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SEARCH STRATEGY

Set No.	Searched for	Databases	Results
S1	Asian Nursing Research	Ebook Central, Public Health Database, Publicly Available Content Database	58472*

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Beneficial Effects of Breastfeeding on the Prevention of Metabolic Syndrome Among Postmenopausal Women

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[ProQuest document link](#)

ABSTRACT (ENGLISH)

SummaryPurpose

This study aims to determine whether breastfeeding may have any beneficial effects on metabolic syndrome in a cohort of postmenopausal Korean women.

Methods

A cross-sectional study with secondary data analysis was conducted using the cohort in the Korean Genome and Epidemiology Study. Data from 1,983 postmenopausal women were analyzed by logistic regression analysis. Controlled covariates were chosen based on a biopsychosocial model and included age, family history of hypertension; type 2 diabetes mellitus; and cerebro-cardiovascular diseases, body mass index, age of menarche, parity, socioeconomic status of family, educational level, past or current smoking experience, and current alcohol consumption experience.

Results

Breastfeeding experience and duration were not significantly associated with a decreased likelihood of metabolic syndrome among postmenopausal women. However, breastfeeding experience (adjusted odds ratio [AOR]: 0.52 [$p = .010$]) and a total duration of breastfeeding exceeding 3 months were significantly associated with decreased likelihood of abdominal obesity (≥ 3 and < 6 months: AOR: 0.49 [$p = .014$]; ≥ 6 and < 12 months: AOR: 0.51 [$p = .009$]; ≥ 12 months: AOR: 0.56 [$p = .024$]).

Conclusion

Our findings indicate that breastfeeding might have beneficial effects on reducing abdominal obesity in postmenopausal women. Health-care providers should publicize beneficial long-term effects of breastfeeding on the prevention of abdominal obesity, a component of metabolic syndrome.

FULL TEXT

DETAILS

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Nurses' Perceptions of Factors Influencing Elder Self-neglect: A Qualitative Study



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ABSTRACT (ENGLISH)

Purpose

Elder self-neglect is a global public health issue and should be taken seriously at large. Nurses, usually working directly with elderly patients, have a better understanding of what factors may cause elder self-neglect. In this qualitative study, we explored the influencing factors of elder self-neglect from the perception of nurses in the context of Chinese culture.

Methods

Face-to-face, in-depth interviews were conducted from November 2018 to December 2018. Purposive sampling was used. Twenty one participants recruited from eight geriatric wards of a general hospital located in Wuhan were interviewed. A content analysis of qualitative nature was performed to analyze the data.

Results

Our conceptual model illustrated the findings based on the three themes of the conflict between personal recognition and social judgment, the choice between current needs and individual beliefs, as well as the compromise between insufficient abilities and limited resources.

Conclusion

Nurses together with family members and social workers can help older adults improve their awareness of self-neglect to bridge the gap with social judgment, learn to focus on their own needs, as well as seek as much support as possible. Nurses should also respect the autonomy and self-determination of elder self-neglecters because self-neglect is related to older adults' values. Furthermore, larger studies are needed to quantitatively test and refine the model.

FULL TEXT

Introduction

The aging of population has become a great challenge perturbing governments and health-care providers worldwide. Self-neglect is a chronic and hidden health problem threatening older people's health and safety which has been increasingly on the public radar. Self-neglect has widely been defined as "The inability (intentional or nonintentional) to maintain socially and culturally accepted standards of self-care" [1]. Self-neglect in older adults, or elder self-neglect, is commonly believed to be a behavior profile of an elderly person, manifesting as refusal or failure to provide himself/herself with adequate food, water, clothing, shelter, personal hygiene, medication (when indicated), safety precautions, and financial management [2, 3]. The features of elder self-neglect are normally cited to include poor hygiene, domestic squalor, hoarding, poor nutrition, social withdraw, service refusal, not taking medication, endangering behaviors, a lack of shame, and so on [4, 5].

Elder self-neglect can lead to series of physical, social, environmental, and health consequences. Elder self-neglect is significantly associated with individual adverse health outcomes, such as increased risks of hospitalization, 30-day hospital readmission, morbidity, and premature all-cause mortality [6-8]. Elder self-neglect also contributes to poor quality of life and is accompanied by subsequent caregiver neglect, financial exploitation, and multiple forms of elder abuse [9, 10]. What is more, self-neglect has a profound impact on the families, neighbors, health-care providers, and surroundings of the elderly [1, 11]. For instance, the messy living conditions of elder self-neglecters may attract

disease-carrying rats and flies, which potentially presents a public health hazard.

Several studies showed that the prevalence rates of self-neglect in the elder population stood between 5.3% and 29.1% owing to methodological discrepancies, such as different conceptual and operational definitions [2]. A study on 4,627 older adults from the Chicago Health and Aging Project indicated a prevalence of 13.2% among black men and 10.9% among black women, versus 2.4% among white men and 2.6% among white women [12]. Another study illustrated that the prevalence of self-neglect was up to 29.1% among 3,159 community-dwelling U.S. Chinese older adults in Chicago [13]. A study of South Korea on 1,023 older adults living alone in Busan Metropolitan City found that at least 22.8% of the participants had one form of self-neglect [14]. Ilhan *et al* [15] stated a prevalence of 16.8% among geriatric outpatient in Istanbul. It is also worth noting that the rate of elder self-neglect may increase as the overall population further ages [16].

Although elder self-neglect is a public health issue with a series of potentially serious consequences, it tends to be under-recognized or under-reported [17]. Sometimes, the features of elder self-neglect may not be noticed as being significant. If the signs are not recognized timely, it may develop into a serious, life-threatening problem. Nurses, especially those working in geriatric departments, usually work professionally and directly with elderly patients. They are at the front line to cope with elder self-neglect issues. Therefore, to obtain insight into nurses' experiences and perceived influencing factors of elder self-neglect is of great importance. This insight will also contribute to a deeper understanding of the concept of elder self-neglect and earlier identification of high-risk elder self-neglecters.

Elder self-neglect is a complex phenomenon associated with a series of physical, psychological, and sociological factors. Multiple quantitative studies on elder self-neglect revealed numerous contributors to elder self-neglect, including advanced age, physical and cognitive function impairment, chronic diseases, pain, frailty, depression, living alone, lower education levels, poverty, lack of family/social support, and neighborhood disorder [1, 3, 8, 18, 19]. Besides these, an observational study of older people deemed self-neglectful by senior caseworkers indicated that early life experiences and lifestyle, distrust, and personality traits might also be associated with elder self-neglect [20].

The issue of elder self-neglect among Chinese populations needs greater attention. China has the largest population of elderly citizens in the world and the population has been increasing at an unprecedented speed over the past decades [21]. As a consequence, there may be a large number of older adults having self-negligent behaviors and suffering from adverse consequences. In addition, elder self-neglect is a social judgment influenced by social, cultural, and professional values [22]. China, a typical Asian country influenced by the Confucian culture, has unique social and cultural characteristics. The culture emphasizes benevolence and people tend to focus on relatives or friends rather than their own, which may be more likely to result in the emergence of self-neglect and may lead to a different understanding of elder self-neglect from western countries. Hence, in this study, we conducted face-to-face interviews among the nurses working in several geriatric departments, with an attempt to describe nurses' perceptions of elder self-neglect and explore influencing factors from nurses' views within the Chinese context.

Methods Design

A qualitative descriptive design was used to obtain nurses' subjective experiences, perceptions, thoughts, and feelings on elder self-neglect.

Settings and participants

The study was conducted between November 2018 and December 2018 in eight geriatric wards of a highly ranked general hospital in Wuhan, China. Inclusion criteria were registered nurses, working in geriatric wards, having experiences in caring elder self-neglecters, and willingness to participate in the research. Purposive sampling was employed and candidates were selected based on their ability to provide in-depth information about elder self-neglect [23]. We screened communicative nurses working in the geriatric wards to confirm whether they had cared for older adults with poor hygiene, poor nutrition, social interaction, little to no exercise, endangering behaviors, or other self-neglect features as they seem. Nurses who indicated they had cared for older adults with the previously described presentations were told the purpose and methods for this research and invited to participate. We then arranged interview times with those who agreed.

Data collection

The first author of this study (W.M.) conducted the face-to-face, in-depth interviews. The researcher has acquired a doctorate degree and has completed and published several qualitative studies. The second author of this study (P.C.) was responsible for the audio recording and recording visual cues related to body language. The nurses were interviewed after work in the meeting room and the interview was conducted only once per person. A topic list, containing 2 questions, was used as a guide. The questions were “How do you think about elder self-neglect” and “Would you please recall some elder self-neglecters you met in work or life, and talk about the reasons why they behave in the way of self-neglect”. To encourage interviewees to share more information, the statement of “Would you please share more information about the topic” was used at the end of interviews. Each interview was audio-recorded and lasted 30 to 45 minutes. The interviews were in Chinese and the quotes in this article were translated to English by the first author of this study (W.M.) and checked by all authors. Data collection and data analysis were carried out until the point of saturation, namely no new themes emerged in the data analysis.

Data analysis

A qualitative content analysis was conducted. The analysis was performed after each interview. The data analysis procedure was as follows [²⁴]. First, after each interview session, the audio records, as well as observation records, were transcribed verbatim within 24 hours. The transcripts were then sent back to the interviewees to affirm accuracy. Then, the transcripts were read carefully and repeatedly to obtain the whole picture. After that, the important phrases or expressions were extracted and encoded from the statements of the interviewees. All codes were grouped into potential subthemes or themes based on how they were linked and related. At last, a general description of the research topic was formulated by generating themes and subthemes. In addition, a storyline, a map, or a model was encouraged to present the result.

The first author and the second author performed the initial analysis independently. After that, all coresearchers discussed whether the analysis results were appropriate in accordance with the transcripts and note comparing. If the authors had different opinions, the discussion continued until all authors achieved consensus.

Trustworthiness of the study

Credibility, dependability, and transferability have been used to describe various aspects of trustworthiness in qualitative content research [²⁵]. Credibility refers to confidence in how well data and processes of analysis address the intended focus. To ensure the credibility of the collected data, nurses with various experiences in taking care of the elderly were selected to increase the possibility of shedding light on the research question from multiple aspects. To ensure the credibility of data analysis, all records were transcribed verbatim, and the transcripts were sent back to interviewees to affirm accuracy. We attempted to minimize bias by seeking agreement among coresearchers and consultations with experts during the course of research. Dependability refers to the degree to which data change over time and alterations made in the researcher's decisions during the analysis process. To ensure the dependability of the collected data, a topic list was used to make sure we question the same areas for all participants. To ensure the dependability of data analysis, open dialogs within the research team were adopted. Transferability refers to the extent to which the findings can be transferred to other settings or groups. To ensure the transferability, we sampled with variation based on different demographic characteristics. What is more, we attempted to present rich findings together with appropriate quotations to enhance the transferability.

