



Development and Innovation

Communication skills in nursing: A phenomenologically-based communication training approach

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ABSTRACT

The aim of this article is to present a communication skills training curriculum for nursing students, based upon phenomenology. Research shows that nurses have difficulty prioritizing dialogue with patients, due to lack of time, organizational and cultural factors. Like other health care professionals, nurses may also have difficulties communicating with patients due to personal fears and shortcomings. The communication training curriculum based upon phenomenology aims at systematically training students to stay focused upon patients' and relatives' narratives, allowing them to reflect upon and better understand their current situation. This approach to communication is applicable in any clinical situation where it is important to provide space for the patients' experiences. The philosophical principles guiding the training are presented here as well as the practical steps in the program. Finally, the approach is compared to other common communication methods used in nursing (motivational interviewing, caring conversations, empathy training). The authors hope that the article will highlight the nurses' role as dialogue partner as well as emphasize the importance of communication skills training in nursing education. This approach can be refined, tested and modified in future research and may serve as an inspirational model for creating a generic communicative competence for nurses.

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1. Introduction

Despite the fact that the importance of a patient-registered nurse (RN) dialogue for the quality of care is well established in research, literature shows that RNs are at times unsure about how to speak about difficult and painful issues with patients (Helft et al., 2011; Wittenberg-Lyles, 2013). Topics such as giving bad news, discussing spiritual concerns and communicating with persons from other cultures are found to be difficult (Malloy et al., 2010). Empirical research from palliative care, oncology and psychiatrics has shown that RNs tend to not prioritize dialogue and listening to the patient, as this type of conversation can be experienced as demanding and draining (Dougherty et al., 2009; Toh et al., 2012). Instead, they tend to focus on routine work and practical tasks, so-called “task-oriented coping” (Howlett et al., 2015; Jaracz et al., 2005). Although most RNs aspire to be good communicators and recognize that a positive patient-RN relationship is vital for quality of care, a variety of factors can result in poor communication between RNs and patients (Nobel and Jones,

2010; Pilsworth et al., 2014). In order to better understand this phenomena, the sociologist Arthur Frank (1995) has coined the terms “the patient's voice” and “the voice of medicine” to illustrate how the perspective of the patient can be ignored or discouraged in communication between patient and health care professional, in favor of objectifying, diagnostic and symptom-focused language and communication. The voice of the patient, also understood as the patient's “narrative”, is one of the pillars modern health care. The “narrative trend” has, since the 1980's, influenced medicine (Charon, 2006; Kleinman, 1988), sociology, (Berger and Quinney, 2004; Frank, 1995), bioethics (Lindemann Nelson, 1997) and caring science (Canales, 1997; Sandelowski, 1994; Wiklund, 2000). Although allowing space for the patient's own voice in clinical encounters is not controversial, neither is it something that occurs automatically. There are structural and psychological reasons that this form of communication may not be prioritized.

Communication theory and skills are not regulated in Swedish nursing education in terms of credits or learning outcomes in the same

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way that credits in nursing science or medical knowledge is regulated. Before writing this article, a survey regarding communication training coursework was sent out via e-mail to the 24 educational institutions in Sweden providing a nursing science degree. Some departments had a clear thread running through the nursing education, while others had few discernible learning outcomes related to communication knowledge and skills. In other countries there is a clear indication in the literature that communication training is important for RNs (Nurses Midwifery Council (2018), Clayton et al., 2014; McCarthy et al., 2014; Nurses Midwifery Council (2018); Pehrson et al., 2016). Although the importance of communication training may be recognized, we have found only two more comprehensive initiatives, the “communication skills training” (CST) from the United States (Pehrson et al., 2016) and “Interpersonal communication skills with applied psychology” from Ireland (McCarthy et al., 2014). There are a few smaller studies which have documented attempts to develop communication skills training for nursing students (Lau and Wang, 2013; Terzioğlu et al., 2016; Zavertnik, 2010).

According to the theoretical foundation of nursing with its' central concepts: person, health, environment, and nursing, it is essential to establish a relationship between the patient and the RN professional (Fawcett, 2017). The RNs' caring relationship is highly dependent on the ability of the patient and the RN to communicate, although the RN has the main responsibility for initiating and maintaining good communication. The focus placed upon person-centered nursing (McCormack and McCance, 2006; Sharma et al., 2015) prioritizes the experience of the patient and the highlights the importance of his/her own narrative for care. This focus requires concrete strategies and skills in order to be achieved. The approach described in this paper has not been previously presented in the English language, although it has been described in a book in Swedish for nursing students in Scandinavia (Bullington, 2018). The aim of this article thus is to present a communication training program based on phenomenology which provides a theoretical and practical training in person-centered communication. It is our conviction that this competence can be useful in any health-care context, and be taught successfully to RNs during the nursing education.

