Simulated Adolescents to Build Empathy and Cultural Care in Bridging Students: A Pilot

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Keywords
adolescents, culturally responsive care, empathy, simulation, simulated patients, mixed-methods research, reflective practice, Kolb's experiential learning cycle

Article History
Received 23 July 2025
Received in revised form 15 Dec 2025
Accepted 12 Jan 2026
Available online 23 Jan 2026

*__Original Research Papers__ are papers that report on original empirical research with a focus on teaching and learning. Papers may be qualitative or quantitative and include an Abstract, Introduction, Method, Results, Discussion, and Reference section, as well as any tables and/or figures.

Abstract

Aim
The aim of this pilot project study was to explore nursing students' learning experience of delivering culturally responsive care and empathetic communication skills while working with an adolescent simulated patient.

Background
Many health care providers voice a lack of confidence in interacting with adolescents. In addition, demonstrating empathetic communication remains a common challenge for many students pursuing careers in the health professions. Furthermore, few studies have explored student performance and empathetic communication in culturally responsive care while working with adolescents.

Design
The study used a mixed-method design using surveys, faculty observations, and focus groups.

Method
The study sample consisted of Bridging students (Registered Practical Nurse to Bachelor of Science in Nursing), (n = 29) randomized into groups of 6 to 7 students. Students completed a self-reporting instrument, the Jefferson Scale of Empathy-Health Professions-student (JSE-HPS), before and after the simulation learning experience. Four faculty members participated as simulation observers and completed the Jefferson Scale of Patient Perceptions of Nurse Empathy (JSPPNE). Focus groups were conducted to gain deeper insight into the students' experiences and perceptions of culturally responsive care and empathetic communication skills.

Results
Students' total empathy scores improved after a simulation working with simulated adolescents and mother. Students' total empathetic scores were higher than faculty observer scores. Focus group data revealed four main themes:

cognitive (awareness), understanding (of the patient's experiences & perspectives), communication skills, and intention to help.

Conclusions
Bridging students reported increased empathy following the implementation of a simulation-based learning experience working with adolescent simulated patients (SPs). Students found working with Simulated Patients (SPs) to be an effective method for learning how to deliver culturally responsive, family-centred care. There is also a need to facilitate deeper self-reflection among students and strengthen faculty feedback mechanisms.

Introduction

In the diverse and complex settings of healthcare, nurses play an essential role in providing family-centred care built on dignity, respect, open communication, and collaboration between healthcare professionals and families (RNAO, 2015). Family-centred care fosters a partnership that values the unique strengths, needs, and relationships within each family. By facilitating active engagement and shared decision-making, nurses support families in managing health challenges, maintaining well-being, and strengthening their ability to manage their states of health, wellness, and illness (Astle et al., 2024).

Background

Family-centred Care

Key concepts of family-centred care include nurses' ability to enable and empower the family unit in acquiring new skills and decision-making while incorporating family members as partners in care, which is most effective when it is also culturally responsive (Astle et al., 2024). Culturally responsive care acknowledges and respects diverse family values, traditions, and beliefs, ensuring that nursing practices align with the unique cultural needs of each family (Astle et al., 2024). Furthermore, culturally responsive care is a process that involves applying knowledge, attitudes, and skills that enhance cross-cultural communication, foster meaningful, respectful interactions with others, and, in so doing, address issues of exclusion that can affect health outcomes (Tyerman et al., 2024, p.24). As populations become more diverse, nursing students need opportunities to develop and strengthen their skills in providing patient-centred, empathetic, culturally responsive nursing care. However, Yuan (2021) noted that students neglected cultural assessments when conducting assessments within high-fidelity simulations. One approach to achieving this is by integrating diversity, equity, and inclusion principles into simulation experiences (Karnitschnig et al., 2023). Consequentially, nursing programs are working to incorporate pedagogical strategies into the curriculum to provide students with opportunities to "use evidence-informed communication skills to build trusting, compassionate, and therapeutic relationships" (College of Nurses of Ontario, 2017, p.6) with clients across the lifespan and culturally responsive nursing care (Holtslander et al., 2018).

Empathy

Research suggests a relationship between healthcare providers' empathy and improved patient satisfaction (Yuguero et al., 2018) and health (Hojat et al., 2011). Although there is no consensus on the definition of empathy, some researchers have described it as a cognitive attribute that allows empathizers to comprehend the emotions or concerns of others. Empathy has also been described as an affective or emotional attribute, providing the ability to feel and perceive experiences from other's perspectives (Hojat, 2016). Furthermore, some view empathy as both affective and cognitive with the intention to help others. Employing Jefferson's definition, this study defines empathy as "a predominantly cognitive (rather than emotional) attribute that involves an understanding (rather than feeling) of experiences, concerns, and perspectives of the patient, combined with a capacity to communicate this understanding" (Hojat, 2016, p. 74).

