Scientific Research Publishing

Open Journal of Nursing, 2024, 14, 11-26
https://www.scirp.org/journal/ojn
ISSN Online: 2162-5344
ISSN Print: 2162-5336

Therapeutic Communication Methods Targeting Families and Family Members: A Literature Review

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How to cite this paper: Watsuji, T. and Hohashi, N. (2024) Therapeutic Communication Methods Targeting Families and Family Members: A Literature Review. *Open Journal of Nursing*, **14**, 11-26.
https://doi.org/10.4236/ojn.2024.141002

Received: December 15, 2023
Accepted: January 19, 2024
Published: January 22, 2024

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Abstract

Background and Purpose: Therapeutic communication is a new term in family health care nursing, defined by Hohashi (2019) as a method of family intervention, and characterized by inclusion of not only verbal conversation but also nonverbal interaction. However, specific therapeutic communication methods have not been systematized. The purpose of this study was to clarify therapeutic communication methods for families/family members from the perspectives of verbal communication and non-verbal communication through a review of existing literature. **Methods:** We conducted a search using the medical literature databases PubMed and Ichushi-Web using the keywords "therapeutic communication". Analysis was performed on seven articles from PubMed and 14 articles from Ichushi-Web that described therapeutic communication methods performed by healthcare professionals for families/family members. Through directed content analysis, therapeutic communication methods were subcategorized, and classified into three categories: verbal communication, non-verbal communication, and verbal/non-verbal communication. **Results:** A total of 23 subcategories were extracted. Verbal communication included 11 subcategories, such as "asking questions using the communicatee's words as they are". Non-verbal communication included five subcategories, such as "noticing changes in the content of the communicatee's story". And verbal/non-verbal communication featured seven subcategories, such as "making the communicatee aware of one's own beliefs". **Conclusion:** Therapeutic communication methods included basic care/caring in family interviews/meetings, as well as verbal communication and non-verbal communication that act on family/family members' beliefs. It is believed that changes in family/family members' beliefs can be used to eliminate, reduce, or improve problematic conditions in the family.

Keywords

Therapeutic Communication, Family Nursing, Family Interview/Meeting, Family Belief Systems Theory, Literature Review

1. Introduction

Family health care nursing is defined as "with the nursing professional as the nucleus, the practical science of independently and autonomously maintaining and improving family functioning by the family system unit, and of preventative and therapeutic support to deal with family symptoms/signs in order to help enabling self-actualization of the family system unit" [1]. Currently, several family nursing theories have been developed as a basis for eliminating, reducing, or improving problematic conditions (such as problems, issues, difficulties, or suffering) in the family. Family health care nursing is a field in which knowledge is still under development, but Concentric Sphere Family Environment Theory (CSFET), Family Care/Caring Theory (FC2T), and Family Belief Systems Theory (FBST) have been developed as three major theories in family health care nursing [1]. Among them, FBST is a middle-range family nursing theory that focuses on family/family members' beliefs that control intentional decisions/acts by the family, and is used in practice [2].

In FBST (**Figure 1**), when a certain specific event (a specific setting or situation) occurs, a family member's evaluative cognition (positive, negative, neutral) occurs using certain intermediate family member's beliefs as cognition criteria. Based on this cognition, it is explained that family members' emotions, family members' decisions/acts, and family members' physical responses are intentionally generated. Nursing professionals conduct family interviews/meetings based on FBST to understand the overall picture of the family belief system, modify family/family members' beliefs through support for family/family members' beliefs, and improve family's evaluative cognition (positive, negative, neutral cognition), and ultimately change intentional decisions/acts by the family (family decision-making, family self-management, maintenance and improvement of family well-being, etc.) [1] [3]. In other words, the therapeutic communication implemented by nursing professionals during family interviews/meetings becomes the basis for family intervention, and by modifying family/family members' beliefs, it is possible to radically treat problematic conditions in the family.

This therapeutic communication represents a new term in family health care nursing, defined by Hohashi in 2019 as a method of family intervention [1]. In family health care nursing, the term therapeutic conversation is commonly used [4] [5]. Communication, on the other hand, is a basic condition for establishing a relationship between families and nursing professionals. Therapeutic communication is superior to therapeutic conversation in that it is a two-way interaction between families and nursing professionals, and includes not only verbal