Ethical considerations

This study was approved by the ethics committee of the Tongji hospital of which the study was conducted (Approval no. TJ-C). Before each interview, anonymity, confidentiality, the right to withdraw at any time without any penalty, and the purpose of the study were explained to the participants. Informed consent was obtained from each participant. During data analysis, the transcripts were anonymized and scrutinized, and any information that might potentially identify individuals, third parties, or institutions was masked.

Results

Twenty one registered nurses (all women) were participated in the study with a mean age of 32.05 years (± 6.01), ranging from 24 to 47 years. The median length of engaging in geriatric nursing care was 10 years, ranging from 1 to 29 years. They all had at least received a bachelor's degree in nursing science. Participants were distributed in

accordance with the professional titles as follows: 3 in junior nurse, 9 in senior nurse, 6 in nurse-in-charge, and 3 in cochief superintendent nurse. Six of them were head nurses.

In general, the nurses reflected that elder self-neglect was not taken seriously in their routine work. Self-neglect was not an exclusive behavior of the elderly and it might occur in all ages. However, it was definitely a health issue for concern because self-neglect in the elderly was much more common and harmful. What is more, elder self-neglect might make treatment and care more difficult. More attention should be taken to elder self-neglect in the future. *I think almost everyone occasionally neglects themselves, such as eating leftovers, bearing pains or taking medicines without medical orders when feeling uncomfortable. But it may be more harmful to older people because they are aging and more vulnerable. But we are too busy to think about it in our daily work. (Participant 9)*

In this study, three themes and nine subthemes emerged from nurses' descriptions. The three themes were the conflict between personal recognition and social judgment, the choice between current needs and individual beliefs, as well as the compromise between insufficient abilities and limited resources. The nine subthemes included poor health awareness; cognitive impairment; depression; low sense of self-worth; frugality; "family-first" value; limited mobility; poor social support; and poor financial conditions. A conceptual model was adopted to clarify the relationships of themes and subthemes (Figure 1).

The conflict between personal recognition and social judgment

The nurses expressed that elder self-neglect was professional and social judgment. Sometimes, the older people were accustomed to such a state of life and might not be aware of or admit to being in a state of self-neglect. Poor health awareness, cognitive impairment, and depression might weaken perceptions of self-neglect.

Poor health awareness

Nurses stated that health awareness of the elderly of this generation was relatively weak in China for a number of historical reasons. Many old people were poorly informed about the healthy lifestyles, self-care skills, and harms, prevention, and treatments of common diseases. This might affect their identification of health and safety risks, resulting in self-neglect. Nurses stated that poor health awareness was responsible for self-negligent behaviors such as unhealthy lifestyles, unwillingness to seek medical help, or nonadherence. The following words were described: *"Some old patients have poorly-controlled blood pressure but they believe that high blood pressure is commonplace among old people ... If they feel no discomfort or their lives are not inflicted by symptoms, they will deem that their health concerns are not serious and neglect the problem ... Some older adults do not know when to see a doctor for their problems." (Participant 1)* *"Many old people think that minor ailments can be tolerated without going to hospital. What they do not recognize is that this action tends to turn minor ailments into major ones at the end." (Participant 21)*

In addition, nurses stated that some older adults did not know how to access to or judge of health information because of poor health awareness. The original purpose of older adults' some behaviors was to promote health but their wishes backfired. The behaviors eventually led to health neglect. *"Current market of health care products is chaotic. Some health care products target the elderly because they have relatively high health needs and poor health and safety awareness. The old people often spend lots of money on trashy health care products. In my opinion, it is a kind of self-neglect. Despite paying attention to their health, they overlook the correct way to keep healthy." (Participant 6)*

Nurses also expressed that some older people who suffered from self-neglect might engage in unhealthy behaviors such as smoking or inappropriate use of folk medications. These older people were stubborn and it was hard to change their long-standing false health perceptions. *"I know an old man who smokes for more than 30 years. I told him that smoking was unhealthy and might cause lung cancer. But he insisted that he had smoked for many years and he was cancer-free. He even said he would rather die than give up smoking." (Participant 16)* *"An old patient of mine used some non-official recipes to control his blood pressure because he did not trust any doctor. He even instigated other patients not to trust doctors and to try the folk remedies." (Participant 18)*

Cognitive impairment

Most nurses agreed that self-neglect could occur as a result of cognitive impairments. The older people with

cognitive impairment, such as sensory abilities deficit or a gradual loss of attention and executive function, usually could not fully engage in essential self-care and might unwittingly put themselves in dangerous situations.

Explanation as follows: *"There were food crumbs on the bedsheet. The sheet was dirty and I was unwilling to sit or lie on the sheet. However, my grandma repeatedly reassured me that it (the bed linen) was good to sit on. It is hard to imagine that she used to be a picky person who was fastidious about the cleanness of almost everything. I guess her skin became increasingly insensitive and could not feel the food crumbs on the sheet."* (Participant 9)

Besides, nurses believed that some older adults lacked awareness of aging-related functional declines. These older adults tended to overestimate their physical strength while underestimate the consequences of unhealthy behaviors, leading to some adverse outcomes. *"My grandpa, who is more than 80 years old, usually stands on a chair to fetch objects from the top of a cupboard. We warn him of the dangerous nature of such behavior, but he turns a deaf ear to our words. He believes that he is perfectly capable of doing that and our worries are unnecessary."* (Participant 10)

Depression

Some nurses noted that depression could make older adults less motivated, away from the usual activities and less interested in social interactions, which might aggravate the state of self-neglect. Some depressed older people might commit suicide, which was the extreme case of self-neglect and self-harm. *"Once there was a depressed old woman in my charge. She was lethargic and apathetic. She always stayed in bed and skipped meals. I think she turned her back on her physical health, daily needs and friends ...she did not care about anything including herself."*

(Participant 13)

The choice between current needs and individual beliefs

The nurses expressed that the context of personal living experience, culture, and beliefs determined the perception of elder self-neglect so that the judgment of elder self-neglect varied with different individuals. Sometimes the judgment was made by us, but the elderly thought there were more important things than their own needs and chose to live in the self-neglect status. The nurses emphasized that there is no right or wrong in elder self-neglect, sometimes we needed to respect their choices and decisions.

Low sense of self-worth

The nurses expressed that some older people thought they could no longer contribute to the society and were worthless to others because of old and frail. Hence, these older people felt shameful or guilty to ask for help from others, let alone demanding more. They tended to silently endure hardship, pain, difficulties, or inconvenience, and did the best efforts to manage everything on their own. Therefore, they refused to seek help and neglected their own needs. *"I have been recently taking care of an 83-year-old woman who could only bend her body forward in a chair because of a huge lump in her right hip, untreated for 8 years. I asked her why she did not see a doctor 8 years ago. She told me that she was very old and useless. She thought she should not see a doctor and that was a waste of money ...She said there was no need to treat the tumor and she could live with it."* (Participant 13)

In addition, the nurses said that some older adults even declined appropriate assistance from others because they refused to admit that they were old and wanted to do something to prove. As explained in the following: *"My father keeps refusing my help at home, saying that he is 'fine' and even able to ride a bike on the roads. However, it usually results in falls. I think his refusal to admit that he is old or to get help from us may be due to his fear of losing his paternal authority."* (Participant 20)

On the other hand, a nurse stated that a few older adults thought they were old and worthless result in giving up their own responsibilities to society and lacking a sense of shame. *"Some old people think they are old and need not to keep their surroundings tidy. They litter or spit without thinking of others. I think they don't care about their public images and ignore their responsibilities which is also a kind of elder self-neglect."* (Participant 12)

Frugality

The nurses expressed that the older generations experienced hunger and poverty, and this experience made them especially cherish resources. Some older adults believed that "one should not waste anything". As a result, they would keep everything. The nurses stated that frugality was seen as a virtue in Chinese culture, however,

sometimes it might contribute to self-neglect such as hoarding behavior. *“Every time we visit my grandma, she always prepares a lot of delicious food which is too much for us to finish. Then in the following days, she will eat the leftovers. She is reluctant to discard the leftovers even if they get stale or even moldy. We have told her several times that this is unhealthy. She just doesn't listen. She says that she knows it is unhealthy but she can't bear to throw it away.”* (Participant 14) *“My grandma keeps everything such as cans and cartons at home. She thinks these things are potentially useful in the future. This hoarding behavior makes home smelly and crowded. What's more, it may bring serious safety and health hazard.”* (Participant 2)

“Family-first” value

The nurses said that most Chinese older adults attached great importance to their family members, especially their offspring, so they tended to devote all their time and energy to their families and, more often than not, ignored their own interests, such as health and personal life. The following words were stated: *“Many Chinese grandparents usually serve as babysitters or care-givers for grandchildren. When these grandparents are busy caring for the children, they have no time to go square dancing, chat with friends or even see a doctor when they are sick.”* (Participant 3) *“In my opinion, ignoring hobbies is a kind of self-neglect. While some old people are willing to give up their hobbies for the sake of the family. I dare not say they are wrong. Sometimes we should respect their self-neglect lifestyle, I think.”* (Participant 17)

Besides, nurses described that some older adults hesitated to ask for help or accept the necessary help for fear of being a burden to their children. Therefore, these older adults chose to ignore their own needs. *“The older people do not want to depend on their children for assistance. They believe that their children have their own lives and have their own trouble to cope with ... So sometimes when they feel uncomfortable, they usually choose to bear the pain or discomfort by themselves.”* (Participant 17) *“When old people feel sad or worry about something, they will refrain from speaking out to avoid causing troubles to their children. They have to bear all the bad feelings on their own.”* (Participant 12)

The compromise between insufficient abilities and limited resources

The nurses indicated that, in fact, some older people exactly knew their needs and really wanted to take care of themselves, but the conditions do not allow. It was not “they want to” but “they have to” live in a state of elder self-neglect.