Adolescence

Adolescence, the developmental stage between childhood and adulthood (ages 10 to 19), is an important time frame for developing lifelong health behaviours. During this period, adolescents experience rapid physical, cognitive, and psychosocial growth. Simultaneously, these developmental changes influence their problem-solving ability and decisions in risk behaviours with the interactions that take place around them (Astle et al., 2024; World Health Organization, 2022). During this crucial development period, it is essential to engage with adolescents and provide education to help them develop lifelong healthy behaviours. However, literature has noted that many health care providers report a lack of effective communication skills while interacting with adolescents, attributed to insufficient educational training (Borzutzky, 2021).

Simulations

Low- and high-fidelity simulations have been used in nursing curricula as an alternative to clinical placement and to assist students in preparing for entry to practice (Parker et al., 2015). Simulated patients (SPs) have been identified as an effective method to enhance students' experiences by allowing them to practice skills with real people in a safe, controlled environment (Lewis et al., 2017; Nestel & Bearman, 2015). Research has shown that when students work with SPs before their clinical experiences, they experience increased self-efficacy and performance and reduced anxiety during well-child visits (Weston et al., 2021). Working with simulated patients (SPs) allows cultural awareness and sensitivity to be developed. It improves intercultural communication by providing opportunities to practice and reflect in a risk-free setting (Markey et al., 2021). Furthermore, Monahan et al. (2024) also found working with adolescent SPs was beneficial in improving healthcare providers' psychosocial assessments among the adolescent population. However, many healthcare providers working with the pediatric population note a lack of confidence in their ability to effectively communicate with adolescents (Borzutzky, 2021; Essig et al, 2016). While literature supports the use of SPs in simulation to enhance nursing students' skills in empathetic therapeutic communication (Fields et al., 2011; Fitzgerald & Ward, 2019; Ward, 2016), and in developing cultural competence (Qin & Chaimongkol, 2021) and to improve healthcare provider interactions with adolescents(Egriss et al., 2016; Monahan et al., 2024), few studies have examined students' performance and empathy in delivering culturally responsive care to diverse adolescent populations.

Theoretical Framework

Kolb's Experiential Learning Cycle (Kolb, 1984) and the National League of Nursing (NLN)/Jeffries Simulation Theory (Jeffries, 2016; Jeffries, Rodgers, & Adamson, 2015) were the guiding theories for this study. Kolb's Four-Stage Learning Cycle was implemented in this project: concrete experience, reflective observation, abstract conceptualization, and active experimentation. Concrete experimentation occurs when learners engage in simulation scenarios, such as caring for a simulated patient with a newly diagnosed respiratory condition. Following the scenario, students engage in reflective observation as they debrief and reflect on their performance during the simulation, working to make connections about what occurred and identify any areas that could be strengthened. During the abstract conceptualization stage, the facilitator helps learners analyze the reflective experience, incorporate what they have learned, and consider what they might do differently when caring for a similar client in future practice. This is active experimentation, where learning occurs and where knowledge can be incorporated into practice (Kolb, 1984; Lavoie et al., 2017).

Method

The pilot project idea was to create a simulation with an adolescent focus while introducing simulated patients rather than high-fidelity simulators. The Society for Healthcare Simulation (2021) defines high-fidelity simulations and simulators as "simulation experiences that are extremely realistic and provide a high level of interactivity and realism for the learner using a broad range of full-body manikins that have the ability to mimic human body functions" (p. 21). High-fidelity simulations were an integral part of the nursing program curriculum, but there were limited simulations focusing on the adolescent population or culturally sensitive care. In addition, the Faculty of Health & Life Sciences (formerly the Faculty of Health Sciences & Wellness) programs were new to working with simulated patients. The pilot project was awarded funding for the simulated patients from the Bachelor of Nursing Education fund.

This study examines the perceptions of Registered Practical Nursing (RPN) students who are bridging to Bachelor of Science in Nursing (BScN) regarding their ability to provide culturally responsive care and empathetic communication, focusing on their interactions with an adolescent and his mother during a simulation. The study also compares students' self-evaluated empathy scores with those given by faculty observers. Additionally, this study evaluates whether students perceive working with SPs as an effective learning strategy for practicing culturally responsive care and empathetic therapeutic communication in simulations involving diverse adolescent populations.

The research questions used to guide this study were:

1. How does a simulation learning experience while working with an adolescent simulated patient and family influence students' perceptions of culturally responsive care and empathy?
2. Do students view their perceptions of empathy differently than faculty observers?
3. In what ways does a simulation learning experience

working with an adolescent simulated patient and family facilitate culturally responsive care and empathetic communication skills?

