlarda reflekte edilmeden kullanılır. Bu kavramlardan birisi de empatidir. Empati duygusal ve bilişsel empati olarak iki farklı boyutta değerlendirilir. Duygusal empati, bir başkasının ne hissettiğini duygusal bakış açısından hissetmektir. Empatik bir gözlemci ve gözlemlenen bir kişi burada karşı karşıya

tasavvur edilir. Böylece kişinin dışa vurumcu bir davranışının algılanması sayesinde gözlemcide geçici bir özdeşleşme sağlanarak duygusal bir heyecan oluşturur. Duygusal durum empatik olarak deneyimlenir ancak yoğunluk açısından daha az belirgin olabilir. Bilişsel empatide yani bilişsel bakış açısıyla kurulan empatide ise bir başkasının ne hissettiğini ve düşündüğünü anlamak söz konusu olduğunda, gözlemci isteyerek ve bilinçli olarak kendini diğer kişinin yerine koyar ve böylece perspektifler, roller üstlenerek belirli referans çerçevesi dahilinde duyguları anlamaya ve kavramaya çalışır (Tablo 1).[17]



Şekil 1. Böhnke'ye göre[22] Refleksiyonun Merkezi Özellikler ve Perspektifleri

Empatik davranma genel sağlık uygulamalarında ve hemşirelik bakım hizmetlerinin sunumunda bakımla ilgili kurulan terapötinin ilk basamağını oluşturur.[18] Genel hemşirelik biliminde bakım uygulamalarıyla ilgili araştırma kanıtları olmasına karşın hemşirelik uygulayıcıları tarafından kavramın nasıl tanımlandığıyla ilgili bir farkındalığa ihtiyaç vardır. Benzer problem ruh sağlığı ve psikiyatrik bakım uygulamalarında da yaşanır. Psikiyatrik bakımda kurulan terapötik ilişkideki empatik davranışları ölçülebilir kılmak için olasılıklara ve hemşirelerin sundukları eğitimlerde söz konusu fenomeni işlevli kılabilmeleri için refleksiyona gereksinim duyulur.

Refleksiyon

Birey kendisine ne yaptığıyla ilgili soru yönelttiğinde, derin düşünme, analiz etme, sezme, eleştirme, öğrenme gibi zihinsel durumlar harekete geçer. Refleksiyon "geri ve bükülmek" anlamına gelen *flektere* anlamına gelen Latince kökten gelir. Sokrates ve Platon refleksiyonu hem bireyin benliğine hem de bireysel olarak bulunduğu duruma yönelik odaklanan genel bir düşünce olarak yorumlarlar. Refleksiyon sürecine yol açan problem önceki deneyimlere göre değerlendirmeye alınır.[19]

Refleksiyonun genel bir tanımı olmamakla birlikte, bireyi hem fiziksel anlamda görmeye yönlendiren hem de ruhsal anlamda iç dünyasını değerlendiren bir kavram olarak ele alınabilir. Örneğin, Bolton[20] refleksiyonu bireyin kendi başına veya dışardan gelen eleştirel destekle kendi dışındaki olayları veya durumları derinlemesine düşünmesi olarak tanımlar. Bussing ve ark. [21] refleksiyonun tanımı konusundaki ayrışmalara karşın dört ortak unsurun varlığından söz ederler. Bunlar; farkındalık, somut bir sorun, bu sorunla ilgili deneyim ve eylemdir. Refleksiyonla ilgili şekil 1'de genel bir bakış açısı sunulur. Buna göre; refleksiyon içinde bulunulan yerel ve zamansal bir bağlamda düşünme süreci olarak yorumlanabilir. Söz konusu süreç aşamasında düşünce geçmiş, şimdi ve

gelecekle ilgili yer ve anlara doğru yön değiştirebilir. Refleksiyonun nesnesi ise bireysel deneyim düşünce ve duygulardan oluşan benlik ve benliğin bireysel durumudur. Bu anlamda refleksiyon yapan kişi bir iç (benlik) ve dış bakış açısıyla hareket ederek süreci başlatır. Karşı karşıya kalınan sorunla ilgili geçmiş deneyimlerle karşılaştırmalara gidilerek alternatif eylem yolları aranır. Bu süreç içerisinde kazanılan iç görüler reflektif eyleme doğru yönelir.[22]

Refleksiyon, reflektif ve düşünümsel süreçler potansiyel olarak psikiyatri hemşireliğiyle ilgili uygulamalarımızda özeleştirel ve daha etik davranmamıza vesile olarak ileri psikiyatrik bakım uygulamalarındaki gelişimi besler ve uygulamaya dayalı öğrenmeyi sürdürmeyi teşvik eder. Başka bir ifadeyle, insanın entelektüel süreçleri daha geniş bir açıdan düşünüldüğünde farklı temsil sistemlerini (duygusal imgeler, duygular, bilişler, kayıt edilmiş eylemler, anılar ve dil vb.) kullanma olasılıkları, kişiye özgü refleksiyon biçimlerine odaklanma için ortamlar oluşturur. Reflektif uygulama tanımı günümüzde özellikle Anglosakson coğrafyadaki çağdaş klinik uygulamalarda önemli bir yer edinmiştir. Refleksiyon özünde psikoterapi ve danışmanlık uygulamasıyla ilgili olarak düşünülse de hemşirelik, sosyal hizmetler, tıp, eğitim gibi çeşitli alanlarda yaygın kullanım bulur.[23,24]