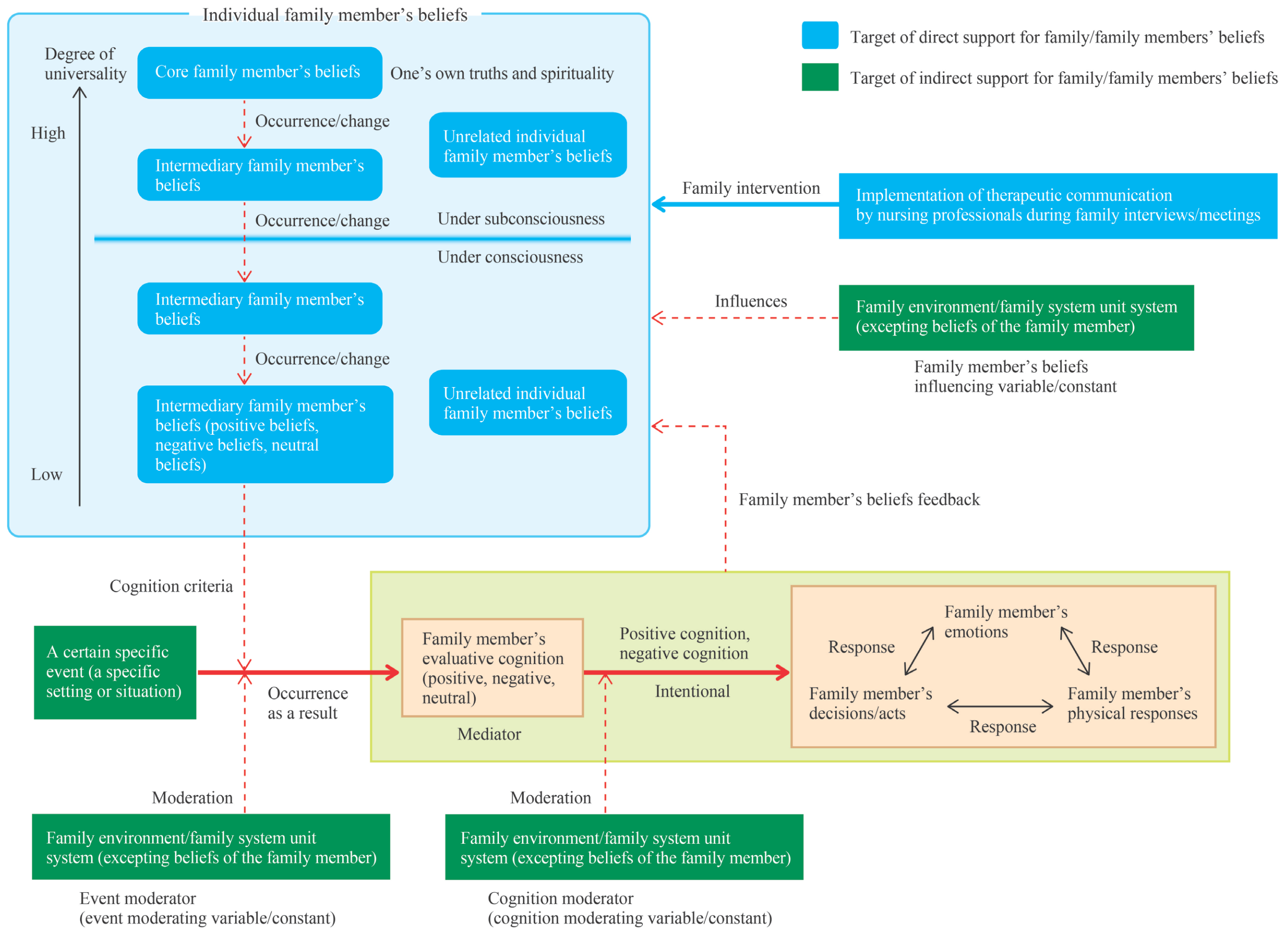

Figure 1. Positioning of family intervention by means of therapeutic communication in the diagram showing individual family member's beliefs (Ver. 1.2) based on Family Belief Systems Theory.

conversation but also nonverbal interaction [1] [3]. In other words, therapeutic conversation is included in therapeutic communication. The term therapeutic communication was first used by psychiatrist Ruesch in 1961 [6], who reported that communication can improve the health of patients. However, the term therapeutic communication is not currently in wide use.

In healthcare settings, communication is a basic condition for establishing a relationship between patient and health professionals [7], with both verbal and non-verbal communication being the essence of care [8]. Furthermore, verbal communication and non-verbal communication are both utilized in therapeutic communication methods [1] [3]. Previous studies have shown that communication improves patient satisfaction, adherence to treatment and patient knowledge, and facilitates the transition from active treatment to palliative care. It has also been shown to reduce stress and burnout among health professionals [9] [10] [11]. However, methods for specific therapeutic communication have not yet become systematized.

The purpose of this study was to clarify therapeutic communication methods for families/family members from the perspectives of verbal communication and non-verbal communication, by reviewing literature published in and outside Ja-

pan. We believe this will enable us to materialize therapeutic communication methods that combine verbal communication and accompanying non-verbal communication, in addition to conventional therapeutic conversation methods that are verbal communication. Another aim was to facilitate the acquisition of therapeutic communication methods by nursing professionals, so as to contribute more to the effective practice of FBST-based family intervention.

2. Methods

2.1. Operational Definitions of Terms

In this study, operational definitions were assigned to the following terms:

- Therapeutic communication: "Among verbal and nonverbal communications between the nursing professional and the family, interaction processes, whether intentional or unintentional, that have the effect of family intervention" [2] [3]. In family health care nursing, family intervention is conducted through family interview/meeting, therapeutic communication forms the basis of family intervention.
- Verbal communication: "Communication using words" [3]. In therapeutic communication, verbal communication serves as a means of family intervention when the message intended by the sender interacts with the receiver.
- Non-verbal communication: "Communication using means other than words" [3]. Non-verbal communication includes gestures, posture, movements (nodding, bearing, etc.), facial expressions, gaze, and paralanguage (intonation, rhythm, voice quality, speed, pauses, etc.), interpersonal distance, and physical contact [3]. Non-verbal communication in therapeutic communication serves as a means of family intervention by the supplementing intentions that cannot be expressed solely by verbal communication.
- Family interview/meeting: "Family interviews, whose main purpose is to collect family information and family assessment, and family meetings, whose main purpose is to implement family intervention" [2] [3]. When conducting family interviews, the flow of conversation/dialogue may switch to a family meeting. Although family interviews and family meetings are conducted for different purposes, it is often difficult to make distinctions between the two. Therefore, these are referred to as family interview/meeting instead of family interview and family meeting [3].

2.2. Search Strategy

For the literature search, we used PubMed, the world's largest medical literature database, and Ichushi-Web, the Japanese medical literature database (**Figure 2**). A search was conducted for all papers registered in the database using the keywords "therapeutic communication" (conducted in October 2022). As a result, 320 articles were found on PubMed and 59 on Ichushi-Web.