To explore our research questions, a mixed-method study design using surveys, faculty observations, and focus groups was conducted in a large academic institution in Canada. The institution's Research Ethics Board approved the study (REB-0306). Our study design was informed by Cheng et al.'s (2016) reporting guidelines for healthcare simulation research. The reporting guidelines for simulation in healthcare research are designed to help authors prepare manuscripts that include simulation-based research, and to support editors in evaluating whether these simulation studies are appropriate for publication (Cheng et al., 2016).

A convenience sample of Bridging BScN students in their second term was used, resulting in a total sample size of *n* = 29. This sample serves as a foundational step for exploratory research and offers preliminary insights into the experiences and perspectives of Bridging Nursing students.

Participation in the study was voluntary, and informed consent was obtained. Students were concurrently in maternal-child practice settings one day a week. Although participants may have had prior experience with simulations, this was their first experience working with simulated patients. Descriptive data on age, sex, work experience, and simulation experience were collected (see Table 1).

Table 1a. Bridging Students Gender (n = 29)

Gender	n	%
Female	25	86.2%
Male	2	6.9%
Other	2	6.9%

Table 1b.Bridging Students Age Range (n = 28)

Age Range	%
19-21	10.7%
22-24	32%
25-27	17.9%
28-30	21.4%
31-33	3.6%
34-36	3.6%
43-45	3.6%
46-48	3.6%
49-51	3.6%

Table 1c. Years of Experience.

Years of Experience	Previous Practice as RPN (n = 29) %	Previous Practice with Simulation (n = 28) %
none	6.9%	10.7%
1 year or less	65.5%	50%
1-2 years	20.7%	35.7%
3 years or more	6.9%	3.6%

Additionally, four faculty members certified by the Society of Healthcare Simulation as Healthcare Simulation Educators participated as simulation observers, evaluating students' empathetic communication and culturally responsive care while they worked with the family unit during the simulation.

Study procedure

The International Association for Clinical Simulation in Nursing (INACSL) Standards of Best Practice (INACSL, 2021a, 2021b) and the Association of Standardized Patient Educators (ASPE) Standards of Best Practices (SOBP) (Lewis et al., 2017) guided the development of this simulation learning experience. Content and simulation experts developed a simulation scenario for use in this study on culturally responsive, family-centred care, focusing on interactions with an adolescent client and his one parent. A partnership was developed with an institution with a Standardized Actor's program with carefully trained SPs. The SPs are trained to reproduce a particular character's history, personality, physical, and emotional state. Furthermore, the SPs respond appropriately to both verbal and non-verbal cues to each learner-specific behaviour and provide feedback regarding their experience from their character's perspective. The SPs are trained to ensure a psychologically safe environment is maintained so learners can take risks and make errors (Lewis et al., 2017). The SPs were provided with the scenario objectives and script two weeks in advance. Virtual meetings were held during the consultation, including practice runs and the implementation of a pilot session. Simulation facilitators and observers were involved in each simulation phase. The scenario was pilot-tested with a senior-level student from the Direct Entry four-year Bachelor of Nursing pathway who had previous simulation experiences in this area. The purpose of the pilot was to ensure that psychological safety and learning

outcomes were met. The feedback was positive, and no changes were made as a result. Preparatory readings focused on therapeutic communication skills, cultural responsiveness, and family-centred care.

Six to seven students per group participated in a 3-hour simulation learning experience working with an adolescent simulated patient and his mother. The simulated experience centred on a male adolescent who was diagnosed with asthma three weeks prior. He was attending an asthma clinic for follow-up care, accompanied by his mother. The SPs followed a script based on the simulation scenario. The script was developed in collaboration with the partner institution that provided our simulated patients. The main character in the scenario is an 11-year-old patient who is shy and quiet and has enjoyed playing soccer since he was a toddler. He feels frustrated with his new asthma diagnosis and is embarrassed to use his puffers at school. Living in an intergenerational household, his grandparents and father do not understand his physical limitations and struggles, labelling him as "lazy" and "ungrateful." Due to embarrassment, the child is reluctant to use his rescue medication and aero chamber when experiencing breathlessness during activities. The SPs playing the adolescent were instructed to use statements designed to elicit empathetic responses, such as "I am so embarrassed to use my puffer and inhaler chamber in front of my friends and coach." In the role of the mother, the SPs were instructed to be impatient and not understand the son's feelings (see Appendix A).