Psikiyatri hemşiresi tarafından gerçekleştirilen profesyonel eylem karmaşık problemlerin temsili bir yorumlanması da kanıt temelli bilginin mevcut tartışılan vakayla ilgili kullanımıyla karakterizedir.[1] Uygulama alanlarında refleksiyon esasına dayanan bir mesleki eylem bireyin mesleki etkinliğini reflekte ederek gelişmesi anlamına gelir. Burada refleksiyon eylemi mesleki bilgiyi odak noktasına taşıyarak bilimsel bilgi ve uygulamadaki eylem arasındaki ilişkiye bir nevi yanıt arar.[12] Başka bir anlatımla refleksiyon psikiyatri hemşiresinin ne yaptığını bilincinde olması anlamına gelmektedir.

Tartışma

Anlama, çok farklı bağlamlarda ortaya çıkar, dolayısıyla çeşitli nesneleri vardır. Bir sözü işitsel olarak anlayabilir, bir yabancı dili, matematiksel bir kanıtı, bir saati, bir senfoniyi, gökkuşağı veya halüsinasyon gibi fenomenleri, ayrıca nevrotik bir semptomu, bir eylemi veya bir bireyi anlayabiliriz.[25] Psikiyatrik bakımda da anlama, psikiyatri hemşirelerinin uygulama alanlarında önemli bir rol edinir. Dziopa ve Ahern[26] anlamayı ruh sağlığı ve psikiyatri hemşireliğinde terapötik ilişkinin önemli bir unsuru olarak nitelerler. Anlaşılma duygusunun verilmesi, hastalara kendilerini önemli hissetmesini sağladığını ve dolayısıyla ruhsal hastalıkları nedeniyle toplumda sıklıkla damgalanmaya maruz kaldıkları durumlarda güçlendirme rolü gördüğünü ileri sürerler. Buna karşın "anlama" görev ve sorumluluk tanımlarında oldukça nadir olarak algılanır ve tartışmaya değer bulunur. Diğer yandan, akut sıkıntılı durumlarda bile anlama arzusu ve istekliliği psikiyatrik bakımın temel unsurunu oluşturur. Başka bir kişinin niyetini doğrudan bir paylaşma ve dolayısıyla anlama deneyimi olarak empati, bir kişinin içinde bulunduğu durum veya başka bir kişinin ifadeleriyle tetiklenen, söze dökülen davranışı ile tanımlanır. Bu nedenle empati yalnızca ses ve mimik çözümlemesiyle ilişkili değil aynı zamanda empati kuran açısından henüz deneyimlenmemiş olsa da duygusal bağlamı da içerir. Bu deneyimlenen duruma uygun bir duygusal tepki sağlar.[27] Hem ve Hegen[28] psikiyatri hemşireleriyle yapmış oldukları etnografik araştırmada, hemşirelerin hastasını anlamak için yoğun kişisel saldırılara maruz kalmasına rağmen empatiyi anlama iradesi olarak kullanma arzusunu devam ettirdiklerini tespit etmişlerdir. Empati terapötik ilişkinin ön koşuludur. Holnburger[29] empatiyi bir diğerinin durumunu veya davranışını onunla özdeşleşmeye gidilmeden duygudaşlık yapma yeterliliği olarak tanımlar. Holnburger 'in empati tanımını açarak empatik terapötik ilişkinin özelliklerini; hastanın gönüllü kabulü ve eşduyum, karşılıklı güven ilişkisi, yardım etmeye hazır olma, anlayış gösterme, hastanın hastalığıyla ilgili deneyimlerine katılım, hastanın hayal kırıklıklarını paylaşabilme ve bunlarla başa çıkmada destekleme, hastaya gerektiğinde sorumluluk alabileceğini gösterme şeklinde sıralarlar. Psikolog Carl Rogers[30] empatinin "hastanın iç dünyasını kendisininmiş gibi hissetme" yeterliği olduğunu söyler. Böylece hemşire hastanın henüz kendisinin bile ifade edemeyeceği şeklinde net olmayan duygu ve anlamlarını değerlendirir. Buradaki empatik anlama denemesi hemşirenin hastaya olan davranışını açıklamaz.[31] Diğer yandan, bazı durumlarda diğeriyle empatik bir eylemde bulunma ve ondan yararlanma için kişinin kendi duygularını anlaması gerekir. Bu gibi durumlar başkalarının duygularının anlaşılması bireyin örneğin hemşirenin duygularını anlamasına yardımcıdır.[27] Ellis'in[32] uygulama alanlarında karar vermede refleksiyon kullanılmasıyla ilgili yazmış olduğu makalede, reflektif uygulamaların sağlık profesyonelleri için kendileri hakkında bilgi sahibi olarak gelecekteki uygulamalarını pozitif yönde güçlendireceğini savunur. Refleksiyon bireyin kendi deneyim dünyasından uzaklaşarak mevcut veya deneyimlenen durumlara yeni bir bakış açısı getirme yeteneğini geliştirir. Aynı zamanda çeşitli nedenlerle huzursuzluğa ve olumsuz duygulara sebebiyet veren zor durumları açığa kavuşturmaya ve rutinin dışına çıkılmasına olanak sağlayan önemli bir araçtır.[33] Hemşirelik girişimi için eylemler ve düşünceler bilinçli hale getirilerek anlam oluşturulur. Böylece öğrenme ve gelişim somut biçime bürünür.[34]