Limited mobility

The nurses collectively said that aging increased the likelihood of physical energy loss, chronic disease, pain, and disability, which would probably contribute to limited mobility. The waning of mobility reduced independence and autonomy, prevented older adults from carrying out some daily activities, and raised the risk of elder self-neglect. *“The reason why some old people skip showers and live under hygienically-poor living conditions is just that they are unable to take care of themselves. They are too weak to do the laundry, go out for a walk, enjoy hobbies or interact effectively with others.”* (Participant 2) *“I used to take care of an old patient in pain. She always skipped meals and was unwilling to communicate with others. I think pain limits her abilities to perform normal tasks of living and makes her disregard their physical, mental or social needs.”* (Participant 10)

Poor social support

The nurses stated that elder self-neglect was a reluctant choice originated from reduced function and limited social support. The self-negligent behaviors might be reinforced by the failure to get timely assistance from close relatives, friends, or social workers when the elderly were in difficulties. *“Nowadays, children are always busy with their own work or work in another city thousands miles away from their older parents. The old people are estranged from families. In addition, an increasing number of old people move into an apartment in the city with little interaction with their neighbors. Without timely help from children or neighbors, the old people with limited mobility have to neglect their needs.”* (Participant 5) *“In some regions, medical services are not easily available. For example, there are many outpatients in our hospital and the procedure is also complicated. It takes at least half a day to see a doctor. The helpless old people may feel troublesome and don't bother to see a doctor even though they are sick.”* (Participant 9)

Poor financial conditions

The nurses believed that the economic or financial status more often than not influenced or even determined the decision of older adults in the process of meeting their own needs. Unfortunately, elder self-neglect could be a spontaneous reaction triggered by a lack of money. *“As a Chinese saying goes, “Money is not everything but you can’t afford to go without it.” If an old person is poor, he/she cannot buy the needed things ... For example, although they know that eating fruit is good for them, they are usually reluctant to buy fresh fruits since they can’t afford them.” (Participant 11)*

In China, not all people are covered by the social welfare or health-care insurance system at present. In many cases, some patients have to pay for the medical services, fully or partially, from their own pockets. Therefore, some older adults might have no choice but ignore their basic health-care needs because of lacking money. *“Some old people don’t want to see a doctor and ignore their health problems because they have no money.” (Participant 15)*

Conceptual model of elder self-neglect

Generally speaking, the nurses saw elder self-neglect as a product of health conditions, personal beliefs, and social and contextual issues rather than an “aging syndrome”. Based on the nurses’ descriptions, three themes and nine subthemes were identified and a conceptual model describing factors influencing the elder self-neglect was developed. Our conceptual model presented the underlying process of elder self-negligent behaviors by explaining its influencing factors. The first layer is the conflict between personal recognition and social judgment. If older people are poor health awareness, cognitive impairment, or depression, they may not realize that they are in a state of social judgment self-neglect. The second layer is the choice between current needs and individual beliefs. Even when old people are aware of their state of self-neglect, they still have the right to choose what they really think is important and make decisions about how to live. The third layer is the compromise between insufficient abilities and limited resources. Older people need to be able to change their status quo or they have to continue to neglect their needs. The conceptual model should not be understood as an absolute or ontological one but as an analytical tool. The primary purpose of the model was to clarify the relationships between the three themes and nine subthemes and make the nature of elder self-neglect understandable as a subjective and contextual assessment and selection influenced by the factors.

Discussion

Elder self-neglect is a complex multidimensional phenomenon and the assessment of elder self-neglect may vary with personal judgment and cultural values. To understand Chinese nurses’ perceptions of influencing factors of elder self-neglect, in this study, we interviewed 21 nurses from eight geriatric wards of a general hospital in Wuhan. Our conceptual model showed the relationship of three themes and nine subthemes which included poor health awareness, cognitive impairment, depression, low sense of self-worth, frugality, “family-first” value, limited mobility, poor social support, and poor financial conditions.

Our finding reaffirmed that self-neglect was a pervasive health issue and jeopardize the health and safety of the elderly. Some subthemes that emerged from our study had considerable overlap with those identified influencing factors by the previous studies. In line with previous researches [22, 26–28], our study found that elder self-neglect was largely due to physical and psychological reasons such as limited mobility, depression, and cognitive impairment. Our finding that elder self-neglect was determined by poor financial conditions and lack of support was also consistent with the previous researches [8, 29].

Frugality was considered to be important for elder self-neglect. Although frugality was mentioned in the previous research [20], the difference was that, in our study, frugality was more a lifestyle preference stemming from older adults’ early life experiences and beliefs than the result of monetary concern. Poor health awareness was much less frequently discussed in the literature. We identified poor health awareness as an important barrier in recognizing elder self-neglect. Old people with poor health awareness might not realize that they were in the professionally recognized condition of self-neglect such as unhealthy lifestyles, poor treatment compliance, or untreated medical conditions.

Our findings expanded upon prior work by identifying a low sense of self-worth and “family-first” value. The newly identified subthemes were closely linked with the Chinese context. A traditional Chinese belief is that one should be

useful to the society at large [30]. Overemphasis on one's own needs and well-being is considered to be selfish and a life without contribution to the society is meaningless. Chinese culture emphasizes the bond between family members, including the connection between generations. Older adults often put the needs of their families above their own. They will, on their own accord, assist their children by providing financial support, doing chores, or caring for grandchildren. They are ready to sacrifice their own health, neglect their own needs, and tend to endure silently and refrain from speaking out their sufferings. Although these values are, in many ways, positive, they may result in elder self-neglect.

The conceptual model can guide our implications for practice and future research. When the elderly are identified with poor perception and recognition of self-neglect, the interventions can be consist of health education and self-care skills teaching. When the elderly are lack of self-centredness and ignore their own needs, nurses should take their values and lifestyles seriously and avoid face a moral dilemma. It is worth noting that nurses have the responsibility to inform the elderly of the danger of self-neglect and help them make choices, but by no means have any condescending attitude towards them. The elder self-neglecters' autonomy and self-determination should be considered within a reasonable context. Finally, health-care providers, family members, social workers, and the government should work together to help the elder self-neglecters who are lack of money and support by formulating relevant policies and giving timely help.

Based on the concept model, special attention should be paid to eliminate barriers of elder self-neglect and to develop effective interventions that fit the older adults' perceptions, needs, and capabilities. Future research should focus on the development of targeted and tailored interventions to improve the identification, support, and management of elder self-neglect.

A strength of the study was that data were independently analyzed by two researchers and repeatedly discussed in our research team. Although the results of this study were based on nurses, getting experiences from their work and life increased the likelihood of diversity in our data. However, several limitations should be noted. In this study, influencing factors were explored only from nurses' experiences, the samples were drawn from one hospital, and they were all women. These might have restricted the scope of data captured. Further studies could be carried out among the physicians, allied social workers, elder self-neglecters, and their family caregivers. This was a small qualitative study that developed a conceptual model, and the next step is for larger studies to quantitatively test the model.

Conclusion

This study offers new insight into factors influencing elder self-neglect in China. The findings shed light on the multiplicity and complexity of influencing factors of elder self-neglect from geriatric nurses' perceptions and indicate that elder self-neglect should be taken seriously as early as possible. Our conceptual model presented the underlying process of elder self-negligent behaviors by explaining three themes and nine subthemes. In accordance with the model, nurses together with family members and social workers can help older adults improve their awareness of self-neglect to bridge the gap with social judgment, learn to focus on their own needs, and seek as much support as possible. In addition to the identification and prevention of elder self-neglect, nurses should fully consider the preferences, beliefs, and values of the elderly and respect the principles of autonomy. What is more, further studies are needed to test and refine the model.

Conflict of interest

No conflict of interest has been declared by the authors.

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Knowledge and Health Beliefs of Gestational Diabetes Mellitus Associated with Breastfeeding Intention Among Pregnant Women in Bangladesh

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ABSTRACT (ENGLISH)

Purpose

This study aimed to investigate the knowledge of gestational diabetes mellitus (GDM) and the health beliefs about GDM management, as well as to investigate the effects of these factors on breastfeeding intention in Bangladesh.

Methods

This study involved a cross-sectional survey of 358 healthy pregnant women who visited antenatal clinics in Bangladesh.

Results

Perceived susceptibility, perceived benefit, and self-efficacy were identified as significant factors for breastfeeding intention ($p < .05$). Participants had a poor understanding and a lack of knowledge of GDM, which can lead to inadequate health behavior. Health beliefs were significantly associated with participants' breastfeeding intention related to GDM.

Conclusion

Antenatal education for breastfeeding in GDM mothers should focus on providing accurate information on GDM and strengthening their health beliefs such as self-efficacy within the context of the mothers' culture.

FULL TEXT

DETAILS

Subject: Software; Womens health; Hyperglycemia; Family medical history; Maternal & child health; Prenatal education; Disease; Knowledge; Hypertension; Questionnaires; Obesity; Gestational diabetes; Families & family life; Pregnancy; Breastfeeding & lactation; Mothers; Variance analysis; Prenatal care; Medical research

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Relationships Among Character Strengths, Self-efficacy, Social Support, Depression, and Psychological Well-being of Hospital Nurses

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[ProQuest document link](#)

ABSTRACT (ENGLISH)

Purpose

From the perspective of positive psychology, our study aimed to explore depressive symptoms and psychological well-being among Chinese nurses, as well as analyze the impacts of character strengths, self-efficacy and social support on the mental health of nurses.

Methods

A cross-sectional and descriptive design using five self-reported questionnaires was used to investigate a cohort of 4238 nurses during 2018. A structural equation modeling analysis was used to verify a hypothetical model linking character strengths, self-efficacy, social support, depressive symptoms, and psychological well-being.

Results

The prevalence of depression among this cohort of Chinese nurses was 58.1%. The mean scores for caring, inquisitiveness, and self-control were 19.93 (SD = 2.82), 15.94 (SD = 3.00), and 16.34 (SD = 2.95), respectively. The hypothesized model was a good fit of the data ($\chi^2/df = 1.77$, $p = .183$, root mean square error of approximation = 0.04, goodness of fit index = 1.00, comparative fit index = 1.00, Tucker–Lewis index = 1.00). Except for the path from self-control to depression, the other hypothetical paths investigated were statistically significant.

Conclusion

Character strengths were directly and positively associated with psychological well-being. Inquisitiveness was the strongest direct protective factor for depression. In addition, character strengths indirectly alleviated depression and increased psychological well-being through mediating variables of social support and self-efficacy. This study should alert nurse managers that more attention should be paid to the character strengths and mental health of nurses. This study provides evidence for interventions based on character strengths as a management strategy to support the mental health of nurses.

FULL TEXT

Introduction

With the development of society, people's demand for health care has been increasing steadily. Nursing is an essential part of the medical and health-care systems, playing an important role in maintaining and promoting human health [1]. Usually, as the main contact point between patients and medical staff, enthusiastic and patient nurses improve the quality of medical services, and promote the harmonious nurse–patient relationship. However, in many cases, factors such as heavy workloads and unstable working environment put an enormous pressure on nurses, making them more prone to negative emotions such as anxiety and depression [2]. Methods to alleviate negative emotions improve psychological well-being among nurses is a focus of nursing managers.