2. Phenomenology-based communication training (PhenBCT)

The phenomenologically inspired approach to communication training developed at Ersta Sköndal Bräcke University College in Sweden enables the patient to reflect upon and stay with thoughts and feelings which otherwise have a tendency to either not surface in health care communication, or are quickly passed over. To focus upon patients' experience and understanding of their current life-situation is important, especially in the midst of sickness, ill-health and death. Disease and sickness have a disruptive effect not only on the body, but on the entire life situation of the suffering person. Identity, relationships, daily activities and goals are no longer as they were when the person experienced themselves as healthy. To gain clarity and a deeper understanding of their situation, the patients are encouraged to stay with, reflect upon and develop their understanding of their own experiences. Communication training based on phenomenological principles provides the nursing students with concrete skills which enable them to avoid falling into the bio-medicine question –answer routine. It trains their ability to listen and respond to patients in such a way that the patient can reflect upon the meaning and significance of what they are experiencing.

The curriculum in PhenBCT at Ersta Sköndal Bräcke University College has been a part of the RNs' education program since 1981. Initially, it was included in a second semester course in psychiatrics, based on Bendix (1980) principles for conversation. In role-play, some students practiced being the nurse and other students played the part of the patient. The role-plays were tape-recorded and analyzed in small groups. However, Alsterlund and Jakobsson (1999) soon found that

students had difficulties actively listening to the patient's experiences. In 1989, all students at the College were given the opportunity to play the role of both the nurse and patient, participating in two conversations with subsequent analysis. During this training, the students and teachers became aware that Bendix principles of communication were not broad enough to encompass different types of clinical encounters. Since 2003, education in nurses - patient communication, theoretically grounded in phenomenology, specifically in the Husserlian phenomenology of *Ideas: General introduction to pure phenomenology* (1913/1962), has been integrated throughout the nurse education program. The application of Husserlian principles (see below) to communication training has been developed over the years by the staff. An elective course for students at post-graduate level is also offered.

3. The four phenomenological principles guiding communication training

The steps in the phenomenological approach to communication are based upon four phenomenological principles, namely; 1) Identification of the natural attitude, 2) Implementation of the phenomenological reduction, 3) Sensitivity to the intentionality (meaning-making process) of the patient and 4) Reflection on the lifeworld. The students are presented theoretical knowledge about these basic concepts in phenomenology, which are then systematically applied to practical communication training through roleplay. We will now briefly describe how these phenomenological principles are implemented in communication training.

The “natural attitude” in phenomenology refers to the way in which we take for granted our ordinary, everyday understanding of the world. This attitude is natural, in that we are, for the most part, immersed in already understood situations and encounters. Husserl discovered that this pre-reflective, shared common understanding of the world can and does in fact prevent us from deeper investigation and understanding of subjective experience (Husserl, 1913, 1956). In phenomenological philosophy and phenomenological research, this common everyday understanding of the world must be put out of play, in order to be present to that which shows itself in and through experience. In the phenomenological communication skills training, the first step for the students is to understand the dynamics of everyday conversation (the natural attitude), which aims at keeping conversation at a level where everyone feels comfortable and maintains a semblance of mutual understanding. In their first role play, the students record and transcribe a short conversation in which one person tells the other about an everyday problem. The student who listens is not instructed to respond in any particular way. They then switch roles. When these interactions are transcribed (by the student who listened), it becomes obvious that “listening” is more or less governed by impulses and tendencies to avoid “hot” issues. Various methods of deflection and avoidance are identified, such as changing topic, quickly providing comforting words and advice, relating one's own experiences etc. Even though it is only role play, the students are often quite surprised when they read their transcripts, as they see that their fellow student said things they didn't hear, as well as how they systematically ignored certain themes.