Türkiye'de empati kavramıyla ilgilenen Dökmen[13], empatiyi

bireyin kendisini diğerinin yerine koyarak onun duygu ve düşüncesini anlama eylemi olarak ifade eder. 1988 yılında ortaya koyduğu empati sınıflandırmasının tüm aşamalarında görüldüğü üzere empatide amaç karşıdakini anlamadır. Bununla birlikte empatiyle diğerini anlama karmaşık bir süreçtir. Çünkü bir diğerinin duygularını bütünüyle anlama salt hayal gücüyle imkânsızdır. Yani iki kişi arasında oluşan ve ortak olunan duyguya karşılıklı ilgi gösterilmesi gerekir. Öte yandan, diğerinin duygularıyla oluşmuş eşduyum süreci otomatik olarak anlamayla sonuçlanmaz. Söz konusu eşduyum edinilen deneyim hakkında bilgi edinme süreci gerçekleşir. Bu durum bireyin kendi duygularının kendisi için de açık olmamasından kaynaklanabilir. Dolayısıyla kişi diğerinin duygularını ödünç alarak kişiselleştirir.[19] Böyle bir durumda hasta-hemşire iletişiminde kurulan eşduyum bireyin kendisini de anlamasını engelleyeceğinden tersi bir etkiye neden olur. Çünkü burada hemşire duyguya eşlik eden diğeriyle aynı perspektiften anlama eyleminde sınırlamaya gitmiştir. Oluşan eşduyumla artık bazı şeyler farklı algılanır. Psikiyatri hemşiresi empatik eylemdeki oluşan eşduyumla perspektif edinmenin beraberinde getirdiği sınırlamadan sakınması için deneyimlenen durumu tekrardan simule ederek başka bir ifadeyle reflektif eylemle diğerinin duygularıyla ilgili deneyiminin bir anlatımına gereksinim duyar. Ancak böyle bir anlatımda duygunun tüm yönleriyle bakış açısı belirlenerek söz konusu duyguyla empati kurulur.[25] Bu durumda refleksiyon, genellikle deneyimlerin anlamı ve uygulamada kullanılan teorik varsayımlarla uyum gösterdikleri sohbet tarzı konuşmalarla teşvik edilir. Buradaki amaç başarılar ve yapılan hatalardan öğrenme gerçekleştirilerek bireysel inanç ve değerler saptamasına gidilmesi ve ne yapılması gerektiğine dair ortak bir karara varılmasıdır .[35] Bu psikiyatrik ve psikososyal bakımdan sorumlu olan psikiyatri hemşirelerinin uygulama alanlarında kullandıkları terapötik iletişimin ön koşulu olan empatiyle ilgili kavramsal analiz yapmanın anlama sürçlerinde oldukça destekleyici olacağının da ifadesidir. Örneğin Bischoff-Wanner[17] hemşirelikte kullanılan terimlerin analizine vurgu yapar. Her bilim alanının kendi kavramlarını tanımasına ve adlandırmasına gerek olduğunu ileri sürer. Buradaki amaç kavramların teori, araştırma ve uygulamada anlamlı bir şekilde uygulanabilmeleri için hangi göstergelerin var olduğunu belirlemektir. Türkiye'deki hemşirelik literatüründe empatiyle ilgili kendi mesleki kavram analizine rastlanmamaktadır. Buna karşın, ülkemizde empati becerisinin hasta-hemşire ilişkisindeki önemini vurgulayan çalışmalar mevcuttur.[38] Örneğin Ağaçdiken ve Aydoğan[36] yaptıkları inceleme yazısında empati becerisinin hemşirelerin kendilerini ve hasta gereksinimini anlamalarına yardımcı olacağını ileri sürerler. Empatiyle sağlanacak anlama eylemiyle iki taraflı gereksinimlerin anlaşılması profesyonel bakım hizmetleri sunumuna yardımcı olacaktır. Bununla birlikte, hemşirelik biliminin hemşirelik uygulamalarında ve eğitimiyle ilgili empatiye dair araştırmalar yayınlanmış olmasına[37] rağmen, empatinin hemşire hasta arasındaki terapötik ilişkide istenilen yerde olduğu henüz söylenemez. Bunun bir nedeni olarak bakım uygulayıcılarının empati terimini hemşirelik mesleğine uygulanmasına ilişkin tanım ve yöntem eksikliğinden kaynaklandığını söylemek hiç de yanlış olmaz. Bu durum ise hemşirelik bakımı uygulayıcılarının empati terimini nasıl tanımladığı konusunun önemini ortaya çıkarır.