Depression, the most common type of mental disorder, is characterized by significant and lasting sadness, feelings of inferiority, pessimism, and thoughts of suicide. Sometimes somatic symptoms may also occur. In China, the prevalence of depressive symptoms among nurses is higher than that among other medical staff [2]. Previous studies showed that the prevalence of depression among nurses in China (61.0%) was nearly twice as high as that in Korea (38.0%) and more than two times higher than that in the United States (18.0%) [3-5]. The tendency of Chinese nurses to experience depressive symptoms is possibly due to the following reasons. First, the shortage of nurses in China is severe, and the ratio of nurses to the general population is 1:340, which is lower than that in developed countries, where the ratio ranges from 1:140 to 1:320 [6]. Thus, Chinese nurses are often required to undertake relatively long working hours, heavy workloads, and large number of patients, but their pay is relatively low [5]. Second, in accordance with the Fifth National Health Service Survey in China, the sense of professional honor among the medical staff has declined, and they reported that they felt that they were not respected by patients [7]. Among the medical staff, nurses' social status was relatively low [5]. Finally, in China, the tension between doctors and patients has become one of the prominent social problems, and violent injuries have become a significant source of depression among nurses in China. Depression not only reduces nurses' quality of life and life satisfaction but also increases their job burnout and turnover rate [8]. Furthermore, depression reduces nurses' work efficiency and increases the risk of medical errors and adverse events [9]. As a result, patient safety is affected. Psychological well-being, in reference to an employees' attitudes and feelings toward their work context, is another critical component of workplace health [10]. In contrast to depression, psychological well-being positively affected employment outcomes such as job satisfaction. The higher the psychological well-being of employees, the lower their turnover intention. Nurses play an important role in medical services, and more attention should be paid to their mental health.

Positive psychology assumes that individuals have inherent capacities for growth, fulfillment, and happiness. If an individual lacks these capacities, depression may occur [11]. Character strengths are regarded as an essential component of positive psychology. A previous study showed that character strengths were closely correlated with depression, psychological well-being, and life satisfaction [12]. However, current studies on depression in nurses are mainly focused on work-related factors such as shift work, job satisfaction, and job burnout, ignoring the role of personal factors such as character strengths and related protective factors (i.e., self-efficacy, social support) in the development of depression among nurses. Thus, our study aimed to explore the association among character strengths, self-efficacy, social support, and nurses' mental health, which may provide references for the development of nurses' mental health interventions.

Background

Developed from Seligman's Values-In-Action Classification of Character Strengths and Virtues, the three-factor model is a reliable potential structure of Values-In-Action classification advantages and a visual classification of traditional cultural virtues [13]. It is composed of caring, curiosity, and self-control, which represent interpersonal, intellectual, and temperance strength, respectively [13]. Specifically, interpersonal strength includes kindness, teamwork, love and being loved, forgiveness, and gratitude. Intellectual strength includes creativity, curiosity, and passion, reflecting humor, courage, and faith. Furthermore, temperance strength refers to the self-control and persistence shown in achieving goals, including judgment, prudence, learning ability, and humility. Studies have shown that character strengths are positively correlated with flourishing, hope and happiness but negatively correlated with anxiety and depression [12,14]. Based on previous studies, the first hypothesis of this analysis was that caring, curiosity, and self-control are directly negatively associated with depression and positively associated with psychological well-being.

Self-efficacy is the belief in, judgment of or subjective self-perception of people's ability to perform and fulfill a goal [15]. A previous study showed that intellectual and temperance strength were the most important predictors of self-efficacy [16]. The ability to lead and to get things done (leadership), give and be asked for advice (perspective), seek out challenges (bravery), understand one's motivations (social intelligence), and enjoy improving others' sense of humor are the most important criteria that make individuals believe in their ability to master things and to regard

demands as challenges rather than threats [17]. Therefore, we believe that self-control and inquisitiveness may improve self-efficacy. In addition, higher self-efficacy was associated with lower depression [18]. Therefore, the second hypothesis of this study was that self-control and inquisitiveness can improve self-efficacy, thereby alleviating depression and improving well-being among nurses.

Social support refers to information that leads a person to believe that he or she is cared for, loved, respected, and a member of a network of mutual obligations [19]. When faced with challenging job demands, social support is believed to help workers cope with stress. Character strengths are composed of interpersonal, intellectual, and temperance strengths, including kindness, teamwork, humor, passion, and creativity. Populations with high character strengths have better interpersonal relationships, more openness to new possibilities, and greater personal strength, which allows them to play a more prominent role in teams and have better social support. Therefore, we hypothesized that character strengths are positively correlated with social support. In addition, research by Feng et al. [20] showed that social support could directly and effectively affect nurses' depression and work productivity. Therefore, the third study hypothesis was that caring, self-control, and inquisitiveness enhance social support, which in turn alleviates depression and improves psychological well-being.

Based on the theory and studies aforementioned, we proposed the stated hypotheses and established a hypothetical model linking character strengths, self-efficacy, social support, depressive symptoms, and psychological well-being, as shown in Figure 1.

This study had the following two objectives: (1) to investigate the prevalence of depressive symptoms and related factors and (2) to explore the impacts of character strengths, social support, and self-efficacy on the mental health of nurses.

Methods Study design

A cross-sectional and descriptive study design was used to test the hypothesized model that links character strength, social support, self-efficacy, depression, and psychological well-being.

Settings and sampling

A stratified cluster random sampling method was used to obtain the final sample. China is geographically divided into 7 regions: Northeast, North, Central, East, South, Northwest, and Southwest China. We obtained details regarding the number and proportion of registered nurses and the level of the hospitals in each region of China from the Chinese health statistics released by the National Health and Family Planning Commission in 2017. Between January and June 2018, 31 hospitals, including 20 tertiary hospitals (>500 beds) and 11 secondary hospitals (101-500 beds), from 15 cities of 13 provinces from 7 geographical areas, were selected to participate in the study. We sent emails to the hospital administrators and nursing managers of each selected hospital, informing them of the purpose and procedure of the investigation, and obtaining their consent and cooperation. After that, we numbered the list of nurses in the selected hospital, and a 25.0% sample was randomly selected, from the total number of registered nurses (RNs) in each of the selected hospitals, using SPSS software. Then, the head nurses and directors from each hospital invited the selected nurses to participate in this study. The sample size was calculated using the formula $n = Z_{\alpha/2}^2 \times P(1-P)/\delta^2$ [21]. Based on the prevalence of depression among Chinese nurses in previous studies [5], P was set as 0.617, $\alpha = 0.05$, $Z_{\alpha/2} = 1.96$, $\delta = 0.05$, and the minimum sample size required was 364. Nurses eligible for inclusion met the following criteria: (1) registered nurse or licensed practical nurse; (2) provided direct care to residents; and (3) spoke Chinese. In this study, the sample of 4238 participants obviously met the minimum and exceeded sample size of 364.

Ethical considerations

The study was approved by the Ethical Committee of the Third Xingya Hospital of Central South University (Approval no. 2017-S559). Participants provided written informed consent before participating in the study.

Data collection

In this study, we enrolled 31 hospitals from 15 cities. The study team comprised 20 nurse managers and 8 nursing postgraduates. One to two nurse managers were responsible for the data collection of nurses in selected hospitals in each city, with 3 nurses recruited as assistants. Before the survey, all researchers participated in standardized

data collection training. Nurses interested in this study contacted the researchers. Then, the researchers collected the standardized questionnaires when the nurses participated in a study meeting or training at the hospital. The researchers explained the research purpose and related content to the nurses and gave them 30 to 45 minutes to complete the questionnaires. After participating in many meetings, the research team completed data collection. Finally, 8 nursing postgraduates summarized and input the data manually.

Measurements Sociodemographic information

The sociodemographic questionnaire included age, gender, years of employment, position, educational background, marital status, sleep, overall working condition, and treatment at work.

Character strengths

Character strengths were assessed using the 15-item Three-Dimensional Inventory of Character Strengths, developed by Dr Duan [22]. The scale consists of three dimensions, namely, caring, inquisitiveness, and self-control, and each dimension has five items. Each item is scored on a 5-point Likert scale ranging from 1 (very much unlike me) to 5 (very much like me), and subscale scores are obtained by averaging the items on the scale. In a survey of medical staff members, the Cronbach's α values for the caring subscale, the inquisitiveness subscale, and the self-control subscale were .86, .80, and .85, respectively [22].

Self-efficacy

Self-efficacy was assessed using the General Self-Efficacy Scale (GSES), which was originally designed to reflect optimistic self-belief [23]. The Chinese version of the GSES was developed to measure self-efficacy in the general population and contains 10 questions with a score range of 1~4 for each question [24]; higher scores represent higher self-efficacy. The Chinese version of the GSES has a Cronbach's α of .87, retest reliability of .83, and split-half reliability of .82 [24].

Social support

Social support was assessed by the Social Support Self-Rating Scale (SSRS), which is a widely used scale designed by Xiao [25] to measure social support in China. The SSRS is a 10-item scale that assesses three dimensions, namely, subjective support, objective support, and support-seeking behavior. The subjective support subscale has four items, whereas the other two subscales have three. The total score for social support is obtained by adding up all item scores, and the scoring ranges from 12 to 66. The higher the score, the better the social support. Generally, the level of social support can be classified into three categories: low (≤ 22), moderate (23–44), and high (≥ 45). The SSRS had sufficient reliability in a Chinese population with a retest reliability of .92 [25].

Depression

Depressive symptoms among the nurses were assessed by the Self-rating Depression Scale, which consists of 20 items. Participants were scored on the frequency of symptoms during the past week, with response options ranging from 1 to 4 points (none or seldom—most or constant). The total depression score was the sum of the 20-item scores multiplied by 1.25 to obtain the index score [26]. An index score of 50 is the threshold for determining whether a participant is depressed or not. When the total index score is more than 50, it means that the participant may have depressive symptoms. Furthermore, the higher the score, the worse the depressive symptoms. The Chinese version of the Self-rating Depression Scale has a Cronbach's α of .78 [27].

Psychological well-being

Psychological well-being was assessed by the 8-item Flourishing Scale, a scale developed by Dr Tang and Duan [28]. Each item is scored from 1 (strongly disagree) to 7 (strongly agree), and the range for the total item scores is 8–56 points. A high score indicates that the individual has a greater level of psychological well-being. Sufficient reliability was shown for the Flourishing Scale in a Chinese population (Cronbach's α of .93) [28].

Data analysis

Data analysis was performed in SPSS 17.0 (IBM Corp., Armonk, NY, USA). Frequencies, percentages, means and standard deviations, independent-samples t-tests, as well as one-way analysis of variance were used to statistically describe and analyze the demographic factors related to depressive symptoms. The Pearson correlation coefficient was used to explore the interaction among character strengths, self-efficacy, social support, depression, and

psychological well-being.

Structural equation model (SEM) with maximum likelihood estimation was used to analyze the hypothesized model using AMOS 22.0 (IBM Corp., Armonk, NY, USA). As suggested by Hooper et al. [29], the chi-square ratio (χ^2/df) was used to evaluate the model fit. Generally, when $\chi^2/df < 0.90$, the model fit was good.