Inclusion criteria included papers that described therapeutic communication methods used by healthcare professionals, including nursing professionals, targeting

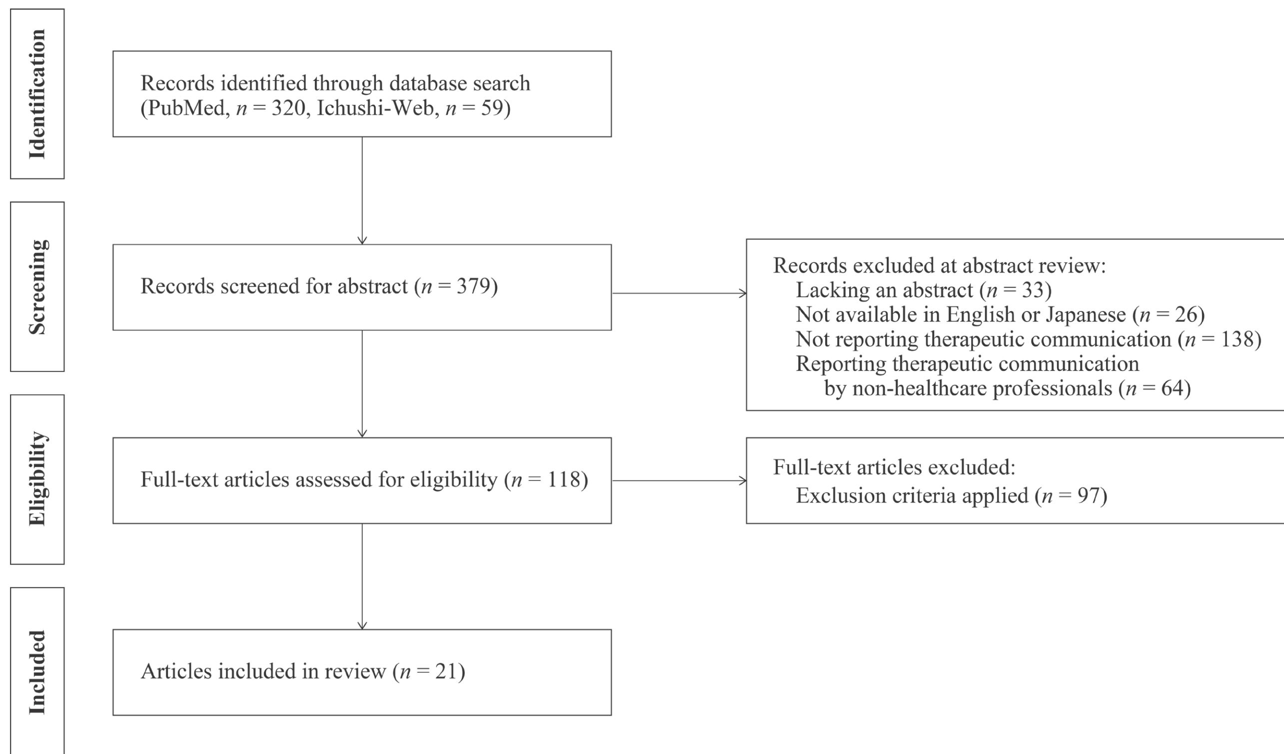

Figure 2. The flow of literature identification and selection related to therapeutic communication methods.

families/family members. Exclusion criteria included papers on therapeutic communication methods by non-healthcare professionals, and papers written in languages other than English or Japanese. Based on these criteria, we carefully read and confirmed the titles and abstracts of the papers, and analyzed a total of 21 papers, seven from PubMed [12]-[18] and 14 from Ichushi-Web [19]-[32].

2.3. Analysis Procedure and Trustworthiness

For the 21 papers, we used Garrard's matrix method [33] to organize the content of the papers using the first author's name, title, journal name, year of publication, and therapeutic communication method as column topics. Afterwards, descriptions regarding therapeutic communication methods were extracted for each context, and each description was treated as a meaning unit. These were aggregated into subcategories according to the commonality of their contents through directed content analysis [34] [35]. The subcategories were then classified into three categories (verbal communication, nonverbal communication, and verbal/non-verbal communication, which comprises both).

To ensure the trustworthiness of the qualitative analysis, the following was conducted. 1) For investigator triangulation, all analyses were reviewed by two family nursing researchers, to minimize the risk of researcher bias; 2) at the initial stage, after both researchers conducted their analysis independently, any disagreements between researchers were discussed until a consensus was reached. If, in the case that consensus was not reached, the analysis was referred to another family nursing researcher, and we made the final decision; 3) for peer debriefing,

regular meetings were held to obtain input from seven family nursing researchers, and we conducted an iterative analysis based on their supervision; and 4) we documented a comprehensive audit trail describing data analysis processes, and returned to the raw data to check for referential adequacy.

2.4. Ethical Considerations

As this research did not directly involve humans or animals, review and approval by an institutional review board was not required; nevertheless full compliance was given to research ethics. When using articles, copyright laws were strictly observed and the sources were clearly indicated. In addition, the research content was carefully perused to ensure that the authors' intentions were not contradicted.

3. Results

For the therapeutic communication methods, a total of 121 meaning units and 23 subcategories were extracted (Table 1). Below, the subcategories are shown enclosed in quotation marks.

3.1. Verbal Communication

Verbal communication consisted of 56 meaning units and 11 subcategories. The subcategories included "providing explanations that are easy for the communicatee to understand", "conveying necessary information to the communicatee", "summarizing and presenting the content of the communication", "clarifying the communicatee's problem", "asking questions that elicit the suffering of the communicatee", "presenting a topic to the communicatee", "asking questions that encourage the communicatee to act proactively", "asking questions using the communicatee's words as they are", "asking questions to confirm the communicatee's cognition and understanding", "asking questions that bring out the demands of the communicatee", and "exploring the direction of idealized family and goals".