Türkiyede hemşirelik eğitimi müfredat programlarında iyileştirme çabaları güncel tartışma konusudur. Örneğin Mert ve ark.[23] Dokuz Eylül Üniversitesi Hemşirelik Yüksekokulu'nda eğitim müfredatlarında refleksiyon uygulamasına başlandığını bildirmişlerdir. Refleksiyonun müfredatta kullanılmasının amacının hemşirelik öğrencilerin bireysel ve profesyonel gelişimini kalitesini artırmak olduğunu ifade ederler. Ancak söz konusu makale dışında Türkiye'deki hemşirelik literatüründe refleksiyonla ilgili herhangi bir çalışmaya rastlanmaz. Benzer durum hemşirelikte empati kavramı için de geçerlidir. Reynolds[18] empatinin klinik hemşireler için önemine dikkat çeker. Hemşirelerin sundukları bakım uygulamalarında hastalar, aileler, meslektaşları ile organizasyonel bir dizi ilişkide bulunduklarına işaret eder. Buna en güzel sağlık sektörünün en büyük meslek grubu olan hemşirelikteki değişim sürecinde rastlanmaktadır.[38] Ekonomileştirme ve profesyonelleşme bu değişimin merkezi yönleridir. Hemen hemen tüm sağlık kuruluşlarında artan ekonomik baskı, niteliksizleşme ve profesyonellikten uzaklaşma olarak değerlendirebilecek bir sarmalı harekete geçirmektedir.[39] Hemşireler ile yöneticiler arasında hemşirelik hizmetlerinin sunumundaki farklı öncelikler nedeniyle hemşireler yeterince desteklenmedikleri duygusuna kapılabilirler. Bu durum ekonomik ve bürokratik gerçeklik ile profesyonel bakım hizmeti sunumu arasında gerilim oluşturarak profesyonel eylemleri zorlaştırabilir. Ünal ve Seren[40] 25 hastanede çalışan yönetici hemşirelerle yaptıkları çalışmada, hemşirelerin hemşirelik dışı birimlerde görevlendirilme durumlarını incelemişlerdir. Çalışma sonucunda yönetici hemşireler hemşireleri bakım alanı dışında görevlendirmeleriyle ilgili gerekçeler arasında personel eksikliği, hemşirelik görevinin bir parçası olarak düşünülmesi, hekimin iş gücünü azaltmak, hemşirelerdeki fiziksel ve ruhsal hastalıklar ve üst yönetimin isteği olarak sıralamışlardır. Çetin ve Yayan[41] yaptıkları çalışmada 824 hemşireye kendi alanları dışındaki görevleri yapma

nedenlerini incelemişlerdir. Çalışmaya katılanlar alan dışı görevlendirmeleri yerine getirme gerekçeleri arasında yönetici ve doktorlar tarafından mobinge maruz kalmayı, işten çıkarılmayı ve hastanın zarar görme korkusunu sıralamışlardır. Schmedes'e[34] göre çatışan ilgi alanları ve bunlara yeterince destek alınmaması gibi durumlar hemşirelik hizmetlerini farklı yönlerden etkilediğini ifade eder. Örneğin hemşireler yöneticileri kendi işlerini yapmalarının önünde engel ve rakip olarak algılarlar. Burada ana sorunun yöneticilerdeki empati eksikliği olduğunu ileri sürerler. Çetinkaya Ulusoy ve Paslı Gündoğan[42] ise 349 ebelik öğrencisinde empatik eğilimin mesleki dayanışmaya olan etkilerini inceledikleri araştırma sonucunda; empatik eğilimlerin mesleki dayanışmaya olumlu bir etki yaptığını bulmuşlardır. Empatik eğilimler ekip çalışmasında terapötik iletişimi olumlu yönde etkileyici bir özelliğe sahiptir. Hemşirelik yönetmeliğinde[43] hemşirelik hizmetlerinin etkinliğini değerlendiren ve sistemin işlemesini engelleyen nedenlerin belirlenmesi ve buna yönelik girişimlerde bulunmayla ilgili sorumluluklar konsültasyon-liyezon psikiyatri hemşiresine (Klph) verilmiştir. Klph gereksinim görülen alanlarda empatiyle ilgili düzenli eğitimler organize etmesi ve gerekli görüldüğünde ekip süpervizyonlarını yapması bu çalışma aracılığıyla öneri olarak dikkate sunulmaktadır.