Results Demographic characteristics of the nurses

Of 5800 eligible nurses, 5000 agreed to participate in the study. In total, 4238 (84.8%) responded effectively; 4152 (98.0%) were women and 2571 (60.7%) were aged 26-35 years. The majority of the nurses had more than five years of work experience ($n = 2807$, 66.2%) and a bachelor's degree ($n = 3103$, 73.2%). Most were unsatisfied with their working conditions ($n = 2219$, 52.4%) and treatment at work ($n = 1956$, 46.1%). Moreover, nearly half of the nurses had sleep problems ($n = 2002$, 47.2%).

The prevalence of depression among these Chinese nurses was 58.1%, and 25.0% had moderate to severe levels of depressive symptoms. There were significant differences in the prevalence of depressive symptoms related to age, education, years of employment, marital status, sleeping status, position, overall working status, and work treatment. Other characteristics are shown in Table 1.

Descriptive results for the major study variables

Table 2 displays the means, standard deviations, and correlations for the main variables. For character strengths, the mean scores for caring, inquisitiveness, and self-control were 19.93 (SD = 2.82), 15.94 (SD = 3.00), and 16.34 (SD = 2.95), respectively. For the other variables, the mean scores for self-efficacy, social support, and psychological well-being were 25.33 (SD = 6.27), 40.61 (SD = 8.06), 41.28 (SD = 7.38), respectively, generally suggesting that nurses had a moderate level of self-efficacy, social support, and psychological well-being. Depressive symptoms were negatively associated with character strengths, self-efficacy, social support, and psychological well-being. Character strengths were positively correlated with psychological well-being, self-efficacy, and social support. Similarly, psychological well-being was positively correlated with self-efficacy and social support.

Structural model

The primary SEM analysis results indicated that the data did not fit the hypothesized model ($\chi^2 = 348.74$, $df = 3.00$, $\chi^2/df = 116.25$, $p = 1.77$, $df = 1.00$, $\chi^2/df = 1.77$, $p = .183$, RMSEA = 0.04, GFI = 1.00, CFI = 1.00, TLI = 1.00). As shown in Table 3, inquisitiveness was the strongest direct protective factor for depression ($\beta = -0.80$, $p < .001$). For psychological well-being, caring was the strongest direct contributor to psychological well-being ($\beta = 0.74$, $p < .001$). Figure 2 shows that character strengths directly played a strong role in improving psychological well-being among nurses. In addition, caring, inquisitiveness, and self-control indirectly alleviated depressive symptoms and increased psychological well-being through mediating variables of social support and self-efficacy.

Discussion

The purpose of this study was to investigate depression and related factors among Chinese nurses, as well as explore the mechanism underlying the effects of character strengths, self-efficacy, and social support on depressive symptoms and psychological well-being among nurses. The National Health Commission of China reported that most of the nurses were 25 to 34 years old and had worked for 5 to 9 years, and the proportion of male nurses in China was 2.0% in 2018, which was similar to the proportion in our study [30]. In our study, however, the proportion of nurses who had a master's degree was 6.3%, higher than the proportion in the official data (0.2%) [30]. Our study showed that 58.1% of Chinese nurses had depressive symptoms, a proportion higher than those of other countries [3, 4]. This result indicated that Chinese nurses were more likely to develop depressive symptoms, which sounded an alarm for nursing managers to attach attention to nurses' mental health. In our study, all sociodemographic factors, except gender and hospital level, were associated with depressive symptoms, which was similar to the findings in the study by Gao et al. [5]. However, for the relationship between education level and depression, our study indicated that compared with nurses with a high educational background, nurses with a low educational level scored higher in terms of depressive symptoms, which was contrary to the study by Gao et al. [5]. Studies have demonstrated that a high level of education positively affects nurses' work attitudes and engagement [31]. Highly educated nurses tend to stay in nursing posts and are confident in coping with adversity at work [32]. Moreover, because of the need for

promotion, nurses with a low level of education need to endure the pressure from work while continuing to study, which may make them more likely to be depressed. In addition, our study found that character strengths were directly and negatively correlated with nurses' depressive symptoms and positively correlated with their psychological well-being. At the same time, character strengths may improve psychological well-being through the mediating effect of self-efficacy, whereas curiosity and self-control were positively correlated with self-efficacy, thus affecting the mental health of these nurses. Here, we studied the relationship among personal factors, social support, self-efficacy, depression, and psychological well-being, which provided evidence to develop psychological interventions for nurses.

The first hypothesis confirmed the direct effect of character strengths on depressive symptoms and psychological well-being. Our research shows that caring, inquisitiveness, and self-control can improve well-being, whereas caring and inquisitiveness are negatively related to depression. The results partly supported the hypothesized model and provide evidence for the three-factor model. As shown in ^{Table 3}, inquisitiveness explained 80.0% of the variation in depression scores, accounting for the largest proportion of all the aforementioned indicators. Inquisitiveness refers to a person's curiosity and creativity in exploring the unknown outside world. Several studies have shown that high inquisitiveness can positively predict life satisfaction and well-being, whereas low inquisitiveness was associated with depression [^{12, 14}]. Nurses with high inquisitiveness are more motivated to explore the unknown and then use theory and knowledge to solve problems in their work, which ultimately optimizes nursing services and promotes innovation in nursing tools and technology. Hence, for a nursing manager, a learning-oriented organizational culture should be established within the nursing team, and support and encouragement should be given to motivate nurses to learn actively. On the other hand, nursing managers should attach importance to nurses' inquisitiveness, provide a platform for their development and provide rewards for their achievements.

Caring, representing interpersonal strength, is another critical factor affecting nurses' mental health. In China, interpersonal support and the harmony of interrelations are issues people are concerned about. People with better interpersonal skills have a stronger sense of belonging and pursuit of a meaningful life. High caring-related interpersonal strength has been associated with well-being [¹⁴], which was in line with our study. Proctor et al. [¹⁴] reported that self-control attaches importance to the promotion of life satisfaction and psychological well-being. In our study, nurses who scored higher in self-control had greater psychological well-being. However, although self-control tended to alleviate depression, the direct effect was not statistically significant, which differed from the findings in previous studies. The inconsistent results may be caused by the different populations in these studies. Currently, many strength-based positive interventions are developing, such as gratitude visits and three good things based on gratitude, counting kindness developed from kindness. A prior study conducted a strength-based intervention in 622 adults and found that this intervention enhanced happiness and decreased depression in the participants [³³]. Humans are born with temperament, but character strengths can be built. Thus, nursing managers should pay attention to the character strengths of the nurses on their teams. If nurses with lack of patience, indifference to interpersonal relationships, and a lack of enthusiasm for life are identified, a positive psychological intervention based on character strengths should be implemented for these individuals.

The second hypothesis was also confirmed: self-control and inquisitiveness can indirectly alleviate depression and enhance psychological well-being via self-efficacy. Self-control and inquisitiveness reflect intellectual and temperance strength, which are the most important predictors of self-efficacy [¹⁵]. Nurses with strong self-efficacy have better nursing competence and deal with difficulties more confidently and calmly. Moreover, studies have shown that self-efficacy lowers depression and anxiety [¹⁸]. As shown in ^{Figure 2}, self-control ($\beta = 0.52$, p

The third hypothesis confirmed the relationship between character strengths, social support, depression, and psychological well-being. Character strengths help people establish and maintain social relationships, obtain a sense of social belonging, and improve their social support. Our study showed that Chinese nurses had a moderate level of social support, which was directly and positively affected by their character strengths. Nurses with professional and family responsibilities inevitably face work-family conflict. Social support is important for nurses; it can relieve their pressure and improve their job performance [^{19, 20}]. In addition, nurses with higher levels of social

support may experience higher personal achievement and less emotional exhaustion [20]. Meanwhile, social support directly and negatively affected depression and positively affected mental health, was similar to the findings from a research by Feng et al. [20]. Therefore, character strengths alleviate depression and improve mental health via social support.

Strengths and limitations

Many studies have explored the impact of work-related factors on nurses' mental health, but few have explored personal factors such as character strengths or put personal factors and protective factors into a framework to explore their overall impact. This study not only explored the direct effects of character strengths on nurses' mental health but also found that character strengths had a positive effect on nurses' mental health via self-efficacy and social support. In addition, this study used a stratified cluster random sampling method to extract samples from seven regions of China, and the samples are well represented. However, our study still had some limitations. First, this study was a cross-sectional study and lacked the ability to establish a robust causal relationship between the study variables. Therefore, it is necessary to further explore the effects of character strength-based interventions on nurses' social support, self-efficacy and mental health. Second, this study used self-report questionnaires, which may have resulted in reporting bias. Finally, this study only investigated nurses in China; thus, more research in other regions and countries is needed to demonstrate the generalizability of the results.

Conclusion

In our study, the prevalence of depression among nurses was 58.1%. Nurses who had lower educational levels, were aged younger than 25 years old, were unmarried, had less than 5 years of work experience, had poorer sleep quality, and were very unsatisfied with their treatment at work, and working conditions were more likely to experience depression, hence nursing managers should pay more attention to these nurses. Furthermore, our study showed that character strengths not only directly improve psychological well-being but also indirectly improve psychological well-being via social support. Meanwhile, caring and inquisitiveness directly alleviated depression. In addition, inquisitiveness and self-control may enhance psychological well-being and alleviate depression via self-efficacy. Our research demonstrated the relationship between character strengths, social support, self-efficacy, depression, and psychological well-being. It provided evidence for interventions based on character strengths as a management strategy to support the mental health of nurses. Future research based on character strengths should be carried out to improve nurses' mental health.

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Conflict of interest

No conflict of interest has been declared by the authors.