Data Collection

Quantitative

The Jefferson Scale of Empathy-Health Professions-student version (JSE-HPS) measured students' self-reports of empathy before and after the simulation (see Table 2). The Jefferson Scale of Patient Perception of Nurse Empathy (JSPPNE) was used by faculty observers to rate their perceptions of the student's empathy during the simulation. Additionally, demographic data was collected to inform researchers of the participants' age, gender, and years of experience in practice as an RPN. Additionally, the Research Assistants (RAs) conducted focus groups to gain deeper insight into the students' experiences and perceptions of empathy during their interactions with the SPs and to explore the need for further empathy development for future practice.

The JSE-HPS is a self-report instrument used to measure 20 statement items to measure perceptions of empathy (Hojat, 2016) in the context of health profession students. The scale is a slightly modified version of the originally created Jefferson Scale of Physician Empathy administered to medical students and physicians (Hojat, 2007). The scale measures three features of empathy: perspective-taking, compassionate care, and walking in the patient's shoes. It employs a 7-point Likert scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). The internal consistency reliability was previously reported as Cronbach's α of .78 (Fields et al., 2011). The higher the score, the more empathic the behaviour orientation. The total possible score on the JSE-HPS is 140. Ten items are reverse scored from 1 (*strongly agree*) to 7 (*strongly disagree*). A standalone question was added to the study, "I believe that the use of simulated actors is an effective strategy for promoting culturally responsive family-centred care", to gauge students' thoughts on the efficacy of SPs. In the current study, Cronbach's alpha for the JSE-HPS tool was .787. The total possible score on the JSE HSP tool is 140, with 20 items each scoring 7.

The Jefferson Scale of Patient Perceptions of Nurse Empathy (JSPPNE) is a 5-item modified version of the patient perceptions of empathy displayed by the nurse (Hojat, 2016; Hojat et al., 2017). The higher the score, the more empathetic the patient perceives the healthcare provider to be. The total maximum score is 35. It uses a 7-point Likert-type response, ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). Higher scores indicate a higher degree of empathy. The JSE HSP tool has demonstrated strong internal consistency reliability, with Cronbach's alpha p previously reported as .951 (Gajewski, 2023). In the current study, the Cronbach's alpha for the total scale was .802, indicating acceptable reliability.

Qualitative

During the debrief focus group sessions, the RAs led the discussion using a semi-structured guide of open-ended questions that focused on the effects of working with adolescent simulated patients in simulation, and their culturally responsive, empathetic, therapeutic communication skills. The focus group interview guide was modified from Fitzgerald & Ward's (2019) study focus guide. (Appendix B).

Table 2 Comparison of student's pre and post simulation empathy scores per Jefferson Empathy Subscales

Table 2a. Jefferson Empathy Subscales

Jefferson Empathy Subscales	Total Pre-M ± SD	Total Post-M ± SD
Perspective Taking (Q's: 2, 4, 5, 9, 10, 13, 15, 16, 17, 20)	5.619 ± 1.4213	5.987 ± 1.4663
Compassionate Care (Q's: 1, 7, 8, 11, 12, 14, 18, 19)	5.9113 ± 1.3418	5.9025 ± 1.6724
Walking in Patients Shoes (Q's: 3, 6)	4.19 ± 1.6415	4.24 ± 1.8365
Jefferson Empathy Total Mean Scores	5.2401 ± 1.4682	5.3765 ± 1.6584

Table 2b. Question with Highest Mean Results

Question with Highest Mean (Empathy score) per Subscale	Pre-M ± SD	Post-M ± SD	P value=
Perspective Taking: 2. Patients feel better when their health care providers understand their feelings.	6.14 ± 1.620	6.66 ± 1.233	0.177
Compassionate Care: 1. Health care providers' understanding of their patients' feelings and the feelings of their patients' families does not influence treatment outcomes.	6.28 ± 1.131	6.62 ± 1.147	0.254
Walking in Patients Shoes: 3. It is difficult for a health care provider to view things from patients' perspectives.	4.10 ± 1.472	4.45 ± 1.682	0.41
Investigators Original Question: 21. I believe that the use of simulated actors is an effective strategy for promoting culturally responsive family centered care.	4.59 ± 1.615	6.50 ± 1.319	p <.001*

Data Analysis

Quantitative

Statistical analyses were conducted using the Statistical Package for Social Sciences (SPSS) version 22. Descriptive statistics were computed for all demographic and study variables. The results obtained from the scales were compared using independent t-tests, and averages were drawn to compare between groups. As is the standard, a *p*-value of < 0.05 was considered statistically significant (Plichta, 2013).

The estimated population size of Bridging Nursing students in Canada is approximately 3,443 (Canadian Association of Schools of Nursing, 2024). To assess the representativeness of this sample, the margin of error was calculated at 5.31%. A larger sample size would be required to achieve a narrower margin of error for more generalizable findings. However, it is an acceptable level for exploratory and pilot studies (Leon et al., 2011).