Empatik eylemde ki bakış açısını veya perspektifini üstlenme başkalarının duygularını düşünsel çıkarsama yoluyla onların durumunu anlamak anlamına gelir. Bir bireyin diğerlerinin perspektifini yakalaması bilişsel, görsel veya duygusal olmakla beraber gözlemcinin etkilenmesini gerektirmemektedir.[17] Preckel ve ark.[44] empatinin empati yapılan eylemin olumlu ya da olumsuz olmalarına bakılmaksızın başkalarının duygularıyla rezonansa girme süreci olduğunu belirtir. Empatik birey kendilik pozisyonunu gözden kaçırmadan diğerine karşı önyargısızdır. Aynı zamanda empati yapan kişi kendi duygularının farkındadır ve ancak bunları kurulan terapötik ilişkide yararlı olunacağı inancı olduğunda söyler. Burada empati kişilerarası iletişimde bir tutum olarak anlaşılmalıdır. Başka bir ifadeyle diğerinin duygularından etkilenmeden yani onunla aynı duygu içinde bulunmadan duygularını ve gereksinimlerini anlamaktır. Böylece diğerinin duyguları ve bakış açısı anlamlandırılır ve uyarlanır. Ancak ben-öteki farklılaşması[13,17] bilinçli olarak devam eder. Altmann ve ark.[45] şiddet içermeyen iletişimde empati anlayışına karşılık gelen karşı tarafın bilinçli, dikkatli, aktif dinleme ve konuşmaya isteklilik gösterme gibi davranışların önemini vurgular. Empatinin hem duygusal hem de bilişsel bir bileşeni vardır, bu nedenle bilgiyi aktaran öncelikle empatik şefkatin özel duygusal kalitesidir. Bu nedenle empati, başka bir sosyal biliş mekanizmasıyla, yani perspektif almayla karıştırılmamalıdır.[15]

Diğer yandan empatiyi, duygusal olarak aşırı yüklenme ve tükenmişlik için güçlendirici faktör olarak değerlendirmek yanlış yorumlanır. Singer ve Klimecki[46] bu durumu empatik sıkıntı olarak adlandırırlar. Araştırmacılar empatik sıkıntının bireyin kendisini aşırı olumsuz duygulardan korumak için bir durumdan geri çekilme isteğini ifade ederken, merhamet ve yardım için motivasyonun eşlik ettiği diğer kişinin acı çekmesi olasılığına karşı endişe duygusu olarak tanımlar. Tablo 2'de olası empatik reaksiyonlar verilmiştir. Hastayla hemşire arasında bırakılan profesyonel mesafenin yeterli olmadığı durumlarda, stres ve olumsuz duygular ortaya çıktığını ileri sürerler. Başka bir ifadeyle, kendi-öteki ayrımının veya kendi-başkası farklılaşmasının[16] başarılı empatik süreçler için ön koşul olduğu anlamına gelir. Bauer ve Ahren[47] hasta-hemşire iletişiminde yetenek ve yeterliliğin belirleyici faktörler olduğunu vurgularlar. Empatinin önemli rol oynadığı ilişki kurma yeterliği süreçlerinde etkileyici faktörler arasında kendini açma ve refleksiyon yapabilme olarak kendini gösterir. Ruh sağlığı ve psikiyatri hemşireliğini alanında sunulan hizmetlerin odak noktası hemşire ile hasta arasındaki etkileşimdir. Rogers[30] empatinin terapötik başarının ön koşulu olduğunu ifade ederek empatiyi terapist ve danışan arasında başlayan etkileşimin bir özelliği olarak tanımlar. Ona göre terapist oluşan ortak süreçte danışanı anlamalı ve anlaşılanı danışana iletmelidir. Bu süreçte refleksiyon psikiyatrik bakım uygulayıcısının terapötik süreçlerde, kendi empatik eylemleri üzerine düşünmesi ve risklerini tanımasının yansıra alternatif eylem yolları geliştirerek günlük uygulamalarına taşıması önemlidir. Psikiyatri hemşiresinden hastayla karşılaşmasını sistematik olarak reflekte etmesi beklenir. Refleksiyon sürecinde hem hemşirelerin hem de hastaların özerkliği gereklidir.[48] Buna karşın araştırma sonuçlarının yetersizliği konuyu tüm boyutlarıyla tartışmaya imkan vermez. Daha fazla memnuniyet, tedaviye daha iyi uyum ve bununla ilişkili olarak artan iyileşme sonucu gibi hastalar için olumlu etkilere ek olarak empatik bakım profesyonel yaşam kalitesine de önemli ölçüde katkıda bulunur. Bu nedenle yeterli iletişim gibi bu fenomeni teşvik eden faktörleri bilmek önemlidir.