3.2. Non-Verbal Communication

Non-verbal communication consisted of 26 meaning units and five subcategories. The subcategories included "being with the communicatee holistically", "showing a supportive attitude to the communicatee", "creating an atmosphere in which the communicatee feels comfortable talking", "securing time for the communicatee to speak", and "noticing changes in the content of the communicatee's story".

3.3. Verbal/Non-Verbal Communication

Those that fell under both verbal communication and non-verbal communication consisted of 39 meaning units and seven subcategories. The subcategories included "showing sincerity to the communicatee", "building a relationship of trust with the communicatee", "accepting the communicatee's strengths", "showing interest in the communication", "active listening to the communicatee",

"showing empathy to the communicatee", and "making the communicatee aware of one's own beliefs".

Table 1. Subcategories and meaning units of therapeutic communication methods.

Therapeutic communication	Subcategory ($n = 23$)	Meaning unit ($n = 121$)	Reference No.
Verbal communication	providing explanations that are easy for the communicatee to understand	using descriptive phrases; using phrases open to interpretation; providing simple explanations to help patients and families understand complex medical terminology and language; providing appropriate explanations of the patient's condition; providing a clear explanation regarding treatment procedures; two other meaning units	15, 17, 18
	conveying necessary information to the communicatee	promoting psychological well-being by providing guidelines regarding health conditions; introducing the related problem; promoting psychological well-being by providing comprehensive information about what to expect in the future; dispelling anxiety by providing evidence for care; correcting misinformation and ambiguous information; two other meaning units	13, 15, 17, 29, 32
	summarizing and presenting the content of the communication	summarizing and presenting the content of interaction	14
	clarifying the communicatee's problem	clarifying the story; making the story specific; making the interviewer's position and purpose of the interview clear; using focused questions to elicit problems in daily life; focusing on main thoughts and ideas about the problem; four other meaning units	15, 17, 21, 31, 32
	asking questions that elicit the suffering of the communicatee	eliciting suffering; listening back to utterances about sexual desire or interest	29, 32
	presenting a topic to the communicatee	suggesting the topic of sexuality; introducing a topic of sexuality that is difficult to discuss; switching the topic from everyday interactions with sexual partner to the nature of sexual acts	32
	asking questions that encourage the communicatee to act proactively	participating in decision making; discussing self-care behaviors; allowing the patient to choose the subject; allowing the patient to specify the subject of act	12, 17, 28
	asking questions using the communicatee's words as they are	repeating words or phrases used by the patient; repeating the other person's utterances on a topic; repeating the last words used by the patient	17, 32
	asking questions to confirm the communicatee's cognition and understanding	checking each other's feelings behind the words; checking things not understood to avoid misunderstandings; asking about points that are not understood in the client's words; not pretending to understand what the client is saying; reaffirming commitment to the patient and family; two other meaning units	15, 17, 23, 27, 29
	asking questions that bring out the demands of the communicatee	using open and closed questions; asking frank questions about sexual values; listening back with different expressions about utterances related to sexuality; responding to what the other person says with a question; expressing doubts in words; two other meaning units	17, 31, 32
	exploring the direction of idealized family and goals	asking questions that open up possibilities; asking about possibilities the person might have; understanding one's family's hopes; thinking about concrete ways to move toward one's dreams and hopes; making a plan to achieve one's hopes; one other meaning unit	19, 20, 25, 29

Continued

Non-verbal communication	being with the communicatee holistically	concentrating on the present moment; being there as another person rather than listening to the patient as a therapist; being here and now; just being present for communication in the terminal stage; showing your presence; two other meaning units	19, 30, 32
	showing a supportive attitude to the communicatee	having the impression that the interviewer has overwhelming power; paying attention to facial expressions and demeanor other than words, casual breathing and posture; being considerate toward the other person's feelings	24, 29, 32
	creating an atmosphere in which the communicatee feels comfortable talking	using humor therapeutically; adjusting to the pace of emotional expression of the sexual partner; having lightheartedness that is conscious of horizontal communication that deepens mutual understanding; maintaining friendliness; four other meaning units	12, 17, 18, 20, 21, 29, 32
	securing time for the communicatee to speak	allotting enough time to express feelings; allotting enough time to express worries; securing time for facilitating the expression of underlying feelings; relieving psychosocial distress by an opportunity to discuss feelings with a health professional; allotting children sufficient opportunities to speak freely; one other meaning unit	13, 17, 18, 21
	noticing changes in the content of the communicatee's story	observing that a change has occurred in a repeated story; observing that a budding difference has appeared in a repeated story	27
Verbal/non-verbal communication	showing sincerity to the communicatee	showing a soothing presence; strengthening the patient-nurse relationship through honest communication; self-disclosing and sharing with the client the therapist's own sense of helplessness and anxiety; informing the client of the interview protocol; listening to the other person politely; one other meaning unit	15, 16, 31, 32
	building a relationship of trust with the communicatee	building a trusting relationship through daily care; forming rapport; trust-building by the therapist; building trust between the patient and the therapist through good humor; building trust between the patient and the therapist through friendly behavior; three other meaning units	16, 19, 25, 26, 32
	accepting the communicatee's strengths	positively acknowledging what the client is thinking; praising the humorous approach to the relationship with the sexual partner; praising the client's skillful negotiation of the relationship with the sexual partner; acknowledging and praising the other person; respecting their singularities; three other meaning units	17, 22, 24, 26, 28, 32
	showing interest in the communication	expressing interest in the problems of the hypertensive patients by professionals; expressing concern for the problems of hypertensive patients by professionals; including supportive language; having the ability to show concern; feeling concerns; two other meaning units	12, 17, 31, 32
	active listening to the communicatee	improving psychological adjustment through active listening; listening carefully; listening reflexively; having the ability to actively listen	12, 13, 17, 23
	showing empathy to the communicatee	empathizing with the importance of discussing sexuality; giving an empathetic response; expressing empathy; strengthening the patient-nurse relationship through empathic communication; one other meaning unit	14, 15, 31, 32
	making the communicatee aware of one's own beliefs	bringing awareness to negative beliefs	32