Qualitative

Qualitative data was collected through handwritten notes from the RAs during the focus groups. Participants answered the open-ended questions in their own words, in as much depth as they chose. A directed content analysis was conducted using transcribed notes from the focus groups. Four researchers coded the students' statements to each open-ended question from the focus group. The codes, along with their meaning and interrelationships, were reviewed and refined until full consensus was achieved, in accordance with Corbin & Strauss (2015).

Results

Twenty-nine students participated in the simulation and focus groups and completed the study pre-simulation learning experience JSE-HPS survey. Twenty-eight students completed the post-simulation learning experience JSE-HPS-survey. The participants' ages ranged from 19 to 51, with the majority (32%) of students aged 22–24. A majority of participants (86.2%) were female (see Table 1). The participants had varying degrees of experience with nursing practice and simulation, with some students having no previous experience working as a Registered Practical Nurse (RPN), and the majority having 1 year or less work experience (65.5%).

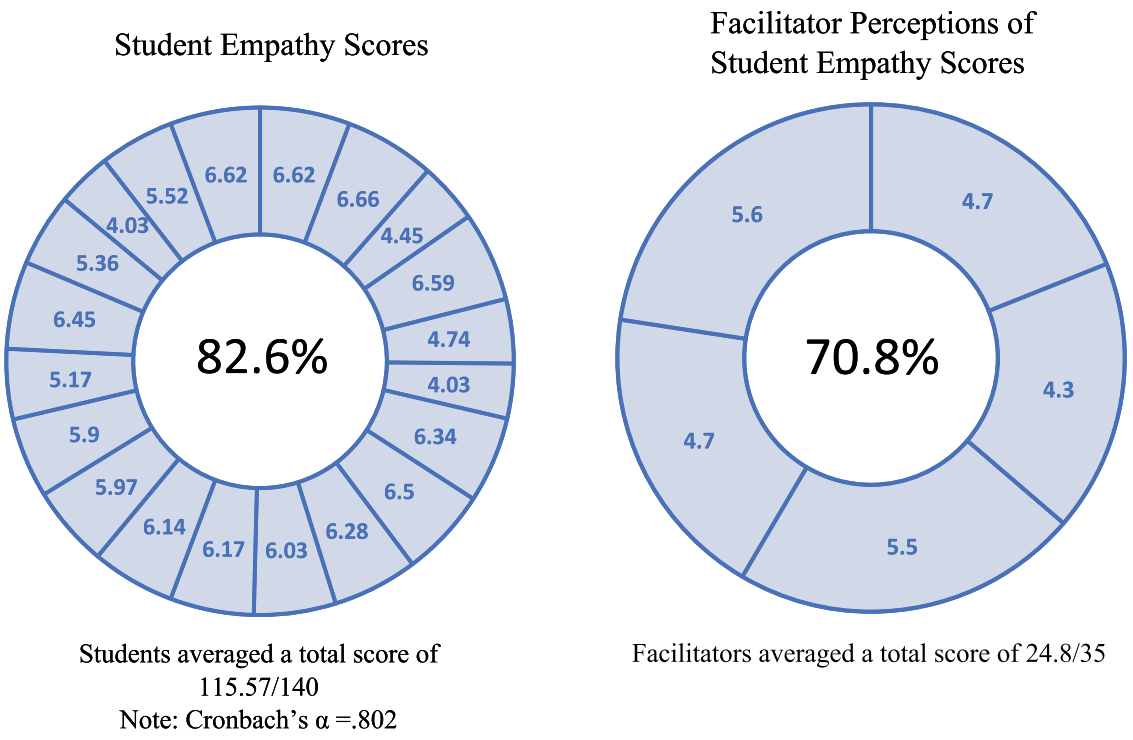

Figure 1. Comparison of student's empathy scores (post simulation) on JSE-HP & facilitator observer scores on JSPPNE.

Additionally, most participants (50%) indicated they had 1 year or less experience with simulation (see Table 1).

Quantitative—Students' JSE-HPS perceptions pre and post intervention

Given the small sample size (n = 29), the quantitative analysis is primarily exploratory and focuses on determining trends rather than establishing statistical significance. The highest mean scores per subscale were found in 'compassionate care' in the pre-test and 'perspective taking' in the post-test. Although scores in two of the three subscales improved from the pre-test to the post-test, there was no statistically significant difference (see Table 2).

From the post-test, the individual question with the highest mean came from the subscale "Perspective Taking 2. Patients feel better when their health care providers understand their feelings", with students rating this question M=6.66 ± 1.233. The total empathy scores for students in the pre-test and post-test were, respectively, 111.86/140 (79.9%) and 115.57/140 (82.6%).