Tablo 2. Singer ve Klimecki[46] Göre Empatik Reaksiyonlar: Merhamet ve Empatik Sıkıntı

Empati	
Şefkat (Merhamet)	***Empatik Sıkıntı***
Diğer ilgili duygu	Kendiyle ilgili duygu
Olumlu duygular: örneğin, aşk	Stres gibi olumsuz duygular
Sağlık	Kötü sağlık, tükenmişlik
Yaklaşım ve toplum yanlısı motivasyon	Geri çekilme ve sosyal olmayan davranış

Ancak empatik yaklaşım olumlu etkilerinin yansıra olumsuz sonuçlara da neden olabilir.[13] Özellikle hastalar algılanabilen duyguların geri bildiriminde kendi duygularıyla ilgili şahsi yorumlama veya açıklamalar yerine bir diğerinin geri bildirimde bulunmasıyla kendilerini aşırı görünür veya utanmış hissedebilirler. Bir nevi aşırı derecede onama almış gibidirler. Öte yandan, özellikle psikiyatri hemşirelerinde tükenmişlik duygusunda artma eğiliminin olduğuyla ilgili araştırmalar mevcuttur.[44] Burada tükenmişliğe yol açan durum aşırı duygusal katılım ve özveriyle ilişkilidir. Bireyin kendi biyografik temalarını dikkate almadan ve bireysel sınırlara saygı duymadan sınır koymadan empatik katılım duygusal tükenme riskini içerir. Kontrolsüz bir empati ile birleştirilmiş bireyin kendi duygularını kabul edememesi bu nedenle özel bir risk kombinasyonunu temsil eder. İkincil travma fenomeni, yani travmatize hastalardan semptomların benimsenmesi de empati ile bağlantılı şekilde tartışılır.[15] Özellikle bu durumun sıklıkla karşılandığı akut hastane ortamlarında ben-öteki ayrımı sağlanmadığı takdirde empatik katılım yoluyla hemşirede dolaylı travma meydana gelebilir. Başa çıkma stratejilerini öğrenmek, hemşirelik mesleğine yeni başlayan profesyonelleri merhamet yorgunluğuyla mücadele etmelerine yardımcı olabilir ve böylece işyerinde daha mutlu bir çalışma düzeni kurabilirler.[51] Genel bir ifadeyle hastalarla iletişim başarısı için reflekte edilmiş bir empati önemli bir faktör olup hastanın içinde bulunduğu psikososyal durumla ilişkili duygusal bileşenleri anlama sürecinde etkilidir. Ayrıca hastaya yönelik empatik bir tutumla yaklaşım motive edici bir etkiye sahip olduğundan hastadaki duygusal stresi azaltabilir. Böylece hastayla profesyonel anlamda reflekte edilmiş eylemi destekleyerek bilgi alışverişini kolaylaştırmış olur.[13,31] Böylece sistem içi çatışmaları azaltarak çalışma motivasyonuyla işbirliğini artırır. İlk konsültasyonda hemşire, terapistin hastaya gerçekte ne olduğunu, neyi zor bulduğunu ve hangi yorumları edindiğini veya okuduğunu çözmesi gerektiğinden, bu durum zaman zaman entelektüel bir meydan okuma haline gelir.[49] Örneğin psikodinamik psikoterapi uygulamasında süpervizyon alan kişi genellikle danışanla yaptığı bir oturumda diyalog çizimler ve kişisel refleksiyonlar da dahil olmak üzere materyal alır ve bunların anlamını süpervizörle birlikte araştırır, çalışmalarla ilgili anlayışlarını genişletir ve yorumlar. Burada terapinin kendisindeki refleksiyon ile geriye dönük anlam oluşturma arasındaki ayrım nispetten nettir. Bu nedenle bireysel refleksiyonla genel anlamda olay öncesi ve olay sonrası için yeni bir perspektif sağlamayı amaçlayan refleksiyon burada birlikte tartışılacaktır. Çünkü ikisi de birbirine bağlı süreçlerdir. Genel bir refleksiyona gidilmeden yapılan kişisel reflektif eylem sadece kendi kendine hizmet etmekten öteye gitmez ve öz farkındalığı artırsa bile bilginin sistematize edilmesine katkıda bulunmaz. Diğer taraftan kişisel refleksiyonsuz yapılan genel bir reflektif eylem ise uygulanan bakım terapisinin uzaktan kişisel ayrıntılara göz önüne almadan kuramlaştırmak herhangi bir somut temele dayanmadığından anlamsız olacaktır.[50]

Sonuç olarak, ruh sağlığı ve psikiyatri hemşireleri için bakım uygulamalarında empati önemli unsurlardan biridir. Empati kullanımıyla sadece hastanın gereksinimlerini anlamak için değil aynı zamanda diğer sağlık personelleri ile iyi bir iletişim kurma yolunda çalışma ekibini güçlendirmek için destekleyicidir. Profesyonel anlamda empatik davranımın gerçekleşmesi için reflektif eyleme gereksinim duyulur. Reflektif eylemle psikiyatri hemşiresi mesleki etkinliğini reflekte etme süreciyle mesleki gelişimine katkıda bulunur. Bu aynı zamanda psikiyatrik bakım uygulamalarındaki teori ile uygulama arasındaki boşluğu doldurmanın bir yolu olarak da görülebilir. Refleksiyon aracılığıyla empatinin uygulamalarda yanlış kullanımı sonucu ortaya çıkabilecek anlamlandırma yanlışlarını ve örtük olan bilgiyi uygulayıcılar için görünür kıldığından yararlı olacağı açıktır.