4. Discussion

4.1. Verbal Communication as Therapeutic Communication Methods

Therapeutic communication methods that use words include "providing explanations that are easy for the communicatee to understand", "conveying necessary information to the communicatee", "summarizing and presenting the content of the communication", "clarifying the communicatee's problem", "asking questions that elicit the suffering of the communicatee", "presenting a topic to the communicatee" and "asking questions that encourage the communicatee to act proactively", that is, methods that are easy to understand and implement have been identified. The Concentric Sphere Family Environment Theory (CSFET) [36], a middle-range family nursing theory, has a system for family assessment/intervention, and the Family Environment Assessment Index (FEAI) is a collection of sample killer questions for family interviews/meetings [37]. Killer questions are defined as "'questions that can accurately collect family information' in family assessment, and 'questions that are effective in changing settings or situations through self-awareness' in family intervention". In order to make full use of FEAI's killer questions, it is necessary to learn therapeutic communication methods and make family interviews/meetings reliable family interventions.

When interacting with targeted subjects, nursing professionals need to be aware of their individual expectations, experiences, and cultural paradigms, or risk biases and misunderstandings [38]. Nursing professionals should pay attention 1) to their own culture (the culture of the nursing professional); 2) to different culture (the culture of the family); and 3) to the culture of the environment (the culture of the environment where the culture of the nursing professional and the culture of the family meet) [3]. Therefore, when communicating with families, nursing professionals need to understand the correct meanings of the words used by the other person. Therapeutic communication of "asking questions using the communicatee's words as they are" and "asking questions to confirm the communicatee's cognition and understanding" is the most reliable method of honestly asking the target persons about the specific meaning and image of their words. Words that can have multiple or complex meanings, referred to here as big words, can lead to misunderstandings in communication [39]. When big words are used, it is necessary to confirm with the other persons the specific meaning of the terms used.

In "asking questions that bring out the demands of the communicatee", the meaning unit of this subcategory clarifies the use of open questions and closed questions. Open questions and closed questions have their respective advantages and disadvantages, and by understanding their characteristics, devising a good order, and using them in combination is the basis of communication [3]. Another meaning unit of this subcategory includes questions that raised questions in response to the other person's statements, and questions that asked questions that were expressed in words. For example, "What was your problem?" is a raising

question, and "What is the reason?" is an asking question. By asking purposeful and effective questions, nursing professionals can help family members become more aware of problems. It is thought that it will be possible to bring out the family member's beliefs, expand or deepen one's own family member's beliefs, and foster awareness of something [3]. Therapeutic communication developed by nursing professionals converts family/family members' beliefs, resulting in eliminating, reducing, or improving problematic conditions (such as problems, issues, difficulties, or suffering) in the family [3].

"Exploring the direction of idealized family and goals" corresponds to a miracle question in therapeutic communication [3]. A miracle question is defined as "a question to build a concrete image of the status following the disappearance of family symptoms/signs, and to construct an image of the solution". Miracle questions allow families to form an image of their ideal family status and identify specific differences between the ideal and reality, resulting in clarifying the future and engendering hope to the family's possibilities.

4.2. Non-Verbal Communication as Therapeutic Communication Methods

It is best to understand "being with the communicatee holistically" and "showing a supportive attitude to the communicatee" in terms of caring when dealing with a subject as a nursing professional. In Family Care/Caring Theory (FC2T) [40], family care is "acts (practices) towards the physical body of the family system unit that are performed with the aim of realizing, maintaining and improving family well-being". In contrast, family caring is "an attitude or mindset for becoming aware of a family's beliefs and demands, understanding them, and harnessing this understanding to family care". These therapeutic communication methods are caring, and it is the essential role of nursing professionals to spend the same time as one person with the same mind, and to bring healing, to have hope and meaning in life, and to realize the happiness of being alive. We believe this can be done by non-verbal therapeutic communication methods [40] [41]. It should be noted that certain non-verbal communications, such as nodding, eye contact, touch, etc., are subject to different interpretations by individuals and may negatively affect interactions between family/family members and nursing professionals [42].

"Creating an atmosphere in which the communicatee feels comfortable talking" included pacing. This means matching the pace of the other person's emotional expression, and can be said to be a therapeutic communication method in which the nursing professional synchronizes with the other person's speaking speed and volume. Note that synchronizing one's own movements and facial expressions with the other person's, as if reflected in a mirror, is called mirroring [43], and like pacing, mirroring may also be effective as a therapeutic communication method. Furthermore, "securing time for the communicatee to speak" suggests a sense of distance that makes it easier for the other person to talk, and

by giving mental preparation and space, pauses and silence facilitate communication [3].

In addition, in order to engage with the family/family members while capturing not only immediate family phenomena but also family phenomena predicted in the future, "noticing changes in the content of the communicatee's story" is important. The Rule of Mehrabian states that when trying to communicate, 7% of information is received from verbal information such as the content of the conversation, 38% from vocal information such as voice quality, and 55% from visual information such as facial expressions [44]. Therefore, in order to observe and identify changes in the content of a story, it is necessary to understand that most of the information provided will be non-verbal communication. Observing the other person's facial expressions and acts, it is desirable to pay attention to words and acts that reveal the patient's feelings, such as whether the other person's expression is soft or wrinkled between the eyebrows, and to create an environment in which the family members feel comfortable talking.