At this point, the students realize that they must do something with themselves in order to resist these “natural” impulses when listening. They must identify and resist their own tendencies to flee from discomfort. It could be that they don't like silence in a conversation, or they don't like “not knowing” or feel bad if they don't comfort the person. When they have identified these tendencies, they are able to be present to that which is said in the conversation. In theoretical terms, they are able to implement the phenomenological reduction. The phenomenological reduction is the step taken by the philosopher/researcher that places in brackets their understanding of “how it is” in order to be as free as possible from pre-suppositions as possible regarding the phenomenon in question. This means that all knowledge, theories, prejudices and pre-understandings are made explicit and put

aside. In phenomenological philosophy, one looks for essences of the investigated phenomenon. In communication training, that which is examined under the reduction is the words and meanings expressed by the person speaking. The students are not looking for essences of phenomenon, but rather, the meaning of the patients' utterances. To give an example, the patient may say to the RN "It's so tiresome to live with small children, I never get any sleep!" A natural attitude response would be "I know, I understand completely" based on one's own experiences of sleepless nights with small children. A traditional medical response would be to ask about the symptoms in order to suggest treatment of the presented sleeping problem. The phenomenologically grounded response is based on the insight that one does not understand what this *means* to the person until one asks, so the response would be "how is it for you when you have small children and can't sleep?" This question opens up for the patient's own narrative of their experiences.

Intentionality (meaning-constitution/meaning-making) in phenomenology refers to the continuous way in which human beings ascribe meaning to that which they encounter in the world. In the context of communication training, intentionality is the way in which a patient understands and responds to his/her life situation. This is the focus of attention for the student. They become sensitive to when the patient says something that can open up into a deeper understanding. Closely related to meaning-making is the concept of the lifeworld in phenomenology. Husserl (1913/1962) described the lifeworld as our ordinary, taken for granted experience of the world *as a world*. It is what we are "given" perceptually through our senses and our consciousness. It is the collective, intersubjective horizon of all our human experiences. In our training, we teach the students to facilitate a reflection upon the individual meaning-making of the patient.

The lifeworld of the patient, i.e. the way that they experience and understand their world in the midst of suffering and ill health, is the subject of an explorative conversation. Lifeworld research within Caring science focuses upon the subjective, meaning creating aspects of ill health and disease (Dahlberg et al. (2009), Dahlberg et al., 2008; Dahlberg et al. (2009); Ekeberg, 2007). It is not unusual that a person who seeks health care is in a crisis. One is no longer the same person as before the accident, illness, injury. Patients seek not only cure for health problems, but also need help orienting themselves in the new life situation. They must find a way forward, and may ask the RN deeply personal questions, such as "how can I perform my important job when I have Parkinsons?" or "How much longer do I have to live with this kind of cancer?" or "How am I supposed to live the rest of my life in this wheelchair as a paraplegic?" or "I love good food, how can I be a diabetic?" In a phenomenologically based conversation, the RN helps the patient stay with these painful issues and gain clarity through reflection and dialogue. This approach to communication is applicable in any clinical situation where the nurse deems it important to provide space for the patients' experiences.

4. The PhenBCT program for nursing students

The communication training curriculum in the three-year nursing program at Ersta Sköndal Bräcke University College begins during the students' second semester and continues through the third, fourth and sixth semester, totaling four credits (see Table 1 for an overview). The first step in the training is to understand the dynamics of everyday conversations. During the third semester the students have an introduction to communication skills in accordance with phenomenological approach. During the final semesters, the students deepen their understanding of the phenomenological principles and become proficient in applying them in communication.

Since the patients' situation is central in phenomenological approach, the students are instructed to let the patients talk about their experience of the situation and to not focus on symptoms. For example, if a patient has dizziness, the student nurse may say 'Tell me about the last time you had dizziness, what happened?' The ability to ask open

Table 1
Phenomenologically based communication training schema.

Semester/course	Lecture	Roleplay	Group follow up	Assignment
2nd semester Human Beings' Vital Functions Signs, Symptoms, Treatment and Nursing Care, 10 ECTS	Introduction to different types of nurse-patient communication	Everyday problem Audio recorded and transcribed conversation	Identify phenomena in conversation and empathetic and sympathetic responses	Written reflection after follow-up
3rd semester Illness in Welfare Society, 10 ECTS	Introduction to phenomenologically based communication skills	A patient with a non-life-threatening condition has asked to talk to the nurse Filmed and transcribed conversation	Analyze the responses in the conversation and discuss whether the nurse uses phenomenologically based communication skills As above	Written reflection after follow-up Encouraged to apply in the clinical placement As above
4th semester Nursing, Quality Assurance and Leadership, 10 ECTS	Lecture about phenomenological approach to communication	The nurse wants to talk to the relative of a patient living in a nursing home about how she/he experiences the situation Filmed and transcribed conversation	As above	As above
6th semester Nursing in Palliative Care, Clinical Course, 14 ECTS	Lecture phenomenological approach to communication part 2	A patient with a non-curable neurological disease has asked to talk to the nurse Filmed and transcribed conversation	As above	Students are asked to reflect on their development since they started their communication training