Hakem Değerlendirmesi: Dış bağımsız.
Çıkar Çatışması: Yazar, çıkar çatışması olmadığını beyan etmiştir.
Finansal Destek: Yazar, bu çalışma için finansal destek almadığını beyan etmiştir.

Peer-review: Externally peer-reviewed.
Conflict of Interest: The author have no conflicts of interest to declare.
Financial Disclosure: The author declared that this study has received no financial support.

KAYNAKLAR

1. Bag B. Biographical Study with Hermeneutic Approach in Psychiatric Care Delivered at Community Mental Health Centers. Psikiyatride Güncel Yaklaşımlar. 2022; 14(4): 460-468.
2. Valdés-Stauber J. Verstehen in der Psychiatrie – Teil 2 Vom Unverständlichen zur Verständigungsdisposition. Nervenarzt. 2018; 89:1032–1042.
3. Schwarz R. Supervision und professionelles Handeln Pflegender. VS Verlag für Sozialwissenschaften | GWV Fachverlage GmbH, Wiesbaden; 2009.
4. McKinnon J. Reflection for Nursing Life. Principles, process and practice. Routledge New York; 2016.
5. Kapsch E. Verstehen des Anderen Fremdverstehen im Anschluss an Husserl, Gadamer und Derrida. Parodos Verlag Berlin; 2007.
6. Wabnitz P, Rixe J. Ohne Empathie geht es nicht. Heilberufe. 2020;72:32–33.
7. Breithaupt F. Die dunklen Seiten der Empathie. Suhrkamp Verlag Berlin; 2017.
8. Turan N, Kaya H, Özsaban A, Özdemir-Aydın G, Özçelik K ve Güneş E. Investigation of the relationship between empathy and burnout levels of nursing students. FNJN Florence Nightingale Journal of Nursing.2019; 27(2):119-132.
9. Ançel G. Developing empathy in nurses: An inservice training program. Archives of psychiatric nursing. 2006;20(6): 249-257.
10. Goodman J. Reflection and teacher education: a case study and theoretical analysis. Interchange.1984;15:9–26.
11. Reynolds WJ, Scott B. Empathy: a crucial component of the helping relationship. Journal of Psychiatric and Mental Health Nursing. 1999; 6:363–370.
12. Dewe B. Professionsverständnisse – eine berufssoziologische Betrachtung. In: Pundt, J. (Eds.): Professionalisierung im Gesundheitswesen. Positionen – Potentiale – Perspektiven. Hans Huber, Bern; 2006: 23-36.
13. Dökmen Ü. Sanatta ve Günlük Yaşamda İletişim Çatışmaları ve Empati. (52. Baskı) İstanbul, Türkiye: Remzi Kitapevi;2014.
14. TDK (Türk Dil Kurumu). Empati ne demek TDK Sözlük Anlamı. Erişim tarihi:07.02.2023. www.sozluk.gov.tr.
15. Bischof-Köhler D (2009) Empathie, Mitgefühl und Grausamkeit Und wie sie zusammenhängen. Psychotherapie. 2009;14:(1)52-57.
16. Eklund JH, Meranius MS. Toward a consensus on the nature of empathy: A review of reviews. Patient Education and Counseling.2021;104(2):300-307.
17. Bischoff-Wanner C. Empathie in der Pflege: Begriffsklärung und Entwicklung eines Rahmenmodells. Bern, Göttingen, Toronto, Seattle, Huber; 2002.
18. Reynolds B. The influence of clients' perceptions of the helping relationship the development of an empathy scale. Journal of Psychiatric and Mental Health Nursing. 1994; 1:23-30.
19. Stekeler-Weithofer. Die Eule der Minerva oder: die Macht der Reflexion. Allgemeine Zeitschrift für Philosophie. 2000;25:63-78.
20. Bolton G. Reflective practice: Writing and professional development. Sage publications; 2010.
21. Büssing A, Herbig B, Ewert T. Implizites Wissen und erfahrungsgeleitetes Arbeitshandeln: Konzeptualisierung und Methodenentwicklung. Techn. Univ. München, Lehrst. für Psychologie: 1999.
22. Böhnke U. Die Multiperspektivität von Reflexionsprozessen in der Pflegepraxis und Pflegeausbildung und deren Relevanz für die Entwicklung einer professionellen Handlungskompetenz. Unveröffentlichte Diplomarbeit. Universität Bremen. Bremen;2001.
23. Mert H, Bilik Ö, Yıldırım Sarı H, Üstün B. Bir Öğrenme Deneyimi: Reflekşın (Reflection). DEUHYO ED 2011;4(2):89-93.
24. Jarvis P. Adult and Continuing Education: Theory and Practice (2nd edn). Routledge. London;1995.
25. Weber-Guskar E. Die Klarheit der Gefühle. Was es heißt, Emotionen zu verstehen. Walter de Gruyter GmbH & Co. KG, D-10785 Berlin;2009.
26. Dziopa F, Ahern K. What Makes a Quality Therapeutic Relationship in Psychiatric/Mental Health Nursing: A Review of the Research Literature. The Internet Journal of Advanced Nursing Practice. 2008;10:1.
27. Bischof-Köhler D. Empathie, prosoziales Verhalten und Bindungsqualität bei Zweijährigen. Psychologie in Erziehung und Unterricht, 2000.
28. Hem MH, Heggen K. Being professional and being human. One nurses relationship with a psychiatric patient. Journal of Advanced Nursing.2003; 43(1): 1001-108.
29. Holnburger M. Pflegestandart in der Pschiatrie, 3.eds..München:Urban und Fischer;2004.
30. Rogers, CR. Empathic: An unappreciated way of being. The Counseling Psychologist, 5, 2–10.
31. Sauter D, Abderhalden C, Needham I, Wolff, S. Lehrbuch Psychiatrische Pflege. Huber; 2011.
32. Ellis N. Decision making in practice: influences, management and reflection. British Journal of Nursing. 2017;26:2.
33. Holenstein, H. (Hrsg.): Spielräume in der Pflege. Hans Huber, Bern;1997.
34. Schmedes C. Emotionsarbeit in der Pflege Beitrag zur Diskussion über die psychische Gesundheit Pflegender in der stationären Altenpflege. Springer Fachmedien Wiesbaden GmbH, Wiesbaden;2021.
35. Stedmon J, Dallos R. Reflective practice in psychotherapy and counselling. McGraw-Hill Education;2009.
36. Ağaçdiken S, Aydoğan A. Hemşirelerde Empatik Beceri ve