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Personal characteristics	n (%)	Depressive symptoms	p	Job characteristics	n (%)	Depressive symptoms	p
Mean ± SD	Mean ± SD	Gender				Hospital level	
Men	86 (2.0)	50.22 ± 9.93	.220	Secondary	946 (22.3)	52.89 ± 10.89	.934

Women	4152 (98.0)	51.59 ± 10.8 4		Tertiary	3292 (77.7)	51.18 ± 10.7 8	
Age (yrs)				Years of employment			
≤25	839 (19.8)	53.89 ± 10.4 2	<.001	≤5	1431 (33.8)	52.88 ± 10.7 0	<.0 01
26–30	1504 (35.5)	52.23 ± 10.7 1		6–10	1434 (33.8)	52.42 ± 10.6 2	
31–35	1067 (25.2)	51.77 ± 10.6 0		11–15	986 (23.3)	50.63 ± 10.7 8	
36–40	456 (10.8)	48.80 ± 10.8 3		>15	387 (9.1)	45.91 ± 10.1 5	
>40	372 (8.7)	46.43 ± 10.5 4					
The highest education				Marital status			
Secondary specialized school	50 (1.2)	54.16 ± 10.7 4	<.001	Married	2894 (68.3)	50.61 ± 10.8 8	<.0 01
Divorce or Widowhood	73 (1.7)	52.93 ± 8.44		Junior college	817 (19.3)	52.85 ± 10.7 3	
Unmarried	1271 (30.0)	53.67 ± 10.5 1		Undergraduate	3103 (73.2)	51.76 ± 10.7 0	
Overall working condition				Master or above	268 (6.3)	44.88 ± 10.1 8	
Very satisfied	60 (1.4)	44.16 ± 10.9 9	<.001	Position			
Satisfied	548 (12.9)	48.80 ± 9.87		General nurse	3379 (79.7)	52.40 ± 10.6 5	<.0 01
Uncertain	1171 (27.6)	54.52 ± 9.39)		Teaching group or Quality control team leader	478 (11.3)	50.14 ± 10.8 7	

Dissatisfied	2219 (52.4)	57.99 ± 10.58		Head nurse or above	381 (9.0)	45.94 ± 10.46	
Very dissatisfied	240 (5.7)	67.00 ± 13.02		Sleep status			
Treatment at work				Normal	2236 (52.8)	48.06 ± 9.92	<.001
Very satisfied	127 (3.0)	45.44 ± 11.16	<.001	Difficulty falling asleep	794 (18.7)	56.37 ± 10.49	
Satisfied	1012 (23.9)	48.70 ± 10.09		Easy to wake up	996 (23.5)	54.44 ± 10.05	
Uncertain	965 (22.8)	53.54 ± 9.76		Insomnia	179 (4.2)	55.46 ± 9.70	
Dissatisfied	1956 (46.1)	55.34 ± 10.64		Drug assisted	33 (0.8)	65.58 ± 16.63	

Variable	Mean	SD	1	2	3	4	5	6	7
1. Depression (standard scores)	51.56	10.82	1						
2. Caring	19.93	2.82	-.32**	1					
3. Inquisitiveness	15.94	3.00	-.43**	.45**	1				
4. Self-control	16.34	2.95	-.33**	.48**	.61**	1			
5. Psychological well-being	41.28	7.38	-.53**	.55**	.60**	.54**	1		
6. Self-efficacy	25.33	6.27	-.32**	.30**	.52**	.47**	.58**	1	
7. Social support	40.61	8.06	-.44**	.21**	.30**	.27**	.41**	.26**	1

	Standardized estimates
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β	CR	p	Direct effects
Caring→depression/PW	-0.45/0.74	-7.83/24.11	<.001
Inquisitiveness→depression/PW	-0.80/0.52	-12.67/15.35	<.001
Self-control→depression/PW	-0.06/0.21	-1.00/6.24	.318/<.001
Social support→depression/PW	-0.44/0.17	-24.10/17.54	<.001
Self-efficacy→depression/PW	-0.13/4.11	-4.90/24.73	<.001
Indirect effects			
Caring→SS→depression/PW	-0.08/0.03	-	<.001
Inquisitiveness→SS→depression/PW	-0.24/0.09	-	<.001
Self-control→SS→depression/PW	-0.14/0.05	-	<.001
Inquisitiveness→self-efficacy→depression/PW	-0.10/3.20	-	<.001
Self-control→self-efficacy→depression/PW	-0.07/2.14	-	<.001

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Examining Knowledge, Skill, Stress, Satisfaction, and Self-Confidence Levels of Nursing Students in Three Different Simulation Modalities

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ABSTRACT (ENGLISH)

Purpose

The aim of this study was to compare the effect of different simulation modalities on knowledge, skill, stress, satisfaction, and self-confidence levels of students receiving undergraduate education in three nursing schools.

Method

This was an experimental study. Students applied the scenario of "Respiratory Sounds Assessment" which was prepared according to three different simulation modalities. In the study, the standardized patient, high-fidelity simulation, and partial task trainer were used as simulation modalities.

Results

An increase was observed in postpractice knowledge levels of the three groups which had similar knowledge levels before the practice. Virtual Analog Scale stress levels of the students in the standardized patient group were higher than those of others. The students' mean scores of satisfaction in learning were higher in the standardized patient group. The students in the partial task trainer group had lower scores of self-confidence in learning. Skill scores of the students were lower in the standardized patient practice than those in others.

Conclusion

Simulation-based experiences give students the opportunity of experiencing situations they may experience in the actual practice beforehand. Therefore, this may increase their performance in real practices, as reality increases in the standardized patient group.

FULL TEXT

Introduction

Modality is a term used for expressing simulation types as a part of the efficiency of simulation. Partial task trainer, standardized patient, task trainer, and manikin-based, computer-based, virtual reality, and hybrid simulation could be given as examples to modality [1].

Different modalities used in simulation-based practices have different advantages or difficulties during practice. Selection of modality and an appropriate planning of simulation determine the features that significantly change the experience of learning [2, 3].

The standardized patient is a person trained for portraying a patient or another person in a scenario for practice or assessment [1]. In simulations that are performed with the standardized patient, students are expected to display appropriate communication skills, conduct interviews, make physical assessments, and design care plans while interacting with patients. Students' experience of a standardized patient simulation before the clinic gives them the opportunity of developing their interpersonal communication skills in a safe and controlled setting. The use of standardized patient enables students to develop their knowledge, skills, and critical thinking holistically [4]. It also increases the skill of empathy, adds a deeper point of view to the patient experience, and facilitates patient-oriented care in nursing practices [5]. Possible difficulties include high cost of this simulation modality and also the influence of standardized patient on the configuration and implementation of the process as planned [4]. Nevertheless, "standardized patient" was stated to be the most commonly used (68.0%) one in a study examining the education of 408 nursing programs [6].

High-fidelity simulation is a simulation method using a computer-based full-body manikin that is programmed for giving realistic physiological responses to students' practices [4]. In high-fidelity simulation, scenarios and practices comprehensively focus on viewing every patient and incident within an extensive framework rather than focusing on one problem [7]. It has been indicated that high-fidelity simulation develops self-confidence, self-efficacy, sense of satisfaction, clinical thinking, clinical competence, clinical judgment, and decision-making [8-12]. In addition, this method is convenient for repetitive usages. The negative aspect of this technology is that it is expensive [4].

Partial task trainer is a manikin or equipment that represents some anatomical parts of the human body and is designed for learning basic psychomotor skills. These models with low technological features are used for the training of psychomotor skills, assessment, or identification of skills by separating complex skills into parts. Using these models enables students to be competent before using their practice skills on real patients [4].

As simulation technology has developed rapidly today, investments in this technology have increased in undergraduate nursing programs in Turkey and the world [13-15]. Nevertheless, if high-fidelity simulations are considered to be costly, it is a fact that many universities, especially state universities, cannot budget for buying these models. In this case, it can be predicted that there will be a difference between the knowledge and skill competencies of nursing students who graduate from schools with and without high-fidelity simulators. For this reason, it becomes obligatory for educators in schools without a high-fidelity simulator to add less costly, innovative learning approaches to their education.

The use of innovative practices and techniques in nursing education helps students to actively participate in the learning process and helps them to develop cognitive, psychomotor, and attitudinal behaviors [16]. Today, the cost increase in the health-care system, patient safety, and ethical and legal sanctions has limited the acquisition of many skills in health education [17]. Developing clinical skills directly on the patient causes students to experience anxiety due to fear of harming the patient and making mistakes. Anxiety, on the other hand, prevents students from adequately reflecting their knowledge and skills on patient care in the clinical field. It is extremely important to ensure that the students perform clinical practices by paying attention to the values and rights of the patients to ensure patient safety [18].

Self-confidence is important for both nursing students and professional nurses. Because nursing practitioners have to give confidence, there is a need to clarify the concept of confidence. Being self-confident will allow more autonomous practice and ultimately contribute to both nurse and patient satisfaction [19]. Nursing students gaining self-confidence and satisfaction before graduation enables them to achieve satisfaction in their professional lives [8, 19]. In the theoretical framework of Jeffries/NLN Simulation Theory, self-confidence and satisfaction are among the most important concepts [20]. Previous studies show that using simulation modalities increases students' satisfaction and self-confidence [21, 22].

Thus, the study aims to compare the effect of different simulation modalities on knowledge, skill, stress, satisfaction, and self-confidence levels of nursing students receiving education in three nursing schools with the same curricula.

Method Study Design

The study was conducted in the randomized controlled experimental study design.

Participants

The population of the study consisted of a total of 266 undergraduates receiving the course of Internal Medicine Nursing in three nursing schools in the academic year of 2018-2019. The curriculums of three nursing schools were the same. The data were collected in the 4th week after the beginning of the academic year. Second-grade students who volunteered to participate in the study from each school were selected and included in the randomization list. Considering the school with the lowest number of students, at least 45 of the second-grade students of each school were selected. The students to participate in the study were determined according to the randomization checklist prepared in the Microsoft Excel 2016. All three schools benefit from different simulation modalities in their educational practices. Students were grouped according to the simulation modalities that their schools possess. Students selected in each school applied a single modality. A priori power analysis was not performed.

Study Tools

The data were collected using the student knowledge test, skill checklist, Virtual Analog Scale (VAS) stress level, and Student Satisfaction and Self-Confidence in Learning Scale.

Knowledge Test

This test was created by the researchers. The knowledge test consisted of 10 questions including instructional objectives of the course of respiratory system assessment and questioning instructional outputs in the relevant scenario prepared. Each of the 10 questions asked to the students in the knowledge test was 1 point. Students who

got 1 point for each right answer did not lose points for wrong answers.

Skill Checklist

The checklist prepared by the researchers according to the literature to assess the skills of the students during practice was used. The skill checklist consisted of 10 steps and the Likert-type score was assessed. The students got 2 points for the complete step and 1 point for the missing step. They did not get any points from the step they did not do.

VAS Stress Level

The VAS was used to visualize the stress levels of the students before and after practice. In the scale, they were expected to assess themselves from 1 (I am calm right now) to 10 (I am too nervous right now). The students marked on the visual scale how they felt.

Student Satisfaction and Self-Confidence in Learning Scale

The psychometric measurements of the scales developed by Jeffries [20] for the purpose of assessing student satisfaction and self-confidence in simulation-based practices were performed by Franklin et al. [22] in 2014. Turkish validity and reliability study of the scale was performed by Unver et al. [23]. Permission from the author who made the Turkish validity and reliability of the scale was obtained to use in the study. Student Satisfaction and Self-Confidence in Learning Scale is a Likert-type scale (1 point: Strongly Disagree, 5 points: Strongly Agree). It was evaluated by calculating students' mean scores.

Data Collection

In each school, the students were informed about the scenario application after the course of respiratory system assessment by their own instructors. The student knowledge test and VAS stress levels were applied to students after informing them. During the scenario, students were evaluated with the skill checklist.