In this way, nonverbal information is an important communication channel that influences emotions and human relationships [45], and we believe that the content and significance of nonverbal communication in therapeutic communication has been clarified. Non-verbal therapeutic communication has the potential to be used for in-depth family interviews/meetings.

4.3. Verbal/Non-Verbal Communication as Therapeutic Communication Methods

"Showing sincerity to the communicatee", "building a relationship of trust with the communicatee", "accepting the communicatee's strengths" and "showing interest in the communication" are the basics of communication [1]. This also applies to the constructive philosophy of family caring [40] and is considered to be important as verbal/non-verbal communication. We determined that the subcategories classified into verbal/non-verbal communication are therapeutic communication methods that can be used for both verbal and non-verbal communication. This indicates that family interviews/meetings include not only verbal therapeutic conversations [4] [5] but also non-verbal exchanges, so it is more appropriate to call them therapeutic communication [1] [3]. In particular, communication in the relationship between patients and healthcare professionals generates common meanings about the current state of illness and health problems, assumptions, values, goals of treatment, etc., through the interaction of their respective backgrounds and worlds, and mutual understanding. It is emphasized as a process of understanding and sharing the world [46].

"Active listening to the communicatee" refers to an optimal communication and requires verbal communication [47]. It also means being close to the patient so that detailed information can be gathered, thereby creating trust in the interaction, improving relationships and improving patient adherence [38].

Furthermore, empathy is not established simply by thinking about the other person's feelings and expressing them aloud, but is a concept that includes the

relationship itself in which we try to understand each other as another person [48]. You can "show empathy to the communicator" by through such empathic responses as nodding, and making full use of verbal and non-verbal communication.

In FBST, the following six methods [2] [3] have been developed as direct support for family/family members' beliefs: 1) belief actualization (transforming of subconscious family/family member's beliefs into conscious family/family member's beliefs); 2) belief conversion (transforming of negative family/family member's beliefs into positive family/family member's beliefs); 3) belief conferment (conferment of new, positive family/family member's beliefs); 4) belief enhancement (increased enhancement of the degree of family/family member's beliefs); 5) belief uniformity (transforming of family member's beliefs into family beliefs); and 6) belief maintenance (maintenance of positive family/family member's beliefs). Through therapeutic communication methods of "making the communicatee aware of one's own beliefs", it is believed that negative family/family member's beliefs, which are negative beliefs that deny a particular family event in that they are unconstructive, negative, or pessimistic, can be converted into positive family/family members' beliefs. It is thought that bringing out the family's story of suffering embedded in negative family/family member's beliefs will cause correction and change in family/family member's beliefs, leading to conversion to positive family/family member's beliefs.

4.4. Limitations of the Review

In this study, we extracted the therapeutic communication methods described in the papers, but in many cases their contents tended to be abstract, and it was difficult to extract concrete therapeutic communication methods such as exception questions and survival questions [3]. As a result, the level of abstraction of the subcategories was not exactly consistent. In the future, it will be necessary to use the results of this study as an interview guide and conduct interviews with nursing professionals and families to clarify the specific therapeutic communication methods.

Moreover, papers researching therapeutic communication methods were few in number. In particular, in Japan, 12 out of the 14 papers appeared in a special issue of the same journal, indicating research into therapeutic communication is almost nonexistent. While only PubMed and Ichushi-Web were utilized as literature databases for this study, it is possible that by searches of CINAHL, APA PsycInfo, Web of Science and other literature databases, would serve to clarify additional therapeutic communication methods.

In order to use therapeutic communication methods, it is necessary to understand the intention (purpose), usage situation, and anticipated effects [3]. Considering the importance of communication in medicine, nursing professionals need to implement effective therapeutic communication in the care process and incorporate it into the care they provide [10]. In the future, it will be necessary to

make the items of the therapeutic communication methods more specific and apply them to family/family members' belief support.

5. Conclusion

Through a literature review, we were able to clarify therapeutic communication methods for families/family members and classify these into verbal communication and non-verbal communication. Consequently, although the term "therapeutic conversation" is currently in wide use, "communication", which is the basic method used by nursing professionals in family interviews/meetings, is more appropriate because it includes non-verbal care/caring, and "therapeutic communication" is more appropriate because it includes non-verbal care/caring, and therefore needs to be more widely popularized. We believe that the practice of therapeutic communication methods can eliminate, reduce, or improve problematic conditions in the family by acting on and transforming family/family members' beliefs, but future verification will be desirable.

Acknowledgements

The authors would like to express their deep appreciation to our laboratory members for their discussions in the data analysis.

Funding

This study was funded in part by a Grant-in-Aid for Scientific Research (B) from the Japan Society for the Promotion of Science (JSPS) in Japan (Grant Number: JP22H03400).

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

References

[1] Hohashi, N. (2023) Understanding Family Health Care Nursing through Applicable Terminology: Studies on Fundamental Family Nursing and Family Functioning (Ver. 3.1). 1st Edition, Editex, Kanagawa.

[2] Hohashi, N. (2019) A Family Belief Systems Theory for Transcultural Family Health Care Nursing. *Journal of Transcultural Nursing*, **30**, 434-443. https://doi.org/10.1177/1043659619853017

[3] Hohashi, N. (2023) Understanding Family Health Care Nursing through Applicable Terminology: Family Belief Systems Theory (Ver. 1.1). 1st Edition, Editex, Kanagawa.