The 21st question, an independent measurement, asked: "I believe that the use of simulated actors is an effective strategy for promoting culturally responsive, family-centred care." This question was statistically significant from the pre- to post-simulation learning experience test (pre M=4.59 ± 1.615, post M=6.50 ± 1.319, p <.001*).

Quantitative—Faculty/Observer Scores of JSPPNE

Four facilitators/observers completed the JSPPNE survey. Over the five sessions, 10 surveys were completed. The researchers compared faculty observers' assessments of student empathy to the students' self-assessments of empathy. The faculty observer assessment of student empathy was 24.8/35 (70.8%) compared to the student self-reported empathy scores of 115.57/140 (82.6%) (see Figure 1). Although there were no statistically significant differences, students' perceptions of their empathy were higher than the faculty observers' ratings of students' empathy. Gallagher (2017) noted similar findings and suggests that healthcare students wish to be regarded in a positive light, which may influence self-reported responses.

Qualitative

Four focus groups, each comprised of 6 to 7 students, were conducted with a convenience sample of 29 participants. Four main themes were identified: cognitive (awareness), understanding (of patients' experiences and perspectives), communication skills, and intention to help (see Table 3).

Each of these themes had several subthemes. The themes highlighted and supported our survey findings and provided insight into working with adolescent SPs to provide empathetic and culturally responsive family-centred care.

Discussion

A simulated learning experience with an adolescent simulated patient and parent created an opportunity to develop students' empathetic communication skills while providing culturally responsive family-centred care.

Table 3. Qualitative themes (working with simulated patients-adolescent & parent)

Themes	Subthemes	Qualitative Statements
Cognitive (awareness)	Knowledge of: family dynamics/role; family centred care; empathy; positionality health teaching	"Need to understand cultural knowledge and how that affects medical knowledge" "Asking a lot of questions so you don't make assumptions to provide clarity; families are complex" "Assess family's understanding (i.e. lazy vs asthma)" "Understanding the why before jumping to conclusions"
Understanding (of patients experiences & perspective)	Positionality (insight into situation); psychosocial understanding; conflict; verbal vs nonverbal communication	"Assess family's understanding, i.e. lazy vs asthma" "Understanding where your patient is coming from, ie. mom: what they know; son: being afraid of getting made fun of" "Put myself in their shoes, see what I would want from my healthcare provider" "Empathy is stepping into the family unit's shoes; if people are anxious/ upset/ fearful - can come across in many ways" "Understanding where family is at"
Communication skills	By building a therapeutic relationship; building trust; validating	"Good to focus on client while also addressing family" "Focus on building relationships" "Validating son's feelings" "Empathetic is being heard and validated" "Active listening" "Communication beyond the medical components"
Intention to help	Authenticity; increased professionalism; meeting goals of care; family/culturally centered care	"Exploring roles in the family + how everyone is impacted" "Connecting with people" "Using empathy to understand" "Exploring being made fun of: provide solutions to support son" "Providing more teaching with asthma and the puffer" "Respect autonomy + choice + space to make their own decisions" "Need to understand cultural knowledge and how that affects medical knowledge"

In this study, we conducted a thematic analysis of empathy in nursing practice guided by Jefferson's definition of empathy (Hojat, 2016). These attributes include understanding the patient's experiences and perspectives, the capacity to communicate this understanding, and an intention to help. The findings of our study reflect how nursing students engage with these components of empathy in practice.

Cognitive (Awareness)

Nursing students demonstrated awareness of the importance of family roles and dynamics, yet there were knowledge deficits in areas such as culturally responsive care and health teaching. The gaps suggest that while students recognize the need for cognitive awareness in empathetic interactions, there are still areas where additional education and support are necessary. These findings support Levett-Jones et al.'s (2019) systematic review which found that while 23 studies of empathy interventions in undergraduate nursing student education were conducted only nine were effective in achieving an improvement in empathy levels in a demonstrative manner. Several factors have been identified as impacting little demonstrable improvement following empathy-enhancing interventions in healthcare education. Gallagher (2017 suggests nursing students may have higher empathetic scores on the outset, possibly as an intrinsic characteristic of those who apply to nursing programs, thus diminishing a teaching effect. Studies that rely on self-report instruments may not necessarily reflect actual behaviour in clinical settings (Neumann et al., 2015). However, studies that provide immersive interventions that create an experience in which students view the world through the eyes of the patient are more effective (Eymard et al., 2010), as are studies on vulnerable populations.

This study was a pilot to determine the effectiveness of a simulation learning experience with simulated patients to promote realism with an adolescent and his mother, provide culturally responsive care, and impact students' empathy.