questions is a key skill in the training program. Open questions include the words: how, when, what, or who, and gives patients the opportunity to talk about what is they consider important to talk about. One stays with the world of the patient by asking questions like “What did that mean for you?” or “How was that for you”? A skill that helps to stay focused on patients' experience of a situation is to repeat the same words or key words that the patient has last mentioned. By repeating key words, patients are encouraged to continue their own thinking and to express their experiences, leading to their own reflections. If the student is preoccupied with thinking about what to say next or what the next question will be, it is difficult to be present and actively listen to what patients is saying.

A skill that is difficult for the students is to be quiet and allow pauses to occur. They can feel uncomfortable and may feel like the conversation has ended or is a waste of time. However, a pause gives space for reflection and allows the patient to control both tempo and content in the conversation. An additional skill that students need to practice is how to handle the patients' questions and advice-giving. Conversational methodology based on a phenomenological approach does not include answering questions or giving advice. Instead a question should be returned back to the patients so that they can reflect themselves on what would be the best way for them to deal with a situation. The purpose of the conversation is to provide time and space for the patient to explore and express their thoughts and feelings about their situation. The feelings that patients express should be addressed and clarified by verbalizing affective communication. Finally, the students should be able to summarize the conversation so as to give the patient an idea of how the conversation was perceived, and give them an opportunity to correct possible misconceptions. The students train these skills in role-plays during their entire education. The scenarios differ in content and become more difficult with each coming semester. See [Table 1](#) for descriptions of the role-plays.

The roleplay lasts for about 15 min and is filmed by the students themselves. Afterwards, the student who played the nurse transcribes the conversation word by word. When all pairs have filmed their role-plays, the entire group of eight students and a teacher meet and follow up the conversations by watching the films, reading the transcribed conversations and analyzing what has happened during the conversation. The group discusses if the student used communication skills in accordance with phenomenological approach and if not, what alternatives could they have used in the actual conversation in order to have a conversation more in line with PhenBCT? When all four pairs' filmed conversations are viewed and analyzed, the students write a reflection about their experiences from this transcribed conversation. They reflect on what they learned about communication with patient/relatives based on a phenomenological approach during the follow-up and what significance this may have in their encounters with patient/relatives.

Students are encouraged to practice PhenBCT during their clinical courses and often report that they do use it, for example, when they encounter patients in care units such as palliative, psychiatric and primary health care. The students express that they feel confident with these communication skills, especially when they meet patients with existential issues or patients who speak about difficult life events. Students also report that they have observed that nurses at their placements sometimes do not seem to have competence in communication and may therefore avoid having these kinds of conversations. When the students graduate, they evaluate this PhenBCT program as important for the nursing profession. Below are some excerpts (translated from Swedish) from several students' reflection assignment in the program:

“To be a good listener means to be an active listener. To consciously place one's attention and focus on another person and consciously push one's own flights of thought aside. A challenge in restraint and presence. [...] I see how my own role in the interview steered the conversation. [...] My questions were to the point and informative,

but were more like an inquest than an invitation to open up and stay with the phenomena of their story. It reminds me of Budo, where it is a question of positioning. To create openings, physical and mental, that allow the body, will and emotions of the other person to take space, and let the natural movement play itself out. To be in the way results in collision, projection of one's own aggressiveness, fear or need to control.”

“Very soon in the conversation I steer us into problems and focus on the symptoms she described. The patient wanted to describe how she experienced her life and I focused after a few minutes on taking a medical history. I ask a lot of concrete questions, like ‘on a scale of 1–10, can you estimate your pain?’ and ‘does the pain come after eating or can it come whenever?’ I missed a lot of opportunities where I had the possibility to ask open, phenomenologically grounded questions about how the patient experienced her situation. [...] Later on I give the patient a lot of practical information. We discussed in the group if this was counterproductive. Instead of calming the patient, it may have intensified her worry.”