[4] Sveinbjarnardottir, E.K., Svavarsdottir, E.K. and Wright, L.M. (2013) What Are the Benefits of a Short Therapeutic Conversation Intervention with Acute Psychiatric Patients and Their Families? A Controlled Before and After Study. *International Journal of Nursing Studies*, **50**, 593-602. https://doi.org/10.1016/j.ijnurstu.2012.10.009

[5] Shajani, Z. and Snell, D. (2023) Wright & Leahey's Nurses and Families: A Guide to

Family Assessment and Intervention. 8th Edition, F.A. Davis, Philadelphia.

[6] Ruesch, J. (1961) Therapeutic Communication. 1st Edition, W.W. Norton, New York.

[7] Gillespie, H., Kelly, M., Duggan, S. and Dornan, T. (2017) How Do Patients Experience Caring? Scoping Review. *Patient Education and Counseling*, **100**, 1622-1633. https://doi.org/10.1016/j.pec.2017.03.029

[8] Long, A. and Slevin, E. (1999) Living with Dementia: Communicating with an Older Person and Her Family. *Nursing Ethics*, **6**, 23-36. https://doi.org/10.1177/096973309900600104

[9] Ong, L.M., Visser, M.R., Lammes, F.B. and de Haes, J.C. (2000) Doctor-Patient Communication and Cancer Patients' Quality of Life and Satisfaction. *Patient Education and Counseling*, **41**, 145-156. https://doi.org/10.1016/S0738-3991(99)00108-1

[10] Kwame, A. and Petrucka, P.M. (2021) A Literature-Based Study of Patient-Centered Care and Communication in Nurse-Patient Interactions: Barriers, Facilitators, and the Way Forward. *BMC Nursing*, **20**, Article No. 158. https://doi.org/10.1186/s12912-021-00684-2

[11] Wako, Z., Mengistu, D., Dinegde, N.G., Asefa, T. and Wassie, M. (2021) Adherence to Adjuvant Hormonal Therapy and Associated Factors among Women with Breast Cancer Attending the Tikur Anbessa Specialized Hospital, Addis Ababa Ethiopia, 2019: A Cross-Sectional Study. *Breast Cancer: Targets and Therapy*, **13**, 383-392. https://doi.org/10.2147/BCTT.S311445

[12] O'Gara, P.E. and Fairhurst, W. (2004) Therapeutic Communication Part 1: General Approaches That Enhance the Quality of the Consultation. *Accident and Emergency Nursing*, **12**, 166-172. https://doi.org/10.1016/j.aaen.2004.03.002

[13] Hudson, P., Quinn, K., O'Hanlon, B. and Aranda, S. (2008) Family Meetings in Palliative Care: Multidisciplinary Clinical Practice Guidelines. *BMC Palliative Care*, **7**, Article No. 12. https://doi.org/10.1186/1472-684X-7-12

[14] Damasceno, M.M., Zanetti, M.L., de Carvalho, E.C., Teixeira, C.R., de Araújo, M.F. and Alencar, A.M. (2012) Therapeutic Communication between Health Workers and Patients Concerning Diabetes Mellitus Care. *Revista Latino-Americana de Enfermagem*, **20**, 685-692. https://doi.org/10.1590/S0104-11692012000400008

[15] Baer, L. and Weinstein, E. (2013) Improving Oncology Nurses' Communication Skills for Difficult Conversations. *Clinical Journal of Oncology Nursing*, **17**, E45-E51. https://doi.org/10.1188/13.CJON.E45-E51

[16] Khoshnazar, T.A., Rassouli, M., Akbari, M.E., Lotfi-Kashani, F., Momenzadeh, S., Rejeh, N. and Mohseny, M. (2016) Communication Needs of Patients with Breast Cancer: A Qualitative Study. *Indian Journal of Palliative Care*, **22**, 402-409. https://doi.org/10.4103/0973-1075.191763

[17] Torres, G.M.C., Figueiredo, I.D.T., Cândido, J.A.B., Pinto, A.G.A., Morais, A.P.P., Araújo, M.F.M. and Almeida, M.I. (2017) Therapeutic Communication in the Interaction between Health Workers and Hypertensive Patients in the Family Health Strategy. *Revista Gaucha de Enfermagem*, **38**, e2016-e2066. https://doi.org/10.1590/1983-1447.2017.04.2016-0066

[18] Fite, R.O., Assefa, M., Demissie, A. and Belachew, T. (2019) Predictors of Therapeutic Communication between Nurses and Hospitalized Patients. *Heliyon*, **5**, E02665. https://doi.org/10.1016/j.heliyon.2019.e02665

[19] Morioka, M. (2016) Understanding Temporal Change in Words. *Japanese Journal of Clinical Psychology*, **16**, 513-517.

[20] Murakami, Y. (2016) Reclaiming Voices: Learning from Recovering Abusers. *Japa-*

nese Journal of Clinical Psychology, **16**, 518-522.

[21] Takashima, Y. (2016) How to Listen: Hearing Objective Facts and Sensing the Subjective World. *Japanese Journal of Clinical Psychology*, **16**, 523-526.

[22] Sugihara, Y. (2016) Ideas for Fostering Therapeutic Conversation: Focusing on Nonverbal Processes. *Japanese Journal of Clinical Psychology*, **16**, 527-530.

[23] Miyaji, N., Kikuchi, M. and Matsumura, M. (2016) Toxic Humans, Curative Humans. *Japanese Journal of Clinical Psychology*, **16**, 535-539.

[24] Sato, W. (2016) Communicating with People Suffering from Auditory Hallucinations: Hearing Voices. *Japanese Journal of Clinical Psychology*, **16**, 544-548.