Understanding (of the Patient's Experiences and Perspectives)

Our analysis identified subthemes such as positionality, insight into the patient's situation, psychosocial understanding, and managing conflict, all of which relate to how well nurses grasp the complexities of a patient's experience. Positionality reflects the need for nurses to recognize their own biases and how these might influence their understanding of the patient's perspective. Multiple authors have supported this need (Kerr & Macaskill, 2020; Rushton, 2023; Smith & Lave, 2024). Psychosocial understanding and insight into the patient's situation demonstrate the need to consider not just the medical but the emotional and social factors affecting patients. Kriebs (2022) posits that nurses are not experts in the patient experience, but only by understanding their own position and genuinely listening to the patient's voice can we truly provide empathetic, patient-centred care. Researchers have noted that when working with adolescents, it is essential to show interest in the adolescent's world. Skills such as being non-judgmental, welcoming, open-minded, supportive and encouraging are essential when interacting with adolescents (Essig et al., 2016).

Communication

Our subthemes of communication skills: building therapeutic relationships, establishing trust, and validating the patient's experiences, highlight essential components of empathetic nursing care. Both verbal and non-verbal communication play significant roles in this process. Our findings suggest that nurses who are skilled in both types of communication can better foster trust and build effective relationships with patients. This finding aligns with the work of Gutiérrez-Puertas et al. (2020), who concluded that interpersonal communication skills are crucial to fostering empathetic relationships. Furthermore, Wu (2021) found that communicating empathy is as important as physical nursing care. Our findings also support those of Essig et al. (2016) and Navein et al. (2022), who noted that respectful, non-judgmental, trusting relationships and the demonstration of empathy are key factors in communicating and working with adolescents. Similarly, Byczkowski et al. (2010) noted that both adolescents and parents view communication, particularly listening skills, followed by interpersonal skills and technical competence, as essential aspects of care from health care providers. Conflict management emerged as a critical skill in communication, as managing patient and family conflicts with empathy can be challenging but is essential for positive outcomes.

Intention to Help

Our findings indicate that authenticity and professionalism are crucial components of an intention to help. Students who demonstrated authenticity in their interactions were more likely to meet the goals of care and engage in effective health teaching. Subthemes such as family-centred care, autonomy

and choice, and respect reflect how the intention to help is realized by honouring the patient's preferences and fostering collaborative decision-making. However, knowledge gaps, particularly in culturally centred care, suggest that despite good intentions, a lack of knowledge can hinder the practical application of empathy.

Although different, our surveys and focus group interview data were complementary. The quantitative results of this study, though not statistically significant, showed an increase in student empathy scores following interactions with simulated adolescent patients, indicating that these learning experiences foster empathetic skills. This finding aligns with Monahan et al. (2024), who reported that adolescent simulation training for pediatric healthcare providers enhanced their ability to conduct psychosocial assessments and improve communication.

Although students' total empathy scores overall improved following the interaction, scores on the Jefferson Scale of Empathy varied. Students scored higher in dimensions such as Perspective Taking' (M 5.987± 1.4663) and Compassionate Care (M 5.9025, SD ± 1.6724). However, scores were lowest in Walking In the Patient's Shoes (M 4.24, SD ± 1.8365), indicating challenges in fully embracing the patient's perspectives. These findings suggest that while students can demonstrate empathy in clinical settings, they still face challenges in fully understanding the complexities of patients' perspectives, especially when influenced by cultural and individual differences. The importance of self-reflection and self-awareness in developing empathetic skills is well-established in the literature (Shao et al., 2018; Sheehan et al., 2013). Similarly, Yuan (2021) identified the need for further training in cultural awareness and communication skills. These factors are central to students' ability to develop and apply empathy and cultural competence in clinical settings.

Furthermore, our quantitative findings revealed that while students perceived themselves to have high levels of empathy (M 115.57/140, SD ± 0.828367347; 82.6%), this self-perception was often higher than the empathy observed by faculty observers (M 24.81/35, SD ± 0.708571429; 70.8%) who were assessing students' performance from the patient's perspective. This finding is consistent with another research with SPs (Fitzgerald & Ward, 2019). Faculty observers rated the student's empathy lowest on the JSPPNE in areas such as "seems concerned about my family and me," "understands my emotions, feelings, and concerns," and "can view things from my perspective." This finding suggests that while students believe they are demonstrating empathy, there may be a gap between intention and observable behaviour. Addressing this gap may require more reflection during the debrief sessions and the need for additional feedback.