5. PhenBCT in relation to other training methods for the nursing profession

In this section we will compare PhenBCT to other communication training for nurses in order to highlight the similarities but also differences between these methods. We cannot in the scope of this short article provide a comprehensive review of all forms of communication training. However, we have chosen some specific approaches to contrast with PhenBCT which are most prevalent in the literature. There are two main types of conversations primarily focused upon the health care professionals' ability to connect with and listen to the patient. First is the “caring conversation”, specifically designed for RNs ([Dewar and Nolan, 2013](#); [Dewar and Kennedy, 2016](#); [Dewar and MacBride, 2017](#); [Fredriksson and Lindström, 2002](#); [Fredriksson and Eriksson, 2003](#); [Priebe et al., 2017](#)). The second most prevalent form of systematic training in patient – RN communication is the Motivational interviewing (MI) ([Miller and Rollnik, 2013](#)), which is used by a variety of health-care professionals. Finally, we have included “empathy training” as it is considered to be an important ability for both RNs and other health-care professionals ([Englander, 2014](#); [Englander and Folkesson, 2014](#)).

5.1. Caring conversation according to Fredriksson

Caring conversation according to Fredriksson ([Fredriksson and Linström, 2002](#); [Fredriksson and Eriksson, 2003](#)) is an approach used when communicating with a patient in need of care. This type of conversation does not entail a specific conversational method. Rather, Fredriksson describes three forms communication: relational communication, narrative communication and ethical communication. The ultimate aim of these three forms of communication is to alleviate the suffering of the patient. Within relational communication, the relationship is based on connection through presence, touch and listening, thereby giving the patient time and space tell their story. The caregiver responds to the patient's story with reflection, interpretation and understanding. Narrative communication occurs when the patient and caregiver share an understanding of suffering that helps the patient cope with the suffering, which can lead to health. The aim of ethical communication is to be able to show compassion and respect during the conversation, making it possible for a suffering person to regain his or her self-esteem and thus make possible a good life ([Fredriksson and Eriksson, 2003](#)).

5.2. Caring conversation according Dewar

Caring conversation, according to Dewar, is a framework for

delivering compassionate care based on human interaction (Dewar and Nolan, 2013). The conception of compassionate, relationship-centered care allows for discovering who people are and what matters to them, as well as how people feel about their experiences. This model has been developed through observation of “excellent human interactions” between health care personal and patients and consists of seven elements or key attributes (the 7 C’s): be courageous, connect emotionally, be curious, consider other perspectives, collaborate compromise and celebrate (noticing and valuing what has worked well, and praising persons). These elements highlight what it means to be “compassionate”. Compassion, according to Dewar is to be understood as: recognizing vulnerability and suffering, relating to the needs of others; preserving integrity and acknowledging the person behind the illness (Dewar and Nolan, 2013). In order to gain personal knowledge of the patient, the RN must be able to engage in compassionate caring conversation. The aim of this type of conversation is ultimately to be able to deliver compassionate care.

In both variants of caring conversation we find that openness to the patient’s experience and point of view are thematically recognized. There is a conscious striving to provide time and space for the patients’ own words. The main difference from PhenBCT is that in caring conversation, the main aim of the conversation is to identify and address suffering. This will necessarily influence the course of the conversation towards talk about suffering. In the phenomenologically based conversation, no such aim is present. This is in accordance with the phenomenological principle of openness. In Dewar’s model, emphasis is placed upon the relationship and the compassionate attitude towards the patient. Attributes that will foster this type of attitude are specified. These attributes are also encouraged in PhenBCT. As far as skills needed in order to provide a caring conversation, Fredriksson describes the following: Presence (being there and being with) touch (contact skin to skin and no contact touch refers to eye contact, and encircling with body), listening as a process/active behavior (paying attention, demands conscious effort, searching for meaning and understanding. How these skills are developed is not clear from the literature. In phenomenologically based conversation, presence, listening, paying attention and searching for meaning are important components of being able to listen and communicate. These skills are systematically trained during the course of the RN education program.