When the scenario ended, the student knowledge test, VAS stress level, and Student Satisfaction and Self-Confidence in Learning Scale were applied.

Procedure

In the study, the subject of the simulation scenario was determined as the evaluation of respiratory sounds. Relevant theoretical practices of the students were completed before the study. The students were provided basic skill trainings (identifying listening areas, discerning normal and pathological sounds) concerning respiratory sounds. The scenario was prepared based on the criteria covered by the International Nursing Association for Clinical Simulation and Learning design standard [1].

At first, a needs analysis was performed within the scope of this standard. The reason to choose this scenario was students' frequently encountering patients with respiratory distress in clinical areas. Measurable objectives when determining the subject were determined as patient safety, communication, and listening respiratory sounds. While preparing the scenario, it was taken into consideration for it to be suitable for three modalities and to meet the learning objectives of the students. The pilot scheme was carried out before the scenario was applied. Before the start of the scenario, the students were briefed about it. The scenarios started with the student entering the patient room and evaluating the patient's respiratory system. The scenario ended with a debriefing (Table 1).

Scenario Application

The scenarios were conducted according to three different simulation modalities as standardized patient, high-fidelity manikin, and partial task trainer. Before the scenario application, the researchers agreed to ensure the standard on scenario application and data collection steps. The students were included in the scenarios individually, and they were prevented from watching each other during the scenario application. The scenario application took about 10-13 minutes. Scenarios and learning goals are given in Table 1. Right after the scenario application, the students were included in a debriefing in groups of 8-10.

Analysis of the Data

The data were analyzed using the SPSS 22.0 (IBM Corp., Armonk, NY, USA). The Kolmogorov-Smirnov test was performed to determine whether the data were normally distributed or not. One-way analysis of variance and *t* test were used because the intragroup and intergroup comparisons for continuous variables were normally distributed.

The Scheffe test was performed as a post hoc test. The significance level was accepted as p **Ethical Consideration** Consent from the students and an Canakkale Mart University's ethics committee approval were obtained before the study (Approval no. 18920478-050.04.04-E.1800171747). Institutional permit was obtained separately from 3 schools where the study was conducted. Verbal permission was obtained from the sample group students by paying attention to the principle of voluntary participation in the study, after giving information about the purpose of the study, what is expected of them, and their legal rights. They were assured that the information obtained would be kept confidential.

Results

Among the students who were included in the study, 99 (71.2%) were women and 40 (28.8%) were men. The age average of the students was 19.60 ± 0.68 years. In all three groups, the age average of the students was similar ($p = .873$). There was a significant difference between the test scores of the three groups before and after the practice ($p = .484$). After the practices, posttest results of knowledge levels of the three groups were also found to be similar ($F = 1.48, p = .231$) (Table 2).

VAS stress scores of the three groups were similar before the practice ($F = 0.82, p = .442$). After the practices, there was a significant difference between the groups in terms of VAS stress scores ($p = .012$). After the practice, stress level of the standardized patient group was found to be significantly higher than that of the other two groups ($p = .896$) (Table 3).

There was a significant difference between skill scores of the students that were assessed during the practice ($p = .001$) (Table 4).

There was a significant difference between the groups in terms of the scores of satisfaction in learning ($p = .001$) (Table 5). There was a significant difference between the groups in terms of the students' scores of self-confidence in learning ($p = .001$). In the practice which was performed with the partial task trainer, the students' scores of self-confidence in learning were significantly lower than those of the other groups ($p = .001$) (Table 5).

Discussion

In the study, an increase was observed in knowledge levels of the three groups after the practice which had similar knowledge levels before the practice. This result of the study simply confirmed the hypothesis "in different simulation modalities, there is no significant difference between the students in terms of knowledge levels".

In the literature, it is supported that all three simulation modalities contribute to students' knowledge levels. Although in the study of Tüzer et al. [24] it was emphasized that the standard patient was more effective in increasing the level of knowledge, in the study of Smithburger et al. [25] it was stated that the use of high-fidelity manikin was more effective. As in our study, it has been shown in the literature that there is no significant difference between simulation modality and students' getting and storing information [26, 27]. All these study results support that there is no difference in terms of the contribution of 3 different simulation modalities to the knowledge level of students. It is seen that the increasing costs of simulators with high validity are not directly proportioned to the simultaneously increasing learning outcomes. The important point for nurse educators here is that the students' level of knowledge increases when any simulator that is independent from the simulation model and suitable for the learning goal is used and when the scenario steps are fully implemented. In line with the results of this study, it is recommended for nurse educators to choose simulators that are suitable for the learning objectives.

One of the most important results of this study which was conducted using three different simulation modalities was that VAS stress levels of the students in the standardized patient group were higher than those of others after the practice. In the literature, it is suggested that stress level increases in simulation-based experiences [28]. The general expectation at that point was that stress scores decreased when the stressful condition was removed. In addition, the fact that stress scores of the students in the standardized patient group remained high could be explained with higher level of fidelity in the standardized patient than others. In the study by Ignacio et al. [29], it was stated that because the fidelity perception was higher in the simulation which was performed with the standardized patient, the students had higher stress levels. Horsley and Wambach [30] emphasized that faculty member presence in the simulation laboratory caused anxiety to increase before and after simulation, but this did not have a

negative effect on students' satisfaction and performance. Stress in the standardized patient group is higher than that of the other groups in accordance with the results of our study and the literature basis mentioned earlier. Therefore, we recommend nurse trainers to pay attention to this issue in line with the results. In particular, we suggest that it will be more effective to use partial task trainer simulators primarily in psychomotor skill practices. It is recommended that nurse educators prefer to use standardized patients primarily in cases where nontechnical skills such as communication other than a technical skill will be taught. This high stress level caused by the standardized patient compared with other methods is actually a situation that the student will actually experience in the clinical setting. In this respect, it is evaluated that the standardized patient method will positively contribute to the student's controlling stress in real fields of application.

In this study, the skill scores of the students were significantly lower in the application performed with the standard patient compared with the high fidelity and partial task trainer. In the literature, there are studies supporting the use of high-fidelity simulators that increase students' skills [31 , 32], as well as studies showing that there is no difference [18]. Our experience is that the stress created by the standard patient method on the student also negatively affects their skill performances. Low skill performances in standardized patient group ought not to be perceived as negative by nurse educators in terms of effectiveness of this method. Considering the fact that learning from their mistakes is the basis of the simulation-based learning experiences, the rate of students making mistakes in real practice decreases. Although this is not revealed in this study, our experience shows this. In addition, it is recommended that nurse trainers ought to examine this with future studies.

Mean scores of the students' satisfaction in learning were higher in the standardized patient group than those in the other two groups. Mean scores of self-confidence in learning were lower in the partial task trainer group than those in other groups. In the literature, it is stated that students using the simulation method have higher satisfaction and self-confidence levels [31 , 33 , 34]. In some comparative studies, on the other hand, it is stated that students using high-fidelity simulation methods have higher scores of satisfaction and self-confidence scale than students using low- and moderate-fidelity simulation methods [7 , 8 , 21].

Conclusion

In all three modalities, it was observed that knowledge levels of the students increased. It is possible to state that standardized patient increases stress of students more than other practices and thus reduces skill levels related to stress. Simulation-based practices give students the opportunity of experiencing conditions in the actual practice beforehand. In this respect, the stress-related decrease which was observed in skill scores of the standardized patient group suggested that practices may be effective in reducing the level of stress faced by students in the clinical practice and increase their performance in the actual practice. In addition, students' satisfaction and self-confidence are higher in scenarios carried out with standard patient. For this reason, simulation-based practice with standard patient can be recommended in preclinical training. In future studies, it is suggested to investigate the reflections of the aforementioned three different simulation modalities on the clinical practice.

Conflicts of interest

The authors declare no conflict of interest.

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This study did not receive funding.

Author contributions

S.U.C., V.K., and D.Y designed the study, analysed the data, and prepared the manuscript. S.U.C., V.K., D.Y., H.K., and S.A. collected the data. All authors approved the final version for submission.

Scenario

File name: Respiratory Sounds Assessment	
Scenario duration: 10 mn.	Analysis duration: 20 mn.
Patient information	
Patient's name surname: Hüseyin Yılmaz	
Gender: male man	Age: 45 years
Primary medical diagnosis: chronic obstructive pulmonary disease (COPD)	Medical history: hypertension for 15 years, COPD for 5 years
Continuously used drugs: Spiriva 1x1puff inh, Ipratrom 4x1 nebul, midlonide 2x1puff inh, 6x2 puff Ventolin when distressed	
<p>Present medical story:</p> <p>The patient was admitted to the emergency service due to respiratory distress. He was taken from the emergency service to the chest diseases service to be hospitalized for treatment.</p>	
<p>Social history:</p> <p>The patient works as a mineworker.</p>	
<p>Knowledge competences</p> <p>1Definition of respiratory tract</p> <p>2Respiratory physiology</p> <p>3Function of respiratory tract</p> <p>4Normal lung sounds</p> <p>5Abnormal respiratory sounds</p> <p>6Respiration types</p>	<p>Skill and attitude competences</p> <p>•Listen to respiratory sounds</p> <p>•Taking medical history in the respiratory tract</p>
Simulation learning outputs	
<p>1Providing patient safety</p> <p>2Communicating</p> <p>3Listening to respiratory sounds</p>	
Primary purpose of the scenario: Listening to respiratory sounds of the patient with COPD suffering from respiratory distress	
<p>Simulator manikin/manikins needed</p> <p>Standardized patient/high-fidelity simulator/partial task trainer</p>	
<p>Report to be submitted to the participant before the simulation</p> <p>You work in the chest diseases service. Admit the patient brought from the emergency service to the clinic for hospitalization. You will listen to his respiratory sounds.</p>	
<p>Preliminary informing</p> <p><input type="checkbox"/> Sharing information related to the simulator</p> <p><input type="checkbox"/> Understanding expectations/goals related to the scenario</p> <p><input type="checkbox"/> Obtaining permissions for videos/photos (if available)</p> <p><input type="checkbox"/> Providing the expected timetable</p> <p><input type="checkbox"/> Telling the role of the participant</p>	

Scenario progress			
Timing	Manikin/standardized patient actions	Expected interventions	Clues
Introduction 1–3 mn.	Standardized patient/high-fidelity simulator: The patient coughs and could barely breathe. He answers the questions of the nurse. Partial task trainer: No intervention	Nurse:•Receives the patient.•Introduces herself.•Washes her hands. Explains the procedure to the patient.	Standardized patient/high-fidelity simulator: If the nurse skips introducing herself, the patient asks, “What is your name, dear?” Partial task trainer: No intervention
3 mn. -10 mn.	Standardized patient/high-fidelity simulator: He answers the questions of the nurse.	Nurse:•Auscultates the front and back area of the lung.•Discerns abnormal respiration (wheezing).•Records data.•Collects materials.Informs the patient.	Standardized patient/high-fidelity simulator: If the nurse misses out the wheezing, he says, “That wheezing really annoys me”. If the nurse skips giving information as she leaves, he asks, “How am I dear? Am I all right?” Partial task trainer: No intervention
Analysis session			
Reaction stage How did you feel? How do you feel right now?	Identification stage What did you do for your patient? What were the goals of the scenario?	Analysis stage What do you think you do the best? What would you change if you had another chance to do?	Summarization stage In sum, what kind of inferences have you attained? What are the key points we have learned from this scenario?