Etik Duyarlilik İlişkisi. GÜSBD 2017; 6(2): 122–129.
37. Avcı D, Aydın D, Özbasaran F. Hemşirelik öğrencilerinde empati-özgecilik ilişkisi ve özgeci davrandığın bazı değişkenler açısından incelenmesi. Balıkesir Sağlık Bilimleri Dergisi. 2013;2(2):108-13.
38. T.C. Sağlık Bakanlığı Sağlık İstatistikleri Yıllığı. The Ministry of Health of Türkiye Health Statistics Yearbook 2020. Erişim tarihi 17.06.2022. www. saglik.gov.tr.
39. Saritaş TC. Gendered Aspects Of Flexible Work And Precariousness In Turkey: A Case Of Nurses In Health Sector. Middle East Technical University. The Degree Of Doctor Of Philosophy. Ankara 2017.
40. Ünal A, Seren Ş. Hastanelerde Çalışan Hemşirelerin Hemşirelik Dışı Birimlerde istihdamı ve Nedenlerinin İncelenmesi. DEUHYO Dergisi.2010;3(1): 23-29.
41. Çetin Y, Yayan EH. Hastanede Çalışan Hemşirelerin Hemşirelik Dışı Görevleri Ve Nedenlerinin İncelenmesi. Anadolu Hemşirelik ve Sağlık Bilimleri Dergisi.2020; 23(2): 221-226.
42. Çetinkaya Ulusoy E. Paslı Gürdoğan E. Hemşirelerde Empatik Eğilim Meslektaş Dayanışmasını Etkiliyor mu? Adnan Menderes Üniversitesi Sağlık Bilimleri Fakültesi Dergisi 2019; 3(1): 19-29.
43. T.C. Sağlık Bakanlığı. Hemşirelik Yönetmeliği. T.C. Sağlık Bakanlığı, Ankara. Hemşirelik Yönetmeliği, 2011a. Erişim: 21.10.2022. ww.saglik.gov.tr.
44. Preckel K, Kanske P, Singer T. On the interaction of social affect and cognition: empathy, compassion and theory of mind. Current Opinion in Behavioral Sciences.2018; 19:1–6.
45. Altmann T, Schönefeld V, Roth M. Evaluation of an empathy training program to prevent emotional maladjustment symptoms in social professions. Psychology.2015;6(14):1893.
46. Singer T, Klimecki OM. Empathy and compassion. Current Biology. 2014;24(18):875-878.
47. Bauer R, Ahrens R. Psychotherapie und Psychosomatik in der Pflege. Wiesbaden: Ullstein Medical;1998.
48. Weidner F. Professionelle Pflegepraxis und Gesundheitsförderung. Eine empirische Untersuchung über Voraussetzungen und Perspektiven des beruflichen Handelns in der Krankenpflege. 3. Eds.. Frankfurt a. M, 2004.
49. Ander U, Klein F, Kropp K, Krug W. Gestaltung der psychiatrischen Pflege. In: Pschiatriepflege und Pschotherapie. Ed Stephanie Amberger ve Sibylle C. Roll. Georg Thieme Verlag, Stuttgart;2010.
50. Hoos-Leistner H. Kommunikation im Gesundheitswesen. S.20 Springer-Verlag GmbH Deutschland Springer Berlin;2019.