5.3. Motivational interviewing (MI)

Motivational interviewing (MI) is a collaborative conversation style, developed in order to help people change unwanted behavior (Miller and Rollnik, 2013). The style of conversation is said to be in between steering and following the patient, although it partakes of both ends of the spectrum. A basic assumption is that most people want to change adverse behaviors, but are ambivalent to change. Many people get stuck in ambivalence and MI works with the person’s conflict between the desire to change and the desire to maintain their habits. MI does not aim at controlling the patient or trying to convince them of the necessity for change, but rather, attempts to strengthen the person’s own desire for change. This type of communication has been used by health care professionals in the prevention and treatment of various health behaviors and diseases. The most common target behaviors are: smoking, alcohol and drug abuse, diet and weight control, exercise and contraception. The identification of (and agreement upon) problematic habits and behaviors is a pre-condition for this type of conversation. It is based on the following four cornerstones: partnership, acceptance, compassion and evocation (Miller and Rollnik, 2013). Partnership means that the health care professional and the patient relate to each other as a meeting between two experts. The patient is the expert on him or herself. Acceptance means that each person is valuable and possesses his or her own dignity and unique potential as a human being. Respect is unconditional. Compassion, in this framework, means to prioritize the needs of the other and to be concerned about the interests

and well-being of the other person. Finally, evocation means that the focus for the motivational conversation is to bring out the patient’s personal resources, instead of talking about what is missing and what is wrong. It is assumed that persons possess both motivation and resources in order to change. In order to implement MI, there are five communication skills that need to be learned - asking open questions, affirming, reflecting, summarizing and finally providing information and advice. An important aspect of MI is to encourage self-talk (speaking to oneself) in order to help an individual change thinking patterns and behaviors.

The main difference between MI and PhenBCT is that the latter has no preconceived notion about what the patient needs to talk about and no underlying agenda of change for the patient. There is no “steering”, other than keeping focus on the lifeworld and through active listening helping the patient express and understand what they are experiencing. However, there are similar skills involved in MI and phenomenological communication. Both methods use open-ended questions and avoid information gathering. Reflective listening, as described by MI, is a way to stimulate a person to keep speaking and reflecting. This is also an important skill in our training program. The final similarity between the two is the ability to give back a summation to the patient of what the professional has understood about what has been spoken about. But in MI there is a focus on change which guides both the content of the conversation and summation of the conversation, gathering up the person’s motivations, intentions and specific plans for change. Phenomenologically based communication has no such aim and is freer in being able to follow the patient in his/her own words and content. The final two skills mentioned “affirming” and “providing information and advice” are not comparable to the phenomenological method. Our students do affirm the integrity of the patient, but do not systematically attempt to bring up strengths and abilities, good intentions or successful efforts. It is important to leave all such things behind in order to give space fully to the story of the patient.

5.4. Empathy training

Empathy training, according to Englander (2014); Englander & Folkson (2014) is an approach based upon phenomenological principles. The specific aim of the training is to help students to develop empathy and interpersonal understanding. Englander’s focuses on the phenomenon of empathy as an intentional act which aims at understanding another person’s meaning-creating expression with a descriptive focus, with a concrete training curriculum to help students put aside preconceived notions and be able to be truly present to the world of the other. This is the same philosophical base as in PhenBCT taught at Ersta Sköndal Bräcke University College. The pedagogical approach, according to Englander (2014), is to introduce the student to a phenomenological attitude and to then train empathic listening in role play dialogues. Focus is placed upon getting rid of communication habits which focus on oneself instead of the other person. Students are expected to then integrate an intellectual understanding of empathy with their concrete efforts to listen empathically to another person. There is no goal to “influence” the person in any way, and the persons’ own narrative is in focus. This is similar to the method taught at Ersta Sköndal Bräcke University College as both are based upon phenomenological principles of openness, pre-suppositionlessness and practical training in listening. The difference is that the curriculum at our program has empathy as one part of communication, but includes a wider range of communication taken into account. The skill set needed in empathy training is similar to those in our program. The phenomenological principles of being able to put aside one’s own pre-understanding and to listen to the experience of the other are the basic premises of both methods.

6. Conclusion

Communication training is important for RNs, yet it is not systematically developed nor regulated in nursing education. We have shown that there are several methods of communication training available, but these are restricted by their aim and health care context. PhenBCT aims at a generic competence which will give all RNs the necessary knowledge and skills in order to be able to listen to the voice of the patient in all contexts. PhenBCT is valuable as a basic communication skill which can be taught at the generalist level. The skills are fundamental for caring practice but may also form a foundation for other interventions that demands general understanding of openness, presuppositionlessness and subjective meaning creating. This approach can be refined, tested and modified in future research and thus may serve as a model for creating a generic communicative competence for nurses.

Conflicts of interest

There has been no conflict of interest in the production of this article. No subjects were interviewed, and all material that has been used from students has either been used with permission or is so unrecognizable that no possibility exists for identification. No funding has been used for this research. No ethical approval has been necessary for the research.

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Appendix A. Supplementary data

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