Impact

This pilot project highlights the potential benefits of integrating opportunities for students to practice interacting with an adolescent client and parent while providing culturally responsive care to foster empathy within healthcare education. Our findings suggest that simulated adolescent patient interactions are an effective strategy for facilitating aspects of empathy, particularly perspective-taking and compassionate care. Furthermore, the study offers valuable insights for enhancing future simulation-based learning experiences, especially by developing more structured opportunities to explore and reflect on diverse patient experiences. There is also a need to facilitate deeper self-reflection among students and strengthen faculty feedback mechanisms. These improvements could help healthcare educators better prepare students to develop the cultural competence and empathy required to strengthen therapeutic patient-centred relationships.

Conclusion

This exploratory pilot study examined the impact of a simulated learning experience with adolescent actors on the development of bridging students' empathy and cultural care. In addressing the primary research question, the findings revealed an improvement in students' empathy scores following the simulation. Students reported the experience as engaging and valuable in fostering culturally responsive communication skills while working with adolescents and a parent. Interestingly, empathy scores among students were higher than those of participating faculty, highlighting a potential gap and the need for continued self-reflection and empathy-building among educators.

While this study had many strengths, there were some limitations. First, the small sample size (n = 29) limits the generalizability of the findings to the broader population. Secondly, using a convenience sample may not accurately represent all Bridging RPN to Bachelor of Science in Nursing students, as they may not accurately reflect the demographics, characteristics, or attitudes of the broader

population of Bridging students, potentially influencing their approach to simulations and empathy. Third, the study was conducted at a single academic institution. Further research is required to validate these findings across broader nursing student populations with larger sample sizes and across multi-site academic institutions to enhance the reliability and applicability of the findings. Additionally, empathy levels were only assessed once post intervention, making it difficult to evaluate changes in empathy as students progress through the program and gain more clinical experience. Future research should explore longitudinal assessments to track empathy development over time. Moreover, observational data collection could be improved by incorporating video recordings, recording focus groups, and utilizing multiple faculty assessors to comprehensively evaluate empathetic interactions.

Conflict of Interest

The authors have nothing to declare or conflict/financial interest.

Acknowledgement

The authors would like to thank the additional facilitators of the study and the students who took part. Acknowledgements to S. Abeygunawardena for data collection assistance.

Funding

This project was supported by Humber Polytechnic's BScN Clinical Education Fund (2022).

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Appendix

Appendix A
Character Information

Scenario

Senthuran is a 11-year-old male attending a follow-up medical appointment at Family Care Center in the Adolescent Respiratory Clinic accompanied by his mother. Three weeks ago, he participated in a spirometry assessment and was diagnosed with Asthma by his pediatrician. He was started on Salbutamol inhaler at that time. Following his diagnosis of asthma three weeks ago, Senthuran has been experiencing exacerbation of wheeziness, chest tightness, and coughing during his soccer games and during recess at school. Senthuran has been playing soccer since he was 4 years old. He joined the competitive soccer team 2 years ago.

Background

Senthuran is the oldest son in the family. He has a younger sister who is 7 years old. He lives with his parents, sister, and paternal grandparents. Senthura's father works in a warehouse doing general labour. He tends to work all hours and often picks up extra shifts to help with the cost of

extra-curricular activities for the kids. Senthura's mother works at a grocery store as a cashier and will also tend to pick up any shifts she can. Child rearing responsibilities have generally fallen to the grandparents who will drop off and pick up the kids from the activities. Due to the failing health of the grandparents, Senthuran have been given increasing responsibilities such as making their lunches, household chores, and helping his sister with homework.

Dominant Character Trait

Senthuran is a quiet and shy boy who enjoyed playing soccer since he was a toddler. Recently, Senthuran's family noticed that he was tired all the time and did not enjoy running or playing soccer anymore. Senthuran's father is alarmed with the changes presented in his son and is worried that Senthuran is becoming "lazy."

Affect/How they present

Adolescent client - Shy, quiet, reserved but responds to student's questions appropriately; voices frustration of his decreased ability to play soccer and run around at recess with his peers without feeling short of breath.

Mother - worried, asking questions, concerned about son's decreased ability to be physically active in sports and school recess; voices concern that her husband just feels Senthuran is being 'lazy'. Is impatient and not understanding or empathetic to her son's feelings.

Appendix B

Focus Group Questions/Debrief Guide

1. What are your thoughts regarding the adolescent's verbal comments/concerns?
2. What are your thoughts regarding the therapeutic communication utilized in this scenario while interacting with the adolescent client and his mother?
3. What are your thoughts of the meaning of empathetic nurse–patient communication while promoting culturally sensitive care?
4. Why is empathy important while providing culturally sensitive family centered care?
5. Share your thoughts in the use of simulated actors in simulation.

Adapted from Fitzgerald, M., & Ward, J. (2019). Using standardized actors to promote family-centered care. *Journal of Pediatric Nursing, 45*, 20-25.