Score	Standardized patient (n=48)	High-fidelity manikin (n=45)	Partial task trainer (n = 46)	Statistical test	P

Min-Max (0-10)	$\bar{X} \pm SD$	Min-Max (0-10)	$\bar{X} \pm SD$	Min-Max (0-10)	$\bar{X} \pm SD$	Pretest	3-9	5.7 7 ± 1.7 0
3-8	5.42 ± 1.22	1-8	5.72 ± 1.49	0.73	.48 4	Posttest	2- 10	6.3 1 ± 1.5 0
4-9	6.02 ± 1.18	3-9	6.52 ± 1.46	1.48	.23 1			t = -2.74
t = -2.60		t = -5.21						p = .009*

	Standardized patient (n=48)	High-fidelity manikin (n=45)	Partial task trainer (n = 46)	Statistical test	p	Post hoc
$\bar{X} \pm SD$	$\bar{X} \pm SD$	$\bar{X} \pm SD$	Before practice	5.06 ± 2.23	5.64 ± 2.43	5.23 ± 2.02
0.82	.442		After practice	5.10 ± 2.82	4.11 ± 2.47	3.65 ± 1.70
4.55	.012*	Standardized patient group > partial task trainer group Standardized patient > high-fidelity manikin group		t = -13	t = 2.74	t = 4.35
				p = .896	p = .009*	p = .001*

Score	Standardized patient (n = 48)	High-fidelity manikin (n = 45)	Partial task trainer (n = 46)	Statistical test	p			
Min-Max (0-20)	$\bar{X} \pm SD$	Min-Max (0-10)	$\bar{X} \pm SD$	Min-Max (0-10)	$\bar{X} \pm SD$	Skill scores	2-18	9.68 ± 3.23
9-20	15.66 ± 2.66	4-20	14.76 ± 4.35	40.87	.001*	Post hoc	Partial task trainer group > standardized patient group	

	Standardized patient (n=48)	High-fidelity manikin (n=45)	Partial task trainer (n = 46)	Statistical test	p
$\bar{X} \pm SD$	$\bar{X} \pm SD$	$\bar{X} \pm SD$	Satisfaction with current learning	4.48 ± 0.68	4.01 ± 0.85

3.68±0.80	12.25	.001*	Post hoc	Standardized patient > partial task trainer group Standardized patient > high-fidelity manikin group	
Self-confidence in learning	4.22 ± 0.48	4.06 ± 0.69	3.50±0.68	16.89	.001*
Post hoc	Standardized patient group > partial task trainer group High-fidelity manikin group > partial task trainer group				

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Developing Strategy: A Guide For Nurse Managers to Manage Nursing Staff's Work-related Problems

Amal Refaat Gab Allah; Hayam Ahmed Elshrief; Marwa Hassan Ageiz

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ABSTRACT (ENGLISH)

Summary Purpose

The purpose of this study was to assess nursing staff's work-related problems as perceived by their managers and thereafter develop strategies that would serve as a guide for nurse managers to manage these problems.

Methods

A descriptive research design was used. The participants included in the study consisted of the following two groups: Group 1—a convenience sample of 150 first-line managers working at three different hospitals; and Group 2—a panel of experts for the Delphi technique, selected using the Snowball sampling technique. Tools for data collection included the following: Tool 1—questionnaire about nursing staff's problems; Tool 2—Delphi technique to develop strategies for managing nursing staff's problems; and Tool 3—opinionnaire format.

Results

The recruited first nurse managers were of the opinion that job stress, work overload, conflict, workplace violence, poor performance, staff turnover, demotivation, lack of empowerment, and staff absenteeism were among the common problems faced by staff nurses at work.

Conclusion



From the expert panelists' perspectives, the newly developed strategy in this study was considered valid; the researchers recommend the strategy developed in this study to be universalized in different health care settings and used as a guide for nurse managers.

FULL TEXT

DETAILS

Subject:	Workforce planning; Patients; Work environment; Collaboration; Social conflict; Communication; Workplace violence; Empowerment; Productivity; Violence; Leadership; Absenteeism; Nursing; Workloads; Nurses; Health services; Professional relationships; Health hazards; Medical research; Descriptive research
Business indexing term:	Subject: Workforce planning Work environment Workplace violence Productivity Leadership Absenteeism Workloads Professional relationships
Location:	Egypt
Identifier / keyword:	Delphi; nurse managers; nursing staff; workplace
Publication title:	Asian Nursing Research; Seoul
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Determinants of Protective Behaviors Against Endocrine Disruptors in Young Korean Women

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ABSTRACT (ENGLISH)

Purpose

A convenience-oriented lifestyle in young people is accompanied by greater consumption of and exposure to endocrine disruptors, which can affect reproductive health, especially in women. We aimed to identify factors that influence protective behaviors against endocrine disruptors among female college students in South Korea.

Methods

Using a cross-sectional survey design, we recruited 199 female college students. A self-administered questionnaire was used, and data were collected at the site.

Results

A healthy lifestyle, information utilization, receiving peer advice on avoiding exposure to endocrine disruptors, and a history of environmental illnesses were found to be significant factors, explaining 42.0% of the variance in protective behaviors against endocrine disruptors.

Conclusion

Health consequences of environmental hazards and importance of maintaining a healthy lifestyle need to be emphasized in young women's healthcare. Health professionals should advocate for and empower women to protect themselves against endocrine disruptors.

FULL TEXT

DETAILS

Subject:	Health behavior; Young adults; Hormones; Womens health; Health education; Food; Investigations; Menstruation; Questionnaires; College students; Pain; Data collection; Bisphenol A; Peer tutoring; Colleges & universities; Cosmetics; Estrogens; Lifestyles; Health literacy; Medical research
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Ra, J. S., & Kim, S. O. (2020). Beneficial effects of breastfeeding on the prevention of metabolic syndrome among postmenopausal women. *Asian Nursing Research*, 14(3), 173-177. doi:<https://doi.org/10.1016/j.anr.2020.07.003>

Summary/PurposeThis study aims to determine whether breastfeeding may have any beneficial effects on metabolic syndrome in a cohort of postmenopausal Korean women.**Methods**A cross-sectional study with secondary data analysis was conducted using the cohort in the Korean Genome and Epidemiology Study. Data from 1,983 postmenopausal women were analyzed by logistic regression analysis. Controlled covariates were chosen based on a biopsychosocial model and included age, family history of hypertension; type 2 diabetes mellitus; and cerebro-cardiovascular diseases, body mass index, age of menarche, parity, socioeconomic status of family, educational level, past or current smoking experience, and current alcohol consumption experience.**Results**Breastfeeding experience and duration were not significantly associated with a decreased likelihood of metabolic syndrome among postmenopausal women. However, breastfeeding experience (adjusted odds ratio [AOR]: 0.52 $p = .010$) and a total duration of breastfeeding exceeding 3 months were significantly associated with decreased likelihood of abdominal obesity (≥ 3 and < 6 months: AOR: 0.49 $p = .014$; ≥ 6 and < 12 months: AOR: 0.51 $p = .009$; ≥ 12 months: AOR: 0.56 $p = .024$).**Conclusion**Our findings indicate that breastfeeding might have beneficial effects on reducing abdominal obesity in postmenopausal women. Health-care providers should publicize beneficial long-term effects of breastfeeding on the prevention of abdominal obesity, a component of metabolic syndrome.

Wu, M., Peng, C., Chen, Y., Yuan, M., Zhao, M., Wang, C., & Zeng, T. (2020). Nurses' perceptions of factors influencing elder self-neglect: A qualitative study. *Asian Nursing Research*, 14(3), 137-143. doi:<https://doi.org/10.1016/j.anr.2020.05.001>

PurposeElder self-neglect is a global public health issue and should be taken seriously at large. Nurses, usually working directly with elderly patients, have a better understanding of what factors may cause elder self-neglect. In this qualitative study, we explored the influencing factors of elder self-neglect from the perception of nurses in the context of Chinese culture.**Methods**Face-to-face, in-depth interviews were conducted from November 2018 to December 2018. Purposive sampling was used. Twenty one participants recruited from eight geriatric wards of a general hospital located in Wuhan were interviewed. A content analysis of qualitative nature was performed to analyze the data.**Results**Our conceptual model illustrated the findings based on the three themes of the conflict between personal recognition and social judgment, the choice between current needs and individual beliefs, as well as the compromise between insufficient abilities and limited resources.**Conclusion**Nurses together with family members and social workers can help older adults improve their awareness of self-neglect to bridge the gap with social judgment, learn to focus on their own needs, as well as seek as much support as possible. Nurses should also respect the autonomy and self-determination of elder self-neglecters because self-neglect is related to older adults' values. Furthermore, larger studies are needed to quantitatively test and refine the model.

Kim, Y., Jung, L. L., In, S. J., & Park, S. (2020). Knowledge and health beliefs of gestational diabetes mellitus associated with breastfeeding intention among pregnant women in bangladesh. *Asian Nursing Research*, 14(3), 144-149. doi:<https://doi.org/10.1016/j.anr.2020.06.001>

PurposeThis study aimed to investigate the knowledge of gestational diabetes mellitus (GDM) and the health beliefs about GDM management, as well as to investigate the effects of these factors on breastfeeding intention in Bangladesh.**Methods**This study involved a cross-sectional survey of 358 healthy pregnant women who visited antenatal clinics in Bangladesh.**Results**Perceived susceptibility, perceived benefit, and self-efficacy were identified as significant factors for breastfeeding intention ($p < .05$). Participants had a poor understanding and a lack of knowledge of GDM, which can lead to inadequate health behavior. Health beliefs were significantly associated with participants' breastfeeding intention related to GDM.**Conclusion**Antenatal education for breastfeeding in GDM mothers should focus on providing accurate information on GDM and strengthening their health beliefs such as self-efficacy within the context of the mothers' culture.

Xie, J., Liu, M., Zhong, Z., Zhang, Q., Zhou, J., Wang, L., . . . Cheng, A. S. K. (2020). Relationships among character strengths, self-efficacy, social support, depression, and psychological well-being of hospital nurses. *Asian Nursing Research*, 14(3), 150-157. doi:<https://doi.org/10.1016/j.anr.2020.06.002>

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