[25] Naka, M. (2016) How Are Memories Transmitted? Forensic Interviews with Children and Collaborative Interviews through Multi-Agency Cooperation. *Japanese Journal of Clinical Psychology*, **16**, 549-553.

[26] Nakamura, M. (2016) Growth-Promoting Communication in Elementary and Junior High Schools: Diagonal Relationships with Mental Friends. *Japanese Journal of Clinical Psychology*, **16**, 554-557.

[27] Sakanaka, N. (2016) When Traumatic Repetition Relaxes: Trauma Care. *Japanese Journal of Clinical Psychology*, **16**, 558-562.

[28] Kubo, J. (2016) Dialogue with Parents Regarding Abuse. *Japanese Journal of Clinical Psychology*, **16**, 563-566.

[29] Tachihara, H. (2016) Opening Dialogue in Treatment Settings: Perpetrator Clinical/Peer Group. *Japanese Journal of Clinical Psychology*, **16**, 567-570.

[30] Kondo, M. (2016) Communication with People at the Terminal Stage. *Japanese Journal of Clinical Psychology*, **16**, 581-585.

[31] Hosogoshi, H. (2018) Outline of Cognitive Behavioral Therapy for Chronic Pain. *Pain Rehabilitation*, **8**, 10-17.

[32] Miki, Y., Sawai, N., Takaki, Y., Maekawa, A., Hohashi, N., Kunikata, H. and Toki, H. (2021) Therapeutic Communication Techniques, Practiced by Certified Nurses in Wound, Ostomy and Continence Nursing, Regarding Sexuality: Extraction by Conversation Analysis. *Journal of Japanese Society of Wound, Ostomy and Continence Management*, **25**, 1-9.

[33] Garrard, J. (2020) Health Sciences Literature Review Made Easy: The Matrix Method. 6th Edition, Jones & Bartlett Learning, Sudbury.

[34] Hsieh, H.F. and Shannon, S.E. (2005) Three Approaches to Qualitative Content Analysis. *Qualitative Health Research*, **15**, 1277-1288. https://doi.org/10.1177/1049732305276687

[35] Elo, S. and Kyngäs, H. (2008) The Qualitative Content Analysis Process. *Journal of Advanced Nursing*, **62**, 107-115. https://doi.org/10.1111/j.1365-2648.2007.04569.x

[36] Hohashi, N. and Honda, J. (2011) Development of the Concentric Sphere Family Environment Model and Companion Tools for Culturally Congruent Family Assessment. *Journal of Transcultural Nursing*, **22**, 350-361. https://doi.org/10.1177/1043659611414200

[37] Hohashi, N. and Watanabe, M. (2023) Family Environment Assessment Index (FEAI-JA) (Ver. 3.4) (N. Hohashi, Ed.). 3rd Edition, Editex, Kanagawa.

[38] Browning, S. and Waite, R. (2010) The Gift of Listening: JUST Listening Strategies. *Nursing Forum*, **45**, 150-158. https://doi.org/10.1111/j.1744-6198.2010.00179.x

[39] Sentell, T., Dela Cruz, M.R., Heo, H.H. and Braun, K.L. (2013) Health Literacy, Health Communication Challenges, and Cancer Screening among Rural Native Hawaiian

and Filipino Women. *Journal of Cancer Education*, **28**, 325-334. https://doi.org/10.1007/s13187-013-0471-3

[40] Hohashi, N. and Honda, J. (2015) Concept Development and Implementation of Family Care/Caring Theory in Concentric Sphere Family Environment Theory. *Open Journal of Nursing*, **5**, 749-757. https://doi.org/10.4236/ojn.2015.59078

[41] Hohashi, N. (2023) Understanding Family Health Care Nursing through Applicable Terminology: Family Care/Caring Theory (Ver. 2.0). 1st Edition, Editex, Kanagawa.

[42] Ruben, B.D. (2016) Communication Theory and Health Communication Practice: The More Things Change, the More They Stay the Same. *Health Communication*, **31**, 1-11. https://doi.org/10.1080/10410236.2014.923086

[43] Ravn, S.L., Andersen, T.E. and Schiøttz-Christensen, B. (2023) Content of Clinicians' Communication with Patients Suffering from Spinal Pain in Assessment Situations in a Specialized Spine Center: A Qualitative Study Evaluating Psychologically Informed Pain Assessments before and after Clinicians' Participation in an Acceptance and Commitment Therapy Course. *BMC Musculoskeletal Disorders*, **24**, Article No. 549. https://doi.org/10.1186/s12891-023-06392-z

[44] Mehrabian, A. (1971) Nonverbal Communication. *Nebraska Symposium on Motivation*, **19**, 107-161.

[45] Ishikawa, H., Hashimoto, H., Kinoshita, M., Fujimori, S., Shimizu, T. and Yano, E. (2006) Evaluating Medical Students' Non-Verbal Communication during the Objective Structured Clinical Examination. *Medical Education*, **40**, 1180-1187. https://doi.org/10.1111/j.1365-2929.2006.02628.x

[46] Ishikawa, H. (2020) Shared Decision-Making: A Possible Key to Improving Patient-Provider Communication in Cancer Consultations. *Journal of Health Care and Society*, **30**, 77-90. https://doi.org/10.4091/iken.30-77

[47] Tracy, M.F., O'Grady, E.T. and Phillips, S.J. (2023) Hamric and Hanson's Advanced Practice Nursing: An Integrative Approach. 7th Edition, Elsevier, St. Louis.

[48] Fujisaki, K. and Hashimoto, H. (2009) Health Communication. 1st Edition, Shinoharashinsha, Tokyo.